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Title page: The National Hospital of Neurology, London (often referred to as "the National" or "Queen's Square"). Founded in 1859, the many distinguished physicians who have worked there include both J. Hughlings Jackson and C-E. Brown-Sequard, the hospital is internationally famed for its teaching and research. Now part of the UCL Hospital NHS Trust, it is called The National Hospital for Neurology and Neurosurgery. This picture shows the early 20th century building now dwarfed by the much larger complex of buildings, one of which is the Institute of Neurology next door (founded in 1950 and merged with University College, London 1997), with which it has retained links.

Below: New building of the German Medical Association (Bundesärztekammer) in Berlin. After very many years situated in Cologne, following the movement of the government and many of the ministries from Bonn to Berlin, following the decision by its General Assembly to relocate in Berlin, in 2004 the Bundesärztekammer moved into this fine new building in Berlin.

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Editorial

Wherever one looks the medical profession it seems to be facing more and more problems despite, or sometimes due to, advances in medical science and their introduction into medical practice. They range from the global problems of human resources and health professionals including physicians, inequities in their distribution across the world, continuing efforts to maintain standards for professional practice and ensuring maximum patient safety, the changing face of medical practice with increasing emphasis on prevention, huge increases in the intrusion of management and administrative bureaucracy associated with medical practice both in hospitals and the communities.

As these problems are addressed, it is vital that the profession in each country is seen to have considered them and prepared its own position, rather than reacting to short term policies proposed by others which may be neither in the best interests of the community, of individuals, or of the profession.

The contents of this issue of WMJ reflects the diversity of both the positive developments in medicine, science and in disease control, strategic plans and health policy developments, as well as some of the problems which still need to be solved.

It includes some further WMA policy statements, one of which, that on medical education, is also the subject of a report on a new strategic partnership between the World Health Organisation and the World Federation of Medical Education. There is also a report on the first meeting of the Taskforce of the Global Health Workforce Alliance (GHWA) to seek practical solutions to the health workforce problems, including investment in education and training of all healthcare workers. The WMA Secretary General comments on one particular effort seeking to persuade physicians who have emigrated to return to practice in their own country where there is a grave shortage of physicians. Another article addresses the problems of medical research ethics posing a question as to whether or not there are limits to the possible harmonisation of activities of ethical research committees. Two papers given at the WMA scientific meeting in South Africa address the important topic of "Health as an investment"

In the context of the problems of shortage of physicians it is interesting to note the results of a ten year cohort study of 545 of doctors who graduated in one country in 1995*. Of approximately 1400 of the final year students who expressed willingness to participate in the survey, a sample of 600 were drawn and of these 545 participated in the questionnaire which was sent to all participants each year for ten years. This was combined with focus groups which were random sub-samples each year, where questions could be more deeply examined. Apart from information on type of work, career choice and training, questions were asked about working conditions and about participants' attitudes to medicine as a career, in the light of their experience year by year.

While all the results of this study are interesting, as will be those of the next ten year cohort study, in the context of the debate on human health resources (particularly recruitment and retention of physicians), it is interesting to note that in this study

- 2 in every 5 doctors in the cohort study (40%) found that the reality of a career in medicine was very different from that envisaged on graduation in 1995;
- While three quarters (75%) of the cohort doctors ten years after graduating were satisfied with practising medicine, a fifth (20%) reported a lukewarm desire to practice medicine.
- The rest (5%) had little or no desire to practise medicine. (3% of the cohort had left medicine during the 10 years of the study, the most common reason being dissatisfaction with medicine as a career.
- 15% had changed their career choice during the study period, a key factor in this being "hours of work and working conditions" followed by working/pay conditions.

While these findings are disturbing (20% having a weak desire to practice medicine after 10 years), when planning to educate more physicians to meet needs it is unfortunate that no other countries have carried out comparable extensive cohort studies. If the profession is to address its future in the light of the problems it faces, then such studies could contribute valuable information in the formulation of such plans.

Alan Rowe

*BMA Cohort Study 10th report 2005



Harmonization of Research Ethics Committees – are there limits?

Prof. Elmar Doppelfeld MD Chair of the Permanent Working Party of German Research Ethics Committees

Biomedical research involving human subjects has to respect their autonomy, dignity, identity, integrity and other rights and fundamental freedoms. Research ethics committees, initially established at the request of national authorities such as the National Institute of Health (NIH) in the late sixties in the USA, the “Deutsche Forschungsgemeinschaft” (DFG) 1973 in Germany and since 1975, part of the Declaration of Helsinki, are universally charged with safeguarding these rights.

Biomedical research while initially performed more on a national level is increasingly spreading out on an international or even intercontinental field. For this reason researchers and research institutions, including the pharmaceutical industry (in research a very important global player) have for a long time stressed the need for the harmonization of the decisions and the procedures of research ethics committees. The main argument concerns the suggestion that there should be only one “medical ethic” in a country, in a continent or around the globe. On the basis of this assumption all legal obstacles causing diversity of ethics committees such as different composition, different kinds of financing, different ways of decision making etc. should be abandoned in favour of a “unique, harmonized research ethics committees’ procedure”. Are these arguments applicable; is the diversity of ethics committees in different countries or in unions of states justified, or only superficial?

First of all it must be recalled that the main task of an ethics committee is the multidisciplinary assessment of the ethical acceptability of an envisaged research project. This raises the question of the character of ethics and its so often requested worldwide uniformity.

Ethics is, at least in the circles of experts, understood as a part of philosophy. Follow-

ing these this view it has served since the age of Aristotle as a method of analysing whether handling of human beings by researchers is acceptable or not, as being “good” or “bad”. The methods of this analysis can be harmonized, such as the examination of the scientific merit of research projects or of their accordance with national or international law. If there are positive answers to these questions, then the decision on the ethical acceptability is based on the question of “good” or “bad”. For the terms “good” and “bad” there are no definitions accepted worldwide. They are moreover influenced by religion, tradition or even different philosophical schools, which may differ even within a country and of course, within the different regions of the world.

A recent example is the worldwide discussion on the use of human embryonic stem cells for research. Even in those countries where the need for such type of research is accepted, the ethical analysis, as mentioned above, may lead to the view that it should not be performed, as it is considered to be “bad”.

In the discussion on the ethical acceptability of medical research, the expression “medical ethics” is widespread, assuming that in this way the diversity of ethics, as marked e.g. by utilitarianism or transcendental ethics in the sense of Immanuel Kant, could be overcome. This attempt needs consideration as to whether the term “medical ethics” is appropriate or not. The known general ethical principles such as respect for the human being, beneficence, non-maleficence (“do no harm”) or justice, are basic and leading guidelines for the whole life of human beings in society. They may be, in an appropriate way, applied to special fields e.g. banking, or even medical research. Everybody understands, that in financial transactions the principles “do no harm” or “justice” are obligatory to prevent any kind of betrayal or deception of the person con-

cerned! The adaptation to special sectors may not deviate from the basic concept of the relevant ethical principles.

The use of the term “ethics in medicine”, used by preference in some circles rather than “medical ethics” is more than a semantic suggestion. It underlines this general approach to ethics and is therefore much more appropriate than “medical ethics”, which can be misunderstood and should be avoided, at least in multidisciplinary discussions. It should be avoided, at least in a multidisciplinary discussions. It follows from these considerations that ethics in medicine, so far as analytical methods are considered, may be harmonized. The basis of the decision to be taken by research ethics committees – “good” or “bad” –, cannot be standardized or harmonized. Any other outcome would be surprising, implying the same definition for “good” and “bad” around a world with differing religions, ethics, differing cultures/social patterns etc.?

In contrast: by long tradition, discussions on “good” and “bad” and conclusions on a regional level are the basis for moral guidelines in any specific society. Professions such as lawyers or physicians, are entitled to contribute to these discussions and decision making for such an ethnic entity. But no professional group has any right to prescribe in isolation regulations for that entity. This is another argument against professional based ethics or morals as binding provisions on all. Since in the work of professions the rights of others have to be respected, profession linked ethics are not necessarily appropriate outside the profession.

Unavoidable diversity is the principal obstacle to any kind of harmonization of research ethics committees other than the process leading to a decision, the decision itself is not open to standardisation!



Research ethics committees are, at least by tradition, embedded into a national framework, which itself is influenced by religion, history, tradition and the system of legislation of that country. In practice the protection of human rights and fundamental freedoms (even when, as in most cases, it is guaranteed by the constitution of the state) may be influenced by juridical decisions of courts competent for constitutional law in different ways. There may exist on that basis a diversity of interpretations of e.g. “free informed consent” or conditions of its expression such as “substitution” in place of consent of persons not able to do so, of data protection etc. Relevant decisions of the courts and national legislation have to be followed in the regulation of ethics committees and their work. These differences appear even in regions of the world with more or less common traditions.

In preparing the Directive 2001/20/EU, the European Union tried to harmonize at least the administrative part of ethics committees. These attempts failed, and everybody knows the results: Member states are obliged to establish a system of research ethics committees which have to consider the usual international principles of ethical assessment and to make a decision within a

given time. Nothing is said, for example, about conditions or interpretation of “free informed consent” in the normal situation, or in research in an emergency situation. The diversity in ethics has been identified as the main obstacle to any kind of harmonisation or standardisation of the work and decision making of research ethics committees. The diversity in legal and administrative provisions for these committees, themselves caused, at least in part by the ethical diversity, constitute a second obstacle.

It is understandable, that researchers and research institutions or sponsors (such as the pharmaceutical industry) are faced with that situation and have a special interest in overcoming it or at least living with it. In an attempt to help in this situation, the European Forum for Good Clinical Practice (EFGCP) recently published an overview on the “Procedure for the ethical review of protocols for clinical research projects in the European Union” (International Journal of Pharmaceutical Medicine, Vol. 21, No 1, 2007). This publication gives an excellent overview of the ethics review systems in 26 European countries plus Switzerland and Norway. The report provides an excellent overview showing the different interpretations of the directive 2001/20/EG by the

member states of the European Union. In this way it assists researchers to prepare multinational research projects within the Union, while respecting national provisions.

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Death of a valiant defender of human rights of prisoners.

The death of Dr. Fusen Sayek, former President of the Turkish Medical Association, marks the loss of an outspoken opponent of torture and inhumane conditions in prison.

In particular during the 90's she put up a fierce battle against the inhumane treatment of people in custody in Turkey. Dr. Sayek died after a long struggle with cancer on 12th February 2007.

Medical Technology

Better heart transplants will quadruple lives saved

Professor Bruce Rosengard, Papworth Hospital, Cambridge, has perfected a machine to pump sterile, oxygenated blood, saline and nutrients through organs for transplantation – especially the heart. For the last 25 years, hearts for transplant have been kept on ice, with gradual deterioration, requiring an operation within 3-4 hours. Now using this new technique, organs in sub-optimal condition can be resuscitated into action; they can be transported much greater distances, such as for example across

American or Australia; and the time for surgery extends to around 12 hours without any significant deterioration. A heart (or other organ) can be removed, for instant at the scene as an accident, where the patient has died, is brain-dead, but the heart still beating. The heart for transplant is connected to the machine via the aorta and pulmonary artery with around 1 litre of blood which is recycled. The organ for transplant arrives at the operating theatre in a better condition than when it left in the donor.

Prospects for the heart transplant surgery

According to Professor Sir Magdi Yacoub, this technique will revolutionise the way heart transplants are done in the future. Cloning of hearts is not the answer although stem cell regenerative therapy does have this place alongside transplantation. These methodologies do interact with one another at the tissue and organ levels very well. It is very significant that this innovative method



will improve heart function for thousands of patients when disease begins to set in. In principle it could be used for every organ in the body, and for the liver and lungs with immediate effect.

The stages are:

- (1) Assess heart function. Estimate the chances of a heart attack in terms of narrowing and blockages in the coronary arteries.
- (2) If the heart is impaired, how can be improve it?

(3) More hearts will consequently become available for transplant, estimates being an increase by a factor of 3-4 times. Only 139 heart transplants were carried out in the UK during the last year, because of an acute shortage of donor organs.

(4) This enables more intricate surgical work to be done on the heart which is outside the patient. Currently 10% of cardiac patients are dying at the waiting list.

(5) The failure rates of tissue grafts in surgery can be very high, and some

don't start to function at all. Four international centres are now running clinical trials to confirm the efficacy of the technique.

At the present there is a huge shortage of organs for transplantation, and the UK is one of the lowest in Europe. Such a methodology would offer hope for the many patients currently condemned to a 'living dead' because of a lack of transplant resources.

Ivan M. Gillibrand

Pain relief

People in Pain Confused About Pain Relievers and Missing Out On Effective Treatment

Experts Urge Clarity to Reduce the Debilitating Impact of Daily Pain

Amsterdam, The Netherlands, 23 June 2006 – Up to 64% of people in pain, including those with musculoskeletal pain, are confused about which pain medication they should and shouldn't take, and many do not know how to manage their pain appropriately, according to the results of a global patient and physician survey announced by the Arthritis Action Group (AAG).(1) The survey builds on previous AAG research, the *Arthritis Research Survey*, showing major inadequacies in the management of pain,(2) and has compelled the group to call for improved communication with patients so they don't endure pain unnecessarily.

“These are disturbing findings – large numbers of people in pain are confused about treatment options and risks, and as a result do not know how to manage their pain properly,” said Professor Anthony Woolf, Chairman of AAG. “Action is needed now to clear this confusion for support patients

and physicians to manage pain effectively to reduce its pervasive impact on daily life.”

The survey of 1204 people with pain, and 604 primary care physicians, was conducted by Harris Interactive, on behalf of AAG, in six countries worldwide – United Kingdom, Germany, Italy, France, Mexico and Australia.

Pain severely impacts on the quality of life

One in five people worldwide has moderate to severe chronic pain, including 100 million Europeans with musculoskeletal pain and arthritis.(3,4) People in pain report that it strongly impacts on their life, affecting their ability to sleep and complete daily tasks.(1) Not only does pain affect quality-of-life, but previous studies show that it can also predict increased mortality.(5)

People in pain are confused and under-informed (1)

- Up to 64% of people feel that conflicting information about pain medications makes it confusing to know what to take.
- Up to 78% of people feel they don't know enough about the benefits and risks of pain medications (either prescription medications, over-the-counter medications, or both).

Pain is not being managed appropriately (1)

Many people are putting themselves at risk by using treatments inappropriately:

- If their pain medication doesn't work after 10 days of use, less than half of



people taking prescription medication and less than half taking non-prescription medication will go to their doctor for advice or treatment. To get better pain relief, people are using strategies such as taking more of the same type of medication, taking a different type of medication, or exercising.

- Up to 47% of people in pain don't use medication at all. Reasons include experience with or concern about side-effects, a perception that they can manage without medication, their doctor advised them to stop taking medication, or because they're worried following stories in the news.

Information gap exposed

Despite patient confusion, detailed discussions about different treatment options and their specific benefits and risks are not taking place in consultation with their physician. Patients report that during their last consultation: (1)

- Less than half discussed how effective their current medication was ($\leq 43\%$), or treatment benefits ($\leq 40\%$)
- Less than a third discussed potential problems or medication side-effects ($\leq 30\%$)

Insufficient information sharing between patients and physicians was attributed to the following:

- Many physicians underestimate the level of patient concern about treatment risks. For example, up to 48% of patients are very concerned about the potential side-effects of non-prescription NSAIDs (of those who are aware of them), whereas only a small number of physicians felt their patients were very, or extremely concerned about this ($=14\%$). Most discussions are about the benefits and risks of prescription medications. (1,6)
- Up to 92% of physicians think patients don't have the expertise to evaluate the relative benefits and risks of treatment. (6)

- Up to 25% of physicians find it difficult to communicate the benefits and risks of prescription medications, and up to 24% for non-prescription pain medications. (6)
- Less than half of physicians are very familiar with the recently updated guidelines for pain medications ($=49\%$). (6)
- Up to 92% of physicians think their elderly patients don't want responsibility for treatment decisions. (6)
- Up to 89% of physicians see consultation time constraints as a problem. (6)

"These survey results highlight the large gap in understanding between patients and physicians," said Sandra Canadelo, Vice Chair of the PARE Manifesto Steering Group, and Chair of the EULAR Social Leagues. "Chronic pain is hugely debilitating for patients, and severely impacts quality of life. Informed discussions are needed to ensure pain is managed effectively, and the best decisions are made to improve the lives of patients."

Background

About the survey

About a total of 1204 people with pain, and 604 primary care physicians were interviewed. This included approximately 200 people with chronic pain and 100 general practice patient-care physicians from each of the following countries: United Kingdom, Germany; Italy, France, Mexico and Australia.

The research was conducted by Harris Interactive on behalf of the Arthritis Action Group between 22 December 2005 and 22 February 2006. The data were not weighted to the patient and physician population proportions in each country and therefore are not representative of those populations.

About the Arthritis Action Group (AAG)

Arthritis Action is an international, physician-led initiative dedicated to advance awareness of rheumatic conditions and management choices so that healthcare providers, patients and carers can work in the true partnership towards maximum quality of life. It aims to help healthcare providers, people with musculoskeletal problems and they cares by:

- Raising awareness of unmet needs in the management of musculoskeletal pain
- Improving timely access to the most effective management options
- Promoting the "optimal practice" management of musculoskeletal pain

About the PARE Manifesto

PARE (people with Arthritis/ Rheumatism in Europe) Manifesto is the campaigning arm of the EULAR Social Leagues. It represents the parents' voice in Europe and seeks to ensure that the "European Manifesto" ten calls to action in a single, agreed document, developed by the EULAR Social Leagues, Arthritis and Rheumatism International and the Organisation of Youth with Rheumatism in 1999, is implemented in Europe where more than 100 Million Europeans are affected by arthritis/ rheumatism. For more information visit www.paremanifesto.org

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pany has built what could conceivably be the world's largest panel of survey respondents, the Harris Poll Online. Harris Interactive serves clients worldwide through its United States, Europe and Asia offices, its wholly-owned subsidiary Novartis in France and through a global network of independent market research firms.

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Pain Relief Survey

- The “*Insights Into Pain Relief*” global survey was commissioned by the Arthritis Action Group, an international group of leading physicians and academics, to gauge the opinions and experiences of people with pain, including arthritis and musculoskeletal pain, and the physicians who treat people with pain.
- The survey was conducted among 1204 patients and 604 primary care physicians

across six individual countries – United Kingdom, Germany, Italy, France, Mexico and Australia.

- The research was conducted by Harris Interactive, on behalf of AAG, between 22 December 2005 and 22 February 2006.
- This survey builds on AAG research conducted in 2004, via the Arthritis Research Survey, which revealed major inadequacies in the management of pain resulting from arthritis and other musculoskeletal problems. It showed that one in three people affected by musculoskeletal pain never consults a physician about their pain.

Key Findings from the “*Insights into pain relief*” survey

Pain severely impacts quality of life

- Many people in pain report it impacts their life, affecting their ability to sleep (up to 42% of patient) and conduct day-to-day activities (up to 61% of patients).
- Physicians warn that a number of health-related issues are likely to result if chronic pain is not managed effectively, including loss of normal day-to-day activity (up to 92% of physicians), impaired social function (up to 86% of physicians), depression (up to 85% of physicians), weight gain (up to 81% of physicians).
- Back pain is the most common musculoskeletal ailment suffered /up to 70% of patients), followed by neck/shoulder pain (up to 61% of patients) and knee/ankle pain (up to 53% of patients).

Many people in pain are confused and under-informed about pain relievers

- Up to 64% of people feel that conflicting information about pain relievers makes it confusing to know what to take.
- Up to 64% of people feel they don't know enough about the benefits and risks of prescribed pain medications, and up to 63% feel they don't know enough

about the benefits and risks of non-prescription pain medications.

Pain medications aren't being used appropriately

- If their pain medication didn't work after 10 days of use, less than 47% of people taking prescription medication went to their doctor for advice or treatment, or to ask for a different medication. To get better pain relief, people are using strategies such as taking more of the same type of medication, taking a different medication, exercise, massage therapy, and pain relieving creams and rubs.
- Up to 47% of people in pain don't use medication at all. Of those, up to 73% say they feel they can manage without medication, up to 25% say it's because they are worried about side effects, and up to 22% say that their doctor advised them to stop taking their medication.

Many people in pain find it difficult to get information from their doctor

- Most people in pain (up to 89%) obtain information about their condition and treatment from their doctor, with up to 78% seeing their doctor as the most important source of information.
- Over half of people in pain (up to 52%) use their pharmacist to find out about pain conditions and pain medications, whilst only a small number of people in pain see their pharmacist as the most important source in information (≤10%)
- At their last consultation with their doctor or nurse practitioner:
 - Less than half a patients discussed how effective their current medication was (≤43%), or treatment benefits (≤40%)
 - Less than a third of patients discussed potential problems or medication side-effects (≤30%)

Survey Methodology

Patients

- For inclusion in the study, patients had to be age 18 or older and suffering from at least one qualifying chronic pain con-



- dition (pain conditions included back pain, neck shoulder pain, knee/ankle pain, joint pain, arthritis, hip pain, morning stiffness, migraine pain, dental pain, serve menstrual pain, sprains/strains, bursitis/tendonitis, post-operative pain, other body pain).
- Approximately 200 pain sufferers were interviewed from each of the following countries: United Kingdom, Germany, Italy, France, Mexico and Australia.
 - All respondents were sampled from list generated by Random Digit Dialling (RDD) in each country, screened by telephone, and if qualified, invited to continue with a survey 15 minutes in length.
 - The data were not weighted to the patient population proportions in each country and therefore are not representative of those populations.

Physicians

- For inclusion in this study, physicians had to be Primary Care Physicians (PCPs) involved in treatment decisions of patients with pain conditions who write 30 or more scripts for pain, inflammation or arthritis per month.
- Approximately 100 general practice patient-care physicians were interviewed from each of the following countries: United Kingdom, Germany, Italy, France, Mexico and Australia.
- All respondents were sampled from physician lists in each country, contacted by phone, screened, and if qualified, invited to continue with a survey 10 minutes in length.
- The data were not weighted to the patient population proportions in each country and therefore are not representative of those populations.

Arthritis Action Group

Arthritis Action is a physician-led initiative, dedicated to advance awareness of rheumatic conditions and management choices so that healthcare providers, patients and carers can work in the true partnership towards maximum quality of

life. It aims to help healthcare providers, people with musculoskeletal problems and they cares by:

- Raising awareness of unmet needs in the management of musculoskeletal pain
- Improving timely access to the most effective management options
- Promoting the “optimal practice” management of musculoskeletal pain

Arthritis Action currently brings together experts from eleven countries across the world, eight of which are in Europe: France, Germany, Ireland, Italy, Spain, Sweden, Switzerland and the UK. Arthritis Action has collaborative partnerships with a number of other organisations which have an interest in musculoskeletal conditions, to help raise musculoskeletal problems as a priority on the European healthcare agenda, for example Bone and Joint Decade and the World Health Organisation.

In addition to participating in international and European-wide activity, individual countries involved in Arthritis Action have their own National Action Groups, dedicated to addressing key national issues to musculoskeletal conditions.

Arthritis Action Mission

Advancing awareness of rheumatic conditions and management choices so that healthcare providers, patients and carers can work in true partnership towards maximum quality of life

The Arthritis Action initiative is driven by the AAG, a steering committee of 17 leading physicians and academics. The group members specialise in the management of musculoskeletal conditions and work with in a range of disciplines including: rheumatology, epidemiology, gastroenterology, geriatrics, clinical pharmacology, orthopaedics and primary care.

AAG Research

In 2002 the group conducted **The Arthritis Research Survey**, the largest survey of its kind to be carried out in Europe. Published in **Annals of Rheumatic Diseases** in 2004, the survey remains the most up to date data

collected which quantifies the impact of musculoskeletal pain on quality of life, assesses the management of condition across Europe and identifies the beliefs and perceptions of treatment held by physicians and people with musculoskeletal conditions.

Key points from the survey findings include:

- From the physician perspective it appears that musculoskeletal pain is well managed, from the population perspective the pasture is less optimistic
- There is lack of communication between physicians and patients concerning musculoskeletal pain and the benefits and risk of medications
- Some people with musculoskeletal pain may be receiving inadequate treatment and therefore may be at risk for avoidable pain or side effects
- Barriers to diagnosis and optimum management of musculoskeletal pain may be attitudinal and could be improved by better communication between patients and their physicians

Pan- European findings from the survey were published in the *Annals of the Rheumatic Diseases* (ARD), April 2004.

Currently underway is the **Environmental Factors Programme**, which is aims to identify the barriers and facilitators to the best practice management of musculoskeletal conditions, using the WHO classified contextual factors.



Informed Consent

Patients with Alzheimer’s disease may lack the mental capacity to give informed consent

Patients should consent to medical treatment. But an inability to give reasoned consent may be more common than doctors appreciate.

The consent to medical treatment, patients should be making voluntary and informed choices, and have the mental capacity to make a decision. Patients lack mental capacity when they cannot understand the information being given to them, or use it to decide on a course of action, or are unable to communicate their decision. Usually, mental capacity is taken as read unless the patient’s difficulties are very obvious. However, recent research suggests that the

numbers of mentally incapacitated patients may be being significantly underestimated.

Professor Matthew Hotopf and colleagues at the Institute of Psychiatry, Preston and Yale tested the degree of cognitive impairment of patients admitted to a London hospital. Some 31 per cent of inpatients were considered to lack mental capacity. However, when clinical teams interviewed inpatients, they rated just 8 per cent as lacking mental capacity.¹

Most patients probably rely on doctors to make the most appropriate decision for them. A need to assess mental capacity in a medically pressing situation could present

significant difficulties to the medical profession. On the other hand, there is clearly also a need to protect vulnerable patients, particularly when major – and irreversible – medical decisions are being made.

These kinds of issues are being considered in the UK’s draft Mental Capacity Bill. The researchers suggest that, even if legislation is seen as too heavy handed, the issue of patients’ mental capacity should be given more attention by doctors.

¹ Raymont V et al. Prevalence of mental incapacity in medical inpatients and associated risk factors: cross-sectional study. *Lancet* 2004; 364 (9443): 1421-7.

WHO/WFME strategic partnership to improve medical education

WHO and the World Federation for Medical Education (WFME) propose a strategic partnership to pursue a long-term work plan – open to participation by all medical schools and other educational providers – intended to have a decisive impact on medical education in particular and ultimately on health professions education in general. The WHO/WFME work plan will benefit from the accumulated experience and assets of each partner and will result in:

- A shared database that will include up-to-date experience in implementing quality-improvement processes in medical schools
- Access, via the database, to information on specific schools and in particular to a

description of their approach to quality improvement

- Promoting twinning between schools and other institutions in processes to foster innovative education
- Means to update the management of medical schools
- Identification and analysis, by WHO regions, of innovations in medical education in order to help define appropriate lines of work for each region
- Assistance to institutions or national/regional organizations and agencies in developing and implementing reform programmes or establishing recognition/accreditation systems

– A review of good practices in medical education that can serve as examples and as a source for further innovation.

The strategic partnership will also address other crucial questions that medical schools now face, such as improving their leadership function. Through a systematic dialogue, the partners will pursue the work plan and provide useful information to medical schools worldwide.

The strategic partnership is another outgrowth of WHO’s strong commitment to supporting Member States’ efforts to attain the Millennium Development Goals (MDGs) (<http://www.who.int/mdg/en/>), adopted at the Millennium Summit of the United Nations in September 2000. A major thrust of the MDGs is improved health sta-



tus, towards which human resources for health will make a crucial contribution. But in order to contribute optimally, the health workforce must receive the best possible educational preparation.

Planning and providing high-quality human resources education demands the active participation of medical schools and other providers of medical education and training, since physicians are important to any model of a health team for developing and developed countries alike. WHO and the WFME have been working together since 1972 towards improving medical education worldwide.

There is no single path towards improving the quality of medical education. Each region and country features different approaches that must be acknowledged, explored and brought to wider use. But to achieve significant and lasting results, institutions must be committed to an ongoing process of quality development. The WHO/WFME strategic partnership aims to foster this commitment.

New on-line TB training course to be launched by WMA on World TB Day

On World TB Day (March 24th), WMA will launch a new on-line course to improve earlier diagnosis, prevention and treatment of multi-drug resistant tuberculosis (MDRTb).

This course has been in development with the Foundation for Professional Development of the South African Medical Association and the Norwegian Medical Association is coordinated by the German Medical Association.

Based on the WHO guidelines on the management of MDRTb, it will allow physician to train on-line at their own pace. The web-based course will be available in several

languages and participating physicians may be able to receive credits as part of their continuing medical education. It will be available in several languages.

The course will be piloted first amongst physicians in South Africa, extended to physicians in Estonia and the Philippines in the summer and then be available globally. It has been made possible by an educational grant from Eli Lilly.

This new course follows the successful web-based course already developed and run by WMA and the Norwegian Medical Association for Prison Doctors on Human Rights and Ethics.

The World Medical Association Statement on Medical Education

Adopted by the WMA General Assembly, Pilanesberg, South Africa, October 2006

Preamble

1. The practice of medicine is dynamic and continues to evolve. Medical education represents a continuum of learning that commences with undergraduate medical school and endures until a physician retires from active practice. Its goal is to prepare practitioners of medicine to apply the latest scientific knowledge for the promotion of health and the prevention and cure of human diseases and the mitigation of symptoms of presently incurable diseases. Medical education also comprises the

ethical standards governing the thought and behaviour of physicians. All physicians have a responsibility to themselves, the profession and their patients to maintain a high standard for their medical education.

Basic Principles of Medical Education

2. Medical education consists of basic medical education, postgraduate medical education, and continuing professional development. The profession, the faculties and educational institutions, and the government share the responsibility for guaranteeing that medical

education meets a high quality standard throughout this continuum. The aim of medical education is to develop competent and ethical physicians that deliver high quality healthcare to the public.

Basic Medical Education

3. The goal of basic medical education is to instruct students in the practice of the profession, and to supply the public with well-qualified physicians. The first professional degree should represent the completion of a curriculum that qualifies the student for a spectrum of career choices, including, but not limited to, patient care, public health, clini-



Medical Education

cal or basic research, or medical education. Each of these choices will require additional education beyond the first professional degree.

Selection of Students

4. A general liberal education is beneficial for anyone embarking on the study of medicine. A broad cultural education in the arts, humanities, and social sciences, as well as biological and physical sciences, is advantageous. Students should be chosen for the study of medicine on the basis of their intellectual ability, motivation, previous experiences, and character and integrity. The numbers admitted for training must meet the needs of the population and be matched by appropriate resources. Selection of students should not be influenced by age, sex, race, creed, political persuasion or national origin, although the mix of students should reflect the population.

Faculty

5. Basic medical education must be taught by a structured faculty. The faculty must possess the appropriate qualifications that can only be achieved through formal training and experience. The selection should not be based on age, race, creed, political affiliation, or national origin.
6. The faculty must foster an academic environment in which learning and inquiry are encouraged and can thrive. As such, active research to advance the body of medical knowledge and the quality of care must take place in academic settings that promote the highest medical standards. The goals, content, format and evaluation of the education provided are the responsibility of the faculty. Medical schools should ensure continued growth of the teaching skills of the faculty.
7. The faculty is accountable for providing its own basic curriculum in an academic environment that allows learning to

flourish. The faculty should review the curriculum frequently, allowing for the needs of the community and for input from practising physicians. Furthermore, the faculty is responsible for regularly evaluating the quality of each educational experience and for reviewing each other.

8. In addition to competent faculty, the institution must require that library resources, research laboratories, clinical facilities, and study areas be available in sufficient quantity to meet the needs of all learners. Moreover, a proper administrative structure, including but not limited to academic records, must be maintained in order to provide the most comprehensive education.

Content of Basic Medical Education

9. The educational content should equip the student with a broad base of general knowledge in the whole field of medicine. This includes a study of the biological and behavioural sciences as well as the socio-economics of health care. These sciences are basic to an understanding of clinical medicine. Critical thinking and self-directed learning should also be required, as should firm grounding in the ethical principles upon which the physicians will function and in the principles of human rights. The student should also be introduced to medical research and its methodology at this stage.

Clinical Education

10. The clinical component of medical education must be centered on the supervised study of patients and must involve direct experiences in the diagnosis and treatment of disease. The clinical component should include personal diagnostic and therapeutic experiences with a gradual increase in responsibilities. An appropriate balance among the patient base, trainees and teachers must be observed.

11. Before beginning independent practice, every physician should complete a formal program of supervised clinical education. This clinical experience should range from primary to tertiary care in a variety of inpatient and outpatient settings, such as university hospitals, community hospitals and other health care facilities.

12. The faculty and medical schools have the responsibility to ensure that students who have graduated and received the first professional degree have acquired a basic understanding of clinical medicine and the basic skills needed to evaluate clinical problems and take appropriate action independently, and exhibit the attitude and character to be an ethical physician.

Postgraduate Medical Education

13. It is highly desirable, and in many jurisdictions it is already a requirement, that a graduate from a basic medical education institution participate in a postgraduate training program prior to obtaining a license. Postgraduate medical education, the second phase of medical education, prepares physicians for practice in a medical specialty. Postgraduate medical education focuses on the development of clinical skills and general and professional competencies and on the acquisition of detailed factual knowledge in a medical specialty. This learning process prepares the physician for the independent practice of medicine in that specialty.

14. The programs are based in communities, clinics, hospitals or other health care institutions and should, in most specialties, utilize both inpatient and ambulatory settings, reflecting the importance of care for adequate numbers of patients in the postgraduate medical education experience. Postgraduate medical education programs, including Transitional Year programs, are usually called residency programs, and the physicians being educat-



ed in them, residents. A resident takes on progressively greater responsibility throughout the course of a residency, consistent with individual growth in clinical experience, knowledge, and skill.

15. The education of resident physicians relies on an integration of didactic activity in a structured curriculum with diagnosis and management of patients under appropriate levels of supervision and scholarly activity aimed at developing and maintaining life-long learning skills. The quality of this experience is directly related to the quality of patient care, which is always the highest priority. Educational quality and patient care quality are interdependent and must be pursued in such a manner that they enhance one another. A proper balance must be maintained so that a program of postgraduate medical education does not rely on residents to meet service needs at the expense of educational objectives. A resident is prepared to

undertake independent medical practice within a chosen specialty on the satisfactory completion of a residency.

Professional Development of Physicians

16. Continuing professional development* is defined as the educational activities that serve to maintain, develop, or increase the knowledge, skills, and professional performance and relationships a physician uses to provide services for patients, the public, or the profession. Physicians should strive to further their medical education throughout their careers. These educational experiences are essential to the physician's continuing professional development: to keep abreast of developments in clinical medicine and the health care delivery environment, and to maintain the knowledge and skills necessary to provide high quality care. The goal of con-

tinuing professional development is to sustain and enhance the competent physician. Medical schools, hospitals and professional societies all share a responsibility for developing and making available to all physicians effective opportunities for continuing professional development.

17. The demand for physicians to provide medical care, prevent disease, and give advice in health matters calls for the highest standards of basic, postgraduate, and continuing professional development.

* Note on terminology: There are different uses of the term 'Continuing Professional Development' (CPD). One way to describe it is all those activities that contribute to the professional development of a physician including involvement in organized medicine, committee work in hospitals or group practices, teaching, mentoring and reading, to name just a few. One of the components of CPD should be Continuing Medical Education, which in many jurisdictions is specially defined and possibly required for licensure.

From the Secretary General

Health Professional Council of South Africa announces amnesty on restoration fees

An Amnesty difficult to understand

South Africa has lost a significant part of its physician work force to other countries during recent years. WHO's World Health Report 2006 estimates that more than 12,000 doctors who have originally been trained in South Africa now work in 8 OECD countries (Australia, Canada, Finland, France, Germany, Portugal, United Kingdom and the United States of America). This amounts to nearly 37% of the South African physician work force and is only the number for these selected 8 countries.

Of course these countries may be the most attractive and certainly physicians did not turn their back to South Africa because it offered them good working conditions, a healthy motivated population and excellent

salaries. South Africa has some of the most difficult problems in the world. It has a high burden of HIV/AIDS cases and during last fall the occurrence of the so-called "Extended Drug Resistant Tuberculosis" (XDR-TB) became a nightmare for TB patients and their care givers.

Although South Africa is a country rich in resources, the majority of its population is still very poor and what Europeans would describe as a regular access to health care, for many of the South Africans is far out of reach. This country badly needs physicians. There are a lot of South African physicians in this world who have left their country. Wouldn't it be good, if some of them returned?

Earlier this year the South African Medical Association (SAMA) reached out to their lost colleagues to bring them news from the South African Medical Council: In a "Call on South African doctors to return home" they told the South African Physicians that "the Health Professions Council of South Africa has agreed to a once-off waiver of penalties for those practitioners, both local and abroad, who failed to pay their annual registration fees on time, or who had allowed their registration to lapse without informing Council." And while the SAMA sees this as a win, the foreign observer still may find this strange.

It is even more difficult to understand when on a further look the amnesty is not really an



amnesty, as the Council expects “all health care practitioners who take advantage of this amnesty period to render professional services to any public sector institution of their choice. We expect them to work for 100 hours in service to public health within six months of their restoration.”

It is certainly without question that physician have to be subject to supervision. The supervision is a public service. If it is done by self-governance there is good reason to pay it by contributions from the physicians. Otherwise it should be paid by the state. To avoid supervision is not acceptable. However, if physicians who have left the country they are simply out of this supervision, and there is absolutely no reason to expect money from them.

To make this clear once more: South Africa is one of the countries with the sharpest loss of health professionals in this world, South Africa is one of the countries with the highest

demand for physicians and yet – as this publicized amnesty reveals – it is threatening punishment to physicians who have not paid fees to the SA Council while they were abroad.

Yes, some may have forgotten to de-register. I did so, when I left my country for the first time. My chamber sent me a letter (after locating me abroad) and told me that, since I had left the country they would strike me off the register. They also told me that I had to reregister as soon as I wanted to come back. I did so. No penalty, no amnesty, no fuss. Even professional matters can be dealt with professionally.

South Africa should embrace every physician who wants to come back wholeheartedly. Instead it threatens them with punishments or an amnesty, which in fact is nothing else than a punishment-in-kind.

We will have to learn how many have accepted the amnesty that ended April

30th. If the number of physicians is small, the Council may have to consider that an amnesty which includes a punishment may not really be perceived as an amnesty. If the number of physicians is significant, the South Africans must consider to waive the penalties and fees for physicians abroad all together, because in that case they would have given proof that their regulation is part of the cause for the health professional shortage. But maybe that is what the Council fears finding out and why there is no real amnesty in the first place.

I wonder what else South Africa does to make the everyday-life of a physician a little bit harder than necessary.

Otmar Kloiber

Further informations:
<http://www.hpcsa.co.za/>

(See also page 28)

General Assembly, Pilanesberg South Africa „Continued“

Scientific Session “Health as an Investment: Leadership and Advocacy” 12 October 2006

Speech by Dr. Thami D. Mseleku, Director National Department of Health, South Africa to the WMA Scientific Session, Pilanesberg.

Let me start by thanking you for extending an invitation to the Minister of Health, Dr. Manto Tshabalala-Msimang, to this gathering of eminent medical professionals. Unfortunately she is unable to be here due to ill health. As we gather here this morning, the South African medical fraternity is also gathering elsewhere to pay tribute to one of the sons of our country, Professor Sam Mhlongo who was known by many, and dared to push the boundaries of medical science. May his soul rest in piece.

It is of great significance that the World Medical Association consciously took a decision more than five years ago to hold its General Assembly in our country, barely

five years after an earlier one in Somerset West in 1996. That assembly was attended at a very high level by our government in the form of the then Minister of Health and current Minister of Foreign Affairs Dr. Nkosazana Dlamini-Zuma and the then Deputy President and now President of the country Mr. Thabo Mbeki. When you visited our country in 1996, this country’s medical associations were many. There was a lot of resistance to unifying into a single national association. It is without doubt that holding the 48th WMA General Assembly on our shores in 1996 gave some impetus to the unity talks of the medical profession because almost two years later on 21 June 1998, a new medical association was launched.

You have come again to South Africa just two years before the South African Medical

Association celebrates its first ten years of existence. An evaluation of SAMA activities will certainly take into consideration internal, national and international performance in line with the goals the association set itself and the promise the association made to the country at its inception. This congress will have some influence in shaping such an evaluation.

Internationalism in the world of medical politics is an important element in the development of health systems. Like all international instruments it must be based on sound principles and have clear focused goals and objectives. Your theme: ‘**Health as an Investment: Leadership and Advocacy**’ is in my view an appropriate one to adopt as the world is facing serious challenges on the health front. Over the past two decades the world has seen and experi-



enced increasing burden of diseases (both communicable and non-communicable) requiring global, national and local collaboration on a scale never envisaged before. One can immediately bring to mind a number of public health incidents that have required intensive investments in scientific research to avoid them becoming emergencies. The emergence of HIV and its progression over the years should be taken as a lesson by all of us that innovative research must be prioritized in our countries, and trans-nationally. It is of course a fact that the size of investment, who really does the investment and the purposes of the investment, are critical factors in determining social and economic outcomes of the health investment. As a country, we have been committed to investing in this area and provided funding to bodies like the Medical Research Council and the South African AIDS Vaccine Initiative to ensure that we confront HIV challenges from all health issue fronts. Severe Acute Respiratory Syndrome is another, which recently served to remind the scientific community that our efforts should always be to prioritise public health. It took the eminent scientists to rapidly come up with measures to curb what seemed a very serious threat to humankind. These reminders emphasise the absolute need to invest in scientific research in anticipation of new diseases that will certainly challenge and push the boundaries of what health systems should provide. Medical research brings together many stakeholders including communities and individuals. With many facets of research spanning diverse areas, it is critical that the guidelines are clear and mechanisms are put in place to monitor how it is conducted. Increasingly the nature of the public health pressures faced by countries, particularly developing countries, will necessarily involve research by allied professionals in multidisciplinary research teams which focus on health issues, as well as health researchers and academics. Costing of interventions and public health strategies increasingly features in research work on managing public health crises for example.

Similarly we cannot say we are investing in health if we continue to marginalize indigenous knowledge systems, in particular the

knowledge that lies in African traditional medical practices. Those African practices continue to be denigrated and called unscientific when they have sustained our people for many years.

As far back as the 1980's the progressive health forces in our country led by the National Medical and Dental Associations, waged endless protests against apartheid health, calling for not only an end to apartheid health but also increased investment in the national health system. This was informed by the tireless work of the health professionals who had gained a lot of experience serving the poor and marginalized of this country. International experiences and lessons shared, played a major role. It was therefore no coincidence that our health system was initially modeled on UK's National Health Service. The foundation of the role of the medical organizations in policy advocacy was therefore laid and it is our expectation that SAMA should be in a position to continue on that trajectory, ensuring that it becomes a partner in developing a sustainable health system to serve the poor, so that the distribution of quality health provision becomes more equitable in our system.

South Africa inherited serious challenges on attainment of its freedom in 1994. The extent of social, educational, health and other challenges we inherited is often underestimated. There was therefore a conscious decision to waste no time in transforming the services, choosing the primary health care route as the preferred mechanism to bring and provide health services nearer to our people. We built on the work already done by various non-governmental bodies like NAMDA and the National Progressive Primary Health Care Network which had paved the way for developing a health system that should be responsive to the needs of ordinary South Africans. SAMA, as a successor to previous doctor formations, was expected to ensure that those values are not lost. It is however not an issue of prescription of one to another but one of ensuring that our health services, whilst trying to compete with the best in the world in some respects as driven by professionals, remain rooted in prioritizing provision for the poor. Focusing and contextual-

izing this is critical for ensuring appropriateness of health care.

It is no mistake that South Africa invests just under 4% of GDP in the health services if one considers the serious socio-economic challenges it faces. In our opinion, investing in health care is fundamental and there should be no disagreement on that. The debate should be on what it is that must be prioritized in doing such investment. The preamble to a resolution adopted by the 50th World Medical Assembly in Ottawa in October 1998 notes WMA's concern '*about health care systems in all countries not having adequate resources to meet the basic needs of their populations*'. In adopting that resolution WMA reconfirmed the guidelines on access to health care, which were adopted at the 1988 Assembly in Vienna. That resolution had emphasized equity in access irrespective of economic factors, cost financing and transportation. This is just but two of your own resolutions that indicate the need to invest better in health care. Almost all health systems, almost ten years on from 1998, are battling even more trying to improve health care investment.

However, health care investment must be viewed from a variety of perspectives. Let us start with the most critical aspect – the health workforce. Many health system planners fail to adequately deal with this aspect even in the well-resourced health systems of the West. It is without doubt that certain professional categories were however prioritized, probably by default, such that even limited resources would be poured to their education and training. The medical profession has certainly benefited immensely from that approach. The nursing profession, even though forming the majority of health professionals in all countries and on whose shoulders health care services rest, has not necessarily enjoyed the kind of resource allocation invested in the medical profession. The breakthrough was only achieved to some extent with the adoption of the Alma Ata Declaration in 1984, which emphasized a primary health care approach to providing health services as being the most preferred vehicle. This still did not mean that countries started investing better in health.



Our government has prioritized the health human resource element by developing a comprehensive human resource plan for health to address the serious challenges we are facing specifically with the health workforce. These range from planning, development, to management. Our efforts now are focused on how each of the sub-sectors engages and implements aspects of the plan that affect their core business. We are interacting and collaborating with the Health Professions Council of South Africa, South African Nursing Council and the South African Pharmacy Council in developing sub-sector specific human resource plans to inform the country's investment in producing the skills that our health system needs now and in the future. This work is very critical to directing investment appropriately so that we can derive better value.

Directed investment in education and training of health professionals is just a single element. Economic development and its impact on health care is a recognized factor. The better the economic prospects of a country the more tension arises within its health system. The presence of a strong private health sector always retards the strengthening of the public health sector. A strong private health sector serves as a major attraction for health professionals because of the economic prosperity that it offers. Several formations within health care have been discussing and debating these issues for some time now, culminating in the World Health Organisation setting up a Commission on Macro-Economics in Health. This was driven by a realization that the country's economic development status and the economic opportunities that ordinary citizens have or do not have, have a direct impact on the health status of a nation. A similar scenario exists in the migration phenomenon, with highly skilled health professionals being attracted more to the better-resourced health systems of western countries. This only perpetuates inequity in the world health care systems. Although the private health sector is largely a recipient of public goods it has not contributed to developing, there is little evidence of a willingness to invest massively in strengthening the public health sector. Many individual practitioners are doing a

sterling job in providing health care services at State institutions, some at no cost at all. This is highly appreciated; however, it is always the collective efforts that bring realizable benefits on a national scale. This is the case in all countries of the world.

On the infrastructure investment side, our government took a strategic decision through its 1994 policy declaration that health services would be transformed. This meant amalgamating 14 separate departments into a single national health system with nine provincial departments responsible for health service provision and one national department responsible for policy formulation. There had to be a massive infrastructure development – building many new primary care clinics and revamping and/or constructing new hospitals. Our hospital revitalization project has been a phenomenal success in improving infrastructure. Where possible we have partnered with the private health sector in erecting new facilities e.g. Inkosi Albert Luthuli Academic Hospital in Durban.

All the issues that I have raised above need good quality leadership. As you may know, leadership also has to be taken into context with the political landscape integral to that. A leadership confronted by serious fiscal constraints in a developing world situation will respond differently to the same stimulus when compared to leadership that has little constraints in financial and human capital terms. That is why for many years it has been easier for western countries to freely recruit doctors and nurses from poor countries and difficult for poor countries to put in place monetary incentives to retain their expensively trained human assets. The lack of proper planning by rich countries has a lot to do with this. Health is a complex and very diverse sector. It is comprised of disparate sections of health professionals that are not necessarily driven by the same values. One may not refer to the centuries old fight between doctors and pharmacists over dispensing of medicines!

The essence of this is that as policy planners and decisions makers, we have to always balance the aspirations of the health professions with the needs of citizens who depend entirely on public health facilities to receive

health care. So whilst your Vienna resolution called for improved investment in health care, resource availability has remained a serious constraint globally. Certainly the policies of some international finance institutions have not necessarily assisted despite the efforts. In our situation we are confronted with challenges that require government to drastically improve the quality of life of ordinary South Africans. This means providing households with running tap water, providing sanitation

Death of Erwin Odenbach, long time physician leader.

Dr. Paul Erwin Odenbach, former Secretary General of the German Medical Association has been a long term adviser to the WMA Council and Associate Members. As a physician, teacher, leader, and friend Erwin has been tirelessly engaged for his patients, society and our work. Being engaged in medical education, regulation, humanitarian action and medical ethics his attitude was always driven by values. It made him an outstanding example for our profession.

His leadership career started with his involvement in the medical students' organization in Germany soon after World War II. He surfaced internationally as the second president of the International Federation of Medical Students Association (IFMSA) and since then has been a leader in organized medicine on the national and international level.

He first encountered the World Medical Association in 1954, addressing the General Assembly in Rome as the IFMSA representative. He continued to be actively engaged with WMA until recently. His last policy piece, a Resolution on Medical Assistance in Air Travel, was adopted by the WMA at its General Assembly in Pilanesberg in October 2006.

On Saturday, February 10th, 2007 Dr. Paul Erwin Odenbach, passed away in peace surrounded by his loved family.



services and habitable housing, while concentrating on growing the economy. We have a government that has a mandate to improve social welfare, provide access to education, promote access to individual economic development through providing the young people of the country with opportunities to be productive citizens and ensure that South Africa continues to play its role with others in developing the African continent.

Leadership and advocacy in our context therefore have to be seen through that prism. The leadership of the professions has a duty to advocate for improved patient care, not over-emphasise its own self-interest in rationing of health care resources. Advocacy must not be concentrated and limited to public platforms that serve to highlight only the perceived failings of interventions without engaging robustly with government agencies responsible for health. Advocacy in our context must also be a broad health professional focus, guided by the desire to propagate the good professional values that are inherent in each. It must go beyond the public health sector and must influence the culture of the private health sector. Without such intensified focus, your resolutions on improving investment in health care will fall short. In many instances the private health industry has massive resources that should be used for public good without compromising the drivers of that sector – profit making. Your leadership as a profession must be able to go beyond advocating for political reasons. It must be guided and be rooted in ensuring delivery of good quality health care to the most poor of society. It must engage professionally and robustly to advance the pro-poor agenda. South Africa invests a lot of resources to educating and training health professionals who form part of our intellectual base as a country. It is only through working hard at establishing and nurturing good relations that we can influence each other.

I therefore hope that SAMA will, after this assembly, engage with my department on the resolutions that you will have adopted.

Mr. Thami D. Mseleku
Director General
National Department of Health –
South Africa

The Health Care System in Japan: Current Situation and Future Perspectives

Dr. Yoichi Hozumi, Vice President, Japan Medical Association

(presentation given during the Scientific Session “Investment in Health”, Palensberg)

A general overview of health care in Japan, with particular mention of health care as an investment.

Overview

Approximately 60 years ago, Japan had just begun postwar reconstruction. Food was inadequate and nutritional and hygienic conditions for the general public were extremely bad. The incidence of infectious and other diseases was high in both urban and rural areas, and life expectancy in 1947 was 50 for Japanese men and 54 for women. Health care in these circumstances was completely inadequate.

Japan lost approximately 1.85 million people in the Second World War; most cities were razed and the national wealth lost. The postwar reconstruction of Japan’s social security system proceeded with the establishment of a new National Constitution under the powerful supervision of the occupational forces GHQ. The new Japanese Constitution guaranteed fundamental human rights for citizens in Article 11 and based on this, guaranteed citizens’ right to live in Article 25, establishing the State’s social responsibility in Paragraph 2, which states that “In all spheres of life, the State shall use its endeavors for the promotion and extension of social welfare and security, and of public health.” Amidst the harsh conditions imposed by the devastation left by the war, Japan began to rebuild, and through the many efforts of its citizens the society’s productive, economic, and educational conditions began to gradually and steadily improve.

Little by little, everyday living conditions also improved. The greatest issue for

hygienic conditions was the supply of running water and maintenance of water quality. The improvement of these secured the supply of pure water for drinking and other domestic uses, enabling the supply and consumption of hygienic food and clean clothing. By 1956, Japan was no longer regarded as being “postwar”, and the average life expectancy had grown to 63.6 for men and 67.75 for women. The country entered a period of economic expansion that saw business boom. Housing improved, and at the same time as the use of electrical appliances such as refrigerators, washing machines, and television sets became widespread, so too did the use of medical equipment such as X-ray, electrocardiographic, and endoscopic equipment spread rapidly amongst medical institutions, with medical technology also advancing rapidly. Throughout the country everyday living became hygienic and consideration to the environment improved with the installation of sewage systems and treatment of waste water, and these developments in particular contributed significantly to the enterprise of the people.

However, as industry expanded, atmospheric pollution was caused by smoke and other pollution was caused by industrial waste water; environmental pollution became a serious concern in some situations and efforts were made to rectify these. Against this background, health management measures to prevent over-consumption of salt and ensure the adequate consumption of protein were spreading. At the same time that medical examinations became commonly carried out as a means of preventing diseases. Group examinations were held for stomach cancer and businesses implemented health check-ups for their employees. Consequently, the early diagnosis of frequently occurring diseases and preventative examinations expanded on a national scale, producing highly significant results. Thus since about 30 years ago, people’s nutrition has improved and the incidence of infec-



tious diseases has decreased; in 2002 the average life expectancy for men was 78, and for women was 85, making Japan the world's top country for longevity.

Japan is an island nation with little flat land; 90% of the country is forest-covered mountains. Not only is Japan a volcanic country that faces the constant threat of massive and epicentral earthquakes, but it also faces wind and water damage every typhoon season. Since plentiful rainfall is beneficial for tree growth, Japan has many fast-flowing rivers. Compared with continents, rivers flow only short distances from their well-springs to the ocean. These plentiful, clear rivers play an important role in rice cultivation, in hydroelectric power generation, and in many other functions in which water has been innovatively utilized. Japan cannot produce oil or natural gas as energy sources and its mineral resources are also small.

Consequently, national production in Japan tends towards importing raw materials from overseas, then manufacturing products using various original processing technologies; promotion of high intelligent added value in industrial production and high computerization, Industrial structuring in areas such as finance, distribution, and services increasing more and more, invigorating the economy. Many innovations have been made to production methods for traditional rice, fruit, and vegetable crops; developments in production technology are not only used in domestic production but are also spread overseas, with the export of production technology now becoming an important industry that also contributes internationally. Deep-sea and coastal fishing are two other important industries; the development and promotion of innovative fish farming technology is becoming increasingly important as a means of securing resources. The international export of seafood is a small industry in Japan, but it also contributes greatly to the development and diffusion of technology. Since the industrial revolution, Japan's basic policy has been to enhance the education system; citizens make efforts to promote intelligent industry, understanding that we receive praise and great benefits from other countries through the development of science and technology and our contributions to the international community.

The development of transportation facilities in Japan has enabled many people and goods to be transported anywhere within the country within half a day, and information can be transmitted instantly throughout the country.

This was a huge leap forward for emergency and disaster medicine in Japan. With these developments, from the 1950s onwards the basic components necessary for providing health care – hospitals, clinics, doctors, and nurses – all of which had been inadequate, gradually increased and health care in regional areas expanded. A health insurance system which operated independently for each health field continued to exist, but there continued to be a large number of people who had not paid their insurance. The Japan Medical Association recommended that the individual insurance systems be integrated and the entire system expanded. Eventually, in 1961, the total health insurance was expanded and a universal health care system available to all citizens was introduced. Through the process of establishing this system, medical fields were classified broadly into four groups.

All citizens were required to join one of four insurance plans depending on their occupation and position: government-managed health insurance administered by medium and small businesses; association-managed health insurance administered by the majority of large businesses; National Health Insurance administered by local government authorities; and National Health Cooperative Insurance, also administered by the same kind of businesses on a local level. The establishment of this system enabled citizens to receive health care equally and fairly anywhere in Japan, at any time and for whatever reason, for a minimal self-payment and without having to undergo screening simply by showing their insurance card to prove they were insured. Under this system, the medical institution providing treatment receives the portion of payment covered by public funds under a reimbursement system known as a fee-for-service system. The system operates smoothly due to the efficient functioning of a medical fee payment fund that carefully checks the details of medical treatment.

Improvement of medical institution facilities and the implementation of this medical insur-

ance system have enabled huge advances in regional health care systems and provided the tremendous benefit of care being available equally and fairly to all citizens.

Because of differences in the history of their establishment and composition of member businesses and organizations, each of the health insurance plans has difference insurance rates. The government-managed health insurance plan is the largest in scale and imposes public benefits in addition to the insurance burden on employers and members.

Against this background the Japan Medical Association, as a pillar supporting the health care of citizens, proactively promoted the establishment and maintenance of this system, and with the cooperation of medical institutions nationwide, the National Health System has made a huge contribution to the health system in Japan.

With the development of the economy and industry in Japan, already outlined, the emergency medicine infrastructure and treatment of chronic illness improved through the continued improvement of hygienic conditions, better nutrition, and the creation of infrastructure for the universal and fair provision of health care.

In 2000 and 2004, the World Health Organization named Japan as a country with one of the highest longevity rates in the world, recognizing the excellence of Japan's health system. Japan ranks Number 1 in the world in a comparison of health achievement; in 2002 longevity was again the highest in the world, with the average life expectancy for men being 78.4 and for women 85.3; and Japan also has one of the lowest infant mortality rates in the world. Japan's excellent National Health Insurance system is the most effective health insurance system of all the developed countries. Since the 1970s, Japan's GNP has skyrocketed. With citizens' growing health consciousness and medical care awareness as well as improvements in medicine and medical technology, the total cost of medical treatment in Japan is gradually growing and management of the health insurance system has been revised repeatedly.

Since 1980, the total fertility rate has dropped below 2.0 for a variety of reasons, and in 2005 dropped to a marked low of

1.25. In a world rapidly ageing, Japan has hurtled fastest into an aging society with fewer children.

As I have explained, medical expenses in Japan are not high compared with other developed countries. Total health expenses are 7.9% of GDP, a low rank of 17 amongst the developing countries. However, in 2000 Japan established a national Long-term Care Insurance system, administered on a municipal basis, aimed at elderly citizens requiring nursing care as a means of lightening the continuously increasing cost of health care for the elderly. The degree of nursing care required is determined through screening and nursing care services appropriate for the elderly person's needs are provided.

“Health as an Investment”

Considering the population dynamics of Japan, despite the difficulty of boosting the productive-age population, it could be possible to secure a potential working population by improving the health of senior citizens. Increased numbers of elderly people capable of working would be an enormous opportunity, creating fresh consumer activity and invigorating the economy. In other words, proactive health care to restore, maintain, or increase health – such as avoiding the risk of disease occurring through preventative medicine and the promotion of social rehabilitation and independence through early diagnosis and treatment – has ample potential to increase the health investment of each individual, thereby increasing the population of potential workers, bringing about an increase in productivity, GDP, and revenue from tax, and thus more stable employment and fresh economic activity. Furthermore, health care is a labor-intensive industry, so a stable supply of workers for medical institutions will facilitate more stable health care. Moreover, the construction of the necessary medical facilities could also create a wave effect in the economy. In this way, there are certainly investment aspects in health care, and it is vital that this is recognized widely by members of the general public. The JMA is currently seeking the understanding of the government headed by Prime Minister Abe, newly formed in September this year, of the

necessity of promoting basic policies such as this.

The JMA is proactively pursuing the following items as comprehensive and central policies for health reform, including the views just mentioned.

1. Creation of a society able to truly rejoice at longevity through enhanced health care and welfare for the elderly.
2. Creation of a society where one can give birth with peace of mind through the expansion of obstetrical care and maternal and child health.
3. Creation of a society where children can thrive and grow healthily through enhanced pediatric care and school health.
4. Creation of a society where people can work healthily and enthusiastically through enhanced industrial health and workers' compensation insurance.
5. Creation of a society with as little occurrence of disease as possible through the promotion of healthy lifestyle and lifestyle disease countermeasures and anti-smoking campaigns.
6. Creation of a society able to provide high quality medical care for those who are sick, through the guarantee and

enhancement of community health care and health insurance.

7. Creation of a society that provides an excellent health care system through the enhancement of community health care centred on primary care doctors and the promotion of cooperation between health services.
8. Creation of a society able to put medical advances into practice in health care through the establishment of lifetime education and a medical specialist system.

Finally, with regard to approaches to government agencies concerning issues such as these, the JMA is campaigning to prevent corruption of the medical care system, including financially motivated proposals for medical system reform, mainly through petitions and the endorsement of Diet members who represent the position of the JMA in the government.

The JMA intends to continue to promote the construction of a foundation for community health care, working with the general public to formulate and propose strategies for realizing the establishment of a health care framework that people trust, in order to create a durable social insurance system that safeguards the health and welfare of Japan's citizens.

The World Medical Association Statement on HIV/AIDS and the Medical Profession

Adopted by the WMA General Assembly, Pilanesberg, South Africa, October 2006

Introduction

1. HIV/AIDS is a global pandemic that has created unprecedented challenges for physicians and health infrastructures. In addition to representing a staggering public health crisis, HIV/AIDS is also fundamentally a human rights issue. Many factors drive the spread of

the disease, such as poverty, homelessness, illiteracy, prostitution, human trafficking, stigma, discrimination and gender-based inequality. Efforts to tackle the disease are constrained by the lack of human and financial resources available in health care systems. These social, economic, legal and human rights factors affect not only the public health dimension of HIV/AIDS but also individual physicians/health workers and patients, their decisions and relationships.



Discrimination

2. Unfair discrimination against HIV/AIDS patients by physicians must be eliminated completely from the practice of medicine.
 - a. All persons infected or affected by HIV/AIDS are entitled to adequate prevention, support, treatment and care with compassion and respect for human dignity.
 - b. A physician may not ethically refuse to treat a patient whose condition is within his or her current realm of competence, solely because the patient is seropositive.
 - c. National Medical Associations should work with governments, patient groups and relevant national and international organizations to ensure that national health policies clearly and explicitly prohibit discrimination against people infected with or affected by HIV/AIDS.

Appropriate / Competent Medical Care

3. Patients with HIV/AIDS must be provided with competent and appropriate medical care at all stages of the disease.
4. A physician who is not able to provide the care and services required by patients with HIV/AIDS should make an appropriate referral to those physicians or facilities that are equipped to provide such services. Unless or until the referral can be accomplished, the physician must care for the patient to the best of his or her ability.
5. Physicians and other appropriate bodies should ensure that patients have accurate information regarding means of transmission of HIV/AIDS and strategies to protect themselves against infection. Proactive measures should be taken to ensure that all members of the population, and at-risk groups in particular, are educated to this effect.

6. With reference to those patients who are found to be seropositive, physicians must be able to effectively counsel them regarding: (a) responsible behaviour to prevent the spread of the disease; (b) strategies for their own health protection; and (c) the necessity of alerting sexual and needle-sharing contacts, past and present, as well as other relevant contacts (such as medical and dental personnel) regarding their possible infection.
7. Physicians must recognize that many people still believe HIV/AIDS to be an automatic and immediate death sentence and therefore will not seek testing. Physicians must ensure that patients have accurate information regarding the treatment options available to them. Patients should understand the potential of antiretroviral treatment (ART) to improve not only their medical condition but also the quality of their lives. Effective ART can greatly extend the period of time that patients are able to lead healthy productive lives, functioning socially and in the workplace and maintaining their independence. HIV/AIDS is increasingly looked upon as a manageable chronic condition.
8. While strongly advocating ART as the best course of action for HIV/AIDS patients, physicians must also ensure that their patients are fully and accurately informed about all aspects of ART, including potential toxicity and side effects. Physicians must also counsel patients honestly about the possibility of failure of first line ART, and the subsequent options should failure occur. The importance of adhering to the regimens and thereby reducing the risk of failure should be emphasized.
9. Physicians should be aware that misinformation regarding the negative aspects of ART has created resistance toward treatment by patients in some areas. Where misinformation is being spread about ART, physicians and medical associations must make it an immediate priority to publicly challenge the source of the misinformation and to work with the HIV/AIDS community to

counteract the negative effects of the misinformation.

10. Physicians should encourage the involvement of support networks to assist patients in adhering to ART regimens. With the patient's consent, counselling and training should be available to family members to assist them in providing family based care. Physicians must recognize families and other support networks as crucial partners in adherence strategies and, in many places, the only means to adequately expand the care system so that patients receive the required attention.
11. Physicians must be aware of the discriminatory attitudes toward HIV/AIDS that are prevalent in society and local culture. Because physicians are the first, and sometimes the only, people who are informed of their patients' HIV status, physicians should be able to counsel them about their basic social and legal rights and responsibilities or should refer them to counsellors who specialize in the rights of persons living with HIV/AIDS.

Testing

12. Mandatory testing for HIV must be required of: donated blood and blood fractions collected for donation or to be used in the manufacture of blood products; organs and other tissues intended for transplantation; and semen or ova collected for assisted reproduction procedures.
13. Mandatory HIV testing of an individual against his or her will is a violation of medical ethics and human rights. Exceptions to this rule may be made only in the most extreme cases and should be subject to review by an ethics panel or to judicial review.
14. Physicians must clearly explain the purpose of an HIV test, the reasons it is recommended and the implications of a positive test result. Before a test is administered, the physician should have an action plan in place in case of a positive test result. Informed consent must be obtained from the patient prior to testing.



15. While certain groups are labelled „high risk“, anyone who has had unprotected sex should be considered at some risk. Physicians must become increasingly proactive about recommending testing to patients, based on a mutual understanding of the level of risk and the potential to benefit from testing. Pregnant women should routinely be offered testing.
16. Counselling and voluntary anonymous testing for HIV should be available to all persons who request it, along with adequate post-testing support mechanisms.

Protection from HIV in the Health Care Environment

17. Physicians and all health care workers have the right to a safe work environment. Especially in developing countries, the problem of occupational exposure to HIV has contributed to high attrition rates of the health labour force. In some cases, employees become infected with HIV, and in other cases fear of infection causes health care workers to leave their jobs voluntarily. Fear of infection among health workers can also lead to refusal to treat HIV/AIDS patients. Likewise, patients have the right to be protected to the greatest degree possible from transmission of HIV from health professionals and in health care institutions.
 - a. Proper infection control procedures and universal precautions consistent with the most current national or international standards, as appropriate, should be implemented in all health care facilities. This includes procedures for the use of preventive ART for health professionals who have been exposed to HIV.
 - b. If the appropriate safeguards for protecting physicians or patients against infection are not in place, physicians and National Medical Associations should take action to correct the situation.
 - c. Physicians who are infected with HIV should not engage in any activity that

creates a risk of transmission of the disease to others. In the context of possible exposure to HIV, the activity in which the physician wishes to engage will be the determining factor. Whether or not an activity is acceptable should be determined by a panel or committee of health care workers with specific expertise in infectious diseases.

- d. In the provision of medical care, if a risk of transmission of an infectious disease from a physician to a patient exists, disclosure of that risk to patients is not enough; patients are entitled to expect that their physicians will not increase their exposure to the risk of contracting an infectious disease.
- e. If no risk exists, disclosure of the physician's medical condition to his or her patients will serve no rational purpose.

Protecting Patient Privacy and Issues Related to Notification

18. Fear of stigma and discrimination is a driving force behind the spread of HIV/AIDS. The social and economic repercussions of being identified as infected can be devastating and can include violence, rejection by family and community members, loss of housing and loss of employment, to name only a few. Normalizing the presence of HIV/AIDS in society through public education is the only way to reduce discriminatory attitudes and practices. Until that can be universally achieved, or a cure is developed, potentially infected individuals will refuse testing to avoid these consequences. The result of individuals not knowing their HIV status is not only disastrous on a personal level in terms of not receiving treatment, but may also lead to high rates of avoidable transmission of the disease. Fear of unauthorized disclosure of information also provides a disincentive to participate in HIV/AIDS research and generally thwarts the efficacy of prevention programs. Lack of confidence in protection

of personal medical information regarding HIV status is a threat to public health globally and a core factor in the continued spread of HIV/AIDS. At the same time, in certain circumstances, the right to privacy must be balanced with the right of partners (sexual and injection drug) of persons with HIV/AIDS to be informed of their potential infection. Failure to inform partners not only violates their rights but also leads to the same health problems of avoidable transmission and delay in treatment.

19. All standard ethical principles and duties related to confidentiality and protection of patients' health information, as articulated in the WMA Declaration of Lisbon on the Rights of the Patient, apply equally in the context of HIV/AIDS. In addition, National Medical Associations and physicians should take note of the special circumstances and obligations (outlined below) associated with the treatment of HIV/AIDS patients.
 - a. National Medical Associations and physicians must, as a matter of priority, ensure that HIV/AIDS public education, prevention and counselling programs contain explicit information related to protection of patient information as a matter not only of medical ethics but of their human right to privacy.
 - b. Special safeguards are required when HIV/AIDS care involves a physically dispersed care team that includes home-based service providers, family members, counsellors, case workers or others who require medical information to provide comprehensive care and assist in adherence to treatment regimens. In addition to implementing protection mechanisms regarding transfer of information, ethics training regarding patient privacy should be given to all team members.
 - c. Physicians must make all efforts to convince HIV/AIDS patients to take action to notify all partners (sexual and/or injection drug) about their exposure and potential infection.



Physicians must be competent to counsel patients about the options for notifying partners. These options should include:

1. notification of the partner(s) by the patient. In this case, the patient should receive counselling regarding the information that must be provided to the partner and strategies for delivering it with sensitivity and in a manner that is easily understood. A timetable for notification should be established and the physician should follow-up with the patient to ensure that notification has occurred.
2. notification of the partner(s) by a third party. In this case, the third party must make every effort to protect the identity of the patient.
- d. When all strategies to convince the patient to take such action have been exhausted, and if the physician knows the identity of the patient's partner(s), the physician is compelled, either by law or by moral obligation, to take action to notify the partner(s) of their potential infection. Depending on the system in place, the physician will either notify directly the person at risk or report the information to a designated authority responsible for notification. In cases where a physician must disclose the information regarding exposure, the physician must:
 1. inform the patient of his or her intentions,
 2. to the extent possible, ensure that the identity of the patient is protected,
 3. take the appropriate measures to protect the safety of the patient, especially in the case of a female patient vulnerable to domestic violence.
- e. Regardless of whether it is the patient, the physician or a third party who undertakes notification, the person learning of his or her potential infection should be offered support and assistance in order to access testing and treatment.

f. National Medical Associations should develop guidelines to assist physicians in decision-making related to notification. These guidelines should help physicians understand the legal requirements and consequences of notification decisions as well as the medical, psychological, social and ethical considerations.

g. National Medical Associations should work with governments to ensure that physicians who carry out their ethical obligation to notify individuals at risk, and who take precautions to protect the identity of their patient, are afforded adequate legal protection.

Medical Education

20. National Medical Associations should assist in ensuring that there is training and education of physicians in the most

current prevention strategies and medical treatments available for all stages of HIV/AIDS, including prevention and support.

21. National Medical Associations should insist upon and assist with, when possible, the education of physicians in the relevant psychological, legal, cultural and social dimensions of HIV/AIDS.
22. National Medical Associations should fully support the efforts of physicians wishing to concentrate their expertise in HIV/AIDS care, even where HIV/AIDS is not recognized as an official specialty or sub-specialty within the medical education system.
23. The WMA encourages its National Medical Associations to promote the inclusion of designated, comprehensive courses on HIV/AIDS in undergraduate and postgraduate medical education programs, as well as continuing medical education.

The World Medical Association Statement on Assisted Reproductive Technologies

Adopted by the WMA General Assembly, Pilanesberg, South Africa, October 2006

Preamble

1. Assisted reproductive technology encompasses a wide range of techniques designed primarily to aid couples unable to conceive without medical assistance. Since the birth of the first so-called 'test-tube baby' in 1978, more than 1.5 million children worldwide have been born following IVF treatment.

2. The term 'assisted reproductive technology' includes techniques such as in-vitro fertilisation (IVF) and intracytoplasmic sperm injection (ICSI). It can be defined as including all treatments that include medical and scientific manipulation of human gametes and embryos in order to produce a term pregnancy. Although some legislatures have considered artificial insemination, whether using donor semen or semen from the patient's partner, as different, many of the issues about regulation in relation to obtaining, storing, using and dispos-



ing of gametes and embryos are closely interlinked. In this statement treatments such as artificial insemination are excluded.

3. Assisted reproductive technologies raise profound moral issues. Views and beliefs about the moral status of the embryo, which are central to much of the debate in this area, vary both within and among countries. Assisted conception is also regulated differently in various countries. Whilst consensus can be reached on some issues, there remain fundamental differences of opinion that cannot be resolved. This statement identifies areas of agreement and also highlights those matters on which agreement cannot be reached. Physicians faced with such situations should comply with applicable laws and regulations as well as the ethical requirements and professional standards established by their National Medical Association and other appropriate organisations in the community.
4. Physicians involved in providing assisted reproductive technologies should always consider their ethical responsibilities towards any child who may be born as a result of the treatment. If there is evidence that a future child would be exposed to serious harm, treatment should not be provided.
5. As with all other medical procedures, physicians also have an ethical obligation to limit their practice to areas in which they have relevant expertise and experience and to respect the rights of patients. These rights include that of personal bodily integrity and freedom from coercion. In practice this means that valid or real consent is required as with other medical procedures; the validity of such consent is dependent upon the adequacy of the information offered to the patient and their freedom to make a decision, including freedom from coercion or other pressures to decide in a particular way.
6. Assisted conception differs from the treatment of illness in that the inability to become a parent without medical

intervention is not always regarded as an illness. While it may have profound psychosocial, and thus medical, consequences, it is not in itself life limiting. It is, however, a significant cause of major psychological illness and its treatment is clearly medical.

7. Obtaining informed consent from those considering undertaking treatment must include consideration of the alternatives, including accepting childlessness or pursuing adoption, the risks associated with the various techniques, and the possibility of failure. In many jurisdictions the process of obtaining consent must follow a process of information giving and the offer of counselling and might also include a formal assessment of the patient in terms of the welfare of the potential child.
8. Patients seeking assisted reproductive technologies are entitled to the same level of confidentiality and privacy as for any other medical treatment.
9. Assisted reproductive technology always involves handling and manipulation of human gametes and embryos. Different individuals regard this with different levels of concern but there is general agreement that these special concerns should be met by specific safeguards to protect from abuse. In some jurisdictions all centres handling such materials require a licence and must demonstrate compliance with high normative standards.

Success of the techniques

10. The success of different techniques may differ widely from centre to centre. Physicians have an obligation to give realistic information about success rates to potential patients. If their success rates are widely different from the current norm they should disclose this fact to patients. They also have an obligation to consider the reasons for this as they might relate to poor practice, and if so, to correct their deficiencies.

Multiple pregnancies

11. Replacement of more than one embryo may raise the likelihood of at least one embryo implanting. This is offset by the increased risk, especially of premature labour, in multiple pregnancies. The risk of twin pregnancies, while higher than that of singleton pregnancies, is considered acceptable by most people. Practitioners should follow professional guidance on the maximum number of embryos to be transferred per treatment cycle. If multiple pregnancies occur, selective termination might be considered on medical grounds to increase the chances of the pregnancy proceeding to term where this is compatible with the national law and code of ethics.

Donation

12. Some patients are unable to produce usable gametes. They require ova or sperm from donors. Donation should follow counselling and be carefully controlled to avoid abuses, including coercion of potential donors. It is inappropriate to offer money or benefits in kind (for example free or lower cost treatment cycles) to encourage donation but donors may be reimbursed for reasonable expenses.
13. Where a child is born following donation, families should be encouraged to be open with him/her about this, irrespective of whether domestic law entitles the child to information about the donor. Keeping secrets within families is difficult and can be harmful to children if information about donor conception is disclosed inadvertently and without appropriate support.

Pre-implantation Genetic Diagnosis (PGD)

14. Pre-implantation genetic diagnosis (PGD) may be performed on early embryos to search for the presence of



genetic or chromosomal abnormalities, especially those associated with severe illness and very premature death and for other reasons, including identifying those embryos most likely to implant successfully in women who have had multiple spontaneous abortions. Embryos carrying the abnormality are discarded; only embryos with apparently normal genetic and chromosomal complements are implanted.

15. Neither this powerful technique nor simpler means should be used for trivial reasons such as sex selection for reasons of gender preference. The WMA holds that physicians should only be involved with sex selection where it is used to avoid a serious sex-chromosome related condition such as Duchenne's Muscular Dystrophy.
16. PGD can also be combined with HLA matching to select embryos on the basis that stem cells from the resulting child's umbilical cord blood could be used to treat a seriously ill sibling. Views on the acceptability of this practice vary and physicians should follow national laws and local ethical and professional standards if confronted with such requests.

Use of spare gametes and embryos and disposal of unused gametes and embryos

17. In most cases, assisted conception results in the production of gametes and embryos that will not be used to treat those from whom they are procured. Such so-called spare gametes and embryos may be stored, cryo-preserved for future use, donated to other patients or disposed of. One alternative to disposal, in countries that permit embryo research, is donation to a research facility. The available options must be explained clearly and precisely to individuals before donations are made or retrievals performed.

Surrogacy

18. Where a woman is unable, for medical reasons, to carry a child to term, surrogacy may be used to overcome childlessness, unless prohibited by national law or the ethical rules of the National Medical Association or other relevant organisation. Where surrogacy is practised, great care must be taken to protect the interests of all parties involved.

Research

19. Physicians should promote the importance of research using tissues obtained during assisted conception procedures. Because of the special status of the material being used, research on human gametes and especially on human embryos is, in many jurisdictions, specifically regulated. Physicians have an ethical duty to comply with such regulation and to help inform public debate and understanding of the issues.
20. Due to the special nature of human embryos, research should be carefully controlled and should be limited to areas in which the use of alternative materials will not provide an adequate alternative.
21. Views, and legislation, differ on whether embryos may be created specifically for, or in the course of, research. Physicians should act in accordance with national legislation and local ethical advice.

Cell Nuclear Replacement

22. The WMA opposes the use of cell nuclear replacement with the aim of cloning human beings.
23. Cell nuclear replacement may also be used to develop embryonic stem cells for research and ultimately, it is hoped, for therapy for many serious diseases. Views on the acceptability of such research differ and physicians wishing to participate in such research should

ensure that they are acting in accordance with national laws and local ethical guidance.

Recommendations

24. Assisted reproductive technology is a dynamic, rapidly developing field of medical practice. Developments should be subject to careful ethical consideration alongside the scientific monitoring.
25. Human gametes and embryos are accorded a special status. Their use, including for research, donation to others and disposal, should be carefully explained to potential donors and subject to local regulation.
26. Embryo research should only be carried out if local law and ethical standards permit it and should be limited to areas where the use of alternative materials or computer modelling does not provide an adequate alternative.
27. Physicians should follow professional guidance on the maximum number of embryos to transfer in any treatment cycle.
28. It is inappropriate to offer money or benefits in kind (for example free or lower cost treatment cycles) to encourage donation but donors may be reimbursed for reasonable expenses.
29. Families using donated embryos or gametes should be encouraged and supported to be open with the child about this.
30. Sex selection should only be carried out to avoid serious, including life threatening, medical conditions.
31. Physicians have an important role in ensuring that public debate about the possibilities of assisted conception, and the limits to be applied to its practice, is informed.
32. Physicians should comply with national legislation and should demonstrate compliance with high normative standards.

World Health Organisation

Key Issues for future WHO work

In her first address to the Executive Committee of WHO as Director General, Dr. Margaret Chan identified six issues to guide the approach to future work. Two addressed fundamental needs – health development and health security. Two referred to strengthening health systems and acquiring better evidence to measure and shape results, and the last two concern operation reliance on partners and good performance of WHO as an organisation.

Addressing health development, Dr. Chan referred to her earlier indication that the measure of WHO's work should be its impact on two groups, women in particular, and the people of Africa, which would require more to be done in some areas of work. In developing these issues particularly in relation to Africa and Women stress was laid on the high attention already taking place to achieve the millennium goals and the importance of the links between poverty and health. The measles reduction success in Africa was an indication of the real potential for health improvement. There was need for the capacities of African people to be released. Turning to the immense suffering due to Malaria in many parts of the world, she stressed that in Africa, where there was no malaria season as transmission occurs throughout the year, in terms of economic impact 25% of household incomes were consumed by malaria. However the progress in scaling up interventions on Malaria was good news.

She also referred both to neglected tropical diseases and also to the impact of chronic diseases, especially their impact on low and middle income countries. The demands and costs of chronic care challenge health systems across the world and for this prevention is the best option. WHO must continue to convince health leaders that chronic disease is part of the development agenda.

Health and Security, the topic for World Health Day, would be the topic for this year's World Health Report (and for World Health Day) would focus on risks and dangers to health from the ways in which

nations and their populations interact internationally. Referring to SARS as an example of how vulnerability to health threats had changed in a mobile and interconnected world, she referred to the impact on health of emerging infective diseases, natural disasters or environmental change.

In 2008, the 60th anniversary of WHO and the 30th of Alma-Ata, the focus of the World Health report would be on primary health care and its role in strengthening health systems.

Dr. Chan spoke of the unprecedented growth in numbers of partnerships, initiatives and funding agencies devoted to pub-

lic health in terms of avoiding duplication and fragmentation of efforts. One way forward to integrated service delivery such as malaria and neglected tropical diseases was to use an integrated primary health care approach. Stress was also laid on health systems, evidence for measuring impact, and access to essential care.

Dr. Chan concluded by commenting on avian influenza and the "need not to let down our guard", Commenting on this she observed that the new International Health Regulations come into effect in June, which should help to reinforce the preparations of the past three years.

International action needed to increase health workforce

GENEVA March 2007 – A new international Task Force was launched and has met to tackle the global shortage of health workers. With a shortfall of 4.3 million health workers worldwide, including more than 1 million in Africa alone, there is an urgent need to increase the number of doctors, nurses, health managers and other health care workers needed to face immediate health crises.

Dr. Margaret Chan, Director-General of the World Health Organization (WHO), welcomed the new Task Force: "The simple fact is that the world needs many more health workers. The world faces global as well as local threats to health. Infectious diseases have staged a dramatic comeback, and chronic diseases are on the rise. We cannot improve people's health without staff to deliver health care."

The new global Task Force, chaired by Lord Nigel Crisp, former Chief Executive of the National Health Service in England, and Bience Gawanas, the African Union Commissioner for Social Affairs, has been set up under the auspices of the Global

Health Workforce Alliance (GHW). It includes two African Ministers of Health – Dr. Stephen Malinga of Uganda and Marjorie Ngaunje of Malawi – and senior health policy makers from across the globe, from public and private sectors, and both developing and developed countries. Together these leaders in health and education will champion the need for significantly increased investment in the education and training of health workers in developing countries, and will build international commitment to practical action.

The Joint Learning Initiative (2004) and the World Health Report 2006 have brought this shortage of health workers to the world's attention, and the World Health Assembly has called for urgent action. Fifty-seven countries have critical shortages of health workers of which 36 are in sub-Saharan Africa. If the crisis is not tackled, these countries will not be able to provide their populations with basic health care.

"HIV/AIDS, malaria and TB, and maternal and child mortality – which together kill many millions of people annually across the



world, will not be significantly reduced unless the crisis in health workers is tackled,” said Lord Crisp. “There is an urgent need for a massive international effort to train more health care workers, including doctors, nurses, managers and community health workers.”

The Task Force will focus on practical solutions, also considering the need and scope for international financial and technical support, links between training institutions and universities in the developed and developing world, and innovative use of distance-learning technology. Already some countries are beginning to address the problem with programmes of education and training. Some countries such as Ethiopia, India and Malawi are beginning to address the problem, rapidly increasing the production of health workers through education and training in various ways. The Task Force will look at the impact of such programmes and assess the scope to replicate these and the resources needed to do so.

The Task Force GHWA Executive Director Dr. Francis Omaswa, welcomed the Task Force. “GHWA has identified a need for some type of ‘fast-track’ training initiative to address the health worker shortage. This new GHWA Task Force will make practical recommendations for action. The Task Force will also work closely with other programmes which address issues such as health worker migration, health financing, and access to HIV/AIDS treatment, prevention and care.”

The Task Force is due to present its initial recommendations to the GHWA Forum in Autumn 2007.

The Task Force members are

- Lord Nigel Crisp (co-chair)
- Bience Gawanas (co-chair, African Union Commission)
- Hon. Stephen Mallinga (Health Minister Uganda)
- Hon. Marjorie Ngaunje (Health Minister Malawi)
- Prof. Srinath Reddy (Director, Public Health Foundation of India)

- Peter Loescher (President Global Human Health Merck and Co)/Jeff Sturchio (Vice President External Affairs, Merck and Co).
- Dr. Joy Phumaphi (Vice-President and Head Human Health Development Network/Alexander Prekker (Lead Economist, Health, Nutrition and Population, World Bank)
- Judith Oulton (CEO, International Council of Nurses)

- Kathy Cahill (Gates Foundation)
- Sarita Bhatla (CIDA, DG Governance and Social Directorate)/Jeea Sarawati (CIDA, Health Specialist African Branch)

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Africa Reports

African Regional Health Report

Africa is developing solutions for fighting disease and improving health, a new WHO report finds

20 NOVEMBER 2006 | ADDIS ABABA/GENEVA/LONDON – The signs are everywhere, across the continent: Africa is finding African approaches to solving its health problems.

In Uganda, 50 percent of all HIV/AIDS patients have been reached with life-saving antiretroviral medicine through an innovative programme that trains nurses to do some of the work traditionally done by doctors and community health workers to take on some of the work of nurses.

In Mali, community cost-sharing schemes have provided 35 of the country’s 57 community health centres with staff trained to deliver babies and perform emergency caesarian sections, making skilled obstetric care available to thousands of women who could not previously afford it.

In Rwanda, a police-led road safety campaign, which has included introduction of fines for failure to wear seatbelts or helmets, resulted in a drop of nearly one quarter in the number of deaths from road traffic injuries in a single year.

And in South Africa, a health-care train routinely transports young doctors and final-year medical students to isolated farming areas that would otherwise have no access to basic medical services. To date the train

has provided health care to half a million people and health screening and education to an additional 800 000.

These steps forward and others chronicled in **The African Regional Health Report: The Health of the People** – the first report to focus on the health of the 738 million people living in the African Region of the World Health Organization – offer hope that over time the Region can address the massive health challenges it faces, given sufficient international support.

“Africa confronts the world’s most dramatic public health crisis, but this report shows there are public health solutions that work in the African setting. These can be extended to all Africans in need, if governments build on lessons learnt from successful interventions while seeking better coordination with the efforts of international partners”, said Alpha Oumar Konaré, Chairman of the Commission of the African Union.

The Report provides a comprehensive analysis of key public health issues and progress made on them in the Africa Region.

- HIV/AIDS continues to devastate the WHO Africa Region, which has 11 % of the world’s population but 60 % of the people living with HIV. Although HIV/AIDS remains the leading cause of death for adults, more and more people are receiving life-saving treatment. The

number of HIV-positive people on anti-retroviral medicines increased eight-fold, to 810 000 in December 2005 from 100 000 in December 2003.

- More than 90% of the estimated 300–500 million malaria cases that occur worldwide every year are in Africans, mainly in children under five years of age, but most countries are moving towards better treatment policies. Of the 42 malaria-endemic countries in the African Region, 33 have adopted artemisinin-based combination therapy – the most effective antimalarial medicines available today – as first-line treatment.
- River blindness has been eliminated as a public health problem, and guinea worm control efforts have resulted in a 97% reduction in cases since 1986. Leprosy is close to elimination – defined as less than one case per 10 000 people in the Region.

- Most countries are making good progress on preventable childhood illness. Polio is close to eradication, and 37 countries are reaching 60% or more of their children with measles immunization. Overall measles deaths have declined by more than 50% since 1999. In 2005 alone 75 million children received measles vaccines.

While drawing the world's attention to recent successes, the Report offers a candid appraisal of major hurdles such as the high rate of maternal and newborn mortality overall in the Region. Of the 20 countries with the highest maternal mortality ratios worldwide, 19 are in Africa; and the Region has the highest neonatal death rate in the world. There is the strain on African health systems imposed by the high burden of life-threatening communicable diseases coupled with increasing rates of noncommunicable

diseases. Basic sanitation needs remain unmet for many: only 58% of people living in Sub-Saharan Africa have access to safe water supplies. Noncommunicable diseases, such as hypertension, heart disease and diabetes are on the rise; and injuries remain among the top causes of death in the Region.

“We know what the challenges are, and we know how to address them – but we also recognize that Africa's fragile health systems represent an enormous barrier to wider application of the solutions highlighted in this report. If we are to continue moving forward, African governments and their partners must make a major commitment and invest more funds to strengthen health systems,” said Dr. Luis Gomes Sambo, Regional Director of the WHO Regional Office for Africa.

New report shows improvements in child survival in Africa for the first time since the 1980s

22 NOVEMBER 2006 | JOHANNESBURG/GENEVA – Sub-Saharan Africa remains the most dangerous region in the world for a baby to be born – with 1.16 million babies dying each year in the first 28 days of life – but six low-income African countries, Burkina Faso, Eritrea, Madagascar, Malawi, Uganda and the United Republic of Tanzania, have made significant progress in reducing deaths among newborn babies, according to a report.

The report, “*Opportunities for Africa's newborns*”, brings together new data and analysis from a team of 60 authors and nine international organizations from the Partnership for Maternal, Newborn and Child Health, (PMNCH). The Partnership represents developing and donor countries, non-governmental agencies, foundations and multi-lateral organizations, including the World Health Organization.*

“Good news does come out of Africa”, said Dr. Joy Lawn, co-editor of the report, who

works in Africa for Saving Newborn Lives/Save the Children-US. “Whilst the survival of the African child has shown almost no improvement since the 1980s, the fact that during 2006 several large African countries have reported a dramatic reduction in the risk of child deaths gives us new hope of more rapid progress to save Africa's children.”

Although no measurable progress has been made in reducing newborn mortality rates for babies during the first month of life in Africa at regional level, a turnaround has been seen in the six countries highlighted in the report, with an average reduction of 29% over the last 10 years. Across the six countries, the reduction ranges from 20% in Tanzania and Malawi to 39% in Burkina Faso and 47% in Eritrea.* The authors identified factors that contributed to this progress. For example:

- In *Malawi*, there is presidential-level commitment to maternal newborn and child health and increased investment by

partners to address the lack of human resources.

- *United Republic of Tanzania* has recorded a 30% reduction in child mortality and a 20% fall in newborn deaths over the last 5 years. District health managers set local budget priorities based on deaths in each district and this has meant increased government spending on essential maternal and child healthcare.
- In *Uganda*, the performance of district health services is ranked each year and published in the national newspaper.
- *Eritrea* has made consistent progress over 20 years in reducing child and newborn deaths with an average annual reduction of around 4% over the last decade through a focus on reaching high coverage of basic public health services, including to the poor.
- *Burkina Faso* ensures that poor women do not pay for the catastrophic cost of an



emergency caesarean section – often more than an average family income for the year.

Up to half a million African babies die on the day they are born – most at home and uncounted. According to the report, Liberia has the world’s highest newborn mortality rate at 66 deaths per 1,000 births compared to less than 2 deaths per 1,000 births in Japan and 6 deaths per 1,000 births in Latvia. Half of Africa’s 1.16 million newborn deaths occur in just five countries – Nigeria, Democratic Republic of the Congo, Ethiopia, United Republic of Tanzania and Uganda. Nigeria alone has over 255,000 newborn deaths each year.

“The health of newborn babies has fallen between the cracks – Africa’s un-named, and uncounted, lost children,” said Dr. Francisco Songane, Director of the Partnership. “We must count newborn deaths and make them count, instead of accepting these deaths as inevitable. The progress of these six African countries demonstrates that even the world’s poorest countries can look after their newborns, their most vulnerable citizens. They have shown the way – we must seize the opportunity.”

The President of the Pan-African Parliament, Hon. Amb. Gertrude Mongella, is spearheading action in maternal, newborn and child health through the African Union and the Pan African Parliament in Johannesburg. “Reaching every woman, baby and child in Africa with essential care will depend on us, the users of this publication. We all have a role to play as governments to lead, as policymakers to guarantee essential interventions and equity, as partners and donors to support programmes,” she said.

The authors warn that opportunities to save newborn lives within existing programmes are often missed. For example two-thirds of women in Africa attend antenatal care yet only 10% receive preventive treatment for malaria and a mere 1% of mothers with HIV receive the recommended treatment to prevent mother to child transmission of HIV/AIDS.

The report found that two-thirds of newborn deaths in sub-Saharan Africa – up to 800 000

babies a year – could be saved if 90% of women and babies received feasible, low-cost health interventions. These include immunizing women against tetanus, providing a skilled attendant at birth, treating newborn infections promptly and educating mothers about hygiene, warmth and breastfeeding for infants. Saving these lives would take only an estimated US \$ 1.39 per capita – or US \$1 billion per year. According to the report, this cost would benefit others, in particular the one million stillborns and 250 000 mothers who also die each year.

Quotations from other Partnership members

Professor E. Oluwole Akande, chair of the African Regional Maternal Newborn and Child Health Task Force

“Policy frameworks such as the Roadmap for Maternal and Newborn Survival are now in place in many African countries to reach every mother and baby with essential care. The gap remains between policy and

action,” said Professor E. Oluwole Akande. “This publication helps to bridge this gap and will be an invaluable toolkit for action.”

Kate Kerber, co-editor of the publication

“We identified the ABCD of progress by examining the six low income countries that are progressing”, said Kate Kerber. “Accountable leadership, Bringing national policy into district-level action, Community ownership, and Demonstrated focus on reaching all mothers, newborn and children with essential life-saving care.”

Dr. Doyin Oluwole, Director of Africa 2010 (one of the authors of the report)

“Maternal, newborn and child health care is the backbone of a healthy health system.” states Doyin Oluwole. “African decision makers are finding that systematically addressing newborn health benefits existing maternal and child health care and promotes integration with other programmes. Integration saves lives and money.”

* The Partnership Maternal, Maternal, Newborn & Child Health (PMNCH)

WHO reports some promising results on avian influenza vaccines but also concerned by global vaccine production capacity

GENEVA – At a two day meeting at the World Health Organization (WHO) on advances in pandemic influenza vaccine development, experts reported encouraging progress.

Sixteen manufacturers from 10 countries are developing prototype pandemic influenza vaccines against H5N1 avian influenza virus. Five of them are also involved in the development of vaccines against other avian viruses (H9N2, H5N2, and H5N3).

At present, more than 40 clinical trials have been completed or are ongoing. Most of them have focused on healthy adults. Some companies, after completing safety analyses in adults, have initiated clinical trials in the elderly and in children. All vaccines were safe and well tolerated in all age groups tested.

For the first time, results presented at the meeting have convincingly demonstrated that vaccination with newly developed avian influenza vaccines can bring about a potentially protective immune response against strains of H5N1 virus found in a variety of geographical locations. Some of the vaccines work with low doses of antigen, which means that significantly more vaccine doses can be available in case of a pandemic.

These developments were discussed at the WHO meeting on the evaluation of pandemic influenza prototype vaccines in clinical trials which took place in Geneva, Switzerland, on 15-16 February 2007. It was a third such meeting in two years the objectives to review progress in the development of candidate vaccines against pan-

demic influenza viruses and to reach consensus on future priority activities.

More than 100 influenza vaccine experts – from academia, national and regional public health institutions, the pharmaceutical industry and regulatory bodies throughout the world – attended the meeting convened by the WHO Initiative for Vaccine Research and the WHO Global Influenza Programme. Information on more than 20 projects was presented and discussed. Most manufacturers are using reference vaccine strains corresponding to H5N1 viruses provided from by WHO Collaborating Centres.

In spite of the encouraging progress noted at the WHO meeting, WHO stresses that the world still lacks the manufacturing capacity to meet potential global pandemic influenza vaccine demand as current capacity is estimated at less than 400 million doses per year of trivalent seasonal influenza vaccine.

In response to this challenge, WHO launched in 2006 the Global pandemic influenza action plan (GAP) to increase vaccine supply, a US\$10 billion effort over 10 years. One of its aims is to enable developing countries to establish their own influenza vaccine production facilities through transfer of technology, providing them with the most sustainable and reliable response to the threat of pandemic influenza. WHO is currently working with several vaccine producers, mainly in developing countries affected by H5N1, to facilitate establishment of in-country influenza vaccine production.

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UN Global goal to reduce measles deaths in children surpassed

In a joint news release the partners in the Measles Initiative, WHO, UNICEF, ARC, CDC and UNF, announced earlier this year that Measles deaths worldwide have fallen by 60% since 1999, exceeding the United Nations goal “to halve measles deaths between 1999 and 2005”.

According to new data from WHO, global measles deaths fell from an estimated 873,000 deaths in 1999 to 345,000 in 2006. The progress was even greater in Africa where measles deaths fell by 75% from an estimated 506,000 to 126,000. (*see* Wolfson L.J. et al., *Lancet* 2007, **369**, 191-200).

Dr. Margaret Chan, WHO Director-General, is reported as saying “This is an historic victory for global public health, for the power of partnership and for commitment by countries to fight a terrible disease. Our promise to cut measles deaths by half and save hundreds of thousands of lives has not only been fulfilled, it has been surpassed in just six years with Africa leading the way”.

The strategy to reduce measles, comprising four components, has been the key to ensuring the massive decrease in measles deaths called for:

- the provision of one dose of measles vaccine for all infants via routine health services,
- a second opportunity for measles immunisation for all children, generally through mass vaccination campaigns,
- effective surveillance for measles, and
- enhanced care, including the provision of supplemental vitamin A.

In consequence, between 1999 and 2005 global immunisation coverage with the first

routine dose increased from 71% to 77% and through immunisation campaigns more than 360 million aged 9 months to 15 years received the vaccine.

The measles vaccination campaigns have also contributed both to the development of a global public health laboratory network and provided a channel for the delivery of other life saving interventions, such as bed nets providing protection against malaria, de-worming medicines and vitamin A supplements. Such activities, combining measles intervention with other health interventions is a contribution to the achievement of MDG 4, – a 2/3 reduction in child deaths between 1990 and 2015.

UNICEF Executive Director Ann M. Veneman said “Immunising children is clearly saving lives and contributing to the achievement of the Millennium Development Goals. We must urgently build on this momentum with integrated community-based health programmes to help save the lives of more than 10 million children who die of preventable causes every year”.

Of the estimated 345,000 measles deaths in 2005, 90% were among children under the age of five, many deaths resulting from the complications related to severe diarrhoea, pneumonia and encephalitis.

The challenge now is to reach a new global goal – the reduction of global measles deaths by 90% by 2010, compared with 2000 levels. This calls for the sustaining of the gains made in countries that have implemented accelerated measles control strategies and for similar strategies to be implemented in countries with high numbers of measles deaths, such as India and Pakistan.

World Leprosy Day 2007

International Appeal to end stigma and ostracisation of leprosy sufferers and their families. While the availability of multi-drug therapy (MDT) since the 1980s has revolutionised

the treatment of leprosy and resulted in the cure of over 15 million people, the age-old stigma and discrimination attached to leprosy continues to add to the suffering of

those now cured of the disease and their families.

Following World Leprosy Day, a second Global Appeal signed by amongst others, Dr.



PK Gopal, President of the National Forum, India (an organisation of people affected by leprosy) and Hilarion M Guia the first Mayor of Culion an island municipality which was once the worlds largest leprosy colony, was launched by Mr Yohei Sasakawa, WHO Goodwill Ambassador for the elimination of leprosy, on 29th January 2007.

This year the appeal, organised by Ateneo de Manila University, the Department of Health of the Philippines, WHO, the Nippon Foundation and Sasakawa Memorial Health Foundation, was led by leaders of people affected by leprosy standing beside Mr. Sasakawa at the launch. It builds on the First Appeal in New Delhi 2006 which "called on people all over the world to change their perception and foster an environment in which leprosy patients, cured persons and their families can lead normal lives free from stigma and discrimination" This was signed by 11 World Leaders including former Presidents of Brazil, Costa Rica, India, Nigeria, the USA, by the Dalai Lama and Archbishop Desmond Tutu.

Since 1995 WHO has supplied MDT free to all identified leprosy patients. Initially this was with funding from the Nippon Foundation and subsequently through MDT donated by Novartis and the Novartis Foundation for Sustainable Development. Despite the initial appeal and the fact that such therapy produces a cure the discrimination and stigma. Associated with leprosy, (active and cured) persist largely due to lack of education. According to John Sasakawa "leprosy and the mystery surrounding its transmission have always given rise to fear- and fear has generated discrimination – not just to those with the disease but their families as well".

Yohei Sasakawa, who for more than 30 years has supported efforts to tackle leprosy "as a medical problem" approached the UN Sub-commission on the Promotion and Protection of Human Rights on this issue in 2005 and 2006. They unanimously adopted resolutions recommending that governments take action to redress the issue of stigma and discrimination associated with leprosy. A report is currently being prepared on this issue by a Special Rapporteur which will go to the Human Rights Council (successor to UNCHR) and hopefully lead to full UN support.

Mr Sasakawa said "Considering the long history of discrimination against people with leprosy and their families, action to resolve this issue is long overdue. An important step toward eradicating this dis-

crimination is to educate society about the disease". He also commented "I have come to appreciate that no one who has had leprosy will be truly free of the disease so long as discrimination remains"

NMA news

Appeal to migrant physicians to return

The subject of the World Health Report 2006 was Human Resources for Health. Over the past few years there has been increasing concern, debate and pronouncements on this topic which, following the WHA decision last year, will be a topic for active consideration and action over the next decade. In consequence there appears to be a move towards openness both in the declarations of countries who are net consumers of migrant health professionals' services and also of the realities of the internal effects of emigration on countries who are net losers of health care professionals.

Recently the Health Professions Council of South Africa, expressly in the context of the health care need in that country, has written to all South African physicians currently practising in other countries, seeking to encourage their return to practice in their own country. As an incentive, a one off "amnesty" until 30th April 2007 is being offered to those professionals willing to return to practice in South Africa. For those returning, the current punitive financial requirements for those wishing to reregister to practice in their own country, will be waived. In a letter, the Head of corporate communications of the Health Professions Council writes "In the interest of encouraging our doctors to return to SA, where they are desperately needed, we will waive the penalty fees for doctors whose names have been erased from the register". The only condition required is an undertaking to practice in the public health care system for 100 hours within six months. Whilst previously some countries have appealed to nationals to return to practice in their own country, such an open appeal with incentives to return must be considered as an index of the seriousness of the shortage in South Africa.

In a commentary on the relevance of both the numbers of African doctors practising in Canada and its dependence on migrant physicians, the Canadian Medical Association comments that South Africa's medical diaspora involves more than 1500 physicians now practising in Canada and thousands more who have moved to the UK, Australia, New Zealand and the USA. In CMA news(1) setting out the background to Canadian and International concerns about this problem, attention is also drawn to a report issued by the Canadian Policy Research Networks in 1st February (2) quoting a remark which, while it is made with reference to Canada, is highly relevant to the realities of addressing this problem both from the point of view of developed and developing countries "The ethics of international recruitment has to be dealt with in the overall context of domestic health human resource planning" While this report considers the options for Canada in dealing with the ethical problems associated with planning its own domestic health human resources, it also presents a valuable extensive overview not only of the ethical problems relating to international recruitment, but also of national and international statements, codes of practice of international bodies both intergovernmental and non-governmental, and of national governments who have addressed this issue in the past 3-4 years.

(1) "South Africa Licensing body issues "amnesty", begs MDs to return home" http://www.cma.ca/index.cfm?ci_id=10037623&1a_id=1 consulted 19.02.07

(2) McIntosh T., Torgeson R., Klassen N. "Ethical Recruitment of Internationally Educated Health Professionals from abroad and Options for Canada" Research Report H/11, Canadian Policy Research Network, Ottawa.

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