Tidsskriftet Tidsskrift for Den norske legeforening

Sosy Indian – no barrier

INTERVIEW

ELINE FEIRING

Email: eline.feiring@legeforeningen.no
Journal of the Norwegian Medical Association

His name is Unni. He learned already in the day-care centre that this is a girl's name in this country. Now, little Unni has grown up. He represents 1.2 million medical students, and he hangs out at the WHO.

Unni Gopinathan. Photo: Gorm Kallestad/SCANPIX

– Six years of medical studies shapes your personality, says Unni.

He has only completed four of them so far, but with two years on leave. He has been shaped. In lower and upper secondary school he was never the class representative, and he did not like to speak in front of the other students. Now he represents the international association of medical students (IFMSA) in The

World Health Organization and speaks to more than one million medical students in front of hundreds of delegates in Geneva. Not entirely without nervousness, though.

– The first time was in January, at the board meeting of the WHO. I was quite nervous. Those of us who are not delegates are invited to speak after all the member states. Your name is called, then you go to the rostrum, say whatever you have to say, and then run out of the hall. Fortunately, I was looking straight at the Norwegian delegation during my presentation, and at least they were listening.

Indian expectations

Unni Gopinathan feels that he is Indian and Norwegian in equal measure, even though he grew up at Mortensrud in Oslo. His parents hail from Kerala in Southern India, and his father was among the first computer engineers recruited to Norway. In the summer of 1986, the family returned for a brief visit to Kerala, so that his mother could give birth in familiar surroundings and the son would be able to learn Malayalam, his mother tongue. Two years before Unni became a schoolboy the family realised that they would be staying in Norway, so then they could teach him Norwegian as well. The parents' background is the key reason why he started his medical studies.

– Well, there was no direct pressure, but I was aware of their expectations. I was most interested in political science and politics, but I found out that perhaps I could reconcile this with something health-related.

– How did you become interested in global health?

– I didn't know what global health was before I started studying medicine, but after one year I was elected to the local board of IFMSA in Oslo and was taken to a meeting in Mexico in 2008. There I learned how health can be seen in a totally different perspective – not only as individual patients and their symptoms and diagnoses, but also in the context of living conditions. Later, the Norwegian Association of Medical Students merged with IFMSA Norway, and I was appointed as internationally responsible for this new, merged association. After that, my interest has continued to grow, he says.

We meet outside the Norwegian Knowledge Centre for the Health Services in Oslo, under a sunny autumn sky. The meeting starts rather abruptly with a photo session with a representative of SCANPIX.

– I'm not so used to this, he says, rather embarrassed, when the photographer shouts: «Don't look so serious!»

Unni Gopinathan is a kind boy. So say his women friends. He is obviously a hit with the ladies, since the tip to have a portrait interview with him came from three of his fellow students, all women, and three of the four references he provides are also women. He won the heart of his girlfriend, who was the chair of IFMSA Sweden, in Tunisia at an international student meeting.

Determinants and stuff

Most of all, he wants to talk about medicine and politics. Global health, social determinants, youth health and the health personnel crisis. Shortcomings of the medical studies. The interaction reform. And he tries to convey the big picture. First, however, he must explain what global health really is.

– «Global health» is an extremely broad concept. It is a challenge to distinguish it from concepts such as «public health» and «international health». International health tends to refer to tropical diseases and other diseases that are widespread in far-away countries. Public health examines disease patterns in the population and defines preventive measures. I would say that global health is a combination of these, but with the addition of concepts such as global cooperation and justice – it's not only a matter for doctors and other health workers; even lawyers, economists and political scientists are involved.

– Is it a little fashionable? Global health I mean?

– Yes, it is. One of the reasons is the millennium goals, which have raised awareness and engagement. In addition, Norway has been strongly engaged in global health. Foreign Minister Jonas Gahr Støre, for example, is very committed to linking foreign policy with global health. Prime Minister Jens Stoltenberg has been an advocate for the global vaccine alliance (GAVI), and Bjørn-Inge Larsen, Director of Health, will be on the global Board of Directors of WHO for the next three years. There is a growing interest among Norwegian students, and we are becoming increasingly aware of the fact that here in Oslo as well as in other parts of the country, we are facing health challenges that are similar to those seen in other countries, but with some different dimensions. The differences between the East and the West, for example. In Oslo, people in the Western part of the city have a life expectancy that is ten years longer than those in the Eastern suburbs. In Glasgow, Scotland, the difference in life expectancy between the districts of Calton and Lenzie amounts to nearly 30 years. This means that there is obviously something wrong with our society. As long as methods to cope with this exist, it is unfair to do nothing, Unni says.

Formed by the medical studies

He believes that his sense of fairness stems from India. Kerala is a relatively poor state, even in an Indian context, but with a well educated population with universal access to basic services, life expectancies and child mortality rates are equal to those found in most Western countries. A train ride from Kerala to any of the neighbouring states is a train ride to a completely different world.

– To me, this is inconceivable and completely unnecessary, Unni says.

The examples above illustrate the concept of health determinants. It doesn't matter that you live in a rich country if your living conditions render you more vulnerable to disease. The social health determinants serve to generate

inequalities in society. The committed medical student is unimpressed by the position this notion occupies in medical studies.

– As doctors, we encounter patients from all walks of life. Therefore, it is strange that we don't learn any more about the causes of these differences and what we as doctors can do to redress them. Knowledge of this kind should be provided in the form of small doses throughout the course of our studies, so that it is integrated when we are about to assess a patient and determine the treatment and the follow-up. A brief course at the end is no good, because then we have already been formed to think is a certain way.

– Equality of input versus equality of outcome – what's the answer, in your opinion?

– I'd say that one should strive for equality of outcome; for example, as a doctor, one should make an extra effort for the patient who fails to understand what you're trying to say, an extra consultation or more time to become familiar with the patient's situation.

Studies have shown that patients with a higher socio-economic status have more tests taken and are made subject to more thorough diagnostics, because this is more demanding for the doctor. In our medical studies, we don't learn enough about these matters. When we finally go to a lecture on this topic, it's either too early or too late for us to grasp why this is important for medical practice. So when Norway goes out into the world claiming that it is important to ensure good health, we should give equal attention to achieving the same thing here at home. So you can see that I'm constantly trying to link matters at home with matters out there, Unni says, smilingly.

A change of paradigm

Harald Siem, who has been the leader of global health efforts in the Directorate of Health for many years, knows Unni from his engagement in the WHO. He says that there has been a change of paradigm in our relationship with the Third World, and would like Unni to explain this in more detail.

– I have been greatly inspired by Professor Hans Rosling in Sweden, who uses his fascinating statistical figures to show how the world has changed over the last fifty years. Concepts such as «The Third World», «developing countries» and «industrial countries» were constructed fifty years ago, and are well beyond their shelf date. This change of paradigm has already taken place, but we are only beginning to understand this. We can see that countries such as China, Brazil and India have a larger influence on great-power politics than before, and are in rapid growth. Brazil has made great progress in the field of health, and both our own and other low-income and middle-income countries can learn a lot from them. In Africa, countries such as Rwanda, Ethiopia and others are among the fastest growing economies in the world. Students from many of the member countries of IFMSA, which are characterised in the media as poor «developing countries», develop projects and organise information and public-health campaigns in their home countries. They have knowledge to

share, knowledge which is important to us. For example, our own country, as well as many low-income and middle-income countries, can benefit from learning how health services are organised in my state.

– You're saying «my state»?

Unni laughs. – People always ask me which country has my primary allegiance. I'm unable to choose between Norway and Kerala. Apart from my parents and my brother, my entire family lives there; I was born there, I speak the language and go there often.

What are we trained for?

The office as Liaison Officer to the World Health Organization at the International Federation of Medical Students' Associations is time-consuming, and Unni has therefore taken one year leave from his medical studies. He travels to Geneva frequently, even though much can be done by way of e-mail and Skype. His job includes organising opportunities for students from all parts of the world to come to the WHO as guest students, to participate in WHO meetings and workgroups, to make a contribution and help influence policies. He has prepared IFMSA's participation in the World Health Assembly, which took place in May, and in the World Conference on Social Determinants of Health, which will take place in Rio de Janeiro in October. He has contributed to the elaboration of the WHO Patient Safety Curriculum Guide for training of health workers, and has established a close collaboration with the WHO's Department of Climate Change and Human Health. He and his fellow student Johanne Helene Iversen, from the organisation Universities Allied for Essential Medicines, have also pleaded with a WHO group of experts to establish fairer mechanisms for patenting of results from research funded by public authorities.

In addition to social determinants of health and health in adolescence, which are closely correlated, the health personnel crisis is a core issue. In 2006, the WHO estimated that the world lacks 4.2 million health workers. This affects the poor countries in particular. The brain-drain must be halted.

– We are trained in the country where we live, but it's a fact that many are forced to find a job in another country. This is all about establishing better working conditions where one lives, and adapting the training to the circumstances where the work is done. This applies to Norway as well – we are mostly trained in hospitals, although the interaction reform states that most of us ought to work as GPs, preferably in small, local communities. In other words, it's a global challenge, says Unni.

Throughout the entire interview he keeps pointing out the inadequacies of the medical studies programme. But make no mistake, there are also many positive sides to it.

– We are trained to be good doctors, but when society is changing, the medical faculties should respond faster than just with a reform every twenty years. Many universities have been better at this than ours have. The faculties of

medicine should take developments in global health much more seriously. And this applies not only to global health; in terms of profession and clinical work, we receive insufficient training in key subjects such as emergency medicine and orthopaedics as well.

– Is this kind of engagement being promoted?

– Yes, I think so. Here in Oslo we have a flexible schedule, and the clinicians who teach are also flexible. But combining study with elected office is a real challenge, so that is why I went on leave this year.

Good supervision – the key to it all

Unni has been on leave previously as well, in 2009 when he was a research student. His research on meningococcal sepsis is still underway, although on a reduced scale.

– I haven't given as much priority to my research as I should have. If my supervisors read this, they will probably vigorously nod their heads in agreement, he laughs.

– But I'm very happy about the research project, mostly because of the supervision. It has been extremely rewarding, and has maintained my interest in research. It's incredibly important for lecturers and researchers to remain accessible to the students as supervisors; it can mean the difference between going that extra mile or giving up. I couldn't have received any better supervision.

– Do you see this as the start of a PhD degree?

– I hope so.

Not by coincidence, we are sitting in the Norwegian Knowledge Centre for the Health Services, more specifically in the Global Health Unit. Unni's interest in this topic made him want to do some research here too, and he has assumed the task of summarising knowledge about seven major national programmes on «task shifting». India, Brazil, Ethiopia, Malawi, Venezuela and Tanzania have implemented this as a strategy to increase the number of health workers.

– «Task shifting» is a possible solution to the health personnel crisis, because in addition to training regular health personnel (doctors and nurses) they also train health workers over two to three years to perform specific tasks, such as vaccinations and Caesarean sections. We are undertaking a case study to identify the factors that lead to success or failure when large national programmes are implemented.

Sosy Indian

Unni Gopinathan has many irons in the fire, but he also finds time for leisure activities. Notably his large circle of friends – his old buddies and girl friends from his younger years at Mortensrud and Nordstrand – would like to see more

of him. But they don't complain and can handle all the talk about global health when they get a chance to catch up with him.

– There are two things that I'm very fond of: global health and football.

– Watching or playing?

– Both. I play a little on the company team of a mate of mine. Now and then, he calls in some of us old veteran players who used to be good. I have also tried dancing, like capoeira, breaking and salsa, but I always have to give up since I miss too many lessons, he says resignedly.

The day before our meeting I receive an e-mail saying that he has lost his mobile phone. Not for the first time, obviously. He has given up trying to defend himself against accusations from his friends that he is absent-minded. There is probably a reason why his classmates in upper secondary gave him the nickname Sosy Indian.

– Speaking of names, how was it to grow up as a boy with the name Unni?

– I can recall that it was a shock when I learned, in the day-care centre's sandbox, that it was a girl's name. I have been assigned to girls' rooms in summer camp, and when I turned up in front of the Army's medical board they expected a woman. This has not been a major problem, though, and I only chuckle when I see the 'Ms' in front of my name on plane tickets.

All this air travel will soon come to an end, however. Temporarily, at least. After two years of leave, when the term of his IFMSA office runs out, he will begin to concentrate on finishing his studies.

– I believe that a few initial years in clinical practice will be beneficial, but in the long term I want to work with global health. The community in Norway has been very inclusive, so perhaps I can find something in the Directorate of Health, the Knowledge Centre for the Health Services or in one of the universities. I may even stay abroad for a while, or find a job at home. In Kerala, that is.

Unni Gopinathan

Born 10 June 1986

- Medical student at the University of Oslo since 2006
- International officer of the Norwegian Association of Medical Students in 2009 and 2010
- Liaison Officer to the World Health Organization (WHO) for the International Federation of Medical Students' Associations (IFMSA) 2010/11
- Duke University Global Health Fellow and guest student at the WHO in the summer of 2011
- Research student, Department of Medical Biochemistry, Oslo University Hospital
- Associated with the Norwegian Knowledge Centre for the Health Services, Global Health Unit

- Works part-time at The Norwegian System for Compensation to Patients

---

Publisert: 18 October 2011. Tidsskr Nor Legeforen. DOI: 10.4045/tidsskr.11.1074
Copyright: © Tidsskriftet 2026 Downloaded from tidsskriftet.no 23 June 2026.