Professional medical associations in low-income and middle-income countries

From a historical perspective, Professional Medical Associations (PMAs) were developed as groups with a shared scientific interest or established by the authorities to act as a regulatory body.[1] PMAs have different roles based on which country they are located in and the health-care system in which they operate. PMAs can be involved in: education and training including Continuing Medical Education (CME), licensing, regulation, ethical issues, setting standards including clinical guidelines, and representing doctors interests.[2] With regards to education, PMAs can be responsible for different areas of educational standards, such as the undergraduate curriculum in medical schools, postgraduate medical education in terms of internship and residency training, and CME.[3] Additionally, they might be involved in examinations and within this role confer certification of qualifications.

Many PMAs also develop codes of ethics as guides to help in solving problems that doctors could be faced with in their practice of medicine,[4,5] but also issues of conflict of interest with the pharmaceutical industry. For example, the European Society of Cardiology[5] discusses how all promotional and educational activities supported by the industry need to comply with regulations developed by the European Federation of Pharmaceutical Industries and Associations and the International Federation of Pharmaceutical Manufacturers Associations as well as any national regulations that may exist.

Given this responsibility PMAs play a crucial part in health reforms globally.[6,7] Despite these important roles, little research has been done on PMAs in low-income and middle-income countries. Recent work (2015–16) in Kyrgyzstan found that very few PMAs were active in many of the different key areas described above. In Kyrgyzstan there was a legal framework for the creation and the function of PMAs, but because of a scarcity in resources these associations are often unable to accomplish their stated responsibilities to their membership, the Ministry of Health, and the country.

One of the main barriers for PMAs in Kyrgyzstan was a shortage of funds. This shortage was due to a lack of clear benefits for members, leading to a vicious cycle since a lack of benefits means less income and less income means an inability to provide more benefits. This shortage of income from membership fees meant that PMAs needed to get funding from pharmaceutical companies. It was found that this was not encompassed by any ethical standards, leading to questions about possible conflict of interests.

PMAs in Kyrgyzstan clearly have a part to play in view of the expertise of their members. However, besides the scarcity of resources available, there is also the lack of vision from the Ministry of Health, the health system, and doctors as to what the function and responsibilities of a medical association should be. To transform this view requires a change in professional culture, in which doctors have to take the initiative to move the role of their profession forward to improve the health of the populations they serve. Expertise in Kyrgyzstan is often concentrated, with many individuals wearing multiple "hats" such as national experts, clinicians, teachers, and advisers. These experts give advice, produce guidelines, and provide training for all doctors of a given specialty.

An interesting lesson from Kyrgyzstan is the creation of specific associations by donors to assist with health-system reforms. The reforms in the health sector generated the need to create non-governmental organisations, such as the Association of Family Group Practitioners, the Association of Hospitals, and the Medical Accreditation Commission in Kyrgyzstan. Their role has included reorganisation of service delivery, new provider payment mechanisms, and new forms of accounting and reporting. These associations are highly dependent on donor assistance for their survival, but they have shown the ability to be efficient partners to the government in reforming health care and other issues related to regulation of medical practice and delivery of public services. This work highlights the importance of such organisations in improving health-care delivery, but also how associations can be used to address specific needs in a given context. Clearly much has to be done to help with the development of PMAs in low-income and middle-income countries, opening up the need for WHO and the World Medical Association to invest in this area of the health system. An approach to develop PMAs in low-income and middle-income countries could be through twinning programmes[8] between medical associations in these settings and high-income settings. PMAs play a crucial role in shaping human resources for health, one of the six building blocks of the health system, but have yet to be supported and fully used in low-income and middle-income settings for the benefit of the health of the populations they serve.

We declare no competing interests. The information provided in this Correspondence is part of a project funded by the Swiss Agency for Development and Cooperation in Kyrgyzstan aimed at reforming medical education.

*Aigul Azimova, Aida Abdraimova, Gulzat Orozalieva, Elvira Muratlieva, Olivia Heller, Louis Loutan, *David Beran*
david.beran@unige.ch

Initiatives in Medical Education, Geneva, Switzerland (AAz, GO); Health Policy Analysis Center, Geneva, Switzerland (AAb); Swiss Agency for Development and Cooperation, Geneva, Switzerland (EM); and Geneva University Hospitals, 1211 Geneva, Switzerland (OH, LL, DB)

1 Pellegrino ED, Relman AS. Professional medical associations: ethical and practical guidelines. *JAMA* 1999; **282:** 984–86.

2 Borow M, Levi B, Glekin M. Regulatory tasks of national medical associations—international comparison and the Israeli case. *Isr J Health Policy Res* 2013; **2:** 8.

3 Blackmer J. Professionalism and the Medical Association. Ferney-Voltaire: World Medical Association, 2007.

4 Linker B. The business of ethics: gender, medicine, and the professional codification of the American Physiotherapy Association, 1918–1935. *J Hist Med Allied Sci* 2005; **60:** 320–54.

5 ESC Board. Relations between professional medical associations and healthcare industry, concerning scientific communication and continuing medical education: a policy statement from the European Society of Cardiology. *Rev Port Cardiol* 2012; **31:** 529–38.

6 Yamey G. Scaling up global health interventions: a proposed framework for success. *PLoS Med* 2011; **8:** e1001049.

7 Hongoro C, Kumaranayake L. Do they work? Regulating for-profit providers in Zimbabwe. *Health Policy Plan* 2000; **15:** 368–77.

8 Yudkin JS, Holt RI, Silva-Matos C, Beran D. Twinning for better diabetes care: a model for improving healthcare for non-communicable diseases in resource-poor countries. *Postgrad Med J* 2009; **85:** 1–2.