A GUIDE TO WORKING ABROAD

## FOR AUSTRALIAN MEDICAL STUDENTS AND JUNIOR DOCTORS

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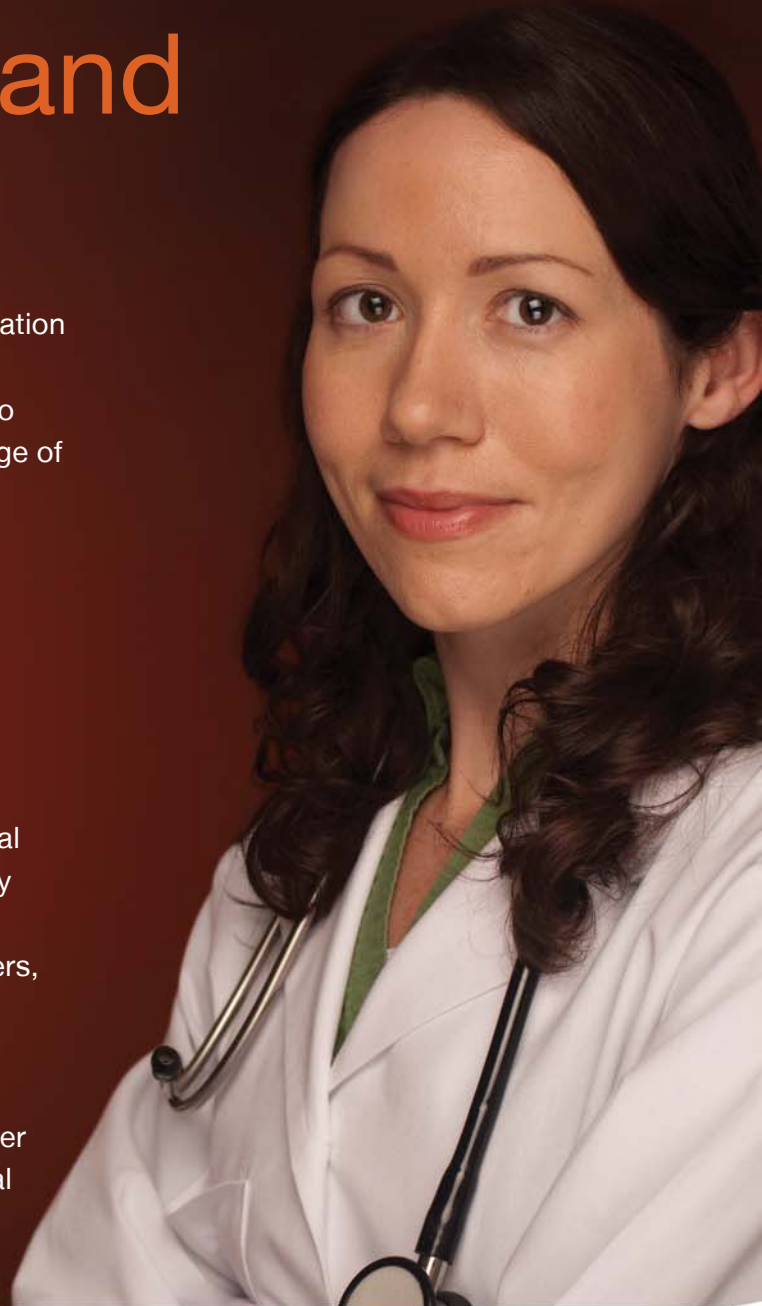
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FOR AUSTRALIAN MEDICAL STUDENTS AND JUNIOR DOCTORS

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PREFACE

Australian Medical Association

Mark Twain once said that "nothing so liberalises a man and expands the kindly instincts that nature put in him as travel and contact with many kinds of people".

When we travel overseas, most of us are touched in a positive way. Similarly, training and working abroad is rewarding professionally and personally for medical students and junior doctors.

Overseas medical training and professional work have the potential to enhance the breadth and depth of knowledge for medical students and junior doctors – and can provide them with challenges and experiences that are not available in Australia. It can also help Australian students and doctors to make a small contribution to global health.

Recognising the benefits that can come from an overseas placement, the Australian Medical Association (AMA) and the Australian Medical Students' Association (AMSA) undertook to develop a motivational and practical guide to give medical students and junior doctors the information they need to decide where in the world to go, and to help them make the most of their time abroad.

The result – *A Guide to Working Abroad for Australian Medical Students and Junior Doctors* – provides everything that travelling students or junior doctors need to make their placement a success. It will be absolutely essential reading for any medical student or junior doctor planning to work abroad. Senior doctors will also find the contents of the guide invaluable.

The guide provides practical advice about all aspects of getting ready for the journey. There is helpful information about managing personal and professional affairs during a placement and the things to be done upon returning home. The guide also explores key concepts in global health and concludes with a thought-provoking discussion on advocacy for global health within Australia's borders.

We are most grateful to the British Medical Association for allowing us to adapt their resource for use in Australia, and we thank the authoring team for their initiative to develop this guide and their hard work in bringing it to fruition.

We commend this guide and trust that it will be a useful resource for medical students and junior doctors embarking on their trip abroad.

Dr Andrew Pesce
President
Australian Medical Association

Dr Michael Bonning
Chair
AMA Council of Doctors-in-Training

May 2011

Australian Medical Students' Association

On behalf of the Australian Medical Students' Association (AMSA) and the AMSA Global Health Network, it is our great pleasure to welcome you to *A Guide to Working Abroad for Australian Medical Students and Junior Doctors*. This guide, produced in partnership with the Australian Medical Association, is the result of an extensive consultation and collaboration process and we hope you enjoy it.

There is increasingly active interest in global health among Australia's medical students. Since 2004 we have seen an exponential growth in the number of university-based global health groups in Australia, culminating in national collaboration, advocacy and activism on global issues. In addition, the AMSA Global Health Conference has become a cornerstone of national unanimity on global health since its inception in 2005.

The corollary to this is that the globalisation of medicine is becoming increasingly evident. Borders no longer define where people will study, train and practise medicine; medical migration is an important issue.

Australia has an important role to play in helping developing countries, especially in the Asia–Pacific, work towards health equity. It is also acknowledged that there is a need to address this issue in our own rural and remote populations. For students and junior doctors, an international or global health experience is crucial for developing a greater understanding and awareness of the issues that affect health worldwide. The aim of this publication is to provide advice on the best way to do that without negatively impacting on the communities in which we learn and practise.

A publication like this does not come together overnight and the dedication of the authoring team, led by Jake Parker and Rob Mitchell, has been extraordinary.

Make the most of this guide and best of luck in your future endeavours, whatever and wherever they may be.

Mr Ross Roberts-Thomson
Immediate Past National President
Australian Medical Students' Association

Mr Trung Nghia Ton
Immediate Past Chair
AMSA Global Health Network

May 2011

FOREWORD

Almost every month, I am asked to give advice to yet another eager young Australian seeking to make a contribution to global development in the health field. In fact, I am constantly amazed at the true idealism of young people wanting to redress some of the terrible social inequities in the world. Now, Australia's young doctors and medical students have come up with this Guide to working abroad which provides an incredibly valuable aid to all those seeking to use their medical knowledge – for long or short periods – to help the less fortunate citizens of our crowded planet.

The Guide is practical, comprehensive and authoritative. It discusses the nature of global health endeavours, the range of tasks which a young person could take on, and the particularities of the different regions of the world. It then advises on how to prepare for working abroad, how to conduct oneself as a guest in another country, and how to make the most of the experience on returning home. A wide-ranging conclusion then summarises the key issues for global health in Australia.

The Australian Medical Association Council of Doctors-in-Training and the Australian Medical Students' Association are to be congratulated on a timely, thoroughly researched, tightly written and really useful guide which is, in fact, destined to become a classic. For those already committed to a placement abroad, it constitutes obligatory reading. For those contemplating such a venture, it will act as a source of inspiration.

Sir Gustav Nossal
Emeritus Professor
The University of Melbourne

May 2011

A Guide to Working Abroad is a unique resource for all medical personnel interested in global health. It is a practical 'how to' instruction manual that also goes to the heart of why people practise medicine.

The MJA has a proud history of engagement with the issue of health care delivery, both in Australia and abroad, and especially for our indigenous population. We are delighted to partner with the AMSA and the AMA CDT to disseminate this important guide and we congratulate them on quality of this publication.

As a medical student, I travelled to Bangladesh to work in the International Centre for Diarrhoeal Disease Research. This was a life changing experience for me. I realised, once I arrived, that I was shamefully ignorant of the culture and the country. The tagline for the tourist authority at the time was 'See Bangladesh before the tourists come' and there was no such thing as a bus timetable. A Guide such as this would have helped me to better prepare for all of the experiences, positive and negative, that came my way in the course of my visit.

I encourage you to read *A Guide to Working Abroad* from cover to cover if you are planning to work or study in a developing community. It outlines the skills that are needed to make an effective contribution, and it emphasises the duty to make adequate preparations for such a task.

The Guide doesn't understate the personal cost or risk of undertaking aid work and it details the need for adequate support. The personal testimonies of doctors contained within the guide are a powerful indication of the challenges this type of work involves.

I hope this Guide will inspire doctors to use their medical skills to help those people and communities who are most in need.

Dr Annette Katelaris
Editor
Medical Journal of Australia

May 2011

CHAPTER 1

INTRODUCTION

"When it comes to global health, there is no 'them'... only 'us'."

Global Health Council
The world's largest membership alliance dedicated to ensuring global health for all

BACKGROUND

Medical students and junior doctors are increasingly interested in opportunities to practise their craft abroad. Some will undertake a medical elective. Others will assume training positions in foreign hospitals and research institutes. Many will commit to an extended period of time working in a humanitarian or development setting.

Organising a placement is not a straightforward task, however. Navigating the quagmire of available resources can be laborious and confusing. And while good sources of information do exist – travel books, websites and databases among them – identifying current and targeted content can be a challenge.

This Guide aims to provide practical information that will help medical students and junior doctors undertake work abroad that is rewarding and meaningful for their own personal and professional development and, more importantly, for their host community. While it has been developed with all international settings in mind, the focus is on medical practice in under-resourced environments.

The Guide's structure reflects the chronology of organising a placement abroad. Chapter 2 introduces key concepts in global health. Chapters 3 to 6 delve deeper into pre-departure planning. Chapter 7 provides practical information about managing personal and professional affairs during a placement and chapter 8 highlights the importance of debriefing on return. Chapter 9 encourages readers to advocate for global health from Australian soil while chapter 10 lists additional resources that may be of interest to readers.

For simplicity, much of the text refers to 'doctors', and does not make explicit mention of medical students. It is the view of the authors (as it is for many patients) that medical students are simply doctors early in their training. It obviously remains that all trainees should introduce themselves and their position whenever they come into contact with patients and local staff.

Though most of the Guide is practical in nature, a safe and effective placement requires more than logistical preparation. Working abroad is not without risk and can, in fact, cause harm. There are important ethical considerations that junior doctors must appreciate before arranging a placement. For this reason, this Guide is prefaced with 10 principles to guide junior doctors who wish to undertake professional work overseas. They are listed below and their prominence is intentional.

The authors hope that readers find this Guide a valuable resource in organising and undertaking a safe and fulfilling placement abroad.

PRINCIPLES FOR WORKING ABROAD

Doctors working in overseas settings stand to benefit in many ways, both personally and professionally. Although the goals of each placement will differ, it is important to remember that there can be unintended consequences. Successful placements ensure that there are mutual and reciprocal benefits for both the visiting doctor and the host institution. A situation where one partner was exploited for the benefit of the other would clearly be unacceptable.

More is being written about the ethical challenges of medical students and junior doctors working in developing settings, and it is worth reading some of this material before you begin your preparations (1-5). In particular, an international group has recently developed *Ethics and best practice guidelines for training experiences in global health* (1).

Independent of these guidelines, the authors of this Guide have developed 10 principles to guide Australian doctors in their overseas work. Bear these in mind as you read the remainder of this book.

1. Recognise that patients' rights are universal.
Patients' rights are based on the concept of fundamental human rights, as articulated in the 1948 Declaration of Human Rights and enshrined in international law (6). The World Health Organization (WHO) has achieved international consensus on a minimum standard: "that all patients have a right to privacy, to the confidentiality of their medical information, to consent to or to refuse treatment, and to be informed about relevant risk to them of medical procedures" (7). The World Medical Association (WMA) has also adopted a Declaration on the Rights of the Patient (8). Both the WMA and AMA Codes of Ethics express more fully the responsibilities of doctors to patients – both individually and collectively (9, 10).

2. Put your host community's interests first.
Though this Guide will help you select and arrange a placement abroad, ultimately it will be your hosts who invite you to practise in their community. It is they who should define your role, and it is essential that you ask a few key questions before you undertake professional activity: What are the community's needs? Is there a gap that needs filling? Practising in this way will make your work abroad meaningful for both you and your hosts.

3. Give local trainees priority.
Australian junior doctors will require some level of supervision and training while undertaking a placement. This should never be at the expense of local trainees.

4. Emphasise education.
While doctors working overseas will gain an enormous amount from the experience, they will also be able to contribute in return. Make an effort to work with local staff to identify, and then fill, skills and information gaps. There should be an educational and capacity-building element to all of your professional activities.

5. Think long-term sustainability.
Just as you will take new knowledge and skills home, there will be opportunities for you to have an impact on your host community beyond your departure. Think about 'big picture' issues (eg, prescribing choices, clinical decision making, resource management, staff recruitment and training and data collection) and how, based on your Australian experience, you can empower local staff to create enduring structural change. Whatever your role, consider how you can promote local ownership and self-reliance.

6. Do not use the 'developing world' for practising your skills.
The 'developing world' provides doctors with a unique opportunity to learn new and innovative ways of understanding health and illness, practising medicine, and performing procedures. But this does not mean you should use your host community as 'guinea pigs' on which to hone your skills. If you wouldn't do it back home, don't do it abroad.

7. Practise quality medicine.
Working in an under-resourced setting invariably means that you will have to practise differently. The aim should always be to provide the highest standard of care to the greatest number of patients with the human, pharmaceutical and equipment resources available. Be creative in how you approach clinical problems and use local colleagues to guide you towards the best decisions.

8. Know your limits.
You should never expect to have all the answers and, for the safety of you, your local colleagues and your patients, you need to know when you are reaching your limits both personally and professionally.

9. Have a focus.
The clearer your role is, the better you will be able to fulfil the needs and expectations of your host community. Define a job description before starting, and review and refine your responsibilities as your placement continues. It is easy to fall into the trap of doing 'a little bit of everything', but it is to everyone's advantage that you focus on your strengths, and where the community need is greatest.

10. Consider the broader implications of your presence.
The presence of a foreign doctor in a community has implications – perhaps far beyond what you might expect. Cultural, social and educational differences all result in power imbalances and a degree of social disruption. Acknowledging this reality is the first step to pre-empting and identifying relevant issues. Remember: first do no harm.

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COMPETING INTERESTS

The authors have declared no competing interests.

CHAPTER 2
ENTERING A GLOBAL ARENA
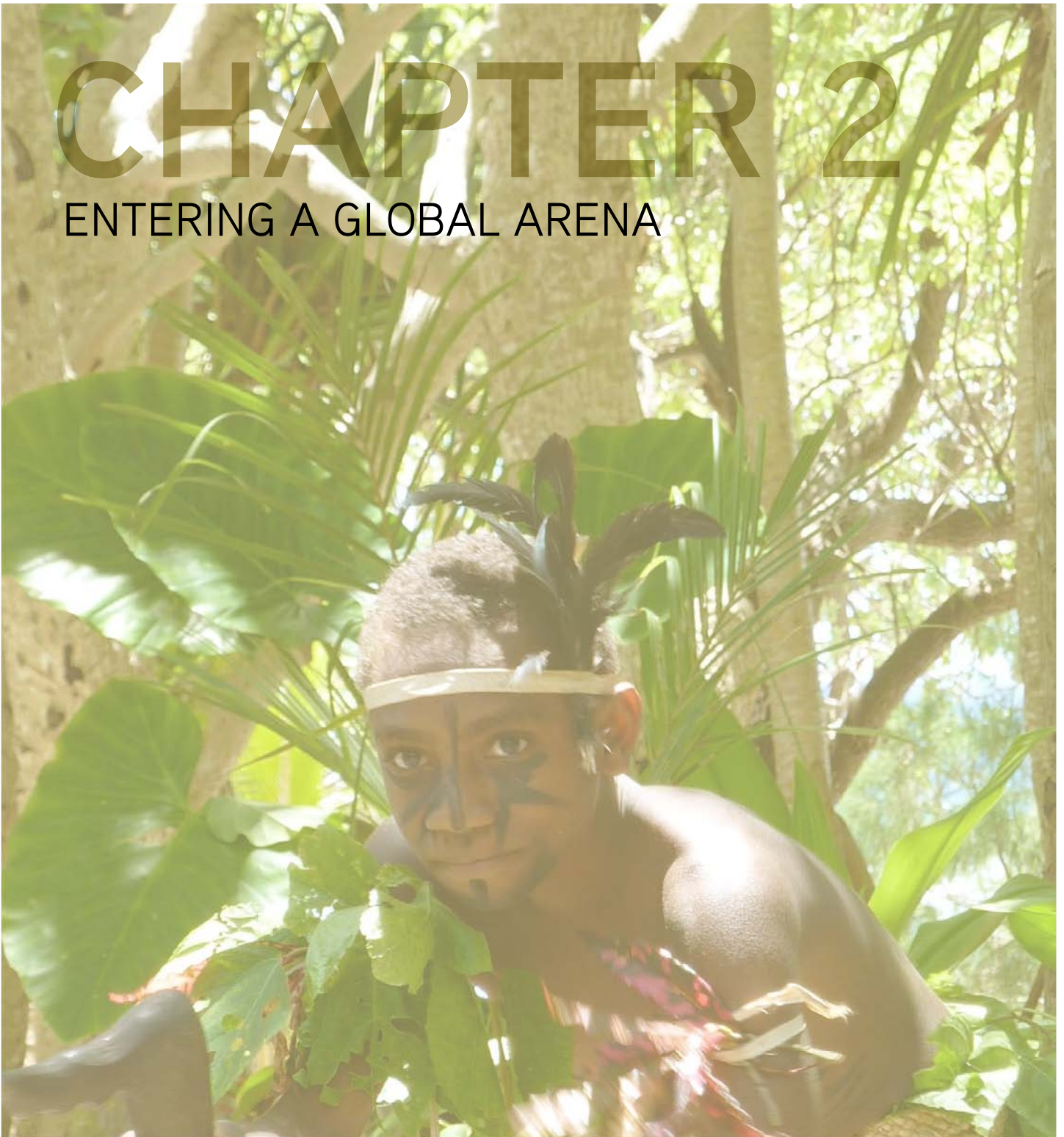
"The defining challenge of the 21st Century will be to face the reality that humanity shares a common fate on a crowded planet. That common fate will require new forms of global cooperation, a fundamental point of blinding simplicity that many world leaders have yet to understand or embrace."

Jeffrey Sachs
International development economist

BACKGROUND

As a doctor working abroad, you will be a member of a global collaboration of professionals working towards the betterment of human health. Before organising your placement, it is worthwhile taking time to consider how your efforts fit within this larger movement.

In the 21st Century, public health challenges increasingly traverse national borders and regional entities. It is vital that doctors are aware of the importance of global health and its influence on the everyday practice of medicine at a local level. Accordingly, this chapter aims to introduce some key concepts in global health that are relevant to professional work abroad.

WHAT IS GLOBAL HEALTH?

In recent years, the term 'global health' has evolved. The progression from 'international health' and 'public health' illustrates a continuing development of philosophy, attitude and practice.

The term 'global health' aims to highlight health issues that transcend nation states or are affected by transnational determinants (eg, climate change) and solutions (eg, communicable disease eradication). It provides a framework for understanding the health of populations in a global context, one that goes beyond the sole perspectives and concerns of individual countries (1). Whether health is viewed in terms of burden of disease or root causes of disease, global health issues are of relevance to all communities on earth.

A recent article in *The Lancet*, "Towards a common definition of global health", defined the term as follows:

> *"Global health is an area for study, research and practice that places a priority on improving health and achieving equity in health for all people worldwide. Global health emphasises transnational health issues, determinants and solutions; involves many disciplines within and beyond the health sciences and promotes inter-disciplinary collaboration; and is a synthesis of population-based prevention with individual-level clinical care."* (1)

Global Health is context-specific and has several elements to it:

> *"... a notion (the current state of global health); an objective (a world of healthy people, a condition of global health); or a mix of scholarship, research and practice (with many questions, issues, skills and competencies)."* (1)

Global health is a multidisciplinary arena, and its research and practice is not exclusively restricted to health care professionals. Indeed engineers, researchers, anthropologists, politicians, sociologists and logisticians, to name but a few, all have a vested interest in this area. Much of the world's emerging burden of illness, such as mental health and trauma, will require new forms of multidisciplinary cooperation on both local and global levels.

KEY PLAYERS

Just as the terminology of global health continues to evolve, so too do its key players. Though nation states have traditionally been responsible for health, global organisations have assumed increasing relevance as illness continues to expand across political boundaries.

Institutions such as the World Health Organization (WHO) play a leading role in advising nation states about health issues that affect the global population. The WHO came into effect in 1948 as a result of a United Nations (UN) proposal to form a global health authority. Today, the WHO is responsible for providing leadership on global health matters, shaping the health research agenda, coordinating disease surveillance and response, setting norms and standards, articulating evidence-based policy options, providing technical support to countries and monitoring and assessing health trends (2).

From global gatherings and assemblies, important statements – such as the Alma Ata Declaration and the Ottawa Charter – have been enacted. It is impossible to deny the profound impact that global cooperation can have: public health campaigns have been launched around the world; infectious diseases such as smallpox have been eradicated; and modern methods of family planning have been disseminated; all as a result of escalated transnational cooperation (2).

BOX 2.1: THE DECLARATION OF ALMA ATA

In 1978, at the International Conference of Primary Health Care in Alma Ata, a declaration which advocated for universal primary health care was passed. It recognised that primary health care "forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community".

The Declaration states that primary health care "is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process" (3).

BOX 2.2: THE OTTAWA CHARTER FOR HEALTH PROMOTION

The International Conference on Health Promotion in Ottawa in 1986 established this charter in response to the growing expectations for a new global public health movement. Health was seen as a resource for everyday life, not simply the objective of living. It highlighted prerequisites for health including peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice and equity. The Charter also suggests that strategic investment in health promotion must be adapted to local needs of individual countries and take into account differing social, cultural and economic systems (4).

In the last two decades, there has been a dramatic shift in the delineation of those responsible for global health. Some have suggested the UN/WHO framework has lost relevance as autonomous global health initiatives and new external players have emerged – for instance, the Global Alliance for Vaccines and Immunisations, the Global Fund, and the World Bank. Unquestionably, this 'power shift' has come with increased development assistance for health initiatives – from US$5–6 billion in 1990 to $21.8 billion in 2007 (2).

However, there remain concerns that a broader spectrum of donors may result in unintended negative impacts, for example:

- reduced quality of health services because of pressures to meet donor targets;
- decreases in domestic health care spending and investment;
- misalignment between global health initiatives and country health needs; and
- distraction of governments from their responsibilities for health (2).

It is undeniable, however, that these new key players have led to improvements in health equity, innovative methods for financing health, enhanced community participation, and fairer pricing of medicines and medical products – all of which has been noticed by the global community (2).

Despite these changes, traditional players – including development agencies (eg, AusAID), non-governmental organisations (eg, the Red Cross) and charitable foundations (eg, The Carter Foundation) – continue to play a critical role in the enhancement of global health, particularly at the grass roots level.

GLOBALISATION

Globalisation can be thought of as "a process of greater integration within the world economy through movements of goods and services, capital, technology and labour… which lead increasingly to economic decisions being influenced by global conditions" (5). It is important, therefore, to consider what impact globalisation is having on health.

Certainly, the sharing of technology, information and policy has been facilitated by international cooperation and instant telecommunications. Pandemics, such as severe acute respiratory syndrome (SARS) and pandemic (H1N1) influenza, illustrate the capacity of governments and global organisations to work together to help control communicable diseases. Similarly, the Millennium Development Goals (see Box 2.4) are another example of transnational collaboration.

Yet globalisation has also led to an increasingly fragmented, reactive and disparate agenda for international health. In this context, some have proposed that the WHO has the unique opportunity to play a coordinating function, with the authority to develop and implement worldwide standards and initiatives that improve health (6).

The Spread of Disease

Globalisation has had a significant impact on the spread of infection because of its effects on increased urbanisation, international trade, and migration. The need to address this challenge has been recognised in the sixth Millennium Development Goal, which aims to stop and reverse the spread of particular infectious diseases by 2015.

Globalisation has also impacted the global burden of non-communicable disease (NCD), which has increased in concert with development. By 2020, the top three health issues in both developed and developing countries will be mental health, cardiovascular disease and trauma (7). Even in African nations, NCDs are expected to exceed communicable, maternal, perinatal and nutritional diseases as the most common causes of death by that year (7). There remains, however, a poor understanding of how to best manage this increasing burden of NCD, especially in the developing world context.

Migration of Health Care Workers

Globalisation has brought with it ever-changing patterns of migration. The 20th Century saw the emergence of 'brain drain' – whereby health professionals from the developing world began to leave their countries for developed countries with higher incomes and better standards of living. This has significantly depleted the human resources available to many already under-resourced areas and, in turn, impacted on access to health care for the most disadvantaged (8).

The worldwide demand for doctors has created a competitive environment, which favours those nations that are able to offer the most enticing incentives for migration. It has become increasingly pertinent that higher-income nations recognise the ethical implications of health care worker migration and proactively take measures to contribute equally to the national health care systems from which they recruit international doctors (8).

THE GLOBAL ENVIRONMENT IN THE 21ST CENTURY

> *"... the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition..."*

WHO definition of health (9)

Just as the economic impacts of globalisation have led to shifts in the social and political structures of the world, the global health landscape is undergoing significant changes. Today, the vast majority of people live longer and healthier lives than ever before. Since 1978, infant mortality rates have dropped dramatically – equivalent to a rate of more than 18,000 children's lives saved per day (10). Improvements have not been uniform, however. The gap in life expectancy alone is an indicator of this – ranging from 80+ years throughout much of the Western world, to just over 40 years in many parts of sub-Saharan Africa. There remain significant inequities in health outcomes within populations as well. Much of this imbalance can be attributed to the social determinants of health.

BOX 2.3: THE SOCIAL DETERMINANTS OF HEALTH

The social determinants of health are the conditions in which people are born, grow, live, work and age, and includes the local health system (11). These circumstances are shaped by the distribution of money, power and resources at all levels of governance. The social determinants of health explain health inequities seen within and between countries.

Responding to increasing concern about these persisting and widening inequities, the WHO established the Commission on Social Determinants of Health (CSDH) in 2005 (11). The Commission has provided advice on how to reduce such inequalities, summarised in three overarching recommendations:

- to improve daily living conditions
- to address the inequitable distribution of power, assets, and resources
- to measure and understand the problem and assess the impact of development programs

Health Systems

Health care systems vary greatly throughout the world. Those of high-income countries feature sub-specialised health services, advanced medical technologies, and a reliance on an extensive medical workforce. This is in stark contrast to the low- and many middle-income countries where health care is characterised by strained health systems with a majority of services provided through primary health care centres that are often lacking in both human and technical resources.

Though the traditional foes of communicable disease persist, new health challenges have emerged. Social forces leading to urbanisation, accompanied by the rise of NCDs and an ageing population worldwide, are placing new strains on already overburdened health systems.

On the positive side, there have never been more resources available for health. There is a growing global stewardship to tackle some of the most pressing global health challenges such as HIV, emergent influenza pandemics, and even global poverty, through initiatives such as the Millennium Development Goals.

Millennium Development Goals

In September 2000, 189 heads of state adopted the UN Millennium Declaration and endorsed a framework to work together to increase access to the resources needed to reduce poverty and hunger, and tackle ill health, gender inequality, suboptimal access to education and environmental degradation (12). The Declaration established eight Millennium Development Goals (MDGs), with specific, measurable targets for 2015. All Goals have been monitored using indicators of progress since 1990 (13).

BOX 2.4: UNITED NATIONS MILLENNIUM DEVELOPMENT GOALS (14)

- MDG 1: Eradicate extreme poverty and hunger
- MDG 2: Achieve universal primary education
- MDG 3: Promote gender equality and empower women
- MDG 4: Reduce child mortality
- MDG 5: Improve maternal health
- MDG 6: Combat HIV, AIDS, malaria and other diseases
- MDG 7: Ensure environmental sustainability
- MDG 8: Develop a global partnership for development

Key developmental steps in health have been made since the inception of the MDGs. The proportion of undernourished children under five years of age declined from 25% in 1990 to 16% in 2010. From 2001 to 2008 new HIV infections worldwide declined by 16% and the number of people with access to safe drinking water increased from 77% to 87% – sufficient to reach the MDG targets if sustained.

That said, there has been little progress in many of the outcomes to date. Maternal mortality rates have barely changed since 1990 and, at the end of 2008, more than five million people living with HIV in low- and middle-income countries were not receiving antiretroviral therapy (15).

The Global Burden of Disease

From a 'burden of disease' perspective, there are some pronounced differences between particular countries and regions. For example, the burden of HIV and AIDS is predominantly shouldered by sub-Saharan Africa, where approximately 90% of worldwide deaths related to HIV occur. The poorest countries of the world still have unacceptably high infant and maternal mortality rates. Women in Africa, for example, may face a one in 26 lifetime risk of death during pregnancy and childbirth, compared with only one in 7,300 in the developed world (16).

Furthermore, although the incidence of tuberculosis (TB) continues to fall and treatment success rates improve, multi-drug resistant TB is emerging as a challenge in certain countries, including those of the former Soviet Union.

For high-income countries, the major burden occurs from NCD. Cardiovascular disease continues to be a leading cause of morbidity and mortality. Most notably, the most significant emerging burden in the 21st Century is in mental health conditions.

TABLE 1: MORTALITY BY REGION INCOME GROUP (16, 17)

LOW INCOME	MIDDLE INCOME	HIGH INCOME
Respiratory diseases	Cerebrovascular disease	Ischaemic heart disease
Ischaemic heart disease	Ischaemic heart disease	Cerebrovascular disease
Diarrhoeal diseases	COPD	Lung cancer
HIV and AIDS	Respiratory infections	Lower respiratory infections

Income as defined by the World Bank (18): Low income: US$975 or less; middle income: US$976–11,905 (low-middle US$976–3,655; upper-middle: US$3,856–11,905); high income: US$11,906 or more. COPD = chronic obstructive pulmonary disease.

The rise of NCD throughout the rest of the world has been accelerating at an alarming pace. Once thought to be a disease of affluence, NCD is now emerging as a global threat. Smoking, lack of physical activity and poor diet contribute to more than 50% of preventable deaths and morbidity caused by cardiovascular disease, diabetes, cancer and chronic respiratory conditions (19). For most of the low– and middle-income countries, where health systems are geared towards communicable patterns of disease, this presents a new set of challenges.

BOX 2.5: A SNAPSHOT OF THE WORLD (17)

In **low-income countries** fewer than a quarter of all people reach the age of 70, and more than a third of all deaths are among children under 14. People predominantly die of infectious diseases: lung infections, diarrhoeal diseases, HIV and AIDS, tuberculosis, and malaria. Complications of pregnancy and childbirth continue to be leading causes of death, claiming the lives of both infants and mothers.

In **middle-income countries**, nearly half of all people live to the age of 70 and chronic diseases are the major killers, just as they are in high-income countries. Unlike in high-income countries, however, tuberculosis and road traffic accidents also are leading causes of death.

In **high-income countries** more than two-thirds of all people live beyond the age of 70 and predominantly die of chronic diseases: cardiovascular disease, chronic obstructive lung disease, cancers, diabetes or dementia. Lung infection remains the only leading infectious cause of death.

Future Global Challenges

"Many political borders serve as semi-permeable membranes, often quite open to diseases and yet closed to the free movement of cures."

Paul Farmer, infectious diseases physician, anthropologist and humanitarian (20)

'Health for all' continues to be a complex goal as inequalities continue to persist throughout the world. As health is intricately connected to the way we live, it is unsurprising that new threats continue to emerge with the rising challenges such as the impact of globalisation, the effects of climate change, the threat of epidemics, and the persistence of global poverty, migration and conflict.

In keeping with this, there are many contexts in which health professionals can contribute to the state of people's health throughout the world. The opportunities are as endless as they are diverse – from local advocacy to global health policy, from humanitarian assistance to public health projects, from teaching to research. By working together in global cooperation, there is hope that 'health for all' will become a reality.

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COMPETING INTERESTS

The authors have declared no competing interests.

CHAPTER 3

DECIDING HOW TO CONTRIBUTE
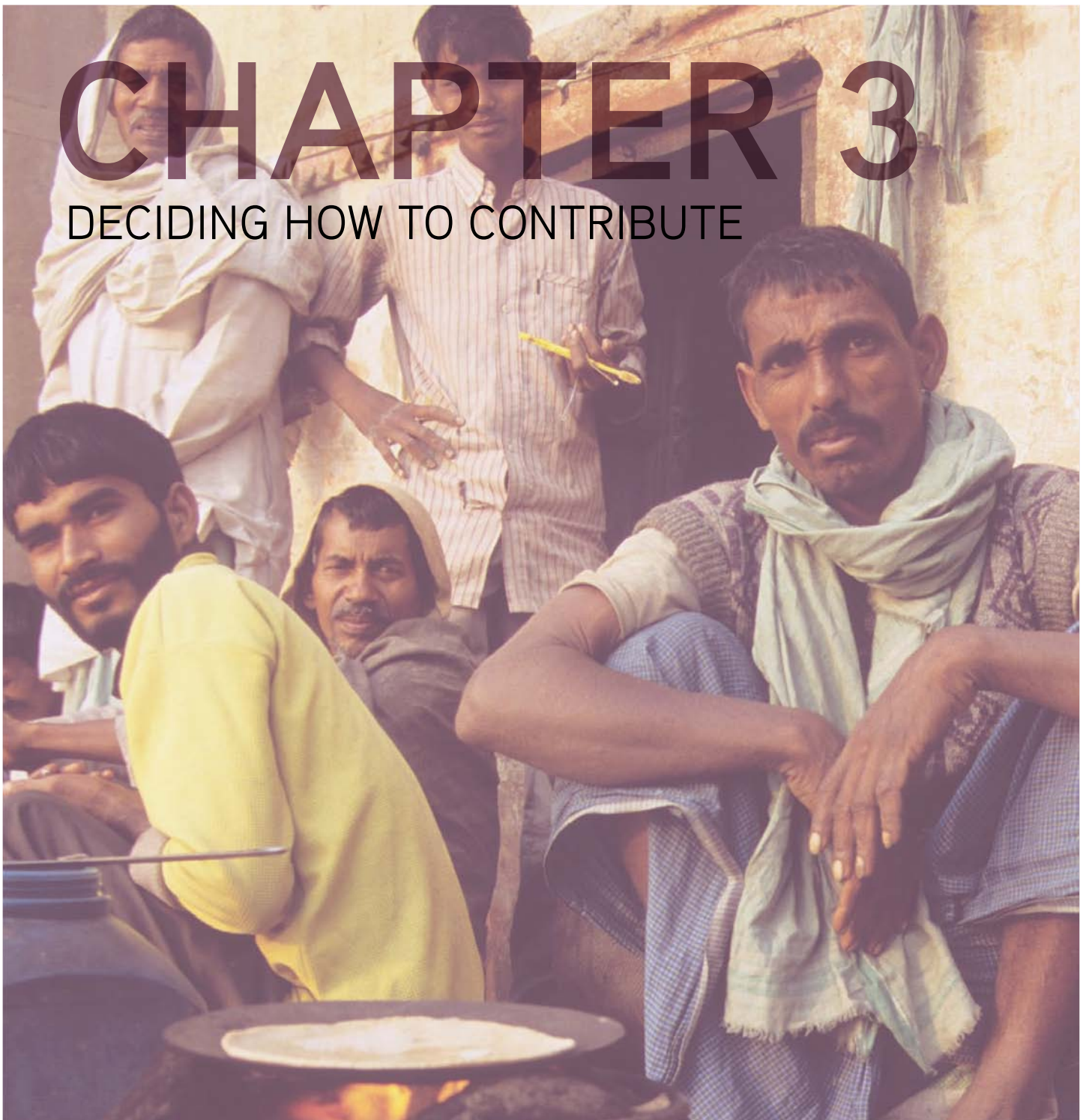
"We are working towards a shared vision of the future for health among all the world's people. A vision of the future in which we develop new ways of working together at global and national level. A vision which has poor people and poor communities at its centre. And a vision which focuses action on the causes and consequences of the health conditions that create and perpetuate poverty."

Gro Brundtland
Former Director General, World Health Organization

BACKGROUND

Before organising a placement abroad, it is worth considering what type of environment in which you would be best suited to work and train. This is not necessarily a straightforward task; the opportunities available for doctors to work abroad are tremendously diverse.

At this moment, there are doctors providing humanitarian assistance in refugee camps, performing surgery in desert tents, consulting in remote village clinics, implementing immunisation campaigns among nomadic populations and walking the corridors of large specialised urban hospitals. There are also doctors reviewing epidemiological data of 'flu-like' illness in the midst of emerging pandemics, revising protocols for pregnancy care in rural health posts, investigating the attitudes to HIV and AIDS among commercial sex workers, training health workers in the integrated management of childhood illness and submitting evidence to governments to improve health policies and structures.

This section outlines some of the common settings in which medical professionals find themselves working, and goes on to explore some of the implications for both the visitor and host. The settings described are neither mutually exclusive nor all-encompassing, but have been chosen to give a reasonable overview of the variety of places in which doctors are able to work around the globe. The vignettes have been selected to give relevant, personal accounts of what working abroad feels like.

The perspective of the host community is sadly neglected in most literature that promotes doctors working abroad. This Guide, too, has included only brief comments about host community needs, expectations and experience. When working abroad, your relationship with the local community is paramount, and the importance of making efforts to understand, respect and learn from your hosts cannot be overemphasised.

The content of this chapter was devised in conjunction with the Global Health Gateway, which is an excellent source of further information. More personal stories can be found on their website at www.globalhealthgateway.org.au (1).

TYPES OF AID

International aid is roughly divided into humanitarian and development arms (although both these terms have many different interpretations and applications). The humanitarian arm is analogous to the emergency department, with an emphasis on responding to crises in a way that saves lives and stabilises the situation. Development aid encompasses everything else, with an emphasis on longer-term improvement and fulfillment of community potential. Obviously, there is a significant middle ground and most organisations invariably participate in both. Characteristics (and examples) of the two arms are highlighted Table 2.

TABLE 2: HUMANITARIAN AND DEVELOPMENT SETTINGS

	HUMANITARIAN	DEVELOPMENT
Situations	Acute crisis (war and conflict, natural disasters, famine, displaced populations)	Chronic deprivation (areas of poverty, slum communities, vulnerable groups, rural environments, post-crisis situations)
Outlook	Short-term (months)	Medium- to long-term (years)
Emphasis	Saving lives and relieving suffering (food, shelter, water, sanitation, emergency health needs, security)	Improving living situation, building infrastructure and enhancing capacity (health care systems, education, agriculture, economic stability, human rights, governance); health promotion
Example orgisations	MSF, ICRC, MERLIN, UN	WHO, UNICEF, AusAID, CARE, World Vision
Potential roles of doctor	Field doctor, coordination team, expert reference	Field doctor, coordination team, visiting specialist and educator, public health officer
Work environment	Intense and often highly stressful; unstable (significant personal risk)	Relatively predictable; stable, depending on country (less personal risk)

MSF = Médecins sans Frontières. ICRC = International Convention of Red Cross/Red Crescent. MERLIN = Medical Emergency Relief International. UN = United Nations.
UNICEF = United Nations Children's Fund. The information in this table is general in nature and provided as an example only. Individual settings will vary.

SETTINGS

This section will consider a variety of settings, which are listed in Box 3.1.

BOX 3.1: SETTINGS EXAMINED IN THIS CHAPTER

Humanitarian settings	Development settings	Well resourced settings	Non-clinical settings
• Refugee 'camp'	• Rural clinic • Urban hospital • Specialist short mission	• 'Western' hospital	• Public health • Research

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The 'refugee camp' setting featured below is archetypal of the kind of work in which doctors can be involved in the humanitarian sphere. Other humanitarian settings include disease outbreaks and natural disasters such as earthquakes, tsunamis, flooding, drought, famine and severe storms. The 'rural clinic' and 'urban hospital' are two broad settings in the development sphere. There are a variety of roles and experiences that doctors can have in these settings. Also included in the development section are 'specialist short missions', although these may also have a role in the humanitarian sphere. The 'Western hospital' is included as an example of the opportunities in well resourced settings; special note is made of possible differences between Australian and foreign facilities. There are also references to work with populations of disadvantage in otherwise well resourced environments.

The non-clinical settings for working abroad are plentiful, albeit not as frequently pursued. 'Public health' settings include internships with organisations such as the WHO, while involvement in 'research' can be accessed through formal educational programs or instigated unilaterally. Other non-clinical settings for involvement in working abroad include advocacy and policy development, which, arguably, can have the most significant impact on health.

As you read through the various settings, consider what sort of experience each could provide (see Box 3.2). If you already have a particular role in mind, think more specifically about the implications the particular setting will have for you and your host community.

BOX 3.2: SELECTING AN APPROPRIATE SETTING

In contemplating which health care setting which might best align with your expectations, learning needs and capacity to contribute, the following questions may be helpful:

• What would you enjoy and be stimulated by?

• What would be difficult or unrewarding for you?

• What is your professional skill set?

• What areas would you not be equipped to work in?

• What type of environment would you be comfortable working in?

• What type of environment would make you feel uncomfortable?

The process for selecting an appropriate placement is explored in subsequent chapters.

HUMANITARIAN SETTINGS

Refugee Camp
Defining Characteristics

The characteristics of a refugee camp, otherwise known as a displaced person's camp, depend on whether it is in the 'emergency' or 'post-emergency' phase. Initially, displaced populations form a chaotic, desperate mass seeking somewhere that is relatively safer. The environment is naturally one of extreme deprivation with complete dislocation from usual resources and relationships. People's concerns revolve around accessing the very basics of survival – water, food, shelter and family – and the priorities of humanitarian agencies reflect the primary objective of survival (Table 3). Organisations often deliver services in a very intensive way through large-scale programs that are typically managed by international staff.

Over time, camps become more complex as individuals seek to rebuild lives in an environment that may be home for many years. This is referred to as the post-emergency phase. The 'camp' becomes increasingly organised but resources remain very limited and there is a continued relative dependence on humanitarian assistance. Organisations are increasingly directed by the local population and the focus shifts from reducing mortality to addressing more complex morbidity issues (Table 3).

TABLE 3: PRIORITIES OF EMERGENCY AND POST-EMERGENCY PHASES

EMERGENCY PHASE	POST-EMERGENCY PHASE
• Initial assessment • Measles immunisation • Water and sanitation • Food and nutrition • Shelter and environment • Basic health care • Epidemics • Public health • Human resources and training • Coordination	• Curative health care • Reproductive health care • Child health care • HIV and AIDS • Sexually transmissible infections (STIs) • Tuberculosis • Mental health

Points to Consider

- The repercussions of **war and conflict** frequently follow displaced persons and present an ongoing threat. The presence of armed groups in camps is frequently a major issue as the camp's role as a 'humanitarian sanctuary' provides them accidental protection, thus undermining humanitarian efforts.

- **Natural disasters** can devastate communities and make it impossible to return for prolonged periods of time. This raises unique issues regarding relocation and redevelopment.

- The **acuity of displacement** determines a lot about camp operations. People displaced suddenly are particularly vulnerable and poor, while those who have been able to make a more ordered exodus may have more social and material resources at their disposal.

- **Sociocultural factors** play a huge role in how humanitarian assistance is received and what styles of interventions may be effective.

- **Political environments** are often complicated and have a significant impact on the provision of humanitarian assistance to displaced populations, particularly if local authorities are implicated in the dislocation or there are strong interests from external stakeholders. Aid programs can therefore be vulnerable to manipulation for political ends.

- Particularly **vulnerable populations** include women, children, elderly, disabled and minority groups. Such populations require special consideration in aid situations.

Role as a Doctor

Providing health care services to displaced populations is the archetypal work of medical humanitarian aid agencies. Medical professionals (including public health personnel) are involved in every level of activity, from working in the field, to regional and national coordination, and to transnational leadership.

Working in this setting would suit numerous medical crafts: doctors-in-training (with a minimum of two years' broad-based work experience), physicians, general practitioners (especially those with advanced rural skills), emergency physicians and intensivists, surgeons and advanced surgical trainees.

Initial missions often require medical staff to work in the field within, or very close to, the displaced population.
Roles will likely be broad and include any number of the following:

- Clinical care at inpatient and outpatient level, often with extremely limited resources and referral options. It may involve all aspects of medical and basic surgical care, including obstetrics, trauma, infectious diseases and malnutrition;
- Basic training of local health workers, including doctors, medical assistants and nurses;
- Human resources management;
- Public health surveillance and response management, including collating statistics and reporting to authorities (eg, Ministry of Health, WHO, or the coordination team);
- Health promotion to local population;
- Specialty projects such as sexual gender-based violence (rape), HIV and AIDS, tuberculosis, cholera, and immunisation campaigns.

With greater experience, there is an opportunity to work in more specialised projects and take on coordination roles such as managing field projects (including both the medical and non-medical aspects thereof), coordinating regional health programs and directing field activities from a national or international head office.

The **personal risk** to doctors when working with displaced populations can be significant as they necessarily work in very close contact with disrupted communities of people, are frequently in small groups, travel in unfamiliar territory, and often have rations of food, water, clothing and other supplies. Risk most commonly involves that of robbery, occasionally of threats and assault, and very rarely abduction. It is important to discuss this in detail with your potential employer before accepting a post. Personal safety is discussed further in chapters 6 and 7.

The opportunity to become part of the community can be limited due to security concerns. However, the relationship of humanitarian organisations with a community can set a very important precedent for all future interactions between the community and health and development agencies. Invariably, there will be internal struggles for power, and it can be difficult for humanitarian workers to remain neutral. However, not only is a good relationship with the community essential for getting the job done well, but it is also the greatest protective device available for humanitarian workers. You will always be dependent on local staff, not only for interpretation and community liaison but also in taking directions about security and the appropriateness of activities. Listen carefully, apologise quickly and do your best to keep people informed and involved.

BOX 3.3: REFUGEE CAMP

Dr Rob Moodie (global health champion)

I spent four months working with MSF as the medical coordinator at Wad Kowli, an Ethiopian refugee camp on the border of Sudan.

It was 1985 and this was one of biggest refugee crises ever seen. Wad Kowli had become home to around 40,000 Tigrean refugees who were suddenly displaced by conflict in Ethiopia. This camp became infamous for unprecedented recorded levels of morbidity and mortality, being hit by epidemics of measles, cholera and meningitis. At the time I was a GP trainee with experience with Save the Children in eastern Sudan, a couple of years working in an Aboriginal co-op in Alice Springs, and a fresh Diploma of Tropical Medicine. This job would test my mettle in every possible way!

As 'MedCo', my job was to lead the team in setting up a reception centre for refugees, where we would put into place basic preventative refugee health measures. However, we ended up needing to stay and provide acute clinical care to an unexpectedly high number of severely ill men, women and children. We had not been set up for this and it was extremely challenging. I remember recognising the first case of cholera and trying to roll out public health measures to keep the epidemic under control. When the wet season hit, it became worse and our 'hospital' was cut off from the camp by a flooded river – we had to build a bridge across it just to get to the population.

My time in Wad Kowli was one of my greatest learning experiences, though at the time I felt I stuffed so many things up, was way out of my depth and really struggling to lead a French-speaking expatriate team. In some ways it was learning how not to do things! Unlike now, we didn't have all the evidence-based guidelines for refugee health and how to deal with humanitarian disasters – but it was our successes and mistakes during this era that gave us the evidence we use today.

Our response to the cholera epidemic is something I view as a great success – especially seeing people who had walked in shrivelled and near death with severe dehydration walk out smiling and strong a few days later. Perhaps the most difficult thing was needing to make decisions that felt like I was 'playing God' – having very real control over whether someone lives or dies.

The environment was very volatile, and we were completely stretched just trying to treat the very sickest people and prevent things from getting worse. Every day I was surrounded by humanity at its worst, and at its best. The toughness of refugees is forever imprinted on my memory, and my contact with the people of Wad Kowli left me with immense respect and concern for displaced populations. My experience here showed me a very different frame of reference for viewing the world and has convinced me that intercultural exchange is essential for breaking down fear of the 'other'.

My advice

- Get some experience in Indigenous Health here in Australia – both for the clinical and cultural experience, and because this is Australia's own priority global health issue.
- Consider public health training and work. There is great joy in using health knowledge and experience to improve the lives of hundreds and thousands of people. To quote Professor Mike Toole, saving lives is about "food, water and common sense".
- Learn from all the jobs you do – especially the ones you don't do well. Being challenged is good and if you can't cope, find out why, then work out a way around it.
- Take a risk and challenge your assumptions, fears and prejudices about the 'other'. Try and see things through another's perspective, even if you don't like the view.

Rob returned from Wad Kowli to see the birth of his first child. Since then he has become a champion of global health, taking leading roles with organisations such as MSF, WHO, UNDP, UNAIDS, AIDAB, and VicHealth. He is now Professor of Global Health at the Nossal Institute for Global Health (The University of Melbourne) and a source of inspiration for many globally minded young doctors.

DEVELOPMENT SETTINGS

Rural Clinic
Defining Characteristics

Health services around the globe are significantly biased towards urban settings despite most of the world's population living outside major cities. This centralisation of clinical resources and expertise leaves staffing and services more thinly stretched over peripheral hospitals and clinics. Often this gap is at least partly filled by charitable organisations which typically set up long-term health services in partnership with local communities. Staff and resources are mostly local, though international visitors can contribute additional skill sets and knowledge, raise awareness, and attract funding from abroad.

Points to Consider

Choosing an organisation that suits you is difficult, as it is often a case of not really knowing how well a project is run until you are part of it. Do your best to find out what their values and priorities are – not the ones on their website or brochure, but what others say about them!

- **Religious versus secular**. There are many organisations with religious foundations providing health services, but how this translates into the project varies greatly. If you would consider going with an organisation with religious affiliation be sure to enquire as to what obligations you will be under and how religious convictions are expressed in the project.

- **Small NGO versus big NGO**. There are innumerable non-governmental organisations (NGOs) working in communities around the globe. Some are involved in one or a few specific projects, while other others, known as 'BINGOs' have literally thousands. Small NGOs are more tied to particular communities – which means both increased dependence on, and accountability to, the community. There might also be greater subjection to sociopolitical pressures. BINGOs have greater resources, are less tied to individual communities and projects, and may offer a greater range of opportunities for doctors.

- **Local versus international**. There are big differences between NGOs that have sprouted from indigenous grassroots activity and those that are seeded from external actors. Local NGOs have advantages in knowing the population, understanding sociocultural complexities, and connections with local networks. International NGOs have advantages in their degree of independence, access to external funding and personnel, and their connection with international networks. Increasingly there is a push for partnerships, with many international NGOs linking their activities to the work of existing local NGOs.

Role as a Doctor

Doctors in non-urban health clinics and hospitals are generalists. Their role is often supplementary to the permanent local doctors or medical assistants and, in addition to clinical practice, contributing to the education of local staff is crucial. Doctors may also be involved in administration, human resources, public health, training of other health staff, health promotion and immunisation campaigns. Typically these jobs are done for six to 12 months, but many NGOs would love to secure a doctor for longer.

This kind of work would suit medical doctors-in-training (with substantial generalist experience), physicians, general practitioners (particularly those with advanced rural skills), emergency physicians and surgeons (including advanced surgical trainees). There may also be opportunities for public health physicians and trainees.

There is a great opportunity to become part of the community in a rural setting, especially if the population is small and you are staying for some time.

BOX 3.4: REGIONAL HOSPITAL – OBSTETRICS AND GYNAECOLOGY

Dr Emily Huning (O&G trainee)

I spent four months of my fourth postgraduate year working at a regional hospital in Nkozi, Uganda doing obstetrics and gynaecology.

At the time I was trying to decide between emergency medicine and O&G as a career path and was looking for some experience outside of Australia. After looking into a few different options, a personal contact put me in touch with the medical superintendent of Nkozi Hospital, south of the Ugandan capital Kampala.

On arrival I was given responsibility for running the labour ward, which had eight labour beds and 30 postnatal beds – a terrifying prospect for someone with only six months' O&G resident experience. On my arrival, the medical super told me they expected me to perform all the caesareans as well, but we quickly established that I was prepared to assist only, and this was taken with relatively good grace. So I assisted with all the emergency caesareans, did a ward round every day, reviewed all the patients in labour ward, did clinical audits and ran some teaching sessions for the midwives. Occasionally, I helped run the HIV clinic, assisted the general surgeon and conducted clinic visits to remote community centres.

I went to Nkozi with really rather personal and selfish intentions – I wanted to see some pathology of the kind I had only read about in textbooks, try my hand at managing some of those complications, and decide whether obstetrics was really for me. I certainly got to see and do things that I may never see or do in a whole career in Australia, but it was very emotionally and clinically difficult to deal with many of the things I saw, especially neonatal and maternal deaths that could have been prevented in Australia.

I was also hopeful that I may be able to do something to help, but I had learned from previous experiences working in central Australia that going into positions like this with the intention of 'saving the world' would, for me, only be counterproductive and highly frustrating. My time in Nkozi made me so much more aware of the issues around public health, particularly regarding maternal morbidity and mortality.

Ironically, one of the strongest and fondest memories of Nkozi is when I became quite sick with dengue fever. The memory of the concern shown for my wellbeing by my friends at the hospital never fails to move me, and I firmly believe that their care and attention saved my life.

My advice

- Know what you want from your placement before you go.
- Be very clear about what you are and aren't prepared to do; what is safe and what is not safe.
- Know the risks you are taking, and be as prepared as possible.
- Consider what the rotation will cost you – in financial, physical, emotional and psychological terms – and arm yourself with as many resources as you can.
- Be prepared to love and hate the experience all at once, and embrace those conflicting emotions.
- Don't expect to save the world.
- Practise relentless self-care to avoid burn out, so that you can go again.
- Where feasible, go with someone else – these experiences are hard to explain to someone who hasn't been there.
- Go! Just do it.

Emily is now continuing O&G clinical training and working on her Masters of Public Health.

Urban Hospital
Defining Characteristics

Although the majority of the world's population (and the world's poor) have traditionally lived in rural areas, the proportion of people living in urbanised communities has increased dramatically in the last 50 years (2). In fact, it is estimated that in 2009 urban population surpassed 50% (3). Though urban areas are typically home to the best health care services, rapid urbanisation is putting a strain on such services and leaving vulnerable sections of the urban population without basic health care. This presents an immense challenge to health workers and development agencies.

The best funded and equipped government hospitals and health programs tend to be in metropolitan hospitals. Positions at 'top' hospitals are in demand among local doctors but may still be an attractive choice for visiting doctors wanting exposure to a particular clinical field. If you are considering this option, be sure that your presence will not be detrimental to local trainees.

On the other hand, there are many smaller urban hospitals and health care clinics that are desperately short of skilled staff. These may be dedicated to a particular vulnerable population, such as slum dwellers, or specialty-based, with interests in HIV and AIDS or women's health. These are typically long-term projects, with local staff and resources forming the foundation of most activities. International visitors can contribute additional skills and knowledge, raise awareness and attract external financial support.

Points to Consider

- **Land rights**. Urban planning is receiving attention from both governments and NGOs as the burgeoning incidence of slums is difficult to ignore. This is an inherently political area with recurrent disagreement about land ownership, as many communities can live in squatter settlements for years. Land rights is a fundamental ingredient to security for any community and loss of control may manifest itself in poor health.
- **Political rights**. Certain populations, especially migrants, may not have political recognition within the administrative boundaries of the city, which affects their capacity to vote (and influence public decision making) as well as access basic services provided by the government (eg, health, education and welfare).
- **Prevention versus cure**. Public health and health promotion issues are magnified in urban migrant communities – especially for the first generation. Particular issues you may face include high population density (eg, as it relates to communicable disease and household accidents), access to drugs, nutrition and hygiene (including poor access to healthy foods and cooking facilities), unemployment and environmental pollution (with increases in respiratory disease and contamination of water sources).

Role as a Doctor

Doctors in an urban setting may fulfill a variety of roles. Unlike the typically generalist health care centres in rural areas, most urban health care centres occupy some sort of niche area. This is even true of primary health care clinics which will often target a particular population. Accordingly, there are many opportunities for doctors with skills in specialty areas. That said, true specialist opportunities are limited and most doctors will find themselves using their particular skills and experience in a broad way. There are also unique opportunities to do work in public health – either exclusively, or alongside clinical work.

The doctor's role is often complementary to the work carried out by the permanent medical staff. In addition to supporting clinical practice, expatriates can contribute to the education of local staff or become involved in public health campaigns. Typically, these jobs are done for six to 12 months, but many organisations would be eager to secure doctors for longer periods.

This kind of work would suit doctors-in-training (including public health trainees), physicians, general practitioners, and emergency physicians. Some projects will also include opportunities for surgeons and doctors with public health training.

BOX 3.5: URBAN EMERGENCY DEPARTMENT

Dr Jo Oo (emergency trainee)

I spent 4½ months as the visiting emergency physician in the emergency department (ED) of Point Pedro Base Hospital, Sri Lanka.

My main role was to oversee the management of patients in the emergency unit and acute care and high dependency patients on the ward. This included:

- Clinical oversight of the ED during the day, and 24-hour on-call duty for emergencies
- Review and management of acutely and critically ill patients on the ward
- Coordination of transfers of patients to other centres when required
- Education and supervision of junior doctors, nursing staff and allied health
- Regular emergency equipment checks, supply restocking and managing pharmacy
- Development and review of hospital protocols including the disaster management plan
- Collating data and reporting to the field coordinator and head of mission

I was also on call to respond to emergencies in the Jaffna Peninsula, the location of the Sri Lankan civil war frontline, when required.

My experience in Port Pedro gave me an in-depth insight into the way instability and war impact on the psychology and health of a population. I was fortunate to develop strong collegial relations with the national staff and lasting friendships with some of my expatriate colleagues. And I was genuinely amazed and humbled by the tenacity, warmth and optimism of the local population in spite of their daily hardships. I was also taught how to cook dahl by our Sri Lankan cook and brownies by my British predecessor!

It was difficult dealing with the government and institutional bureaucracy that affects your patient care but that you are helpless to change. Other challenges included working in a confined environment with little recreational opportunity, and the occasional difference in opinion with other expatriates (eg, human resource management).

This sort of work would suit:

- A doctor with good general medical skills who is able to work autonomously and in remote conditions
- A flexible and open personality, with a willingness to adapt to different circumstances, cultures and attitudes and deal with often suboptimal conditions
- A person able to comply with restrictions because of security or situation in both their professional and personal lives
- Someone who is able to live and work closely within a team

My advice

- Plan your training where possible (paediatric, obstetric, infectious/tropical diseases, emergency experience are invaluable in 'developing world' settings).
- Talk widely to people who have done similar work to get a good idea of what you are getting yourself into, but be wary of personal commentary: different personalities experience/handle the same situation differently!
- Learn about the cultural customs and dress codes before packing.
- Enjoy the opportunity: share, talk and learn with the local people.
- Bring ear plugs.

Jo has now returned to Australia and is working as an emergency physician.

Specialist Short Mission
Defining Characteristics

Specialist short missions are designed to provide specialist services not usually available to the local population. Typical destinations are regional hospitals that have the facilities to host a specialist team but lack the specific expertise. The hosts usually identify potential patients and organise the logistics so that the team can provide the greatest care to the greatest number of people during their brief visit. Education and training of local health workers is an additional valuable contribution.

Points to Consider:

- **Resource intensive**. Visiting teams work from existing health structures and seek to achieve as much as possible within a short space of time (usually a few weeks). They are, therefore, resource intensive for both hosts and guests, but do allow busy doctors to contribute without significantly disrupting their own home practices.
- **Realistic contribution.** Working in a specialist field can bring particular joy when you can use your experience to solve something that has baffled others. But as a specialist you are also likely to see a lot of patients whom you can do little to help simply because of a lack of resources.

Role as a Doctor

Doctors in this setting are 'experts' providing specialist clinical services and education. Special surgical teams (such as plastic surgery, ophthalmology and cardiothoracic surgery) are particularly suited to this type of work, and it often involves transporting an entire specialist surgical team and the required materials and equipment. However, many other doctors can contribute and may be variably integrated into the local health care team. This kind of work best suits experienced general and special surgeons and advanced trainees, as well as other medical specialists – adult and paediatric.

BOX 3.6: CARDIOLOGY/CARDIOTHORACICS SHORT MISSION

Dr Zoe Wainer (cardiothoracic trainee)

I was part of a cardiothoracic surgical team working with the Sydney Seventh Day Adventist Hospital in Tonga.

The team in which I went was invited by the Kingdom of Tonga to perform cardiac surgery on children and adults with congenital and acquired heart defects (mostly rheumatic heart disease). This required taking everything necessary for cardiac bypass surgery including 30 to 40 staff (including cardiologists, cardiothoracic surgeons, anaesthetists, intensivists, nursing, allied health and support staff) and three tonnes of equipment.

A team goes to Tonga each year. The cardiologist and echo technicians arrive ahead of the surgical team and spend a week doing echos from dawn to dusk. When the rest of the team arrives we have a cardiac conference and triage the children based on how critical their condition is and whether it can be surgically corrected by the team in the given setting. The surgical team then spends seven to 14 days working 12–15 hours a day operating on as many people as possible, in the knowledge that we will not be returning for another year. Follow-up is then coordinated by the local health care providers.

My role is that of a cardiothoracic trainee and surgical assistant filling a gap in skills. I strongly believe that if there is a local doctor who can do the job I must step back and make way for them. I am very uncomfortable with the idea that trainees may see short mission trips as an opportunity to 'practise' their trade, see interesting pathology and get to operate more than they might at home. That said, I was still able to assist with a lot of surgery and gain good surgical experience.

Apart from some administrative difficulties in getting equipment delivered, the other big challenge was operating during an earthquake. We were in the middle of surgery, with a child on bypass, when the tremor started. Then there were three long and scary minutes as the 7.1 Richter scale quake rocked the walls. I can only say that I was immensely glad that it was a new and well built hospital!

Tonga is quite small and the local community was very supportive of our trip. The Tongans showed wonderful hospitality, inviting us to dinners every evening.

I am aware that this sort of project is very resource intensive and, while all participants make significant personal contributions, the same amount of money spent on prevention could save many more lives. But I also see that there are now a couple of dozen children living healthy, happy lives who were otherwise headed down the pathway of heart failure, suffering and early death. There was also a sense of 'if only we'd done one more', as someone would always miss out. The people with whom I went were inspirational, with extensive experience, and it was a privilege to be a part of the team.

Zoe has been involved in five cardiac surgical volunteer trips to Tonga, Fiji and East Timor. She is continuing her cardiothoracic training in Melbourne and is a Board Member of AMA Victoria.

WELL RESOURCED SETTINGS

'Western' Hospital
Defining Characteristics

As Australian doctors, we are all familiar with the characteristics of hospitals in well resourced settings. There is relative ease of access to health services including a plethora of available investigative tools and treatment options. There are tightly regulated systems that integrate the medical profession with other health care and social services, and attempt to ensure quality, efficiency and equity. This familiarity can often blind doctors to the significant differences in health care systems and practice between countries. Indeed, one of the biggest dangers of working abroad in a well resourced setting is making assumptions that turn out to be incorrect.

The host community may react quite variably towards you as a 'foreign' doctor – just as you would notice the array of receptions given to our own overseas trained doctors here in Australia. Good advice is to 'act like a guest, but don't expect to be treated like one', as, unfortunately, you won't always be made welcome.

Points to Consider

- **Unique clinical experience**. Opportunities exist to follow an area of personal interest, including sub-specialty areas. There is also the opportunity to work and learn at institutions that are well reputed as centres of excellence or because of their cutting-edge and/or alternative approach.
- **Vulnerable populations**. Well resourced settings can serve a huge variety of populations, including vulnerable groups such as refugees and asylum seekers, Indigenous peoples, homeless people and those in high-risk occupations such as sex workers.
- **Inequitable systems**. The Australian health care system is among the most equitable in the world and it can be a shock to see other wealthier societies delivering very inequitable services. The United States health care system is a case in point.
- **Racism and discrimination**. One often unnoted experience that comes with a different perspective is a heightened sensitivity towards discrimination – against both you and certain patients. Use it as an opportunity to understand and increase your sensitivity to the presence of racism and discrimination back in Australia.

Role as a Doctor

The role of a doctor in a well resourced setting is quite similar to that in Australia, in terms of job descriptions and expectations. Unless you are working in particularly unusual circumstances (such as remote medicine) you are unlikely to be asked to take on unfamiliar responsibilities.

Differing structures and clinical nuances give you a unique perspective and can offer a very good opportunity for critical reflection, which can be harnessed for learning and, where appropriate, teaching. As a foreign doctor your skills and knowledge will be respected and likely sought. The role for most doctors working in well resourced settings is to learn medicine and experience life in a new and different way. This kind of work would suit all doctors-in-training, or fellows and consultants looking to gain expertise in particular sub-specialty area.

BOX 3.7: BRITISH TERTIARY HOSPITAL

Dr Nicholas Simpson (emergency and ICU trainee)

I am currently working in aeromedical retrieval throughout greater Glasgow and the Western Isles.

We are based at a heliport in central Glasgow. My day starts with a morning briefing at 0800 (weather conditions, flight ranges, forecasts) and a full equipment check. Throughout the day we respond to calls, often doing full 24-hour shifts. Primary retrievals are roadside accidents and time-critical incidents with an expected call-to-departure time of two minutes. Secondary retrievals are transfers of critically ill patients from peripheral to central hospitals who often take some hours to stabilise, intubate and safely transport. In shocking weather (not uncommon in Glasgow) we will go out in the Sea King (navy search and rescue helicopter).

Apart from the retrievals I also run paramedic tutorials and teaching programs for the remote hospitals in these regions. Teamwork is crucial. I report to the clinical lead (consultant retrieval physician) and work alongside flight paramedics and pilots. I also supervise medical students and training clinicians and paramedics.

I have really enjoyed gaining skills in prehospital care and working with paramedics and appreciating their skill sets has been an eye opener. On the down side is the Glasgow weather, the long shifts and fatigue.

I found this job through the online British National Health Service (NHS) careers site, but similar jobs are available in NSW, Queensland, WA and the NT. I took this job after completing four months as the senior house officer in Cardiology at Edinburgh Hospital and deciding I wasn't ready to come home.

My advice

- Start planning early and get plenty of information on requirements (eg, General Medical Council [GMC] registration). It has become harder recently to get UK jobs (because of new legislation protecting European Union nationals), but it is certainly not impossible.
- Be persistent, and don't listen to 'naysayers'. It is more difficult to work in the UK now, but with time and careful planning, it is readily possible (I am currently working there).
- Check out local locum agencies for job opportunities via the web (eg, in the UK there are Medacs Healthcare, BMJ Careers and NHS Jobs).

Nick is continuing his work with aeromedical retrievals and considering staying on even longer. He is a former chair of AMA Victoria's Doctors-in-Training Subdivision.

NON-CLINICAL SETTINGS

Public Health
Defining Characteristics

The discipline of public health is markedly different from the clinical practice in which most doctors are experienced.

Points to Consider

- **Multidisciplinary**. Public health is not exclusively the domain of doctors, or even that of health professionals: economists, social scientists, epidemiologists and political analysts all play key roles. The perspective of non-health professionals towards 'health' can often seem entirely different to the perspective of doctors and other clinicians.
- **Office versus clinic**. For doctors entering public health for the first time it can seem very strange to be working towards bettering health without actual patients in front of you. Clinicians can offer a unique perspective to public health, and they are often strong advocates for ensuring that end points actually reflect real human needs.
- **Distance from issues**. Public health deals with hugely important and often highly emotive health issues – but it often approaches them from a far removed perspective, and the risk is always that the human factor is forgotten. A different kind of thinking is required to approach health from a macro and more abstract perspective.

Role as a Doctor

For doctors-in-training, the most popular opportunities to work in public health are through intern programs through the WHO and some large public health institutions. Typically these are three-to-12 month placements based at the headquarters or, less commonly, in a field office. Participants can apply through established intern programs or through individual approaches to public health organisations. Usually it is a volunteer position, with limited financial assistance for living or other expenses. The work involves working on a designated office-based project but also gives exposure to the internal workings of public health institutions and can be a useful gateway into further public health work. Doctors with more public health experience can be involved in work with governments, international institutions and public health organisations either as ongoing employment or in a consultancy role.

This kind of work would suit doctors with an interest in public health who are able to work independently and have skills in critical thinking and data synthesis. A basic understanding of epidemiology is necessary and formal training such as a Masters of Public Health (MPH) is extremely valuable – if not essential.

BOX 3.8: INTERNATIONAL PUBLIC HEALTH INTERNSHIP

Dr Farnaz Sabet (medical resident)

I spent three months doing an internship at the Eastern Mediterranean Regional Office of the World Health Organization (WHO) in Cairo.

I was involved in two projects. The first involved researching and then devising a program to help reduce the high rates of suicide in Afghani women, and the second involved assessing child-abuse policy and action in four countries in the region. This involved literature reviews, emails, phone calls and face-to-face meetings with key stakeholders, and also some statistical work. While I was supervised, most of my day-to-day work was independent and I needed to be able to work on my own with very little guidance.

This opportunity gave me a useful insight into how the WHO works and I felt I was able to make a good contribution to the two areas on which I was working. I met many fascinating people as the work environment was a real international melting pot and everyone had interesting stories. The WHO office is full of non-medical staff and this makes the perspectives on health more rich and interesting. Personally, it was interesting for me to work in a region where I was in a minority in terms of sex, religion and race, and I managed to survive life in one of the most hectic areas in Cairo!

I found it challenging to see the politics and feel a disconnection from the reality of the issues in which I was working. A few kilometres from the slums of Cairo, the WHO office is beautiful and most people sit in air-conditioned offices enjoying attractive UN salaries as they deliberate the health of the region. As a clinician, I found the environment sterile and removed. I became painfully aware of how difficult it is to effect policy change, of the numerous institutional barriers and of incompetent yet egotistical people who hold power.

My advice

- Be prepared to learn lots, as studying medicine does not really prepare you for public health work (although there are many organisations that would value a clinician).
- Do some sort of public health preparation: an MPH is definitely an asset and will provide an added perspective to clinical training, and there are many books and articles available for you to become familiar with international public health.

In a 'developing world' setting a posture of learning and humility is paramount and you must realise that most of the studies and projects have been done in Western settings and cannot be easily transposed. You will realise that no one really has the answers, and that an awareness of cultural and religious issues is extremely important in international public health work.

Farnaz completed an MSc in Global Health Science at Oxford University through the Rhodes Scholarship program and has returned to clinical practice in Melbourne.

Research
Defining Characteristics

Research offers an opportunity for doctors to contribute to the knowledge and evidence on which their profession is based. The setting will depend very much on the type of research (refer to Table 4). In all cases, the research cycle will likely involve conception and study design, ethics and academic approval, testing and logistical planning, study implementation, compilation and analysis of results. Completed research may be published and/or presented.

TABLE 4: THE MANY FACES OF HEALTH RESEARCH

EPIDEMIOLOGICAL	Population-based, using quantitative and qualitative data. Answers public health questions about disease trends, associations and prevention.
CLINICAL	Medical practice-based, using quantitative data with supplementary qualitative data mostly for interpretation and application. Answers clinical questions about disease, diagnosis, treatment and prevention.
LABORATORY	Basic science-based, with emphasis on quantitative data. Answers technical questions about pathological changes, disease characteristics, disease–drug interface, etc.
SOCIAL	Social science-based, with use of both quantitative and qualitative data. Answers social questions about health and disease beliefs, practices and perceptions.
OPERATIONAL/ APPLIED	Focused on management improvement and the enhancement of health services.

Points to Consider

- **Learning**. Research is a great way to learn analytical skills and add publications to your CV. The process of planning, testing, conducting and evaluating brings insight, develops skills and reveals a perspective that is completely unique. But the attitude with which you conduct the research is even more important. Be humble, and always be open to learning things that don't fit on a spreadsheet.
- **Who benefits?** Conducting research in a community is a privileged position that needs to be respected. Research done sensitively can bring great outcomes for the communities involved, so consider the ramifications of your research and don't get trapped into pursuing it for its own sake.

Role as a Doctor

The easiest way for doctors to be involved in research is through established academic programs. Research is frequently a part of higher degrees, including the very popular Masters of Public Health. These placements are facilitated by the institution and are typically done over three to six months, although often less than half the time will actually be spent in the field. Other research opportunities can be found through research institutions, though often these require at least some research experience.

This kind of work would suit doctors who are interested in advancing health knowledge and have at least a theoretical knowledge of research tools and techniques. They need to be able to work independently, think critically and synthesise data.

Doctors may find they have to take leadership in ensuring data collection and research projects in vulnerable communities are conducted in accordance with accepted ethical standards. The ethics approval process is no less important in resource-poor settings, despite being potentially difficult to navigate. There are particular challenges to research ethics in developing countries and it is worth reflecting on these before you begin a project (4).

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COMPETING INTERESTS

The authors have declared no competing interests.

CHAPTER 4

SELECTING A REGION

"The best way to find yourself, is to lose yourself in the service of others."

Mahatma Gandhi
Political and spiritual leader of the Indian independence movement

BACKGROUND

The geographical location in which you work will heavily influence your personal and professional experience abroad. It is worthwhile considering which region of the world aligns best with your expectations, learning needs and capacity to contribute.

This chapter highlights some of the overarching health challenges faced by the various regions of the world. Some of the key differences are highlighted in Table 5. The information provided here is general in nature, and it may not represent every individual country in the region. Before you embark on your travels, you will need to undertake more detailed research. A list of useful resources that may provide further information can be found in chapter 10.

TABLE 5: MORTALITY AS A PERCENTAGE OF REGIONAL POPULATION (1-3)

AETIOLOGY	OCEANIA	ASIA	AFRICA	EASTERN MEDITERRANEAN	LATIN AMERICA	USA AND CANADA	EUROPE
INFECTIOUS DISEASES	15%	19%	56%	26%	14%	5%	5%
HIV, TB, MALARIA	3%	4%	25%	4%	3%	0.5%	1%
NON-COMMUNICABLE DISEASES (NCDs)	75%	61%	25%	50%	68%	87%	86%
CARDIOVASCULAR DISEASE	30%	29%	10%	27%	28%	36%	50%
MALIGNANCIES	26%	12%	4%	7%	15%	24%	20%
MATERNAL MORTALITY RATE (PER 100,000 LIVE BIRTHS)	430	300–490	900	160	130	10	10
PERINATAL CONDITIONS	2%	6%	9%	10%	4%	<1%	<1%
INJURIES/CONFLICT/VIOLENCE	7%	12%	7%	11%	12%	7%	8%

OCEANIA

BOX 4.1 OCEANIA IN BRIEF

- Significant potential for contribution
- Wide range of health care settings
- Established training opportunities in some areas
- Politically stability in most parts
- Close to Australia

Watch out for...

- Language barriers may exist
- Threats to personal security in some areas
- Under-resourced health care systems in certain countries

The Oceania region offers a unique mix of health challenges. Diseases most often associated with extreme poverty occur side-by-side those found in wealthier countries. Deaths caused by infectious diseases, although accounting for a relatively small proportion overall (15%), are over-represented in low-income Oceania countries. Several island nations, for example, experience rates of tuberculosis more than 50 times that found in Australia (4). Many other Pacific island nations suffer epidemic levels of chronic disease, particularly cardiovascular disease and respiratory disease. Non-communicable diseases contribute more than three-quarters of the mortality, a figure that highlights the role of lifestyle factors in the region's health challenges. To compound this, natural disasters are not infrequent and it is often the most under-resourced countries that face the most devastating events – and their health consequences.

Of particular note, health demographics vary widely within particular Oceania countries. Despite a well resourced health system, Australia and New Zealand face significant challenges in achieving health outcomes for their Indigenous peoples that are comparable to those for their non-Indigenous counterparts.

The capabilities of health care systems within the region vary widely. With suboptimal resources and an overwhelming patient load, many Pacific island health systems struggle to provide even the most basic of health services to their communities. Some areas are also prone to violence, and this affects the capacity of local and expatriate staff to deliver care. This is especially true in parts of Papua New Guinea.

ASIA

BOX 4.2 ASIA IN BRIEF

- Significant potential for contribution
- Wide range of health care settings
- Emerging economies with significant opportunity to develop sustainable health initiatives
- Distinctive cultural experience
- Close to Australia

Watch out for...

- Language barriers may exist
- Personal security may be a concern in some areas
- Under-resourced health care systems in many countries

By virtue of their climate, population density and strained health systems, Asian communities suffer higher morbidity and mortality rates from communicable diseases than their Western counterparts. Infectious diseases claim more than five million lives every year, which equates to almost 20% of all recorded deaths in the region. This figure could be greatly reduced with the application of basic public health programs, widespread primary health care and access to essential pharmaceuticals. Notably, Asia possesses the highest level of trauma and injuries in the world – more than one-tenth of recorded deaths. This is, in part, influenced by the disproportionately high number of natural disasters that occur in the region. In 2008, 40% of all recorded natural disasters, and 80% of all recorded disaster-associated deaths, occurred in Asia (5). Asia has, therefore, a continual need for timely and effective emergency relief operations, as well as post-disaster development and rebuilding programs. Only 60% of deaths in Asia are accounted for by NCDs, a relatively small fraction when compared to neighbouring regions; this figure is partially explained by the higher rate of mortality in younger populations.

Although Asian health care systems are typically under-resourced, many provide advanced sub-specialty services, ranging from cardiac catheterisation to intricate neurosurgery. Much like Australia, Asia struggles to provide these specialty health services to communities spread over sparsely populated regional and rural areas.

Workforce pressures are particularly evident in certain areas. For instance, Timor Leste has but one medical professional per 10,000 population. Australia, by contrast, enjoys more than 25 times that rate.

AFRICA

Africa's health challenges are as complex as her history. Infectious diseases account for a greater mortality in Africa than in any other region of the world (more than 55%). HIV, TB and malaria make up an astonishing 25% of the total recorded mortality – sixfold higher than in any other region. Both maternal and perinatal mortality rates are some of the highest in the world. To compare, approximately 90 mothers die as a result of pregnancy or childbirth in Africa for every one mother who dies in a high-income region. NCDs account for fewer than one-quarter of all deaths within the African region, a tiny proportion when compared to the nine out of 10 deaths recorded in Australia. Injuries comprise seven per cent of total mortality, with conflict claiming approximately 40,000 lives in the region each year.

Most African health care systems are significantly under-resourced in terms of physical infrastructure, medical workforce and training facilities. Consequently, these systems struggle under the substantial health challenges that they face – although progress is being made. A less obvious but critically important casualty of chronic under-funding is medical research. Sadly, new pharmaceuticals, treatments and new diagnostic tests are rarely developed with Africa's health challenges in mind. To exacerbate the situation, the geographic proximity of African nations has facilitated the rapid and extensive spread of transmissible diseases, which will require longstanding transnational public health programs to control.

EASTERN MEDITERRANEAN

As with other developing regions, infectious diseases account for a high proportion of mortality in the Eastern Mediterranean. prematurity, low birthweight and birth asphyxia – represent 10% of the all deaths in the region, higher than anywhere else in the world. Conflict claims approximately 100,000 lives each year, which is more than seven times the world average. The potential for humanitarian aid operations within the region therefore remains high – although organisations have historically had difficulty getting access to populations in conflict zones. Sadly, implementing long-term development initiatives is often only feasible after the restoration of peace.

CENTRAL AND LATIN AMERICA AND THE CARIBBEAN

BOX 4.5 CENTRAL AND LATIN AMERICA AND THE CARIBBEAN IN BRIEF

- Significant potential for contribution
- Unique cultural identities
- Wide range of health care settings

Watch out for...

- Language barriers may exist
- Personal safety may be a concern in some areas

The people of Latin America and the Caribbean possess health status somewhere between that of the emerging and the developed world. Though a comparatively high 14% of people die from infectious diseases, almost 70% of all deaths are attributable to NCDs. Moreover, the rates of maternal and perinatal mortality are the lower than those of all emerging regions. That said, the local populations still face major health challenges. Traumatic injuries are commonplace, and are recorded as the causative factor in an extraordinary 12% of all deaths. Disparities between the health status of the Indigenous peoples of Central and South America and that of their non-Indigenous counterparts also require further attention.

Health care systems in Latin America and the Caribbean are under significant strain, with immense patient load and vast rural populations. Health care settings range from small rural clinics to large urban hospitals, with all manner of facilities in between. English is not widely spoken in the health care settings, so an intermediate to advanced knowledge of the local language or access to an interpreter is required.

USA AND CANADA

BOX 4.6: USA AND CANADA IN BRIEF

- Highly developed health systems with access to cutting-edge technology
- Extensive research opportunities
- English-speaking region
- Politically stable

Watch out for...

- Segregation between private and public health care systems
- Onerous medical registration requirements
- High indemnity and insurance requirements
- Expensive living costs

North America is one of the few uniformly highly developed regions, which is clearly reflected in its health demographics. Deaths caused by infectious diseases rank the lowest in the world while almost 90% are secondary to lifestyle diseases and malignancies. This data attests to a health care system that manages communicable diseases well, resulting in a population with a higher mean age compared to other regions. Consequently, health conditions that primarily afflict the older age groups are far more prevalent: dementia accounts for almost five per cent of deaths, which is six times the world average.

The health system of the Unites States of America is one of the most medically advanced and heavily invested in the world; both government and private providers are key stakeholders. Access to health care services remains a controversial issue and reforms were passed in 2010 in an attempt to address high numbers of people with inadequate health insurance, if any. In contrast, Canada's health care system is almost equally as advanced and remains publicly funded. All Canadian nationals have access to health care based purely on need. Opportunities in postgraduate medical studies and advanced research projects are often seen as an advantage to working in Northern America.

It is noteworthy that there are certain subgroups in North America that remain vulnerable to poor health. These include Indigenous populations, migrants and inner urban citizens in cities where inequity is entrenched.

EUROPE

BOX 4.7: EUROPE IN BRIEF

- Highly developed health systems with cutting-edge technology
- Extensive research opportunities
- English-speaking in many areas
- Politically stable

Watch out for…

- Language barriers may exist
- Onerous medical registration requirements
- Expensive living costs

Like other highly developed regions, Europe's major burden of disease is that of NCDs, accounting for more than 80% of deaths. An astonishing 50% of all deaths are attributed to cardiovascular disease. Rates of infectious diseases, trauma, maternal and perinatal mortality are among the lowest in the world.

Most health care systems in Europe have sub-specialist services and are supported by leading-edge medical technology and pharmaceuticals. As many European countries are members of the European Union, this allows for reciprocal health care rights between member nations.

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COMPETING INTERESTS

The authors have declared no competing interests.

CHAPTER 5
ORGANISING AN ADVENTURE
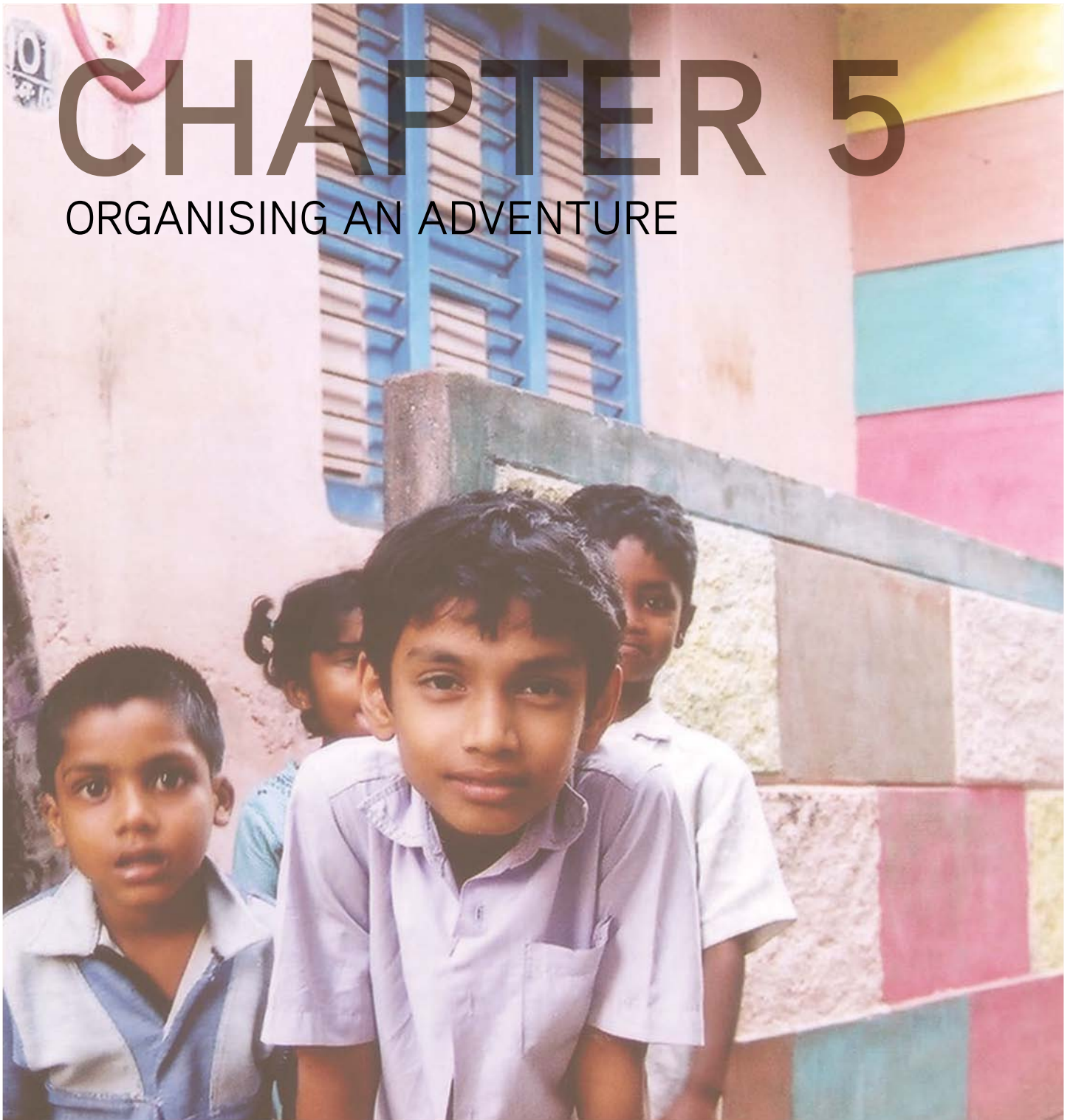
"Travel is fatal to prejudice, bigotry, and narrow-mindedness."

Mark Twain
American author and humorist

BACKGROUND

Once you've chosen the health setting and geographical location in which you might be suited to work, it's time to organise your placement. This chapter outlines a basic framework to assist in negotiating a position matched to your goals and capabilities. In organising a placement, always remember to be principally guided by the health needs of the community you wish to visit.

There are five essential steps to successfully organising a fulfilling professional placement overseas. They are:

1 Set goals   **2** Search   **3** Match   **4** Apply   **5** Confirm
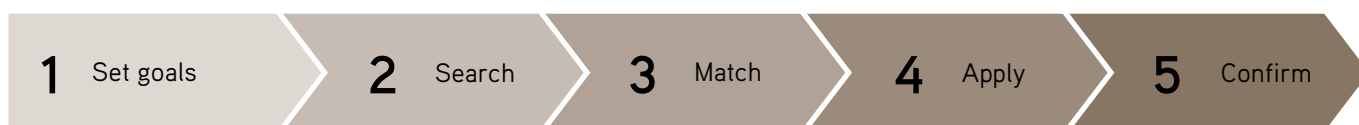
SET GOALS

Begin by defining the key elements that you would value in a placement abroad. List all the goals you wish to achieve, both personal and professional. A list of commonly reported goals in a survey of training doctors is shown in Box 5.1.

Consider the needs of any potential host community and how they align with your abilities – medical or otherwise. In practice, a positive and sustainable contribution in most settings requires either a commitment to a placement of several months' duration or multiple return visits. In brainstorming how you may contribute, remember to think 'outside of the box'; there are lots of examples of expatriates showing great initiative by running community health education sessions, providing sanitation equipment, and even rebuilding schools or health clinics.

It is also important to reflect on the limitations of your experience. Be realistic about the tasks you will be able to perform competently and be aware of the danger of overestimating your skills. Consider how you might politely decline to perform a procedure if you felt insufficiently trained or inadequately supervised to undertake it safely.

BOX 5.1: POTENTIAL GOALS OF WORKING ABROAD

Professional
- To contribute to the health of the host community
- To gain unique clinical experiences
- To challenge one's professional abilities
- To work with a unique array of professionals from across the world
- To work in a different clinical setting
- To understand better the health and needs in other countries
- To gain further experience in a particular area of medicine not available in Australia
- To gain an appreciation of a variety of health care systems
- To contribute to a specific research or public health program
- To work within a particular NGO or government program

Personal
- To experience the reward of helping people in real need
- To experience more about a particular country or live within a foreign culture
- To explore the possibility of working or living abroad at a later date
- To develop skills in leadership, flexibility, resourcefulness, cultural safety and self-management
- To gain experiences that contrast with those available in Australia
- To move with your family to a particular country

SEARCH

There are a range of resources that will help you explore potential placement options, including Internet search engines, organisations, established databases and professional contacts.

The organisations that send health professionals beyond Australian borders are as diverse as they are numerous. Some are listed in chapter 10. Working overseas with an established organisation offers a range of benefits. They will often:

- provide a predefined professional scope of practice for their staff;
- have well established clinical and pastoral support systems;
- adhere to best practice guidelines promoting better outcomes for local communities;
- offer additional training on cultural safety, personal security and clinical practice in the resource-poor setting;
- provide long-term support to health development programs which are more sustainable and therefore have a higher health impact;
- organise logistics and travel arrangements;
- mitigate much of the personal risk associated with involvement in international health care projects; and
- have the necessary contacts and vision to link individual projects into a broader national or international strategy.

Although they often represent an appealing option when working abroad, organisational placements also have limitations. Complex internal procedures and multiple levels of bureaucracy may make even the most simple of tasks seem onerous. Additionally, there is often a stringent application process before being accepted. Take the time to consider the mission statement, size and culture of an organisation prior to signing up; not every organisation will suit every individual. Be sure to pick the right one for you.

Medical placement databases are becoming more common and provide information regarding health care facilities that accept junior doctors and medical students for placements (see chapter 10). They vary in size, accessibility and quality, so don't be disheartened if you don't find a suitable option in the first one you review. Additionally, the Internet allows you to identify placement opportunities (but may also yield a lot of inaccurate information).

Colleagues, professional colleges, academic institutions, hospitals, professional interest groups, family and friends can be useful sources of information when seeking placement opportunities. With increasing numbers of students completing elective placements abroad, be sure to ask your medical student and junior doctor contacts for ideas.

MATCH

After exploring your options, create a shortlist of the positions that best match your goals. Collect information about the health care facility, the community, the job and the living conditions before making any final commitments:

- **The health care facility**. Find out about patient capacity, the health services it delivers, training opportunities, availability of library resources, its public or private status, or if it has any religious affiliations. Get the address and ask specifically about details regarding transport to and from the facility, which is particularly important when travelling to rural locations.
- **The community**. Research the health demographics of the region including the major burdens of disease. How many people live there? What is the predominant religion? What is the main industry?
- **The job**. Directly inquire about the responsibilities that a professional of your level of training will be expected to undertake, the level of supervision available, as well as the language spoken in clinical practice.
- **The living conditions**. Find out about the availability of local accommodation, and the amenities it offers. Flushing toilets and running water are a rare treat in many areas of the world. Also find out about options for food purchase and preparation, such as access to hospital catering or kitchen facilities, local markets and restaurants. Enquire about access to Internet and telephone services as well as reliability and voltage of power. Research the climate and the wider environment.

APPLY

It is beyond the scope of this Guide to provide detailed application advice; for more comprehensive information, consider reading *Beyond borders: McGraw-Hill's guide to health placements* by Hamish Graham (1) or *The elective pack* from University College London (2). If you are formally applying for a position by sending a cover letter and curriculum vitae, consider including the following:

- motivation and expectations for the placement
- current level of qualifications and training ambitions
- relevant clinical skills and experiences
- other relevant skills, such as language, teaching or research skills
- desired placement dates
- registration status
- any particular ventures that you may wish to undertake, including fundraising, teaching, or research initiatives
- supporting documentation such as copies of qualifications, references or proof of enrolment
- your willingness to bring some requested medical resources

The time it takes to get a response from an application may be prolonged: allow several weeks. In light of this, it may be worthwhile applying for more than one placement simultaneously.

CONFIRM

Once an application has been approved, be sure to accept the offer in a timely manner and thank the facility for the opportunity; it is no small task to host an expatriate for a prolonged period. This may be an ideal opportunity to clarify any outstanding questions you may have.

Finally, expect the unexpected. Confirm your arrival one to two weeks prior to your arrival.

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COMPETING INTERESTS

The authors have declared no competing interests.

CHAPTER 6
PREPARING TO WORK ABROAD
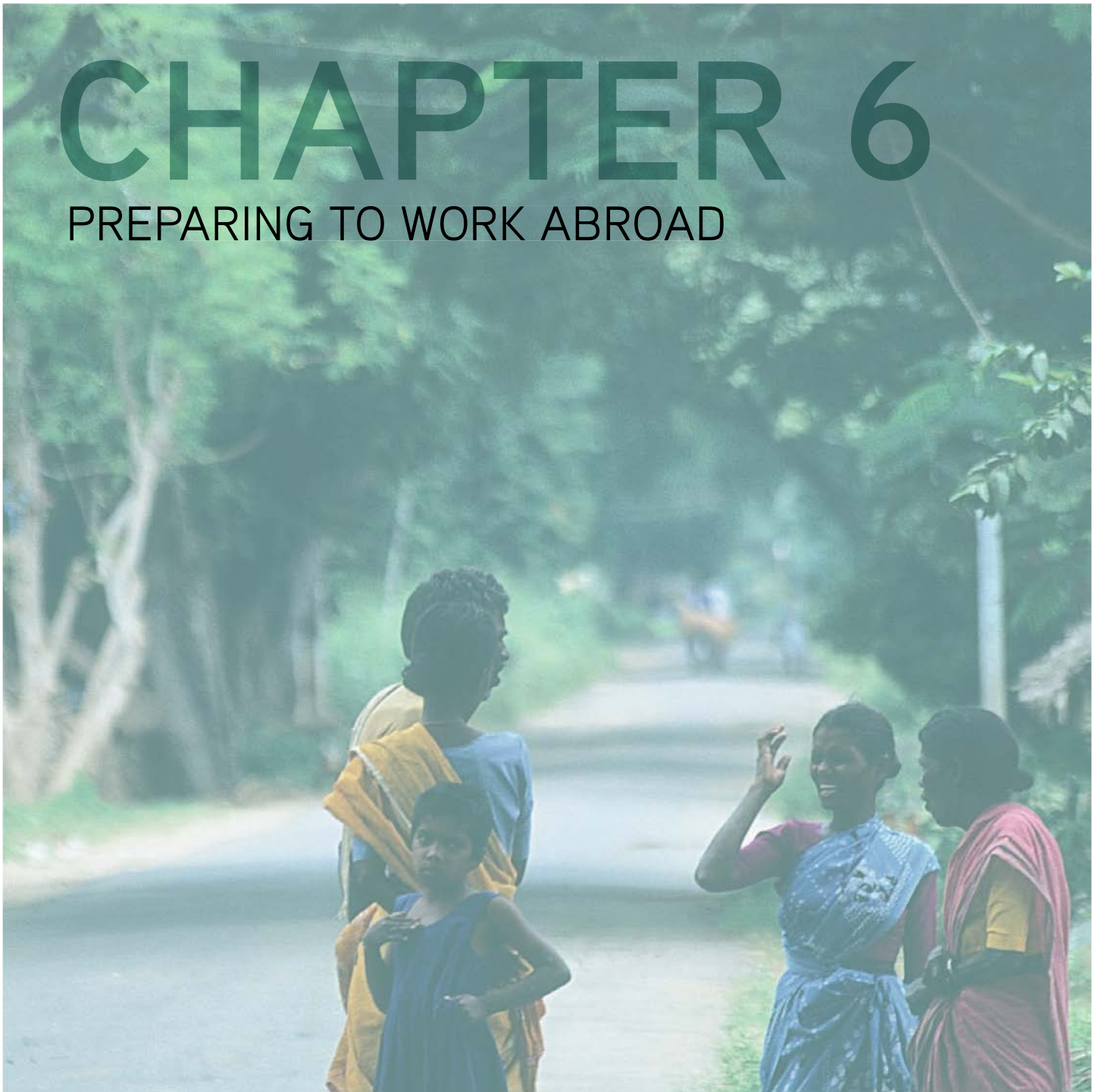
"One's destination is never a place, but a new way of seeing things."

Henry Miller
American novelist and painter

BACKGROUND

Having organised a placement, it is important to reflect on the practicalities of overseas travel. This chapter of the Guide provides general pre-departure advice, as well as information that specifically relates to medical practice.

GENERAL CONSIDERATIONS

Many of the suggestions and strategies below will be known to you already; medical students and doctors-in-training who undertake overseas work commonly have extensive travel experience. Bear in mind that the advice is of a general nature and may not take into account factors specific to your circumstances.

Preparation Principles

By now you will have taken time to consider your motivations for travelling overseas and the type of environment in which you will be working. You may have gone as far as selecting a particular health care setting or destination. These decisions will help determine the way you approach your pre-departure preparation.

It is useful to keep in mind some general principles as you develop and refine your plans. This Guide recommends that you:

1. Prepare well in advance
2. Talk to those with experience
3. Use all available resources
4. Review your personal circumstances
5. Always consider your footprint

You may have personal, economic, spiritual or professional reasons for working abroad. It's important you don't lose sight of these underlying motivations as you undertake the long and complex task of preparing to do so.

BOX 6.1: PREPARATION TIMELINES

The amount of preparation required will depend on the type of work you wish to do, the length of the placement, and whether you will be working with an organisation. Generally, it would be prudent to begin preparations at least six to 12 months in advance. More complex placements will require longer preparation.

Working backwards from the placement starting date, draw up a timeline with all the tasks that you need to complete.
You may want to include:

- appointments with a travel doctor for information, immunisations and scripts;
- training courses, clinical workshops and cultural safety teaching sessions;
- applications for occupational leave as well as visas;
- applications for medical registration or equivalent in your host country (if required); and
- confirming your placement with the host health care facility.

Financial Analysis

Finances will have a significant impact on the type and length of placement you choose. If you plan to work abroad for an extended period of time, it may be worthwhile visiting a financial adviser. In any case, you should consider how sources of income and expenditure will impact on your capacity to afford a trip abroad. See Table 6 for examples.

TABLE 6: BUDGETARY ANALYSIS

INCOME	EXPENDITURE
Savings	Student debt (HECS/FEE-HELP)
Wages	Mortgages and loans
Allowances	Insurances
Interest on investments	Credit cards
Dividends	Training and registration costs
Rent	Travel and transport
Grants	Accommodation and living expenses
Scholarships	Family commitments
In-kind donations	Taxes and charges

In undertaking a budgetary analysis and making financial preparations, you should also:

- ensure that you have plans to cover existing expenses;
- leave your financial details with someone you trust;
- notify your bank that you will be travelling overseas, and nominate an individual to liaise with them;
- confirm the validity of your travel, life and income protection insurance;
- clarify the tax implications of working overseas, both in Australia and your destination; and
- complete a power of attorney (or similar) and will.

Security Concerns

Though no overseas travel is without risk, many doctors choose to work in areas where security threats are magnified. Regardless of your destination, it pays to do a security analysis before you leave. You will need to consult sources to develop an overall picture of the situation at your destination. These may include:

- the host organisation or facility;
- local NGO consortia;
- the foreign government (via the relevant ministry or department); and
- the Australian Government

The Australian Government provides general and destination-specific advice for Australians travelling overseas via the Department of Foreign Affairs and Trade. Its website www.smarttraveller.gov.au (1) is an excellent source of up-to-date information and details country-specific advisories as well as general travel advice.

Although you may seek advice from various sources, the decision to travel to a certain region or environment must be made by you. Risk assessment is not a finite science, and your own values and motivations will factor heavily in your decision making. That said, it is useful to be as objective as possible in your security analysis and you should consider all possible sources of risk.

Having made a decision to travel abroad, you will constantly need to assess and reassess your security. Chapter 7 details some handy tips for managing personal safety when you are 'on the ground' in unfamiliar territory.

Practical Preparation

You may already know a lot about the environment to which you are headed. To ensure that you have considered the practical elements of your trip, you might like to use the 'Ten Cs' framework (see Box 6.2).

BOX 6.2: THE 'TEN Cs' FRAMEWORK

Key steps in preparing for your departure:

1. **Communication**: determine local languages and your requirements for translation aids.
2. **Correspondence**: develop a plan to stay in touch with home.
3. **Climate**: investigate weather patterns and how they might impact on your work and travel plans.
4. **Culture**: undertake a cultural analysis and consider what concessions, and behaviour and dress modifications, you may have to make.
5. **Costs and currency**: plan how you will manage your money while travelling, and develop a budget.
6. **Customs and cargo**: research local and customs laws and how they apply to your intended activities, movements and behaviours; also consider baggage restrictions.
7. **Clothing**: consider your clothing requirements for work (eg, scrubs) and play (eg, sports attire) and make sure these are culturally appropriate; don't forget personal protective equipment, including gloves, masks, eyewear and enclosed footwear.
8. **Current and converters**: assess your requirements for electrical converters based on the country's electrical standard.
9. **Clearance and certification**: ensure you have considered Australian and international immigration requirements, and have a valid visa and passport.
10. **Contingency**: buy a travel insurance policy, and consider other safeguard measures.

Travel Health

Just as travel insurance is crucial, it is essential that all travellers seek expert advice with respect to travel health. Source professional input at least three to six months weeks before you depart. Immunisations and chemoprophylaxis for vector-borne diseases are a standard part of most consultations. You should also make every attempt to stabilise chronic medical conditions prior to departure, and make sure you have sufficient supplies of your long-term medication (eg, contraception). If you are carrying PBS-subsidised drugs, read Medicare Australia's advice before you leave (2). In addition, don't forget an adequate supply of contact lenses, solutions and/or spectacles (if you use them), and remember to wear an alert bracelet or necklace if relevant.

In certain environments it will be essential that you carry antiretroviral treatment if there is any risk that you could be exposed to HIV. Before you leave, consult a travel doctor or infectious diseases physician about the postexposure prophylaxis (PEP) product of choice. Some health funds will reimburse the cost of the drugs, which can be expensive. PEP is also available for other infective agents – consult your travel doctor for further advice.

Ensure that you have considered your access to personal protective equipment while abroad. Your host organisation may not be able to provide you with basic hygiene and safety equipment, including sterile and non-sterile gloves, masks, scrubs, eyewear, or even hand-washing liquid.

Regardless of where you are travelling, you should carry a medical kit. This should include pharmacological and non-pharmacological products. Most travel guides will provide you with a list of suggested inclusions.

Most importantly, you must have a comprehensive travel insurance policy; this will facilitate access to medical treatment in the event that you require it. Though Australia has health care agreements with some countries, these are limited to emergency treatment. More information, including the list of countries with active agreements, can be obtained from the Medicare Australia website (3). Be aware that cover does not extend to medical evacuation back to Australia.

Psychological Preparedness

Travelling and working abroad can be immensely rewarding, but also immensely stressful. Different settings offer challenges in different forms and potencies.

It is possible to anticipate and mitigate some sources of stress prior to your departure. You can also act to increase your resilience. In order to do this, ask the following questions before you leave.

What difficult situations might you see as a part of your personal or professional interactions?

You may be faced with a wide range of clinical and cultural situations that might challenge your professional or personal expectations while abroad, such as:

- a lack of sufficient resources required to provide the desired standard of care;
- exposure to high levels of morbidity and mortality, particularly in vulnerable groups such as women and children;
- medical practices deemed unethical in Australia;
- exposure to and interaction with extreme poverty, violence, illness and disability;
- excessive or unwanted attention by particular individuals or the general public; or
- professional and/or social isolation.

What support systems will you have during your placement?

Identify support systems that will be available to you throughout your placement, and plan how you will access them. A resilient doctor in Australia may find it difficult to manage 'standard stressors' in a new environment. Family, friends, colleagues and more formal supports, including counselling services, may be available to you throughout your placement.

Other pre-emptive stress-management strategies that you can employ prior to your departure are:

- list the assumptions and expectations about your role, your identity and expected achievements;
- talk to others who have been on similar deployments;
- educate your friends about the potential impact your work might have on you;
- construct a self-care plan;
- pack a range of recreational materials; and
- plan to have some 'down-time' when you return home.

Self-reflection

Your personality, values, and leadership styles will shape your experiences abroad. For this reason, it is worth reflecting on your interpersonal style before you head overseas. Factors to consider include:

- **Your temperament and personality**. Are you cool and calm in stressful situations, or do you get frustrated or upset? Do you tend to reflect deeply about things, or prefer move on quickly or bottle things up? How will you manage when confronted with difficult situations, such as slow progress with a project, loneliness, or challenges to deeply held values?
- **Your leadership and teamwork style**. Do you like to be in charge, or prefer to play an assisting role? Are you able to be flexible and work with, and for, other people?
- **Your interpersonal style**. Are you talkative and inquisitive when around new people, or do you prefer to wait for others to initiate conversation? How do you make friends? How do you approach difficult conversations, such as breaking bad news, raising concerns, or confronting people about their behaviour? How do you respond to feedback and criticism? How do you go about getting help or advice?

There are tools and resources available that can help you to understand your personality traits and how these affect your work and interactions with others. A local starting point is the Mandala Foundation, which is discussed in chapter 7.

PROFESSIONAL CONSIDERATIONS

While employers have responsibility for the governance and quality of their systems and processes, individual health professionals have an ethical and professional responsibility for their practice. The following advice is aimed at ensuring that junior doctors are suitably prepared to work in a foreign environment.

Experience and Training

Requisite skills and experiences will vary from job to job, agency to agency and setting to setting – as examined in detail in chapter 3. At a minimum, the following attributes are usually required:

- Initial professional qualification and registration
- A minimum of two years' post-registration experience
- A commitment to the aims of the project
- Personal resourcefulness

The extent and range of clinical exposure required will vary with the nature of your position; some organisations will have various specific requirements. Others, especially those engaged in relief work, might have limited criteria but mandate that you have had exposure to a broad range of specialties. Be aware that some agencies may require formal public health or tropical medicine training (depending on the setting); see chapters 9 and 10 for more information on the types of courses available in Australia. Frequently, NGOs operate their own focused pre-departure training programs.

Junior doctors often face difficulty in articulating their skill set. If you are required to inform an employer of your capabilities, it may be useful to refer to the Australian Curriculum Framework for Junior Doctors (4). This resource, available from www.cpmec.org.au, provides a list of capabilities that might reasonably be expected of a doctor who has completed prevocational training in Australia.

A good strategy is to ask experienced mentors, advisers and senior colleagues about the training and exposures that would be most beneficial for your area of practice, and at your stage of progression.

Scope of Practice

Every placement abroad comes about in a different fashion. In some circumstances you may apply for a particular role with specific responsibilities; in others, you could find yourself in a position where there is no job description and the requirements are not clearly delineated. In other words, your role (and scope of practice) may, or may not, be predefined.

Ultimately, you will have to define the limitations of your care, having in mind the nature of the position, your skills and level of knowledge, the resources available, the degree of supervision and the cultural context. 'Knowing what you don't know' is especially important – particularly when working in a professionally challenging setting. You should never expect to have all the answers and, for your patients' safety, you need to know your limits. (This is true for your clinical practice, as well as your physical, mental and emotional wellbeing.) Use the 10 principles outlined in chapter 1 of the Guide to guide your decision making. You can also speak to trusted and experienced advisers.

In emergency work, The Sphere Handbook: Humanitarian Charter and Minimum Standards in Disaster Response sets out what people affected by disasters have a right to expect from humanitarian assistance (5). Underlying the Standards is the Humanitarian Charter, which is based on the principles and provisions of international humanitarian, human rights and refugee law, and the Red Cross and NGO codes of conduct (6,7). You should always practise within the bounds of these documents.

Supervision

In Australia, systems of clinical hierarchy and supervision are universally implemented and widely understood. The role of the trainee is generally recognised and supported. This may not be the case in foreign organisations.

Inevitably, the nature of supervision (eg, direct, indirect or distant) will differ between sites and settings. It is possible that you might be recruited to work under suboptimal supervisory conditions, and you may find yourself being asked to undertake clinical and non-clinical duties beyond your level of expertise (this is not uncommon for junior doctors working in under-resourced settings). You should discuss with your overseas employer issues such as scope of practice, access to supervision, legal responsibility, professional liability and indemnity prior to commencing work. Also consider seeking expert local advice about the professional, cultural and legal ramifications of engaging in practice with varying degrees of supervision.

Occupational Leave

Securing leave from work is usually a significant but not insurmountable hurdle for junior doctors. There may be several options available, depending on the jurisdiction and your contractual arrangements, including short-term humanitarian or professional development leave, extended leave without pay or long-service leave.

Every employer is different, and you will need to get advice on the applicable career break or secondment policies. In certain circumstances, you may need to terminate your contract or resign, in which case there may be ramifications for your public hospital employee entitlements (including access to maternity and paternity leave, long-service leave and superannuation). Seek advice where necessary on implications for your right of return. Whatever your arrangements, make clear written agreements with your employer, especially about continuity of employment (and the related employment rights and allowances). Your local AMA branch will be able to provide advice about your entitlements.

Foreign Employment and Industrial Issues

Prior to your departure, you may be limited in the type of industrial information you can ascertain. Inevitably, you will need to get local advice and your employing organisation or institution is probably the best place to start.

AMA staff will be unable to advise on specific terms and conditions of employment abroad because these contracts are governed by overseas employment law. The national medical association in the country of employment should be the first port of call for detailed industrial relations advice. (You may like to consider joining.)

Registration Requirements

The regulations governing registration are not always as clear cut elsewhere as they are in Australia. In some countries, registration is carried out at the regional level with requirements varying from region to region. Ease of registration will often depend on how much the country or region needs doctors, and most organisations recruiting doctors to areas of need will arrange registration for you. Try to find out as much as possible about registration before you go – particularly the documentation required.

In some cases, you may need a job offer before you can register. Another common requirement is a Certificate of Good Standing; this can usually be obtained from your university, employer or the Medical Board of Australia, who will send it directly to the appropriate health regulator. The conditions for registration will often depend on your individual circumstances and the type of work you will be engaged in.

Also consider your need to maintain Australian medical registration while abroad. The Australian Health Practitioner Regulation Agency (AHPRA) is responsible for registering doctors with the Medical Board of Australia and has a comprehensive website with relevant information (8). If you do not intend to practice in Australia for an extended period of time, it is possible to apply for non-practising registration, which carries a reduced fee. Be aware that the Board has a broad definition of practice that includes "using professional knowledge in a direct non-clinical relationship with clients, working in management, administration, education, research, advisory, regulatory or policy development roles, and any other roles that impact on safe, effective delivery of services in the profession" (9). You should clarify your obligations with your local AHPRA office prior to departure.

Accreditation and Recognition of Training

The pressure to continue along a training pathway is a significant factor is dissuading doctors from working abroad. Junior doctors often fear that they will be disadvantaged by delaying their application to a vocational training program, deferring an accredited registrar position, or interrupting their path to fellowship. While there may be some truth to these perceptions, there is also a lot of myth.

Admittedly, there are certain periods along the training continuum at which it is easier to take time out to travel and work abroad; these would include residency or senior house officer years, and during the fellowship period. In between times, doctors are often discouraged to defer their training because time spent abroad is, in most cases, unrecognised.

There are, however, exceptions to this rule. In developing this Guide, the AMA wrote to all royal colleges and trainee associations to clarify their processes with respect to the recognition of training and employment taken overseas. A significant number of colleges replied, and their responses are detailed in Table 7.

You are encouraged to contact your employer, director of training or college administrator for further information. Box 6.3 details how a physician trainee did this, and managed to gain prospective approval to undertake 12 months of recognised training abroad.

TABLE 7: RECOGNITION OF OVERSEAS TRAINING BY SPECIALTY COLLEGE

COLLEGE	RECOGNITION AND ACCREDITATION	SUPERVISION ARRANGEMENTS	FURTHER INFORMATION
Australian College of Rural and Remote Medicine	Applications for overseas training are considered on a case-by-case basis. Up to six months' training time in an overseas post is recognised. Overseas training posts can be undertaken at any stage after core clinical training requirements (12 months of hospital rotations) have been met. The amount of time recognised depends on the relevance to training requirements and the college's primary curriculum. Registrars are encouraged to apply prospectively in writing for recognition of overseas training.	The college does not arrange supervisors.	www.acrrm.org.au
Australasian College of Sports Physicians	There is no formal policy on recognising the skills gained from volunteer and paid humanitarian work. Trainees can train overseas for an unlimited period provided that the proposed program meets the college's requirements for supervision and case load. Overseas training posts require prospective approval.	Supervisors are approved prospectively. Trainees can only work in a remote location if the training post has received prospective approval. Registrars travelling to remote locations (within Australia and overseas) with sporting teams are offered remote supervision.	www.acsp.org.au
Australian College of Emergency Medicine	Recognition of knowledge and skills obtained from volunteer or humanitarian work are assessed on a case-by-case basis. Provisional trainees can complete up to six months' training in an approved overseas post. Advanced trainees can complete between 18 and 24 months' training in an approved overseas post. Both emergency department (ED) and non-ED training could be completed abroad. Overseas training posts require prospective approval.	All accredited training posts require a supervisor. For some remote locations this requirement can be satisfied by a supervisor who can provide regular contact by an appropriate means of communication and intermittent face-to-face contact.	www.acem.org.au
The Royal Australian College of General Practitioners	The RACGP recognises skills gained in humanitarian work if undertaken as an advanced or extended skills post, ie after completion of the first basic (community-based) term. The maximum length of training abroad is negotiable but at least 12 months of Australian-based general practice is always needed to complete training. Applications should be made prospectively to the Censor-in-Chief of the RACGP. They must be supported by a senior medical educator from the trainee's RTP. If a trainee can successfully argue a case for the relevance of an overseas post and its setting as contributing to their training it is likely to be accepted.	All settings and supervision in overseas posts requires prospective approval by the RACGP. A mix of on-the-ground supervisors and Australian RACGP-accredited supervision accessed via Internet-based technology can be acceptable. Ideally, all places should be recognised by the local learned medical college or training program for local registrars.	www.racgp.org.au

COLLEGE	RECOGNITION AND ACCREDITATION	SUPERVISION ARRANGEMENTS	FURTHER INFORMATION
The Royal Australian and New Zealand College of Obstetricians and Gynaecologists	There is no formal process for recognising skills obtained from volunteer or humanitarian work. Up to 12 months' training time in an overseas post is recognised. This applies to elective trainees (years 5 and 6 of O&G training) and trainees in a sub-specialty program. Trainees in Integrated Training Programs (consortiums of college-accredited hospitals offering basic O&G training for years 1 to 4) can undertake training in accredited hospitals in the United Kingdom. Eligible trainees can undertake training in any overseas post for which they have obtained prospective approval. Elective-level training and overseas sub-specialty training can be undertaken at sites not formally accredited by the college provided the trainee obtains prospective approval.	Remote supervision of trainees in remote locations is generally not allowed.	www.ranzcog.edu.au
The Royal Australasian College of Physicians	Basic training needs to be undertaken in an accredited training post in Australia or New Zealand. Some recognition of prior learning from overseas training will be considered. Training outside Australia and New Zealand by advanced trainees is encouraged. Trainees must satisfy the College that the training and supervision in an overseas post is satisfactory and of an acceptable standard. Trainees are required to seek prospective approval for overseas training.	There are many relief organisations where supervised clinical experience can be obtained. Trainees undertaking such posts should consider having an Australian or New Zealand co-supervisor with whom they can communicate at least every three months. Training undertaken in developing countries could be considered for a maximum six months of non-core advanced training. Posts that do not enable trainees to have an immediate clinical supervisor are not recommended.	www.racp.edu.au
The Royal Australian and New Zealand College of Psychiatrists	Overseas training in an appropriate training post can be accredited towards college fellowship. Accreditation of training is made on a case-by-case basis (arranged by applicant). Basic training – no more than 18 months' FTE (50% of the minimum of 36 months of FTE mandatory basic training) can be completed in an approved overseas post. Advanced training – no more than 12 months' FTE (50% of the minimum of 24 months FTE of mandatory advanced training) can be completed in an approved overseas post. Trainees must apply prospectively for recognition. Generally, no more than 12 months, training completed in an approved training program outside Australia and New Zealand will be accredited retrospectively.	Supervision requirements for trainees training abroad must be met by the service in which they are training.	www.ranzcp.org

BOX 6.3: ORGANISING AN ACCREDITED PLACEMENT ABROAD

Dr Daniel Stefanski (infectious diseases registrar)

From 2006 to 2009 I worked in Botswana for the Botswana–University of Pennsylvania Partnership and managed to negotiate 12 months' RACP accreditation for advanced training in infectious diseases (ID). After passing my RACP clinical exams in mid 2005 I knew I wanted to work in Africa and get experience in a country with high HIV prevalence. I had previously been a medical elective student in Zimbabwe, so I picked out Botswana as a neighbouring but stable, English-speaking country.

The Internet proved invaluable for finding a position. I discovered that there were four potential employers with programs in Botswana, including Harvard and the University of Pennsylvania (UPenn). I found email addresses and sent a letter and my CV to each. Since I intended to stay for several years, I also made a trip in person to meet the key people in each organisation. This helped convince them I was serious about a career in global health, rather than a short-term placement.

Although I initially intended to do research, I decided that it would be best to immerse myself in clinical work to give me a perspective of the health system 'from the coalface'. This was also the best use of my existing skills. On this basis, the UPenn program was the best fit as it was both clinical and educational in focus. I was fortunate to be asked to fill a vacancy six months later.

The opportunities were fantastic. I was employed as an internal medicine 'attending' physician in the medical ward of the referral hospital in the capital, Gaborone. With the second highest prevalence of HIV and TB in the world, the ward was overwhelmed by patients. There was a large and increasing burden of NCDs which required a broad clinical approach. I also worked in the HIV treatment clinics, TB/HIV clinic and multi-drug-resistant TB clinic. By 2008, I was invited to sit on the Botswana HIV Treatment Guidelines Committee, a great opportunity to participate in policy development.

Teaching was the most important component of my work. I took over a clinical and education outreach program and, with my colleagues, expanded it to 13 rural and remote hospital sites covering 100 doctors. It was wonderful to establish all those relationships and it really had a tangible impact. It's easily the most satisfying job I've ever had.

I applied for ID accreditation with the RACP. A professor at the Burnet Institute agreed to be an Australian-based supervisor (and wrote a letter of support to the college) and I had a UPenn ID professor act as a local supervisor. He was in-country directly supervising me for six months in every year. He wrote a letter to the college outlining the spectrum of clinical experience I would gain. Largely because I had direct ID supervision, the RACP granted 12 months core clinical accreditation (spread over a two-year period, which suited me well). Admittedly, it was the experience and work that counted. RACP accreditation was just icing on the cake!

My advice

- In order to have your overseas training recognised, apply prospectively and as early as possible.
- Enlist the support of a local supervisor; this will definitely be to your advantage.

Daniel has now returned to Melbourne where he is completing his advanced training in infectious diseases.

Medical Indemnity

Indemnity may be one of the simpler things to organise prior to heading abroad. Everyone's situation is different, and it is essential that you contact your medical defence organisation (MDO) to clarify your arrangements. At a minimum, you will need to consider the following factors.

Maintaining Cover and Contact in Australia

Even though you are overseas, you may need to retain indemnity coverage for your practice in Australia. It is very likely that you will carry a practice liability and will require 'tail cover'. It is also important to ensure that your cover does not lapse during your absence – especially if you are overseas at the time your policy is usually renewed (usually June 30).

If you will be travelling and not working for three months or more you may be eligible for a premium refund or reduction. If this is the case, your MDO may be able to change your category to a 'non-practising' or 'run-off' type of cover depending on the period that you are away. This arrangement would not be suitable for anyone who may provide medical services of any nature while they are away – with the possible exception of Good Samaritan acts.

Claims or issues may arise in your absence. While you are travelling, your employer or MDO may be notified of an event that occurred prior to your departure. Make sure both have your contact details while you are travelling, in case they need to contact you to obtain a statement or other information. Your MDO may also allow you to nominate a family member as a contact person, should you be unreachable. It is also a good idea to carry with you the contact details of your MDO; many choose to store the 24-hour contact number in their mobile phone.

If you find that you do not provide any medical services in Australia for three years, you become eligible for the Australian Government Run-off Cover Scheme (ROCS). This may obviate your need to take out insurance.

Coverage for Your Work Overseas

Your MDO may be able to cover your overseas work. It will depend on where you are going, the work you are doing and the period you will be abroad. It will also usually be subject to underwriting approval, and may be time limited (eg, 12 months). Most MDOs will require that you place your request for cover in writing, and include the necessary practice details.

If you intend to work for a longer period of time (usually greater than 12 months), you may need to source indemnity from a provider in the destination country. There is an advantage in having an insurer who is familiar with the intricacies of the local health care and medicolegal environments. As in Australia, some public employers abroad may provide indemnity cover as a part of your employment package (eg, the NHS in the UK).

Though most MDO products cover Good Samaritan acts, you should confirm your level of cover with your provider.

Returning Home

Remember to contact your MDO on your return so that it can reinstate your local indemnity cover. If you are thought to be overseas but are practising in Australia, there may be implications for your insurance.

Providing Medical Supplies

Before you depart, find out whether you can bring something of value to your hosts. For instance, the facility might be in short supply of commonly used medicines, single-use products, portable equipment or reference and educational materials. Ask your host facility directly for a list of what they need and try to avoid equipment that requires ongoing expensive supplies.

There are a variety of organisations that can help you procure and transport medical supplies overseas. Many global health interest student groups send supplies overseas each year. Contact local organisations for further information.

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COMPETING INTERESTS

CHAPTER 7

WORKING ON THE GROUND

"The purpose of life, after all, is to live it, to taste experience to the utmost, to reach out eagerly and without fear for newer and richer experiences."

Eleanor Roosevelt
Former First Lady of the USA and Chair of the UN Universal Declaration of Human Rights Drafting Committee

BACKGROUND

This chapter provides advice about managing your personal and professional affairs while abroad. Much of the information dovetails with the content in chapter 6. The aim of this advice is to ensure that your placement is both safe (in terms of impact on the host community, as well as your own health and wellbeing) and effective (in terms of professional output, as well as your ongoing education and development).

GENERAL CONSIDERATIONS
Personal Safety

There are several elements to safety – personal, professional and cultural, to name but a few. The risks to safety are amplified in zones of conflict or instability – and particularly so for aid workers. Attacks on humanitarian workers have increased sharply since 2006 and the trend shows no signs of regressing.

Box 7.1 provides some handy tips about remaining secure, and how risks can be mitigated. Additional precautions will need to be taken by those working in hostile environs, and most NGOs will have a process for distributing relevant advice. For example, the International Federation of Red Cross and Red Crescent Societies has produced *Stay safe* – a guide to safety which can be accessed for free on the Internet (1).

BOX 7.1: PERSONAL SAFETY
Key steps in managing your personal safety while abroad:

On the move

- ensure a third party knows your intended destination, route, and arrival details
- minimise the valuables you carry, and carry essential items in your hand luggage
- place locks on all entry ports into your baggage
- place a business card or identifier inside all pieces of luggage
- never leave your baggage unattended
- assess the safety of proposed forms of transport

On arrival

- act confidently in an unfamiliar environment; don't flaunt your vulnerability
- be wary of un-uniformed taxi drivers – especially at airports
- determine the location of security checkpoints and police stations
- register with the local embassy or other Australian representative
- clarify the role of the security, police and military forces

On the ground

- act conservatively and in accordance with local customs
- keep valuables out of sight and avoid displays of wealth
- use a money belt for carrying your credit cards, money and passport; never leave them in your hotel room
- lock other important items in your luggage in your hotel room (or equivalent)
- keep your laptop with you at all times, or secure it to a permanent fixture
- clarify if it is safe to wander the streets alone, especially at night and if you are female
- be vigilant when crossing or using roadways; motorcycle and car accidents are a major cause of injury to travellers
- avoid large crowds and demonstrations, particularly at times of civil unrest and where the risk of terrorism is high
- carry a mobile phone
- monitor the media and security briefings for updates
- adhere to the instructions of locals

Many of these tips are based on Ruth Stark's suggestions for 'staying safe' in her book *How to succeed in an overseas job* (2).
It is a good source of advice for those seeking further information.

You may find that your host organisation provides formal up-to-date security assessments; alternatively, other organisations may do so on behalf of your NGO or facility. The media will also provide up-to-date information, but its veracity cannot always be counted on. Always take heed of official government advice and bear in mind that local knowledge is often the most accurate.

Cultural Considerations

There are many facets to cultural understanding, and this Guide does not purport to offer comprehensive advice on managing cultural affairs. A key principle, however, is that all visitors should try and minimise embarrassment and offensive behaviour by observing local practices as extensively as possible. See Box 7.2 for some questions to guide your cultural adaptation; this list is certainly not exhaustive, but provides a useful starting point. You might like to consider reading a more authoritative source on intercultural medical placements; an excellent starting point is Hamish Graham's *Beyond borders: McGraw-Hill's guide to health placements* (3).

BOX 7.2: CULTURAL CONSIDERATIONS

Examples of questions to ask about your destination:

- History: How have history and recent events defined local social and political structures?
- Geography: Is the population predominantly urban or rural?
- Politics: What is the primary system of government?
- Foreign relations: Is the country part of a regional or strategic alliance?
- People groups: Are there distinct cultural, ethnic, economic or tribal groups?
- Community structure: Is there a hierarchy within the community?
- Religion: What is the predominant religion, and does observance impact on daily life?
- Clothing: Are there particular dress codes for men and women?
- Gender roles and relationships: Are there restrictions on personal and professional interactions between genders?
- Giving and receiving: When are gifts usually given and received, and are there expectations of reciprocation?
- Buying: Is haggling an accepted practice?
- Photography: Is it appropriate, with consent, to take photos of local people and places?

Given that Australia is a multicultural and relatively liberal society, many training doctors find cultural adaptation a particularly challenging part of their overseas placement. You may be asked to make cultural concessions that are out of keeping with your own values and principles. (For example, you may be challenged by differences in religious practice, gender roles and power relationship.) Reaching a decision that is respectful of your own beliefs, as well as those of your host community, may require considerable thought and reflection.

Remember that cultural adaptation doesn't happen overnight; it's a process. This is reflected in the various phases in the W-curve model of intercultural sojourning (see Figure 1).

FIGURE 1: THE W-CURVE OF INTERNATIONAL SOJOURNING

High

Mood

Low

Honeymoon (Arrival)

Crisis (Culture Shock)

Recovery

Adjustment

Honeymoon (Return Home)

Crisis at Home (Re-entry Shock)

Recovery

Adjustment (At Home)

Time
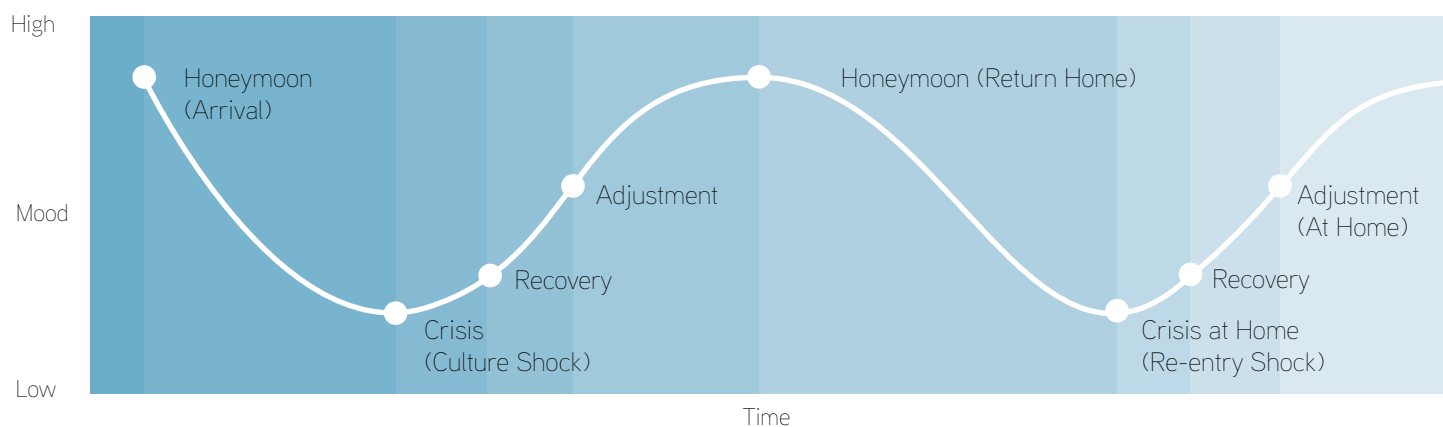
Source: Based on Oberg (4) and Gallahorn and Gallahorn (5)

Assimilation

Assimilating with your host community is an extension of the cultural adjustment process.

Make an effort to:

- develop and nurture key personal and professional relationships
- communicate in a culturally appropriate way
- treat everyone with respect
- take a genuine interest in community activities
- demonstrate your knowledge and interest in local news and events
- talk the local language and indulge in local cuisine as much as possible
- live at the level of local staff
- observe local cultural and spiritual practices
- find ways of being helpful
- consider wearing local dress when appropriate
- ask permission to engage in local activities, and visit certain sites
- be friendly and gracious

You should avoid:

- being 'high maintenance'
- portraying a dominant, 'know-all' or VIP image
- refusing to engage in local practices
- gossiping with locals about locals
- getting involved in local politics
- overindulgence in alcohol, drugs and sex

Managing Stress

Stress is an inevitable by-product of working overseas outside of one's comfort zone. While it can be motivating, it can also be debilitating; if not well managed, it can have an impact on wellbeing, judgement and performance.

Doctors will be familiar with concepts of resilience and burn-out, as well as the types and signs of stress. These are just as applicable in the international setting. So while 'in the field':

- don't expect too much of yourself early on
- try not to overwork
- maintain an open mind, some perspective and a sense of humour
- practise healthy habits (don't overindulge in caffeine, alcohol, over-the-counter or other medications; avoid unhealthy foods; get some exercise; and ensure a good night's sleep) as well as safe sex
- keep a journal and communicate regularly with home
- share things with a trusted colleague or companion

It is worth considering the mechanisms you will use to debrief about personal and professional issues. While it is important to decompress on your return home, it is equally important that you have the capacity to reflect on critical incidents while you are in the field. This issue is dealt with in chapter 8.

These tips are derived from resources produced by the Mandala Foundation (6). More information about psychosocial preparedness for overseas work can be obtained from its website at www.madalafoundation.org.au. Another source of advice is the Antares Foundation (7).

PROFESSIONAL CONSIDERATIONS

This section discusses professional issues that may be encountered in overseas settings. Many of the tips are borrowed from Ruth Stark's book *How to succeed in an overseas job* (2). It is an excellent source of information if you are considering further reading, and will be available shortly.

Finding (and Defining) Your Role

The previous chapter recognised that every placement abroad comes about in a different way. You may have applied for a particular role with specific responsibilities; alternatively, you may have 'fallen in' to a position for which there is no job description and the requirements are not clearly articulated.

Whatever the situation, on arrival, one of your first jobs will be to figure out what your job actually is. The reality of many postings abroad (especially in the development and humanitarian setting) is that even if a job description does exist, it will probably provide an incomplete picture of the position requirements.

For medical professionals, overseas postings may involve clinical, administrative, advisory, research, teaching or managerial components. In most cases, you will probably be doing a mixture of these, and you should clarify the exact nature of your position. Beyond this, the following steps might be helpful in determining (and negotiating) your 'true' role:

- Find out the 'real' reason you were hired – this may vary substantially from the job advertisement.
- Determine who you are working for – this will help define your responsibilities and approach to professional duties.
- Seek out your immediate supervisor – ask them directly about what they expect from you.
- Identify the key players in, and external to, your organisation – this will help identify any additional responsibilities and expectations.
- Talk to the person who was previously in your position – he or she may be able to provide useful background and practical advice.
- Communicate your skills and capabilities to your superiors – they need to be aware of your level of expertise.
- Underpromise in relation to what you might be able to contribute – but always aim to overdeliver.
- Clarify the nature of your supervision – this is especially important in research and clinical settings.
- Be prepared to be flexible and accommodating – in overseas postings, circumstances can change quickly.
- Define your scope of practice – no matter what your job description says, you have to be aware of your own personal and professional boundaries.

This last issue is of particular relevance to junior doctors, who, by definition, are still acquiring medical knowledge and clinical skills. This is poorly understood by some employers with a non-medical background; it is often assumed that anyone with the title 'Doctor' has a predetermined and predictable set of skills.

Dress Code

Special consideration should be given to your professional attire when working abroad. The dress code in many settings is more formal than in Western countries, and knowing what to wear can sometimes be difficult.

The type of work you will be doing will determine your choice of professional dress. In some circumstances, you will receive specific direction from your employing organisation or facility, and may even be supplied clothing. This is especially true of some NGOs. If it is left up to you, the following tips might be of use:

- If in doubt, dress modestly.
- It is always safer to dress up than to dress down.
- First impressions last – you can always remove a tie or jacket later.
- Official meetings warrant formal attire.
- After a period of acclimatisation, consider wearing comfortable local dress.

If you are undertaking a clinical placement, don't forget to take:

- enclosed footwear – most hospitals require it;
- personal clinical equipment (eg, a stethoscope or light source); and
- a set of scrubs and your own personal protective equipment.

Professional Relationships

Building relationships is the key to a successful overseas placement. Little else matters, including the care you provide, if you are unable to work alongside your colleagues. Staff in some countries may be more interested in your personal qualities and capacity to build meaningful relationships than they are in your academic credentials.

Remember that the world of humanitarianism is a relatively small one. Your reputation is important, and stories can spread very quickly across borders. It is worth considering some specific strategies for working alongside local counterparts.
Ruth Stark provides the following tips (2):

- Make local staff your key professional advisers – they will be able to educate you as to historical, political, cultural and protocol issues.
- Be reasonable in your expectations – local educational standards, salary arrangements and work ethics may not be what you are used to.
- Share your life, but keep troubles to yourself – it is important to nurture the personal aspects to your relationship (without overburdening them with your issues).
- Include local staff in planning and decision making at all levels – this is key to sustainability and success.
- Never surprise or embarrass a local counterpart – this is not conducive to a mutually respectful relationship.
- Wherever possible, let local staff take the lead – remember, you are working in their environment and with their people.

As in Australian settings, it is always preferential to talk in terms of 'we' rather than 'I'. This reinforces the notion of inclusiveness and minimises the risk of being seen as paternalistic, arrogant or disrespectful.

When undertaking work in teams, endeavour to clarify your role and responsibilities, and how they fit within the group as a whole. The way groups are structured and function will be influenced by local social and cultural practices, so be careful not to make assumptions based on your Australian experience. If you have questions, it is always best to ask for advice.

Fortunately, medicine is a global profession and, despite regional differences in education and practice, most practitioners will have a solid understanding of the basic scientific method. It is also worth reflecting on the fact that fundamental medical ethics have universal relevance, and that many of the profession's key principles are enshrined in internationally recognised documents (see chapter 1). These factors make the task of working alongside international colleagues significantly easier.

Language

There are several important aspects to communication in a foreign environment, and language is one of them. As mentioned previously, a key strategy is to learn, practise and speak as much of the local dialect as you can. A small effort can go a long way.

In the clinical setting, language barriers can be particularly problematic. You would be well advised to learn basic medical terminology in the local dialect. This includes basic anatomy (abdomen, head, legs, etc.), symptoms (pain, vomiting, diarrhoea, etc.), investigations (blood tests, x-rays, etc.) and medications (oral rehydration solution, paracetamol, artesunate, etc.).

Consider local cultural predilections with respect to communication – especially body language (including eye and physical contact). For instance, you may be advised to talk at a different volume than you would normally because loudness may be interpreted as aggression. Also find out about the appropriateness of talking to the opposite gender, and review your technique for communicating via interpreters.

In the professional setting, English will often be the medical language of choice. Even if that is the case, remember that your national and international colleagues may not be fluent. Adjust your language accordingly.

Clinical Practice

Different regions of the world practise medicine in very different ways. Inevitably, you will notice significant differences in workforce models, resource provision, clinical decision making, use of biotechnology, equity of access and so on. Experiencing (and learning from) these differences is one of the joys of travelling.

Though a detailed discussion of clinical practice in international settings is beyond the scope of this Guide, it is worth noting that there are aspects of medical care that are entirely contextual and dependent on cultural norms and values. Examples would include examining patients of the opposite gender, gaining consent, deciding resource priorities and managing end-of-life care. Importantly, the Western model of medical ethics, where patient autonomy and self-determination are of paramount importance, may not be reflected overseas. Take time to consider these factors before you engage in independent practice.

Be sure to ask for local treatment manuals and guidelines relevant to your practice, and work within their recommendations. Many developing countries have standard approaches to common presentations; these are often symptom based and written at a level appropriate for nursing staff, clinical officers or health care assistants. Not uncommonly, these are based on WHO publications (eg, *Pocket book of hospital care for children* (8)) which usually constitute an excellent resource. Many NGOs also have established clinical protocols and processes; MSF for instance has a suite of references and guidelines (9,10).

Dealing with Government

Working with government officials is often a necessary part of overseas medical practice – especially in under-resourced settings. Particularly where a formalised health service is still developing, low- and high-level government officers may have direct oversight of clinical and non-clinical activities. These might include employees of the immediate health service, the supervising ministry or a responsible intergovernmental organisation (eg, WHO or UNHCR).

This means that you may have to work alongside government officers, and it is useful to consider a few strategies for doing so. The following suggestions are based on the advice of Ruth Stark (2):

- Make courtesy calls – visit those government powerbrokers who have oversight of your work, and start to build relationships.
- Involve local staff in government dealings – this gives credibility to your message, and will minimise the risk of being criticised of 'white anting'.
- Give credit to government officials – look for opportunities to acknowledge the local hospitality and support you have received.
- Avoid frank criticism of government – rehearse your skills in diplomacy, and deploy them when required.
- Exercise patience – dealing with bureaucracy is often frustrating, but it can be a necessary evil.
- Show respect for official channels of communication – these may often seen as burdensome in comparison to those at home, but observance of local protocol is essential to acquiring meaningful government support.
- Secure permission prior to undertaking or publishing research – approval processes may not be as formalised as at home, but following the written or unwritten rules is a basic professional courtesy and ethical requirement.
- Manage your cooperation with other NGOs – although a coordinated approach to advocacy is often useful, you don't want to be seen to be 'ganging up' on local government officials.

Working with the Media

Sometimes working with the media is a necessary part of health practice in the overseas setting. For instance, you might need media support to promote a public health message, recruit patients for a clinic or promulgate a message as part of an advocacy campaign. This Guide is not designed to provide a detailed resource for dealing with the media – for this, you should consider undertaking a formal training course. It is useful, however, to consider a few key tips before engaging with journalists; see Box 7.3. Always talk to your supervisor or employer before engaging in media contact; there may be local protocols and nuances you need to be aware of.

BOX 7.3: WORKING WITH THE MEDIA

Consider the following tips before engaging with the media:

Define your objective
There is little to be gained from talking to the media if you don't know what you want to achieve from it.
You may want to communicate your objective to the journalist before you start.

Be clear on your message
Once you have determined your objective, decide what your key message is.
Deliver it over and over again, no matter what questions are asked.

Consider your angle
To get air time, the story needs to fit into the broader news cycle, and align with other contemporary issues. Be strategic in your timing.

Use a figurehead
It is useful to nominate a single or small group of individuals who will become the 'face' of your campaign.
Make sure that they have the authority to speak to the media.

Be prepared, and check the facts
Know your material; you don't want to be caught out. Don't comment on anything you are unsure about.
If required, ask for briefing material before responding to an unknown authority, statement or position.

Use sound bites
You need to be able to condense your message, if possible, to a simple catch phrase: less than seven seconds is ideal.
Be succinct and memorable.

Practice media strategies
Utilise bridging phrases, repetition and rapport-building techniques. Watch the politicians and see how they do it.

Be brief in your answers
A good interview is a lively exchange of questions and answers – not a monologue. Protracted explanations are unlikely to get picked up.

Ethical Dilemmas

You may have noticed that there are several references in this Guide to ethical decision making. It is inevitable that, in resource-poor environments, you will face ethical dilemmas on a daily basis; examples include choosing how scarce resources are allocated, deciding whether to charge fees for clinical services, and determining what to do with data that was collected without informed consent.

It may be that the 'right' answer may not be as obvious as in the Australian context. While advice on ethical dilemmas is beyond the scope of this Guide, it is important that you have a framework in mind to inform your decision making.

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COMPETING INTERESTS

The authors have declared no competing interests.

CHAPTER 8

RETURNING HOME

"In health there is freedom. Health is the first of all liberties."

Henri-Frederic Amiel
Swiss philosopher

BACKGROUND

Before you work abroad, take some time to consider your homecoming. Thorough preparation – including having plans regarding work, finances and living arrangements – will make returning home much less stressful. You should take time to identify support mechanisms that might help while you are away or when you come home. Also think about how you will learn from your experiences and how they can be shared with others. These concepts, along with those of debriefing and reflection, are explored further in this chapter.

IN-FIELD DEBRIEFING

Debriefing is a critical element of clinical practice in any environment. Though it is important that you have mechanisms to allow you to debrief and decompress on your return home, it is equally important that you have the capacity to reflect on your experiences while you are in the field.

A written debrief is a useful exercise for both the writer and addressee, and can take a variety of forms, from formal report to essay-style pieces of writing. It should include the following:

- description of your roles and responsibilities
- your expectations, the realities and insights into any 'mismatches'
- highlights
- challenges and disappointments
- potential improvements (initial briefing, support, equipment, infrastructure, etc.)
- ongoing or newly identified community needs (specialist services, etc.)
- areas of inefficiency and suggested improvements
- living conditions, travel arrangements

PROFESSIONAL REFLECTION

Professional reflection involves focusing on the practical elements of your work: what was done, how it was done, whether objectives were reached, alternative approaches that could have improved the result, etc. Reflection is an integral part of clinical learning, and invariably continues after you return home. It may be useful to identify other international health workers, particularly those who have worked in similar environments, with whom you can discuss your clinical experiences. Taking photographs or keeping notes may help facilitate this.

Other suggestions for maximising your reflection and sharing the clinical experience include:

- making a presentation at a clinical meeting or grand round;
- taking a tutorial or lecture for local medical students;
- making a presentation to others interested in working in similar areas;
- writing an article for a newsletter, newspaper, community or health interest group;
- publishing research undertaken in a medical journal or magazine; and
- keeping a blog.

PERSONAL DEBRIEFING AND RE-INTEGRATION

Depending on the location, duration and type of work, people working abroad may experience stressors that can manifest as psychological disorders. In studies of aid workers, up to 40% experience psychological difficulty while away or soon after returning (1).

Though there is no sound evidence to support the efficacy of formal debriefing in preventing the development of psychological disorders, it may, for some, help to address stress-related symptoms, enable integration of experiences, provide closure, reduce the sense of isolation and normalise difficulties with readjusting (2).

Personal debriefing involves individual reflection about experiences and helps in gaining a deeper understanding and resolution. This kind of debriefing may take place while abroad or on return and includes individual reflection, such as keeping a journal or posting a blog, as well as sharing experiences with others, for example through discussion with family, friends or colleagues. It also includes formal counselling. Critical incident debriefing is a structured, formal debriefing usually occurring within 24 hours of a traumatic incident. Recent reviews show that it may have limited value in preventing long-term psychological recovery (3,4). Nonetheless, for those considering working in areas where the likelihood of witnessing traumatic or distressing events is high, it is worthwhile investigating the availability of critical incident debriefing support.

Though many workers expect a 'culture shock' when travelling in another country, it is common that a similar readjustment occurs when returning home, particularly if returning from an environment of extreme contrast. This idea was introduced in chapter 7 with the W-curve model of intercultural sojourning. Reactions vary from mild to severe and may include several different features, such as:

- **Withdrawal**. Working abroad can be an adventurous, challenging and, at times, even dangerous endeavour. The adrenaline can flow freely and frequently. Suddenly, this all stops when you arrive home. Not unlike an addiction, some workers crave the fulfilment and energy that they no longer feel back at home.

- **Disappointment**. Returnees want to discuss their intense, life-changing experiences when they return home. It can seem, however, as though no one wants to listen – or often not for long enough. Family and friends are genuinely interested for a time, but often find it impossible to relate, and quickly change the subject to a more local and mutual interest.

- **Anger**. After being surrounded by poverty, disease and suffering for prolonged periods, a relative lack of gratitude among the people back home for basic services can anger international workers. The world that you have come back to can seem selfish and unappreciative of the relative wealth, security and affluent lifestyle that they have become accustomed to.

- **Guilt**. International workers are commonly shown great admiration when they arrive home; they can be heralded as heroes or saviours. Paradoxically, this may induce feelings of guilt, with some workers developing feelings of abandonment and responsibility for those left behind, and believing that the real heroes are the national health workers who don't have the luxury of being able to return to a comfortable and affluent lifestyle.

Below is a list of other useful suggestions from seasoned returned international workers:

- Do not come straight home. Take a break. The longer the placement, the longer the break should be. Develop your timeline for returning home with this in mind.

- Expect to be upset. Do not think you will be immune from problems after you come home. The longer and the more intense your experience, the greater the risk.

- Make sure that your family and close friends know that you may be upset when you return. Ask them to listen to the best of their capability. Ask them just to be there when you return. Remember that their lives have also changed while you were away.

- Expect to have withdrawal effects. See your doctor and get some help if you experience symptoms such as poor sleep or anxiety. Be aware of the dangers of self-medication with alcohol or recreational drugs.

- Expect other people to be uninterested, unconcerned, self-focused and apathetic, including your family and friends. It may be hard for them to listen to you for long periods without losing connection with unimaginable experiences.

- Journal your thoughts. It allows them to flow and may release some of the confusion, frustration and anger. Do not show your journal to anyone else. This allows you to write down anything at all.

- Get psychological counselling whether you feel you need it or not. There is no shame in this. If you think you do not need it, you do. If you think you certainly do not need it, you certainly do. Almost all universities and international organisations provide access to free counselling. Counselling offers a means to express your thoughts and coping techniques that may help now as well as on future placements.
- Talk to other returned international workers. Most universities have local global health groups and most organisations have support groups who meet informally in the major cities. Talking with others who have been through the turmoil and readjustment is therapeutic and reassuring.

BOX 8.1: EXPERIENCES OF A RETURNED HUMANITARIAN WORKER

Dr John Parker (general practitioner)

I have learnt that coming home from missions is difficult for both the person arriving and those close to them. I certainly suffered post-traumatic stress syndrome and it probably contributed to the eventual collapse of my medical practice and even my marriage. Looking back, I shudder at how badly I managed my return and how little support I sought and received. Maybe telling this story will help others manage their return from missions better and allow those close to them to understand.

After spending six months in one of the worst humanitarian disasters in recent times, I left Goma in the Democratic Republic of the Congo on a Tuesday and had five days' holiday in Tanzania before flying to Geneva for a debrief. The debrief occurred over two days but only took three hours. It consisted of two hour-long meetings with various officials who gave the impression of having better and more important things to do. The third hour was spent with a psychologist. She too was somewhat distant and uninterested. From Geneva I flew back to Melbourne for a half-day debrief at the Australian Red Cross office before flying back to Mackay. Eleven days after leaving Goma, having spent over 100 hours travelling, I arrived back home. A day later I was back at work.

It was a dreadful mistake. My partners had not been happy at my precipitate departure six months previously. It had left them with a heavy workload. I do not think that they appreciated how hard I had been working. I had not appreciated how unhappy they had been. That first morning, back in my consulting room, none of the partners welcomed me and was I practically ignored. I was exhausted, jet lagged, irritable, withdrawn and very hurt. Fortunately, at home things were much better. My wife was loving and supportive. The children were spontaneous, excitedly welcoming and overflowing with affection. But my irritability, withdrawal and moodiness confused them. I must have seemed ungrateful and selfish. Like many doctors, I had no general practitioner of my own and I was seeking no professional help. I was self-medicating with alcohol, which calmed me down in the evenings, numbing the acute distress and hurt and helped me sleep.

John's first mission was as a humanitarian worker in Rwanda after the 1995 genocide. He has since completed several further missions to Africa, Afghanistan and most recently ran a Trauma and Burns Unit in northern Iraq.

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COMPETING INTERESTS

The authors have declared no competing interests.

CHAPTER 9
PRACTISING GLOBAL HEALTH IN AUSTRALIA

"The only real nation is humanity."

Paul Farmer
Infectious diseases physician, anthropologist and humanitarian

BACKGROUND

Contributing to global health doesn't necessarily require an adventure overseas. This chapter of the Guide outlines how you can advocate for social and political change, further your understanding of issues through postgraduate education, and participate in relevant initiatives all without leaving Australia.

You can do so because global health begins at home. Consider this: is the wellbeing of a resident from a wealthy suburb of Melbourne or Sydney any more or any less important than the life of a subsistence farmer in Zimbabwe? Both are human beings, and each is entitled to "a standard of living adequate for the health and well-being of himself and of his family" (1).

Though Australians rank among the wealthiest and healthiest people in the world, the same cannot be said for all members of society. Disparities in health and socioeconomic status are stark reminders of the inequity within Australia's population. Health outcomes for Indigenous Australians continue to lag shamefully behind those of non-Indigenous Australians, and higher morbidity and mortality rates characterise populations of low socioeconomic status as well as those living in rural and remote areas.

Similar inequities are evident in our geopolitical neighbourhood. As this guide highlights, one doesn't have to travel to sub-Saharan Africa to encounter poverty. Some of the world's poorest and most isolated nations are located in the Pacific region. Countries like Papua New Guinea and East Timor have life expectancies 10% lower than the global average, on par with Eritrea and Haiti, and lower than Iraq and Bangladesh (2).

For these reasons, this chapter explores how your contribution to global health doesn't have to end (or start) with a placement abroad.

ADVOCACY

What is Advocacy?

Advocacy has been defined as the 'art of persuasion' (3) and refers to "a set of targeted actions directed at decision makers in support of a specific policy issue" (4). In practice however, advocacy may take a number of different forms depending upon the approach. It may involve:

- advocacy *for* those affected by a situation;
- advocacy *with* those affected by a situation; or
- advocacy *by* those affected by a situation.

The most sustainable advocacy is often done by those directly affected by a situation, although many advocacy initiatives will use all three approaches at different times (5).

> *"It takes a lot of confidence and courage to speak up before government ministers of the North, in a language they understand and in a place more familiar to them than to oneself. It takes much more knowledge and imagination to present to them a reality that they are too privileged ever to experience for themselves."*

Maria Teresa Diokno-Pascua, Philippino economist and activist (6)

The Roles of an Advocate

Among other things, advocacy involves identifying the root cause of a problem, raising awareness and educating the community, lobbying decisionmakers, being a voice, building capacity and empowering others to take forward their cause directly. Therefore, an advocate – be it an individual, organisation or coalition – may take on a number of different roles. These roles are often determined by the form, approach and objectives of the advocacy campaign. Examples of potential roles are summarised in Figure 2.

FIGURE 2: POTENTIAL ADVOCACY ROLES

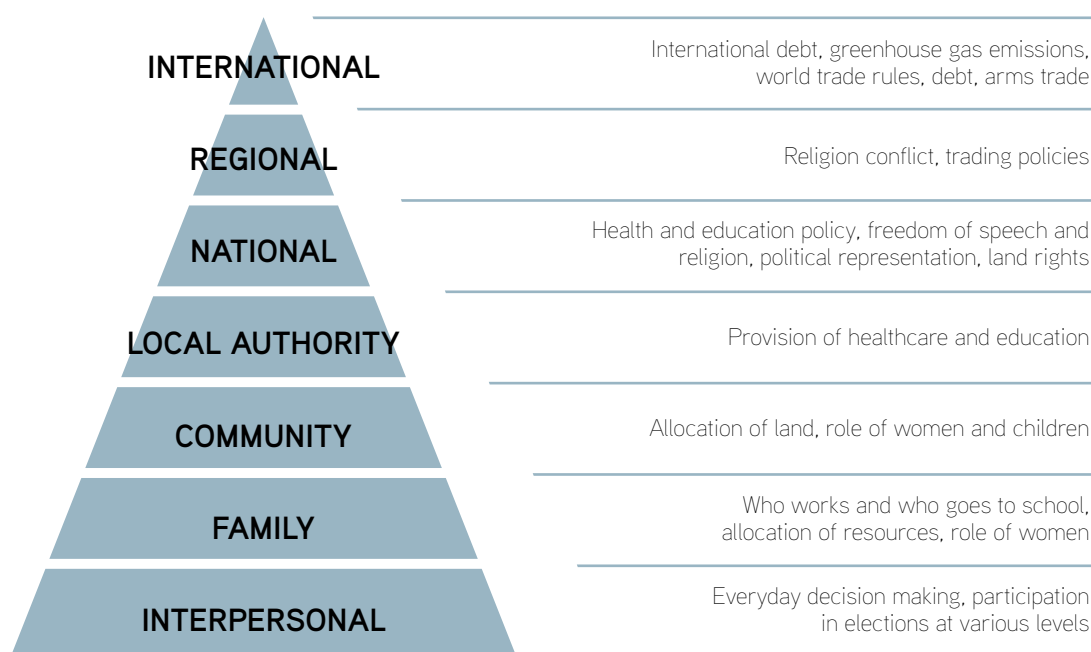| ROLE	CHARACTERISTIC	
Represent	Speak **for** people	
Accompany	Speak **with** people	
Empower	Enable people to speak for themselves	
Mediate	Facilitate communication between people	
Model	Demonstrate the practice to people or policymakers	
Negotiate	Bargain for something	
Network	Build coalitions	

KEY

Advocate

Those affected by a situation

Targets/those in power

Source: Tearfund UK (5)

Levels of Advocacy

Advocacy can take place at a number of levels, ranging from interpersonal, everyday decision making within a family or organisation, through to engaging issues of national and international importance. Different levels of advocacy are depicted in Figure 3. Importantly, decisions made at one level affect people at another level. Therefore, advocacy is necessary at all levels in order to bring about lasting change.

FIGURE 3: LEVELS OF ADVOCACY

Level	Issues
INTERNATIONAL	International debt, greenhouse gas emissions, world trade rules, debt, arms trade
REGIONAL	Religion conflict, trading policies
NATIONAL	Health and education policy, freedom of speech and religion, political representation, land rights
LOCAL AUTHORITY	Provision of healthcare and education
COMMUNITY	Allocation of land, role of women and children
FAMILY	Who works and who goes to school, allocation of resources, role of women
INTERPERSONAL	Everyday decision making, participation in elections at various levels

Source: Tearfund UK (5)

Advocacy within Global Health

Advocacy plays an important role in the field of global health. Providing a voice to the voiceless is paramount in highlighting the great inequity in health determinants, health care provision, and health attainment in different parts of the world. Médicins Sans Frontières (MSF) is an example of a well known medical humanitarian organisation that openly seeks to raise awareness by speaking out about the plight of, and acting on behalf of, the populations for whom it works (7). Most international aid and development organisations incorporate advocacy into their core working business, particularly those based in developed countries where efficient communication channels facilitate access to both the voting public and senior policymakers. The exact method by which NGOs do this will differ from organisation to organisation – on a scale from quiet persuasion of key decisionmakers (eg, the International Federation of the Red Cross) to vehement denunciation of implicated parties (eg, Amnesty International).

"Silence has long been confused with neutrality, and has been presented as a necessary condition for humanitarian action. From its beginning, MSF was created in opposition to this assumption. We are not sure that words can always save lives, but we know that silence can certainly kill."

James Orbinski, former President of Médicins Sans Frontières International Council (8)

Medical students and doctors are engaged with both local communities (through their work) and stakeholders (professional associations, policymakers and the like) who may be the targets of advocacy efforts. Therefore, there are multiple entry points for medical professionals to engage in advocacy.

Many instances of successful advocacy campaigns involving medical professionals exist. One example is the concerted advocacy efforts by a range of groups, including MSF and the Treatment Action Campaign, which led to improved access to antiretroviral therapy for rural and resource-poor communities in South Africa.

CAMPAIGNING

What is Campaigning?

Amnesty International defines campaigning as an organised course of action to achieve change. Through targeting specific issues, campaigning aims to influence the policy and behaviour of institutions or specific public groups (9).

In order to be successful, there are a number of key principles that can assist decision making and the development of effective campaign strategies (10):

- Focus – are the objectives of the campaign specific?
- Clarity – are the objectives and strategy communicated clearly?
- Credibility – are the motivation and information-basis trustworthy and reliable?
- Relevance – does the campaign connect with those people it seeks to involve and offer a solution relevant to the problem?
- Timing – is the campaign appropriately timed to support the largest exposure and effect?
- Commitment – is the campaign sustainable?

Many of the above principles are interrelated, and need to be integrated strategically in order to achieve desired objectives. A number of tools can be used to evaluate a campaign strategy – including the SWOT analysis (**strengths**, **weaknesses**, **opportunities** and **threats**).

Campaigning Techniques

Campaigns may take on a variety of forms and employ a range of techniques to mobilise a target audience and achieve objectives. Importantly, campaigning is a dynamic process with new techniques and variations constantly emerging. It pays to be creative. Which techniques are most appropriate, and how they are employed and integrated, will be determined by the overall campaign strategy.

Some common examples of techniques employed by campaigning organisations include:

- use of the media
- lobbying
- public events and protests
- letter writing and petitions
- speaking tours
- celebrity support
- outreach
- websites and online social networking

The Internet provides a wealth of information and materials to assist in preparing, planning and running campaigns using various techniques. The resources list at the end of this guide is a useful starting point.

Starting a Campaign – Key Considerations

"Campaigning is only worthwhile if it leads to real, long-term change. A newspaper headline, a big event, or a lobbying meeting are worth nothing unless change follows. Sometimes it's hard to measure the impact of campaigning, and we know that change can take a long time. But we know our efforts have made a difference in the campaigns to ban land-mines, cut Third World debt and have begun to change the rules of world trade. We believe that if we continue to campaign for change, alongside our emergency response to disasters and our long-term development work, Oxfam will play its part in the fight to overcome poverty and injustice."

Adrian Lovett, former Director of Campaigns for Oxfam Great Britain (11)

As is evident in the following sections, campaigns can range in size from local initiatives in a community organisation or workplace, through to international coalitions and alliances lobbying governments and multinational corporations. Though the scale of these undertakings varies enormously, the basic stages in organising, developing, and executing a campaign are remarkably similar. These are identified below:

Step 1: **Problem identification**
Defining the issue to be addressed

Step 2: **Background research and analysis**
Understanding of causes and effects of problem, market research, identification of key stakeholders, etc.

Step 3: **Planning**
Formulation of strategy: goals, objectives, measures of success, methods, allies, scale, SWOT analysis, etc.

Step 4: **Implementation**
With available resources, based on agreed strategy

Step 5: **Evaluation**
Ongoing throughout process with comprehensive review

Managing change and relationships within any organisation is a key part of the process (12).

Campaigning within the Local Community

Grassroots campaigning can be both rewarding and effective. The 'Global Call to Action Against Poverty' provides various examples of community-based actions (13), as does the 'Global Poverty Project' (14). For medical students, local global health groups and medical students' societies are well placed to lend support to initiatives and can serve as valuable promotional channels.

National and International Campaigns

Recent years have seen a groundswell of public support for large-scale campaigns coordinated by coalitions of NGOs and community groups. Prominent examples include the global 'Make Poverty History' movement and, in Australia, the 'Close the Gap' campaign to achieve Indigenous health equality. While both of these campaigns have gained prominence in the media and public arenas, countless others exist that involve medical student and professional medical networks domestically and internationally. The Medical Association for the Prevention of War (MAPW) for example, while campaigning at a national level in Australia, is an active affiliate of the International Physicians for the Prevention of Nuclear War (15).

The Importance of Evaluation

The impact of campaigning activities will not be known unless formal evaluation processes are carried out. This is an essential but frequently overlooked component of the campaign cycle. The evaluation of campaign activities and their impact may take a variety of forms, depending upon factors such as human resource capacity and the nature of the campaign objectives. Regardless of the approach taken and methods used, the important aspect of evaluation is that lessons are learnt and built upon to improve the effectiveness of future campaign initiatives. This point has been well made by Noam Chomsky (16).

BOX 9.1: TIPS AND TRICKS FOR ADVOCACY AND CAMPAIGNING

- Be specific in what you are seeking to achieve. Set goals that are clearly defined, measurable, and attainable. Employ discrete objectives to direct your approach towards achieving those goals.
- Time any initiatives to precede or coincide with pertinent public or political events, such as the release of policy documents, notable days of recognition, conferences or public discussions. This may encourage media attention, thereby raising the initiative's profile, while providing contextual relevance.
- Diversify the techniques used to promote a message.
- Be creative when presenting information to capture a target audience in a unique and fresh way. Ask the question: *has this been done before?*
- Engage like-minded partner organisations to share resources and add legitimacy to an initiative. Ensure roles and responsibilities are clear and delineated between organisations to foster a mutually beneficial relationship. Play to each other's strengths.
- Key into an organisation's agenda, whether enlisting support from parent organisations (as above) or campaigning against a particular organisation's practices. Conveying a message that is relevant to the interests of the organisation and its stakeholders will demand attention and work to your advantage.

EDUCATION

During recent years, concerted pressure from students has resulted in increased content within medical curricula dedicated to addressing global and public health issues. Many institutions have sought to cater for student interest by incorporating case-based learning activities, lecture series and honours programs into medical curricula. This learning provides a theoretical platform from which to explore the rapidly expanding sea of literature relating to international public health and development, and to begin to identify potential career opportunities.

There are many avenues through which to enter the professional global health arena. Government systems, bilateral projects, NGOs, research and public health institutions all provide starting points. Yet as with many careers, it is increasingly likely that prospective employers will require some formal postgraduate qualifications.

A wide range of educational programs is available to accommodate every level of interest. Short courses in global health-related fields are offered by universities, research and policy institutes and NGOs. These may be delivered via intensive summer programs, evening classes or distance education by correspondence, allowing flexibility with work or personal commitments.

For those with more time, a Masters in Public Health or a degree in a similar area is widely regarded as the entry point to a career in many global health fields. Several providers in Australia offer a range of courses and degrees in disciplines including international public health, epidemiology, international development and many others. Programs vary in content, delivery and mode of assessment, so it is worthwhile spending time researching those best suited to your individual learning preferences, field of interest and future career ambitions.

Table 8 illustrates the range of educational opportunities available, together with some of their advantages and limitations.

TABLE 8: EDUCATIONAL OPPORTUNITIES

TYPE OF STUDY	EXAMPLE TOPICS	ADVANTAGES	LIMITATIONS
Online courses	• Refugee health • Maternal and child health • Infectious diseases	• Easily accessible • Often at no cost • Study at your own pace • Many delivered by well respected institutions • Can cover a wide range of topics in a short period of time	• No official qualifications gained • Little quality control of course material • Limited depth of course material • Usually little academic interaction and support
Short courses and diplomas	• International health • Global health research and practice	• More in-depth course content • Official qualification gained • Course material quality controlled • Part-time for a relatively short period • Some academic interaction and support	• Still a limited depth of content • Heavier time commitment • Some costs involved
Masters and doctorates	• Public health • International health • Tropical medicine • International development • Applied epidemiology • Development economics	• In-depth course content sometimes with research components • Gain an official qualification • Course content quality-controlled • Often strong academic interaction and support • Increasing opportunities for distance learning and for joint MBBS/MPH degrees	• Usually full-time or part-time for a longer period of time • Often require face-to-face contact; limited possibilities for distance learning • Can be expensive • Only offered at certain educational institutions

INITIATIVES AND INVOLVEMENT

For Medical Students

Recent years have seen a groundswell in interest among Australian medical students to learn more about global health and the ethical challenges facing the future medical workforce in an era of unprecedented globalisation.

Coordinated by the Global Health Network (GHN), a subcommittee of AMSA, there is a global health interest group at every medical school in Australia. Each group works within the local university and wider community to raise awareness about global health issues. Several groups now oversee large-scale medical aid projects, and others coordinate in-country research and volunteer placements for medical students.

Each year the national AMSA Global Health Conference brings together medical students from throughout Australia and overseas to explore and debate current issues influencing global health policy and practice. The conference's diverse academic program traditionally offers delegates a holistic approach towards understanding economic, social, political and environmental determinants of health in developing communities. As the only student-run academic forum held in Oceania that focuses solely on global health, the conference is a unique platform for sharing knowledge, exchanging ideas, highlighting initiatives and driving AMSA's position on global health issues.

More recently, policy development has been a feature of discussion groups established around the country under the model of local 'think tanks'. Born out of an initiative at Monash University, the concept involves committed medical students meeting regularly to discuss topical health issues of national and global significance. Discussions, supported by background research undertaken by participants, have led to the emergence of national campaigns (see Box 9.2) as well as the development of policies that now define AMSA's stance on a variety of public and global health issues.

BOX 9.2: CODE GREEN – A CLIMATE EMERGENCY

In the lead-up to the highly publicised 15th Conference of the Parties in Copenhagen in 2009, AMSA adopted Code Green as a national advocacy campaign on the impact of climate change on health (17). The campaign was run in partnership with Doctors for the Environment Australia, and incorporated three components:

(i) a short introductory video made publicly available through the AMSA website;

(ii) a resource guide published online for medical students; and

(iii) a public symposium to launch the campaign, featuring keynote speakers such as Senator Bob Brown (leader of the Australian Greens), Professor John Thwaites (former Victorian Government Minister for Health and the Environment) and Professor Tony McMichael (WHO Consultant on Climate and Health and former Director of the National Centre for Epidemiology and Population Health).

At a wider level, the International Federation of Medical Student Associations (IFMSA) is the global body charged with representing the interests of medical student associations around the world. The IFMSA is recognised by the UN and WHO (see Box 9.3) as the international forum for medical students. Through AMSA, Australian medical students have the opportunity to attend one of the biannual general assembly meetings of the IFMSA. The opportunity also exists for students to undertake part of their medical studies overseas through the Federation's longstanding exchange program. Think Global, an official project of IFMSA, leads global health-related activities by coordinating training and advocacy campaigns and supporting the initiatives of national member organisations. See www.ifmsa.org (18).

BOX 9.3: DID SOMEONE SAY GENEVA?

The WHO offers opportunities for students to spend time at one of its regional offices or Geneva headquarters through its student internships program. For further details on the program, visit http://www.who.int/employment/internship/interns/en/index.html (19).

The above initiatives represent only some of the current avenues through which medical students can engage with global health issues. Undoubtedly, there is still much more to do and countless other opportunities exist to get involved. Why not consider contacting your local global health group, providing your own ideas and input on initiatives, or even run your own education or advocacy campaign?

For Doctors

A number of initiatives have also recently been established for professionals with an interest in global health. One such example is Melbourne's 'Global Health Symposia' lecture series, run by junior doctors and supported by the Victorian branch of the Australian Medical Association in conjunction with the Nossal Institute for Global Health.

In Sydney, 'Global Health Drinks' (www.globalhealthdrinks.org) represents an informal community of Australian junior doctors who are passionate about global health. The group supports trainees and new health practitioners to engage with international health through a variety of avenues. Regular gatherings with guest speakers is one avenue through which the group promotes awareness within the community.

There are also numerous advocacy groups that engage in the global health space and would welcome medical practitioner members. Membership of these groups provides an opportunity to engage in policy-making and representative activities. The AMA develops public health policy on global health issues that are relevant to Australia. Examples include climate change, Indigenous health and chronic disease (20). Other organisations include the Medical Association for the Prevention of War, Doctors for the Environment Australia and the Public Health Association of Australia.

Two good resources for keeping abreast of global health-related events and activities in your area are the Australian Council for International Development and the recently launched Global Health Gateway (see Box 9.4).

BOX 9.4: THE GLOBAL HEALTH GATEWAY

Launched in 2010, the Global Health Gateway is an open network for everyone in Australia and New Zealand who is committed to a positive future in global health. Developed by junior doctors, the portal provides a number of free online services, including:

- a calendar of events,
- public discussion forums,
- information on education and training,
- links to work and volunteer opportunities, and
- fun activities such as book and film clubs.

For more information, visit www.globalhealthgateway.org.au (21).

INCORPORATING GLOBAL HEALTH INTO CLINICAL PRACTICE

There exist numerous opportunities to incorporate global and public health activities into one's clinical practice. The capacity in which you can contribute will naturally vary according to your stage of medical training and level of clinical experience.

Global health in its broadest sense encompasses the health and wellbeing of all Australians. However, in considering working with marginalised and disadvantaged populations for whom health outcomes are poorer and sociocultural barriers impede access to health information and services, some communities deserve particular attention.

Indigenous Australians

The significantly poorer health outcomes experienced by Indigenous Australians when compared with the national population are clearly documented (22). A discussion of the health care needs of Indigenous communities in Australia is well outside the scope of this publication, but the importance of meaningful dialogue, from local community to senior policy levels, cannot be underestimated. Though a growing body of literature provides background to the statistics, there is no substitute for informed and respectful firsthand experience to provide context to the figures.

There are many and varied circumstances in which one can work in Indigenous health, ranging from Indigenous community-controlled health organisations in inner city environments to regional hospitals and remote clinics. Timeframes can also vary significantly, from long-term employment to short-term locum relief that can provide valuable support to local doctors, reducing burnout and enhancing continuity of service. Regardless of context, working in partnership with Australian Indigenous communities provides a rich learning experience that can be filled with positive challenges and satisfying rewards.

Migrants, Refugees and Asylum Seekers

The specific health care needs of immigrants are increasingly being recognised. Some excellent resources are now becoming available for health professionals interested in the area (23). A selection of these is included in chapter 10. Local organisations working with recent immigrants, refugees and asylum seekers are also a valuable source of information. Some, like the Asylum Seekers Resource Centre in Melbourne (24), provide a health service that is supported by the volunteer contributions of medical and allied health practitioners. Why not look into the services offered in your local area?

Towards a Public Health Career

The website of the Australasian Faculty of Public Health Medicine (AFPHM) provides information about further training and key competencies for public health specialists (25). If fellowship as a public health physician is too daunting a prospect, many opportunities exist for doctors-in-training to explore areas of interest in global or public health, in capacities ranging from full-time employment in domestic programs to assisting with research collaborations voluntarily. Programs such as the Prevocational General Practice Placements Program (PGPPP) and state-based public health training schemes facilitate short-term accredited rotations in a wide range of settings. Such experiences provide a taste of public health medicine and may open doors to exciting clinical career opportunities both at home and abroad. Many staff in schools of public or population health with experience in international health are happy to discuss career and capacity-building opportunities, as well as their own work.

WHERE TO NEXT?

This chapter has provided a general overview of selected opportunities that exist for medical students and junior doctors to become involved in global health in Australia. It has introduced the concepts of advocacy and campaigning, and identified some of the opportunities for further study and clinical practice in the field. Clearly the content is not exhaustive – far more detailed and comprehensive information is readily available on the Internet. It is with this in mind that you are directed to the resources in chapter 10. Spend time exploring websites of interest; make enquiries with organisations that resonate with your values and beliefs and don't underestimate the importance of thinking globally while acting locally.

REFERENCES AND RESOURCES

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2.   United Nations Development Program. Overcoming barriers: human mobility and development. Human development report 2009. New York: UNDR, 2009. http://hdr.undp.org/en/media/HDR_2009_EN_Complete.pdf (accessed May 2011).

3.   The Australian Advocacy Institute. http://www.advocacy.com.au/aaimenu.htm (accessed Sep 2009).

4.   The Policy Project. Networking for policy change: an advocacy training manual. Washington DC: The Futures Group International, 1999.

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10.   Amnesty International. Campaigning manual. London: Amnesty International, 1997.

11.   Medsin. Campaigning resource pack. http://www.medsin.org/resources/campaigns/pack (accessed Jul 2009).

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14.   Global Poverty Project. How-to guides. http://www.globalpovertyproject.com/howto (accessed Sep 2009).

15.   Medical Association for the Prevention of War (Australia). http://www.mapw.org.au (accessed Mar 2010).

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18.   The International Federation of Medical Students' Associations. http://www.ifmsa.org (accessed Aug 2010).

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21.   Global Health Gateway. http://www.globalhealthgateway.org.au (accessed Aug 2010).

22.   Australian Bureau of Statistics and the Australian Institute of Health and Welfare. The health and welfare of Australia's Aboriginal and Torres Strait Islander peoples. Canberra: ABS and AIHW, 2008.

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24.   The Asylum Seeker Resource Centre. http://www.asrc.org.au (accessed Jul 2010).

25.   The Royal Australasian College of Physicians. Australasian Faculty of Public Health Medicine. http://www.racp.edu.au/page/racp-faculties/australasian-faculty-of-public-health-medicine/ (accessed Aug 2010).

COMPETING INTERESTS

CHAPTER 10

LEARNING MORE
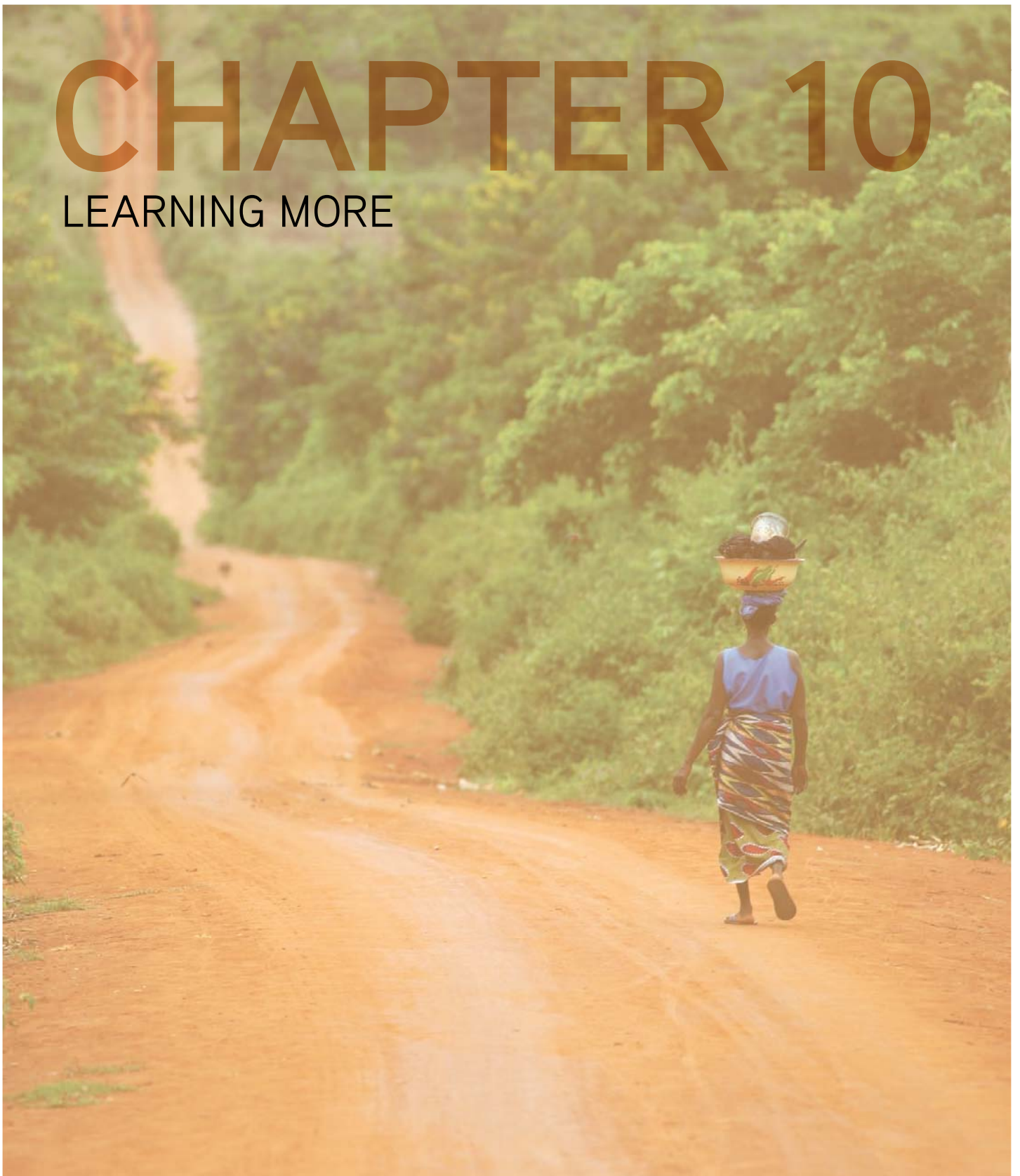
"Never doubt that a small group of thoughtful, committed citizens can change the world; indeed, it's the only thing that ever has."

Margaret Mead
American anthropologist and social commentator

BACKGROUND

Having considered the information in this Guide, you may be interested in reading more about specific organisations or opportunities. Below is a comprehensive list of resources and references.

FURTHER READING AND RESOURCES

Guides to Working in Overseas Settings

Printed Materials

- Graham, H. Beyond borders: McGraw-Hill's guide to health placements. North Ryde: McGraw-Hill Australia, 2005.
- Stark, R. How to succeed in an overseas job. Seattle: University of Washington Press, in press. (Contact ruthstark05@yahoo.com)
- Wilson, M. The medic's guide to work and electives around the world. 2nd ed. London: Hodder Education, 2005.

Online Materials

- British Medical Association. Guide to working abroad – http://www.bma.org.uk/international/working_abroad/Workingabroadguide.jsp
- Department of Health (UK). International humanitarian and health work: toolkit to support good practice – http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/Browsable/DH_4102935
- University College London Centre for International Health and Development. The elective pack: the medical student's guide to essential international health and development – http://www.ucl.ac.uk/cihd/undergraduate/elective_info/elective_pack

Employment and Volunteer Opportunities

Deploying, Coordinating and Supervising Organisations

- Australian Agency for International Development (AusAID) – www.ausaid.gov.au
- Australian Defence Force – www.defence.gov.au
- Australian Council for International Development (ACFID) – www.acfid.asn.au
- Australasian Faculty of Public Health Medicine – www.afphm.racp.edu.au
- Australian Volunteers International – www.australianvolunteers.com
- Australian Youth Ambassadors for Development (AYAD) – www.ayad.com.au
- CARE (Australia) – www.careaustralia.org.au
- Caritas – www.caritas.org.au
- Child Family Health International – www.cfhi.org
- Concern Universal – www.concernuniversal.org
- Council for International Development – www.cid.org.nz
- Department for International Development – www.dfid.gov.uk
- Fred Hollows Foundation – www.hollows.org
- Global Focus Aotearoa – www.globalfocus.org.nz
- The Global Fund – www.theglobalfund.org
- Health Volunteers Overseas – www.hvousa.org
- International Committee of the Red Cross – www.icrc.org
- International Medical Corps – www.imcworldwide.org
- International Rescue Committee – www.theirc.org
- International Rescue Corps – www.intrescue.org
- International Service – www.internationalservice.org.uk

- Justice Africa – **www.justiceafrica.org**
- MDG (Millenium Development Goals) Monitor – **www.mdgmonitor.org**
- Médecins du Monde – **www.mdm-international.org**
- Médicins Sans Frontières (Australia) – **www.msf.org.au**
- Medical Emergency Relief International – **www.merlin.org.uk**
- Mercy Corps – **www.mercycorps.org**
- Operation Smile – **www.operationsmile.org**
- Oxfam (Australia) – **www.oxfam.org.au**
- Pacific Islands Association of NGOs (PIANGO) – **www.piango.org**
- Plan International – **www.plan.org.au**
- Project HOPE – **www.projecthope.org**
- RedR – **www.redr.org**
- Response International – **www.responseinternational.org.uk**
- Save the Children – **www.savethechildren.org.au**
- United Nations Volunteers – **www.unv.org**
- UNHCR (regional office) – **www.unhcr.org.au**
- Voluntary Service Overseas (VSO) – **www.vso.org.uk**
- Volunteering for International Development from Australia – **www.vidavolunteers.com.au**
- World Food Program – **www.wfp.org**
- World Vision – **www.worldvision.org.au**

Workforce Agencies

- Australian Development Gateway – **www.developmentgateway.com.au**
- Dev Net – **www.devnetjobs.org**
- GoVolunteer – **www.govolunteer.com.au**
- Interserve – **www.interserve.org.au**
- Medics Travel – **www.medicstravel.co.uk**
- RedR Australia – **www.redR.org.au**
- Volunteer Match – **www.volunteermatch.com.au**
- Relief Web – **www.reliefweb.int**

Medical Student Projects and Electives

- Global Health Network – **www.ghn.amsa.org.au**
- International Federation of Medical Students' Associations – **www.ifmsa.org**
- John Flynn Placement Program – **www.acrrm.org.au/john-flynn-placement-program-0**
- MDA National Elective Network – **www.mdanational.com.au/students/electives-network.aspx**
- The Student Movement of International Physicians for the Prevention of Nuclear War MedEx multilateral student exchange program – **www.ippnw-students.org**
- Projects Abroad – **www.projects-abroad.org**

Preparation and Training

Academic Institutions

- Australian Council for International Development (ACFID) – www.acfid.asn.au
- Australian Institute of Tropical Medicine (James Cook University) – www.jcu.edu.au
- The American Society of Tropical Medicine and Hygiene – www.astmh.org/Approved_Diploma_Courses/2085.htm
- Burnet Institute Centre for International Health – www.burnet.edu.au/home/cih
- Institute of Tropical Medicine Antwerp – www.itg.be
- International Health and Medical Education Centre, University College London – www.ucl.ac.uk/cihd/
- John Hopkins Centre for Global Health – www.hopkinsglobalhealth.org
- Liverpool School of Tropical Medicine – www.lstmliverpool.ac.uk/learning_teaching/post_grad
- The Lancet Global Health Network – www.thelancetglobalhealthnetwork.com/
- London School of Hygiene and Tropical Medicine – www.lshtm.ac.uk/prospectus/
- National Centre for Epidemiology and Population Health, Australian National University – www.nceph.anu.edu.au
- The Nossal Institute for Global Health, University of Melbourne – www.ni.unimelb.edu.au/
- Public Health Association of Australia– www.phaa.net.au

Other Training Courses

- Australian Council for International Development (ACFID) – www.acfid.asn.au
- Community Empowerment – www.scn.org/cmp
- Mandala Foundation – www.mandalafoundation.org.au
- Medical Peace Work – www.medicalpeacework.org
- International Association for Humanitarian Policy and Conflict Research (HPCR International) – www.hpcr.org
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- RedR – www.redr.org.uk
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Organisations

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- Amnesty International – www.amnesty.org.au
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- Family Health International – www.fhi.org
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- Global Health Education Consortium (GHEC) – www.globalhealthedu.org
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- Human Rights Watch – www.hrw.org
- Humanitarian Practice Network – www.odihpn.org
- Interaction – www.interaction.org
- International Federation of Health and Human Rights Organisations – www.ifhhro.org

- International Health and Medical Education Centre – www.ihmec.ucl.ac.u*k*
- International Physicians for the Prevention of War – **www.ippnw.org**
- National Aboriginal Community Controlled Health Organisation – **www.naccho.org.au**
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- Partners in Health – **www.pih.org**
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COMPETING INTERESTS

The authors have declared no competing interests.