

UROLINK: a model for working together in a changing world

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Introduction

'It can no longer be acceptable to ignore the health problems of those who do not have access to even basic medical care.'

These words of the late Professor Geoffrey Chisholm [1] provide a reminder that despite increasing 'globalization' urological services are confined largely to the economically privileged, whether citizens of wealthy countries or wealthy citizens of impoverished ones. Professor Chisholm, when President of the BAUS, encouraged discussion on how British urology might contribute more to the wider urological needs of the world, although the seeds for this were sown some years earlier (Table 1). As a result, in 1990 a working party was set up by the BAUS Council which proposed forming 'UROLINK', an acronym derived from 'Urology Overseas Links', to encourage BAUS members to contribute more actively and effectively to developing world urology and co-ordinate these efforts. UROLINK's objectives are summed up in its original mission statement: 'To promote and encourage the provision of appropriate urological expertise and education worldwide with particular emphasis on the materially disadvantaged'. Underpinning these aims is a belief that an approach by individuals, forming links with overseas counterparts, as reflected in the name UROLINK, is most likely to bear fruit.

In a rapidly changing world there must be a will to adapt and during the 10 years of UROLINK's existence there has been a considerable shift in policy by international aid agencies and other nongovernmental organizations. The term 'developing world' has replaced 'third world'; the emphasis is now on partnership not patronage, ownership not charity and sustainability rather than short-term sustenance. Nevertheless, the disparity between rich and poor and the need for international co-operation is greater than ever.

UROLINK philosophy

Surgeons enjoy many unique privileges, including membership of a profession sharing common goals of promoting health, and with a long tradition of

international co-operation, frequently able to transcend national, cultural, ideological and political boundaries in the interests of the needs of patients.

UROLINK identified five areas of activity (Table 2) with a deliberate emphasis on small-scale links and projects. This 'bottom-up' approach remains the best way of supporting colleagues who have few opportunities for postgraduate education, professional development or participation in international meetings. UROLINK began as a BAUS working party in 1990 and remained a working party until 1996, when it became an official BAUS committee. With the restructuring of the BAUS organization in 1999 UROLINK's role was enhanced by establishing a faculty of BAUS members willing to be actively involved in promoting UROLINK's goals, and by working more closely with trainees through SURG (Specialist Urological Registrars Group). UROLINK's effectiveness has been greatly strengthened by generating funds from a variety of sources, including commercial companies, and by individual fund-raising initiatives. This has enabled financial support to be provided in a variety of ways, e.g. the purchase of equipment and educational material, and grants towards travel costs, although most overseas visits have been, and remain, self-funded.

UROLINK in action

There are many excellent national and international urological organizations that are important in promoting urology internationally. This is recognized by UROLINK, which has never sought to compete with them, but believes that collaboration at a personal level is more likely to be a basis for effective co-operation leading to mutually beneficial and sustainable projects. Such low-key, small-scale activities are also more likely to reach colleagues in parts of the world where doctors' incomes may be so low that professional contact and educational activities are absent or severely limited.

Linking with an overseas department is the basic UROLINK building block. Many urologists have at some time had contact with overseas colleagues through visiting trainees, professional meetings, or overseas travel. Such contacts can be the 'seed-corn' for a link

Table 1 Milestones in UROLINK's development

| Year | Event |
|------|---|
| 1983 | Proposals to form Tropical Urology Society |
| 1985 | Proposal to establish links with the Association of Surgeons of East Africa |
| 1986 | Prof. Blandy invites suggestions for assisting the 'Third World' |
| 1988 | Prof. Chisholm facilitates a 'Tropical/Third World' meeting |
| 1989 | Survey of BAUS members' views |
| 1990 | Working Party formed: UROLINK adopted*, and aims defined |
| 1996 | UROLINK becomes a BAUS Committee |
| 1999 | UROLINK incorporated into restructured BAUS organization |

*UROLINK Chairs: 1990–98, N.W. Harrison; 1998–2000, C. Chapple; 2000–2001, C. Evans.

Table 2 UROLINK's key areas of activity

| Area | Activity |
|-----------|--|
| Links | Encouraging the establishment of links between individuals, departments and organizations |
| Visits | Encouraging and facilitating professional visits to work with colleagues overseas |
| Training | Supporting appropriate urological training of surgeons in their countries, and in the UK |
| Equipment | Assisting with the provision of books, journals and equipment where needed |
| Advising | Providing BAUS Council with advice on overseas matters relating particularly to the developing world |

nurtured by keeping in contact, offering help and responding to requests. A preliminary visit to assess needs and opportunities is recommended and from such small beginnings links may grow; in several urology departments these contacts have expanded to involve nursing, technical and other staff on exchange programmes, which may then capture the imagination and interest of other departments or even the hospital organization as a whole.

Visits

Links have to be nurtured and maintaining contact is essential to sustain interest and respond to changing needs; visits are an essential component. UROLINK has found that a teaching 'faculty' of two to four consultants making a brief visit of perhaps 5–10 working days is an effective model compatible with busy professional lives. This model has been particularly well developed at Kilimanjaro Christian Medical Centre (KCMC) in Moshi,

Table 3 UROLINK teaching faculty visits

| Year | Visit |
|------|---|
| 1991 | ASEA Annual Meeting, Malawi |
| 1994 | Patan Hospital, Katmandu, Nepal |
| 1995 | KCMC, Moshi, Tanzania |
| 1995 | Patan Hospital, Katmandu, Nepal |
| 1995 | Kagando Hospital, Uganda |
| 1997 | KCMC, Moshi, Tanzania |
| 1997 | Holdsworth Hospital, Mysore, India |
| 1998 | Nazinmoja Hospital, Zanzibar |
| 1999 | Patan Hospital, Katmandu, Nepal |
| 1999 | KCMC, Moshi, Tanzania |
| 2000 | Mulago Hospital, Uganda |
| 2001 | Royal Victoria Hospital, Banjul, Gambia |
| 2001 | KCMC, Moshi, Tanzania |

Tanzania; others examples are listed in Table 3. KCMC is an important medical institution in northern Tanzania which acts as a referral hospital for a region of ≈ 5 million people, although the urology department receives patients from all of Tanzania, with a population of over 26 million [2]. In 1991, Dr Lester Eshleman, an American urologist who spent most of his professional life in Africa, set up a training course in basic urology at KCMC for local surgeons which, in conjunction with the Association of Surgeons of East Africa, became an Institute of Urology to support training in urology for the region. UROLINK has been closely associated with this project since it started and KCMC has become the most frequently visited overseas department. As a result of Dr Eshleman's initiative, ≈ 20 surgeons from seven East African countries have been through the 1-year urology course (some have completed a second year to take an MSc in Urology awarded by the new Tumaini University, with which KCMC is linked). Many of these surgeons return for the UROLINK visits which, after Dr Eshleman's retirement, are now known as the 'Lester Eshleman/UROLINK Biennial Teaching Faculty'. As one participant wrote on a post-faculty evaluation form: *'Please come again, it is my only opportunity for CME'*. There is now encouraging evidence that those who have learnt their urological skills at KCMC are passing them on to local surgeons, thus establishing a sustainable process through a cycle of learning and teaching. Dr Eshleman's contribution to urology was recognized by BAUS in 1999, when he was awarded the prestigious St Paul's Medal.

Many urologists in the more deprived parts of the world, as indicated by the above quote, are starved of educational opportunities, and a less formal visit from an individual urologist simply to talk about urology, discuss cases and teach 'on the job' can be of great value, as well being a first step in establishing more regular links.

Paediatric problems, particularly complex and major congenital abnormalities, find their way to referral centres and are frequently presented to visitors. Many of the conditions are a challenge even to an experienced paediatric urologist and it has been particularly helpful to include paediatric expertise in faculty visits. It is always helpful and rewarding to respond appropriately to a challenging case, but the opportunity to teach more basic paediatric urological skills and to discuss case-management strategies may be the more important contribution.

Equipment

Much urological surgery, especially re-constructive techniques like urethroplasty, hypospadias repair and the closure vesico-vaginal fistulae, require only basic instruments. However, endoscopic surgery, which was the stimulus to the development of urology as a speciality, requires relatively costly equipment. In many affluent departments workable instruments that have been superseded remain unused, and UROLINK has been able to collect, sort and distribute serviceable instruments. Manufacturers have also been generous in donating equipment. This has enabled urologists with newly acquired endoscopic skills to use them for the benefit of local patients, and to generate essential income. In the long term, low-cost robust instruments, preferably manufactured in the developing world, must be the sustainable solution. Meanwhile, the best way of ensuring that equipment arrives at its intended destination, is used effectively and cared for, is to take it in person on an overseas visit and to demonstrate it in use, including cleaning, sterilization, storage and repair.

Access to information

Many urologists have little or no access to current journals and UROLINK, through an initiative with the former *British Journal of Urology* started a scheme whereby the publishers generously agreed to send duplicate subscription copies to nominated individuals or departments in the developing world. More recently, the publisher of the *BJU Int*, together with five other publishing houses, have agreed to provide free access to their journals through the Internet to >100 of the poorest countries in the world, thus giving them potential access to scientific information free of charge. Indeed, the Internet is an example of a technological advance which has the potential to transform the working life of many health professionals in the developing world [3].

There is a need to be sensitive in dealing with overseas colleagues from different cultures, often with very different material circumstances. UROLINK visitors

have always been impressed by how great the effect is of a modest investment in equipment, and by how much there is to be learnt from colleagues who have to be both innovative and resourceful.

Trainees

UROLINK encourages and helps urology trainees to spend time overseas, even though the relevance of visiting parts of the world where the scope of urology is more limited may seem less obvious than going to a top European or American department; there is much to be gained. Several individual trainees have spent up to 3 months in developing-world departments recommended by UROLINK and, without exception, have returned full of enthusiasm for the experience, and with a determination to revisit, to develop their own links and to encourage others to seek similar opportunities. UROLINK recognizes the current need for closer supervision of trainees and now has a policy of taking one or more trainees on faculty visits where they have helped to stimulate interaction and discussion, made new contacts and have valued the opportunity of learning together in a different cultural environment; many plan to return.

There is still a place for longer visits, e.g. 6–12 months, to appropriate recommended overseas departments which, with proper planning and agreement, can be undertaken during specialist training. Longer visits enable not only a greater contribution but also increase the scope for exciting research initiatives, learning and teaching, and other opportunities, e.g.

- experience of a different disease spectrum;
- exposure to a different economy, culture and climate;
- enhance clinical skills and judgement;
- opportunities for more open surgery;
- a need for resourcefulness and ingenuity;
- opportunities to learn together in action;
- make new contacts and friendships;
- a broader perspective on health care.

Urology in a changing world

Change and evolution is part of life but the increasing rate of change poses particular problems. Science, technology, information and knowledge have all increased rapidly, but at the same time the gulf between rich and poor nations has increased. The richest 20% of the world's population enjoy 80% of the world's income. Unfortunately, this gap has widened; in the 1960s the same wealthiest 20% owned 30 times that of the poorest fifth and currently it is more than 80 times. The hope and optimism of the 1960s has largely been replaced by despair, disillusionment or disinterest. In 1978 the

WHO set the year 2000 as the target for achieving 'A level of health to enable everyone to lead a socially and economically productive life', an aspiration better known as 'Health for All by 2000'. Clearly, despite some impressive health gains (Table 4), that aspiration has not been met; indeed, in many areas health has worsened (Table 4). The gulf between the materially affluent and the materially impoverished 'two-thirds' of the world continues to widen, despite increasing scientific knowledge and technological abilities. The statement by Maurice King in 1975 remains as true a quarter of a century later: 'In our age the greatest challenge before world medicine is to see that the most useful parts of knowledge that we already have are brought to those who need it'. To do this requires no new knowledge but a change in the priorities of governments, leaders and individuals. Urologists should not underestimate their opportunities to influence change by their attitudes and actions. Urology as a speciality has developed rapidly and thrived by innovation, embracing changing technology, and by international co-operation. With UROLINK we can help to meet the challenges facing a changing world, by listening and responding to colleagues in the developing world as they develop their own proposals. Nund [4], writing from India, emphasizes the importance of local innovation and local solutions.

In 1995 [5] a code or charter of Basic Urological Rights was proposed (Table 5) to highlight those areas of urological need where perhaps the greatest impact was possible on health and well-being. Perhaps the *BJU Int*, which is now associated with the International Society for Urology, could promote such a charter, and

challenge governments and individuals to respond. To achieve these objectives the leadership of urologists in the developing world will be needed, as well as international support. Many ideas from developing countries have subsequently been adopted by the developed world. The use of assistants who are not doctors is a good example and an essential resource to use wherever doctors are a scarce or an expensive commodity. Doctors, and specialists in particular, tend to be in cities, whereas in the developing world most of the population and their health problems are in remote areas. Such medical assistants have been trained to undertake orthopaedic procedures in Malawi; with appropriate training and support many of the core urology functions could be undertaken by similar people who are also more likely to remain and work in their local communities. A relatively small investment at 'core' level could have a marked effect on the quality and length of life for many in the developing world, in stark contrast to the small gains for the few which massive resources injected into health in affluent countries tends to produce.

Haematuria

Haematuria is a symptom of potentially serious urological disease whenever it occurs. In the past, studies in Africa suggested that infection and schistosomiasis were the commonest causes in the tropics; the symptom is common and largely ignored. However, a recent re-evaluation in Nigeria showed that urological malignancy was the underlying pathology in more than a third of patients presenting with haematuria, when the disease is usually at an advanced stage. The need for an educational programme to alert people to the significance of haematuria as an event requiring investigation and, of course, the ability to respond to this, should be a high priority. The development of mobile diagnostic services

Table 4 The world health balance sheet

| <i>Change</i> | <i>Detail</i> |
|---------------|---|
| Gains | Eradication of smallpox Eradication (almost) of polio Increased child immunization Introduction of oral re-hydration therapy Promotion of breast feeding Improvements in food production and water availability Improvements in literacy |
| Losses | Deaths from preventable and treatable diseases, e.g. malaria AIDS Severe malnutrition Unmet basic surgical need Chronic disability Increases in smoking and alcohol-related diseases Urbanization, pollution, poverty Severe poverty Collapsing health services |

Table 5 The Basic Urological Rights charter

| <i>Condition</i> | <i>Treatment</i> |
|------------------------|---|
| Retention of urine | Early relief by urethral or suprapubic catheter |
| Haematuria | Surgical treatment — endoscopic where appropriate Education and early diagnostic investigation |
| Urethral strictures | Treatment by bouginage or visual urethrotomy and self-catheterization |
| Urethral trauma | Safe initial management Referral for definitive treatment |
| Vesicovaginal fistula | Early surgical repair |
| Male circumcision | Safe techniques |
| Carcinoma of the penis | Early diagnosis and treatment |

to outlying hospitals and health centres is proposed as an appropriate way to tackle the issue in Nigeria [6].

Challenges for urologists in a changing world

Wealth and health go together, and this is true for both developing and affluent countries. As the gap between rich and poor nations widens the poor are even further marginalized and other factors, e.g. demographic change, are predicted to affect health demands during the next 30 years. For example, many of the diseases more associated with industrial countries are age-related (cancers, cardiovascular disease, diabetes and prostate disorders) will all increase in the developing world as the proportion of the elderly increases. Such basic problems as retention of urine will become more common in countries where many people already go untreated, as the facilities and skills for even passing a catheter may be unavailable or unaffordable. Yet it is known that the training of surgeons in endoscopic techniques is a cost-effective way of managing retention, so a challenge to urology must be to provide these skills more widely, and to seek simpler, effective and cheaper alternatives.

The medical profession has changed significantly in recent years in its attitudes and approaches to colleagues and patients, moving from paternalism to partnership, autocracy to teamwork, secrecy to transparency and prejudice to equality. Values need be readjusted and some of these challenges are summarized in Table 6. UROLINK is there for all urologists who see the need for a fairer

distribution of resources and a wider availability of the benefits of knowledge already gained.

Many urologists marvel at their overseas colleagues, who serve their communities with limited resources and material rewards, yet maintain high standards of ethical and professional practice. Several urologists working in these circumstances have referred to the satisfaction and fulfilment which comes from managing common problems in innovative ways. They have expressed their wish to capture the attention and help of colleagues from more economically privileged circumstances [7]. UROLINK's hope is that every urology department will have an overseas 'twin'. In this way, the load could be shared and together the partners can make a significant impact on attitudes and visions for the future.

There will be difficult choices, and a poem from India captures the pain of making such choices.

*'Mother decide, who will go without today?
Will it be Ram who is strongest,
And does not need it so much?
Or Raj, who is the weakest,
And will not need it so long?
Or Sita who is a girl anyway?
Decide mother and kill part of yourself.'* [Anon]

For urology to retain its respect and credibility internationally, the UROLINK philosophy is vital to broaden the vision and keep a sense of perspective in a complex, changing and increasingly inter-dependent world.

Table 6 Challenges for urologists in a changing world

| <i>Problem</i> | <i>Solution</i> |
|---------------------------|--|
| Use resources effectively | Cost-effective treatments Avoiding waste |
| Evaluate outcomes | Audit activity Short- and long-term results Discard ineffective treatments |
| Innovation and research | Find local solutions |
| Education and learning | Life-long learning and professional development Teaching others; learning from others |
| Promote core urology | Implement basic urological rights |
| Target the poverty gap | Influence attitudes by lifestyle and actions |

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