

In this month's *Bulletin*

Ivermectin effective against intestinal and skin parasites (pp. 563–571)

Heukelbach et al. report that mass treatment with ivermectin was effective for the simultaneous control of intestinal helminthiasis and parasitic skin diseases in a poor community in north-east Brazil. The population of 605 was affected by ectoparasites — ascertained by clinical inspection — and intestinal worms — established by serial stool inspection. The authors treated 525 people — most of them with two doses of ivermectin. Follow-up examinations at one month and nine months revealed that treatment effects lasted for a prolonged period. For example, the prevalence of hookworm infection fell from 28.5% to 7.7% nine months after treatment. Of the parasitic skin diseases, scabies prevalence, fell from 3.8% to 1.5% nine months after treatment.

TB control must involve private sector (pp. 580–594)

How can private health-care providers — which in many developing countries outnumber their public counterparts — be more effectively involved in improving the outreach of public health programmes, such as DOTS? In 2000, DOTS programmes detected less than 30% of estimated new tuberculosis cases. The global target of 70% may not be achieved without meaningfully involving the private sector in DOTS implementation. Lönroth et al. compare the processes and outcomes of four projects operating within the recently developed framework for public-private mix in TB control to identify the factors that make such projects work. They conclude that success requires the national TB programme be strongly committed to supporting, supervising and evaluating the projects and that using a local nongovernmental organization as an intermediary may facilitate collaboration.

Nurse migration needs better management (pp. 587–594)

The policy challenge facing many developing countries is how to sustain

an ageing nursing workforce and to decide where the supply of nurses will come from in the short- and long-term. Buchan et al. describe the profile of the migration of nurses and the policies governing their international recruitment to Australia, Ireland, Norway, the UK and the US. The flow of nurses to these countries has increased, with the UK, Ireland and the US recruiting primarily from lower-middle- and low-income countries. Norway and Australia primarily recruit from other high- to middle-income countries. Buchan et al. propose several policies for better managing nurse migration.

Policy-makers should focus on why people migrate (pp. 595–600)

The significant increase in the migration of medical practitioners and nurses from developing countries is, in many cases, compromising the capacity of health-care systems to deliver equitable care in such countries. On the basis that migration is unlikely to stop — given the advances in global communications and the development of global labour markets — Stilwell et al. examine the complex issues surrounding health worker migration and discuss strategic approaches to its management. They conclude that a greater understanding by policy-makers of the key influences behind the decision to migrate is needed in order to devise strategies to recruit and retain health staff in both source and destination countries. However, economic revitalization may be the only truly effective intervention.

Data on health worker migration are inadequate (pp. 601–607)

The effective management of health worker migration requires policy decisions based on good statistical data if such policies are to be correctly implemented and properly evaluated. However, as Diallo reports, most statistics on the subject are neither complete nor fully comparable, are often under-used, limited and ill timed. Although there is a wide range of potential sources of data, the quality of statistical evidence

on health worker migration is poor. Diallo's paper discusses the strengths and limitations of the principal available data sources and recommends the harmonization of definitions and the strengthening of data collection mechanisms.

Developing countries can reverse the brain drain (pp. 608–615)

In order to reverse the "brain drain" bold and creative strategies must be implemented and supported by national policies, argue Saravia et al. Governments of source countries need to offer world-class educational opportunities, construct knowledge-based research and development industries, and sustainably finance the required investment. Brazil, China and India are already implementing strategies offering world-class education in areas crucial to national development, such as biotechnology and information technology, paralleled by investments in research and development. As a result, only a small proportion of the most highly educated individuals migrate from these countries.

Health worker migration in the 1970s: what's changed? (pp. 624–630)

This month's public health classic, Alfonso Mejía's landmark study of physician and nurse migration in the late 1970s, remains the most detailed analysis of the phenomenon — quantifying stocks and flows of physicians and nurses between more than 40 countries. It provides an important benchmark against which to consider current trends in health worker migration. In 1972, about 6% of the world's physicians were located outside of their country of origin, the majority of whom were in the US, the UK and Canada. The main donor (principally Asian) countries reflected colonial and linguistic ties. As Stephen Bach notes in his accompanying commentary, however, these historical ties are now weakening as recipient countries recruit primarily on the basis of economic requirements. ■