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Title page: The historic Meistersaal (1910–1913), Potsdammer Platz, Berlin, site of the 176th WMA Council meeting (lower photo) was built as a Guild House by architectural students. Later noted for its nearness to the Berlin Wall ("The Hall by the Wall"), it was to become famous especially for its superb recording acoustics. It was damaged in WW II and after restoration was used for concerts in the 50s and 60's. Further restored in 2003, the Hall continues to be used for concerts, lectures and meetings etc.

Website: <http://www.wma.net>

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Editorial

It is with sadness that we open this issue of the WMJ with the obituary of Dr. Andre Wynen, Secretary General Emeritus of the World Medical Association. However, it is timely that the principles of the WMA and the issues he fought for are reflected in the report of the release of the doctor and nurses imprisoned and under sentence of death in Libya and by the emphasis placed by the Council in reaffirming the Declaration of Hamburg concerning Torture. Also, in the report of the 176th WMA Council meeting the concerns expressed about threats to the autonomy of physicians, of their patients and on the governing of the medical profession.

In a world of constant and rapid change, we include reports on WHO and other international initiatives to contain increasing threats to public health, the problems of the shortages of health professionals and on global partnerships to enhance the production of therapeutic agents.

In the busy life of physicians engaged in day to day care of the sick and injured, while endeavouring to keep track of changes in knowledge and advances in technology, it is difficult to find time to reflect on the pressures which changing social attitudes place on the basic ethical tenets upon which medical practice is based. In particular the increasing pressures imposed by economic constraints impose a duty on physicians both individually and collectively to reflect and act on the principles which should govern their professional activity. The role of national medical associations in stressing the importance of these messages to its members cannot be overemphasised. As the WMA Secretary General indicates in his column, it is important to recognise that political objectives can be achieved in many insidious ways of which all physicians need to be aware.

New Chair of WMA Council

Dr. Edward Hill was elected chair of WMA Council at the 176th Council meeting. Dr. Hill, a family physician from Tulepo, Mississippi, Dr. Hill was President of American Medical Association in 2005, had been Chair of the AMA Board of Trustees for three years. Qualifying in medicine at the University of Mississippi he served as a general medical officer in the US Navy and for 27 years practiced in the rural Mississippi Delta, later becoming Director of the Family Practice residency Programme at North Mississippi Medical Centre, the USA's largest rural hospital. Dr. Hill developed and directed a local health programme which successfully reduced the foetal mortality rate from one of the highest in the USA to below the national average.

Dr. Hill has been President of the Mississippi State Medical Association, President of the Mississippi Academy of Family Physicians, Delegate to the American Academy of Family Physicians and President of the Southern Medical Association. "Dr. Hill succeeds Dr. Yoram Blachar who, after four years, stood down from the post."





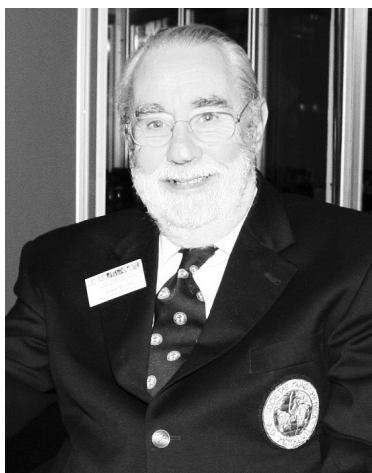
Dr. André Wynen 1924–2007

André Wynen, Secretary General Emeritus of the World Medical Association, a staunch protagonist and defender of the medical profession and its patients, its autonomy and professional ethics, died on 10th June, 2007, at the age of 83. He was known and respected by his professional colleagues and many others world wide for his promotion of the highest standards of medical ethics both in the practice of medicine, in the care of the sick and in the interests of humanity at large.

André Wynen, the son of a civil engineer was born on the 8th December 1923. Brussels. During the Second World War, he was called-up at the age of 16 to serve in the Recruitment Corps of the Belgian Army. Following the German occupation, having failed to escape from France to Africa he returned to Belgium, eventually joining the Resistance. He suffered imprisonment first in Breendonk and then in Buchenwald concentration camps, surviving, despite his many terrible experiences which included exposure to typhus, many victims of which he nursed. On his liberation and return to Belgium, he was found to have tuberculosis which was treated in Switzerland. It was not until 1947 that he was able to take up his medical studies again. He had completed his first examination at the then illegal faculty in Namur in 1942, before he was imprisoned, but after his recovery from tuberculosis resumed his interrupted studies, qualifying in 1950.

Dr. Wynen's chosen professional career was that of surgery, practising as a general surgeon. He first practiced in Braine l'Alleud where he later built a small hospital and subsequently the 250 bed hospi-

tal with all its services. There he gained considerable experience in traumatology from road traffic accidents in the area. André Wynen also operated at the Cavell Hospital, a private hospital in Bruxelles where, following a major financial crisis leading to its threatened closure, the workers trade union (including the hospital doctors who were members of the



Association Belge des Syndicats Médicaux of which Dr. Wynen was a founder and for many years the President) reacted against its closure by occupying the building for more than three months. Eventually, following the intervention of the Minister and negotiations led by Dr. Wynen, his proposition for solving the problems (based on the principles under which Braine l'Alleud hospital had been established) was accepted and with 37 colleagues, the non profit making "Institut Médical Edith Cavell" was formed, ensuring continuity of medical care in this re-established private hospital. This is one illustration of his engagement on behalf of health professionals and patients, ensuring the survival of the hospital and proper conditions under which doctors and other health workers could care for their patients.

Dr. Wynen played a major role in Belgian national medical politics not only in the formation of the Association Belge des Syndicats Médicaux, but also Hospital and other organisations. He was deeply involved in the major conflict between the physicians and the government over a reform of the Leburton Law. This would have penalised patients who chose to consult a physician who had not accepted the agreement with the social security system. The patients' freedom of choice for med-

ical care was a principle which Dr. Wynen regarded as a fundamental right of all citizens, as did many of his colleagues. The defence of this principle led to a successful national doctors' strike, organised in such a way that arrangements ensured the provision of urgent and emergency services. Eventually the government agreed to negotiations with the Medical Trade Union and the law was modified. A further indication of Wynen's tenacity in defending patients' care, occurred when he later engaged with the government when it tried to limit the number of installations of scanners in Belgium. This involved him in a court case in which in the end he was successful, although it placed him at considerable personal risk. He was even publicly threatened with imprisonment.

On the international scene Dr. Wynen was equally active medico-politically as Head of the Belgian Delegation and as President of the Comité Permanent des Médecins de la CEE during the Belgian Presidency 1967–1970. He was also a Member of the Advisory Committee on Medical Training (ACMT) of the EEC, a co-founder of the European Academy of Post-graduate Education and a participant in many other international organisations.

Dr. Wynen's devotion to the medical profession and deep concern with professional standards, the ethical aspects of medical practice (including its role as the advocate of patients), was demonstrated by his continuing activity in the World Medical Association (WMA). The WMA had been founded after the Second World War and in a reaction to the horrifying breaches of medical ethics during that period, focused its main activity on establishing world wide international principles and codes of medical ethics. André Wynen had a driving concern in the establishment of the highest standards of medical ethics to govern the practice of medicine, the professional autonomy of its practitioners in the preservation of life and the care of those who are sick. This duty of care was one which could be detected throughout his life, from his early nursing care of his fellow prisoners with typhus to his fights,



many years later, to seek the release of physicians sick and imprisoned e.g. under the Pinochet regime in Chile, an action in which he spared neither himself nor any other effort to achieve success.

As Chairman of Council and later for 17 years as Secretary General of the WMA, Dr. Wynen contributed to the preparation and adoption of the important Declarations of Tokyo and Helsinki and during a difficult period in the history of the WMA, greatly contributed to its survival and renewal.

His huge contribution to the work of the WMA was recognised by his colleagues all over the world when he was made Secretary General Emeritus. He was the recipient of a considerable number of honours from many countries and only 18 months ago, his international significance in medical care was recognised by his own government when he was invested as a Grand Officer of the Order of Leopold.

Sometimes controversial and always formidable in his defence of the principles on which both the duty and rights of physicians are based, he was considerate, kind and a good friend to many across the world. Dr. Wynen could never be thought of without his wife Nicole and his family to whom he was deeply attached. His partnership with Nicole was something to be envied. Indeed following his serious cycling accident, many would agree that his remarkable recovery would not have been possible without the outstanding support of his wife, nor indeed would he have been able to continue his many activities without her support.

André Wynen's contribution to advancing the care of patients and defending health related human rights, the autonomy of his professional colleagues in the practice of medicine, the promotion of high standards of medical education and of medical ethics, will be greatly missed both nationally and internationally.

Release of Palestinian Physician and Bulgarian Nurses

Both the World Medical Association and the International Council of Nurses welcomed the release of the Palestinian physician and the five nurses who have been incarcerated for eight years, ultimately under sentence of death in Libya. These health professionals had been accused by Libya of deliberately infecting more than 400 Libyan children with

HIV. Despite the clear evidence of a number of leading world experts to the contrary, the Libyan Courts found them guilty and ultimately condemned them to death. Following extensive representation from throughout the world and other interventions, the death sentence has been dropped and all the health professionals have left Libya for Bulgaria.

176th WMA Council meeting

The 176th Council meeting took place this year in Berlin, Germany on 10-12th May 2007.

While the Council meetings associated with the General Assembly take place each year in a different member state, this was the first time for many years that the mid-term Council meeting has taken place outside France. The meeting was held in the Meistersaal, Berlin at the invitation of the German Medical Association and had the biggest ever attendance at a council meeting, 130 individuals from 16 countries.

Dr. Kloiber, the Secretary-General, called the meeting to order and Professor Hoppe, in welcoming the Council to Berlin, gave a brief outline of the history of the Meistersaal in which the meeting was taking place, following which *Dr. Coble (a Past President)* gave an introductory talk for the benefit of new members of Council outlining the way in which the WMA had developed since the Washington meeting in 2002. He said that major improvements in governance were adopted in Santiago, including the introduction of council orientation guides, resulting in improved functioning of council etc. and ensuring that the voice of the minority was heard. In Helsinki the Canadian Medical Association had proposed the formation of a Business

Committee stimulated by a previous survey of the membership on their expectations of the WMA. This survey identified concerns about autonomy, the need to be strong on Public Health, on advocacy and outreach especially to NMAs, the other health professions and the World Bank etc. This had all been done.

Six months before the General Assembly in Tokyo a search committee was established by Council, resulting in the appointment of a new Secretary General, Dr. Kloiber, the following year. Research concentrated on improving outreach, regular meetings developed and individuals were identified who showed the qualities of Caring, Ethics and Science, without which he commented "caring and ethics alone is nothing but well-intended kindness, not Medicine". These individuals were presented at the Santiago Assembly in the book "Caring Physicians of the World" (CPW). They comprised individuals not known world wide but demonstrating social qualities as well as those related to activities associated with professional ethics, medical science and practice. The volume "Caring Physicians of the World, launched in Santiago was also presented to the World Health Assembly. The CPW initiative extended outreach to NMAs and included meetings in Africa, in Europe,



176th Council in session.

Latin-America, North America and the Asian/Pacific region. The question was then how to proceed? The book has now been translated into Spanish in South America and the South African Medical Association was organising a further meeting in Africa. "We need to increase the ability of the medical profession to emerge." Dr. Coble announced that a course on Leadership is being organised later this year for those with knowledge and judgement and quoted Osler and Tolstoi as examples of the qualities of those able to inspire hope and trust. He also stressed that there was a need now to inspire members of NMAs and was sure that the Leadership course would be a step in this direction.

Council meeting

Dr. Kloiber then formally opened the Council meeting and called on the retiring Chair, *Dr. Yoram Blachar*, to address the Council.

Dr. Blachar

Dr. Blachar recalled he had been active in the WMA for more than 10 years, as a member of Council, Chair of the Socio-

Medical Affairs committee and finally for the past 4 years Chair of Council. This was at a time when members had expressed dissatisfaction with the organisation's activities and in consequence the organisation underwent major change which, with the assistance of many members of council, had taken place under his chairmanship. He continued "With the hard work of *Dr. John Williams* and through many workgroups in which members had taken part, we were able to revise and update the weighty stock of Statements, Resolutions and Declarations, to rescind and archive those which merited it and to reaffirm those Statements that were still relevant. The WMA also underwent an important change in governance. We were able to establish the Executive Committee and kept the finance Committee updated with a running account of the financial status of the association. As a result of the survey conducted amongst you, we learned your priorities for topics to be dealt with and issues and problems to be raised on our agenda. The crux of the WMA's activities was and remains the ethical area, but other topics such as health care reforms, physician autonomy, medical malpractice and others were given prominent place on our agenda. In addition, a workgroup was formed to implement the need to diversify the WMA's activities and expand its

sources of income beyond that of membership dues alone."

Stressing that it was difficult to exaggerate the importance of WMA, he indicated that it was the central body shaping ethical principles in medicine accepted worldwide. "Despite the changes experienced by the organisation in the last few years it remains the most important meeting place of medical representatives from all corners of the globe. The problems faced by physicians worldwide are similar, if not identical, in every country. We physicians are forced to deal with limited resources for expanding technologies and new treatments and are faced with the end of the paternalistic era. All these factors and more, impact on the relationship between our patients and physicians. This relationship has evolved into one of partnership in determining care, particularly since in the age of the Internet, medical information has become accessible to all through the click of a mouse. In addition, in an era when sacred cows are slaughtered daily, we physicians are fodder for the media"

Addressing the constant threats to the profession, and observing that differences between geographical areas and different countries can be stark, *Dr. Blachar* referred to the existence of areas in which the severe shortage of physicians was so bad that "barefoot doctors" had to be trained instead of physicians, to the influence of economic pressures, to the heavy workload and to the transfer of some functions from physicians to nurses and other paramedical professionals. In the context of the issue of physician migration, which was of importance to WMA and to society as a whole, he said that "this creates a serious shortage to the point of endangering entire populations in certain countries where the "brain drain" from poorer less developed countries to more established countries is acute. This issue raises ethical questions which must be addressed".

Dr. Blachar expressed his thanks for his term as Chairman and his gratitude to the two Secretary Generals with whom he had had the privilege of working. He referred to *Dr. Delon Humans's* contribution in bringing new life to the WMA, helping it to



World Medical Association Declaration Concerning Support for Medical Doctors Refusing to Participate in, or to Condone, the Use of Torture or Other Forms of Cruel, Inhuman or Degrading Treatment

Adopted by the 49th WMA General Assembly Hamburg, Germany, November 1997 and re-affirmed by the 176th WMA Council, Berlin meeting 2007.

PREAMBLE

1. On the basis of a number of international ethical declarations and guidelines subscribed to by the medical profession, medical doctors throughout the world are prohibited from countenancing, condoning or participating in the practice of torture or other forms of cruel, inhuman or degrading procedures for any reason.
2. Primary among these declarations are the World Medical Association's International Code of Medical Ethics, Declaration of Geneva, Declaration of Tokyo, and Resolution on Physician Participation in Capital Punishment; the Standing Committee of European Doctors' Statement of Madrid; the Nordic Resolution Concerning Physician Involvement in Capital Punishment; and, the World Psychiatric Association's Declaration of Hawaii.
3. However, none of these declarations or statements addresses explicitly the issue of what protection should be extended to medical doctors if they are pressured, called upon, or ordered to take part in torture or other forms of cruel, inhuman or degrading treatment or punishment. Nor do these declarations or statements express explicit support for, or the obligation to protect, doctors who encounter or become aware of such procedures.

RESOLUTION

4. The World Medical Association (WMA) hereby reiterates and reaffirms the responsibility of the organised medical profession:
 - i. to encourage doctors to honour their commitment as physicians to serve humanity and to resist any pressure to act contrary to the ethical principles governing their dedication to this task;
 - ii. to support physicians experiencing difficulties as a result of their resistance to any such pressure or as a result of their attempts to speak out or to act against such inhuman procedures; and,
 - iii. to extend its support and to encourage other international organisations, as well as the national member associations (NMAs) of the World Medical Association, to support physicians encountering difficulties as a result of their attempts to act in accordance with the highest ethical principles of the profession.
5. Furthermore, in view of the continued employment of such inhumane procedures in many countries throughout the world, and the documented incidents of pressure upon medical doctors to act in contravention to the ethical principles

subscribed to by the profession, the WMA finds it necessary:

- i. to protest internationally against any involvement of, or any pressure to involve, medical doctors in acts of torture or other forms of cruel, inhuman or degrading treatment or punishment;
- ii. to support and protect, and to call upon its NMAs to support and protect, physicians who are resisting involvement in such inhuman procedures or who are working to treat and rehabilitate victims thereof, as well as to secure the right to uphold the highest ethical principles including medical confidentiality;
- iii. to publicise information about and to support doctors reporting evidence of torture and to make known proven cases of attempts to involve physicians in such procedures; and,
- iv. to encourage national medical associations to ask corresponding academic authorities to teach and investigate in all schools of medicine and hospitals the consequences of torture and its treatment, the rehabilitation of the survivors, the documentation of torture, and the professional protection described in this Declaration.

The policy of the Declaration of Hamburg was reaffirmed by the Council at their 176th meeting in Berlin, stressing the need for it to be given wider publicity (see p. 38).



reach greater visibility, strengthening ties with organisations such as WHO and making cooperation with the World Health Professions Alliance both a fact and an great advantage. Dr. Blachar thanked Dr. Kloiber who had brought to the WMA greater financial stability and organisational and administrative efficiency, while planting the seeds of future growth and development of the organisation. Closing, Dr. Blachar said "I wish my successor as enjoyable a candidacy as I experienced, and I hope to have the opportunity to continue to contribute to this great organisation. Thank you for allowing me to serve the WMA".

Dr. Kloiber thanked Dr. Blachar both for the privilege of working with him as Secretary General during the past two years and also before that as a member of the Bundesärztekammer. It had been obvious that Dr. Blachar wished to raise the WMA to a new level and style of work. This had been particularly difficult for WMA with not only the problems of governance and finance but also the changes taking place in medicine internationally. He thanked him for his friendship and trust which he had much appreciated.

Death of Dr. Odenbach

Dr. Kloiber, after reporting apologies for absence, reported the sad death of Dr. Odenbach. He had been a great supporter and worker for WMA over a very long period, extending back to his first appearance as a student representative of the International Medical Students Association nearly 55 years ago, then as a member of the German Delegation over the many years which followed. He would be greatly missed. Council stood in silent tribute.

Continuing, Dr. Kloiber observed that this was the biggest Council meeting ever, with 16 states being represented on Council directly. He recognised 10 new members of the Council and welcomed as observers, Dr. René Salzberg (FMH), Dr. Reyes (ICRC), Professor Orof Mezzich (World Psychiatric Association) Mr. O Meretoja (Confermel)

Chair of Council

Dr. Edward Hill (USA), Past President of the American Medical Association was elected *Chair of Council* by acclamation.

Dr Hill, acknowledging his thanks on being elected, referred to the improvements in the last two years which were a tribute to a well motivated Secretary-General and to the Strategic Plan. Faced with major problems which would require evidence-based solutions, there is a need to address some NMAs' problems which will require more staff and new policies. He would do his utmost to advance the work of the WMA.

Vice-Chair of Council

Dr. K. Iwasa (Japan) was elected Vice-Chair by acclamation.

Treasurer

Dr. J. D. Hoppe (Germany) was re-elected.

Council then proceeded to elect members of Standing Committees and Committee Advisers.

Dr. Kloiber then introduced Ms. Seeböhm of the Bundesärztekammer, the new Legal Adviser, and paid tribute to the work of Ms. Leah Wapner, Secretary General of the IMA, who had provided assistance with the legal work during the interim period and would continue to give assistance. He thanked the Israeli Medical Association for making this possible.

Report of the President, Dr. Nachiappan Arumugam

Dr. Arumugam said that in the last six months he had met lots of members. Some thought of WMA as a powerful body in the middle of Europe. Others wonder who it is and what it does. He had attended a number of NMA meetings to meet them and discuss their problems. Dr. Arumugam referred to the current challenges to the practice of medicine, the need to get people interested

and spoke about meetings he had attended in South East Asia, Thailand and India, saying that he had found a general feeling of need to get to NMAs, promote activities and present the challenges. In particular he enlarged on the problems of globalisation, migration of physicians, problems associated with EU legislation, with training and the privatisation of medical education, payment systems and medico-legal problems. There was also the problem of differences in medical ethics. He was grateful for the opportunity which these visits had offered to explore these issues with NMAs.

Dr. Hill thanked the President for his report and moved to the Secretary General's Report.

Secretary General's Report

Dr. Kloiber said that the written report (see also p. 43) was in a different format. It fell into two parts namely, a general part and also a part dealing with cooperation with WHO which would be taken later in the agenda. Some work had fallen to the Finance and Planning Committee which has had more work to do, including the consolidation with finance. All the efforts have been successful in this work which included control of Dues, support in Kind control and Advocacy. There was better support of relations with NMAs.

The biggest project had been "Caring Physicians of the World" (CPW), with the book CPW in Santiago, including sponsorship of the edition in Spanish launched in March this year in Florida. With Dr. Coble there will be a Leadership Course in the autumn. This would be at and with the assistance of INSEAD, an international university in Fontainebleau (France). Nominations for this course will be dealt with by an advisory committee and the new executive committee.

Turning to the World Health Professions Alliance Dr. Kloiber commented that his predecessor had initiated this alliance with the Nurses and the Pharmacists – a very clever and necessary move. It was easy for international bodies to say of individual professions "you are giving a very partial



Participant of the 176th WMA Council Meeting.

view". The Health Professions Alliance is the answer to this. It doesn't mean giving up the individual positions of professions. Often our problems are similar. WHPA has held two forums in 2004 and 2006. A common conference on Regulation is planned for May next year. He commented that in the Pacific, in Asia, in Europe and probably in America, governments are becoming increasingly intrusive in regulation. There was a need to express our views on Self-regulation.

Dr. Kloiber concluded by saying that he had been asked by the Chairman of Council to work on the Consolidation of Standing Documents and would ask Mrs. Melke Borow (IMA) to give a brief report on this.

Dr. Snaedal, President Elect, (Iceland MA) spoke of a project in which the WMA had been involved, namely the Istanbul Protocol. There had been a new invitation to participate in the work.

Dr. Hanson (CMA) in the context of Human Health Resources referred to "task shifting" and asked what was WMA's position on this for the World Health Assembly. While he agreed that there should be consolidation with other Health Professionals he commented that we have individual views and in this context there may be problems, especially in "task shifting".

Mr. J. Johnson (BMA), referring to the Regulation Conference next year, said that they had problems in their own area in the

UK. He would welcome input from other NMAs.

Mrs. Malke Borow (IMA), referring to the Consolidation of the Standing documents said that they had tried to consolidate these and make them readable in one document. Obviously revisions could be introduced during this process (for example the introduction of Observer membership) and the possible delegation of representation to member NMAs when the need for representation was geographically in their area.

The Chair commented that proposals for change need to be submitted.

China

Dr. Blachar said that the delegation, which included the President and Secretary General, had recently met with the Chinese Medical Association (ChMA) concerning the issue of organ transplantation. Dr. Zhong, President of the ChMA had given an overview of the history of organ transplantation in China, indicating that while the 1960's and 70's were not very successful in terms of organ donation, the last couple of years had proved more productive due, in part, to great advances in technology. However, the legal framework for these surgical procedures has not advanced as quickly as technology.

The ChMA had done much work to formulate and clarify guidelines on the ethical

aspects of organ transplantation. The ChMA Ethics Committee had discussed several issues and principles which will clarify the need to obtain written informed consent of the individual donor or his/her family before any donation can be made. The ChMA realises the importance of emphasising ethical rules to those who participate in organ transplantation.

The discussions with ChMA included consideration of the matter of procurement of organs from prisoners, which opened up issues of Chinese culture and ethical practice. While at the same time the ChMA made clear their recognition of the human rights of prisoners, there were cultural differences in the interpretation of these. Dr. Zhong also emphasised the strict laws regarding the death penalty which now required approval by the Chinese Supreme Court.

The WMA delegation acknowledged the cultural differences between the West and China, but reiterated the fact that international ethical rules, including the WMA Statement on organ transplantation, prohibit the procurement of organs from prisoners. The WMA delegation also maintained that there was no way of guaranteeing that a prisoner is free from coercion pointing out that the prohibition in this Statement protects prisoners' human rights.

The ChMA and WMA delegation agreed on the prohibition of organ trade and on the need for further work on ethical guidelines on organ transplantation in China, noting that there remain differences of opinion on the notion of free and informed consent and harvesting of organs from prisoners.

Finally Dr. Blachar said that although differences between the two sides remained, he felt that China was moving in the right direction and was particularly encouraged by the new law prohibiting organ trade.

In a second meeting with the Vice-Minister of Health, Prof. Huang Jiefu, the Chinese Government position was explained. Especially the dependency on informed and documented consent and but also the prohibition of organ trade were two law projects the Chinese Government wished to pursue



immediately. After a long discussion Prof. Huang indicated that he would support a move towards a ban on organs from prisoners.

The delegation recommended that further negotiations continue with the aim that the ChMA state its commitment to WMA ethical policy on consent and organ transplantation, and that the ChMA report back to Council with an update at the General Assembly.

The Council *approved* the recommendation that the discussions continue with a view to the ChMA stating its commitment to WMA policy on organ transplantation and consent. A further report would be made to the Assembly in Copenhagen in October.

Mr. J Johnson (BMA), commented that for the first time in a long period the ChMA was present at this Council meeting. He also reported that the BMA was organising a conference on Transplantation in London which would include international experts.

FINANCE AND PLANNING COMMITTEE (FPC)

The Chair of Council called the meeting to order, welcomed new members, received apologies and the meeting approved the minutes of the last meeting.

Mr. J. Johnson (BMA) was nominated by Dr. Hanson (CMA) and was *elected Chair of the Committee by acclamation*. In thanking the committee *Mr. Johnson* pointed out that in the United Kingdom, surgeons were by custom addressed as Mister not Doctor, although they were medically qualified!

Finance

The report on the membership dues payments was received and the *Secretary General* said that developments had been positive and thanked NMAs for their help in this process. He reported that special arrangements for some NMAs continued and the report was *received*. Following some discussion during which the Secretary

General noted a recent improvement in payment of dues arrears, reports on Comparative Dues and on Dues arrears were *received*.

Financial Statement

Mr. Hallmayr presented the Pre-audited Statement for 2006 noting that the fully audited Statement would be available in June 2007. *Dr. Bagenholm* welcomed the good result and asked whether, nevertheless, we should be careful. M. Hallmayr agreed, the trend must become a firm one.

The Committee recommended that the Statement be approved. This was later *adopted* by Council.

Business Group.

Explaining that the Business Group was an “ad hoc” Group, *Dr. Kloiber* reported that in the past 18 months the activities had been reduced to three, reinvestment in Portal development, Meetings, and Future Information Technology. The content needs to meet short, mid- and long-term problems and include content management, on-line payment by members and an on-line chat board.

Concerning conferences it is possible to reduce costs. He drew attention to the fact that most other conferences bring in some income, and referred to the successful “Well Doctor” conferences organised by the AMA and CMA, held in Canada and the USA biennially over the past four years. Following further discussion, the BMA offered to host one next year and the Australian Medical Association in 3 years time. There was very little risk attached to these successful conferences and some profit.

The Chair commented that the Business Group had proved its worth and during discussion the CMA offered to revise and update the WMA website, a generous offer which the Committee gratefully acknowledged. It further discussed the Web Portal and *recommended* that the mandate of the Business Development Group be extended and be authorised

1) to develop a business plan for a phased approach to the establishment of a WMA Web Portal,

2) to investigate corporate sponsorship for a WMA Web Portal,

3) to proceed to develop a business plan for future WMA meetings and conferences.

This recommendation was later *adopted* by the Council.

WMA Meetings

The committee received reports on the arrangements for the WMA General Assembly in Seoul, South Korea in 2008 and for Copenhagen, Denmark in 2007.

After considering an oral report on planning of future meetings and a presentation by the Indian Medical Association on its plans for the General Assembly in 2009, it *recommended* that Council should commend the theme for the 2008 Scientific Session to the 2007 Assembly as “Health and Human Rights”.

Membership

The *Secretary General* referred members to the written report and commented on the strong membership of associates in the USA and in Asia. In the discussion the Chair suggested that it would be helpful if NMAs had copies of the form for Associate Membership, which was noted by the Secretary General.

The report of the Associate Members was *received*.

OUTREACH

Public relations

The report on Public Relations was *received*.

The Public Relations Consultant, *Mr. Nigel Duncan*, urged NMAs to increase the use of press releases as a mechanism for increasing the visibility of the WMA.

World Medical Journal

The committee *received* a proposal to change the format of the World Medical Journal, an offer for cooperation from the Nature Publishing Group and a paper regarding the Title of the World Medical Journal in its present format.

The Chair said this was a major matter; the papers were before the committee, including the proposal from Nature and a decision must be taken today.

The Secretary General referred to the major effort and changed format which had been introduced by the Editor and the need for NMA input and support. As an international organisation WMA had to have an instrument of communication. He stressed that the World Medical Journal was an asset. Both the options before the committee present the committee with a need to go ahead with exploring the possibilities. There would be a need for considerable discussion of the proposals.

Dr. Davis (America Medical Association), presented a report on ideas for revamping and relaunching the World Medical Journal as a scientific journal, stressing that NMAs should be involved in this project.

His proposal was to include original clinical research, health services research, medical ethics and medical education, healthcare policy and public health in a peer reviewed journal. Possible areas of special focus could include international comparisons of healthcare systems and their performance, global spread of diseases and risks, globalisation of healthcare, health and human rights, health impact of conflicts, medical ethics guidelines and medical education standards.

He outlined further detail on governance, web-site, funding and the way forward. The pros and cons of the two options were presented and committee addressed the two proposals before them.

Discussions focused on the strategic objective of WMA publications, the audience they intended to reach, the value and reputation of the title "World Medical Journal" and whether the focus of the content of the



Medical Ethics Committee in session.

journal should be clinical in nature or related to medical ethics and human rights. The *WMJ Editor* while agreeing that the proposition was a compelling one and should be explored, pointed out that a change in focus to clinical issues would represent a fundamental change in the policy of the journal. As his paper indicated, its function had always quite specifically excluded discussion of clinical problems (*see the introduction to the Handbook of WMA Declarations 1992 & 1996*), and the proposed change would be a major change of policy. He also drew attention to the need for a vehicle for communicating material relating to the main activities of the WMA in future, were the new proposal to be implemented.

After a long discussion during which differing views were expressed, the committee *recommended* that:

1. The proposal to revamp and re-launch the World Medical Journal with assistance from NMAs be further explored, including seeking outside funding, *be accepted*.
2. That there be a further report to the next council meeting.
3. That the proposal to adopt a new clinical journal published by the Nature Publishing group as an official publication of the WMA, *be not accepted*.

It was noted that, if the proposal above was implemented, in the interim period a new house publication would be needed as a communications vehicle for administrative, political, ethical and other non-clinical issues within the WMA, possibly a "World Medical Bulletin".

4. The report of the World Medical Journal was *received*.

These recommendations were later *approved* by council.

MEDICAL ETHICS COMMITTEE

Dr. Kloiber convened the meeting of the Medical Ethics committee and called for nominations for the Chair. Dr. Bagenholm (Sweden), was *elected* by acclamation.

Dr. John Williams commenting on the oral report, said that he had retired in December but had done some work for the unit since then. An on-line course on Medical Ethics similar to the course for prison doctors was being prepared with the Norwegian Medical Association. It was an interactive course based on the WMA Manual of Medical Ethics, and would be launched very soon. Turning to the Manual of Medical Ethics he reported that this had now been translated



into 13 languages and an Estonian translation was nearly ready. Some 220,000 copies had now been issued.

Policy review

The committee turned to work in progress and considered the WMA proposal for a Rapporteur on the Independence and Integrity of Health Professionals. In response to a question from the Chair, *Prof. Nathanson (BMA)*, said that there had been little progress in the past 10 years. There is a Special Rapporteur with a focus on Health Professionals but the work was difficult because of the case load. She considered that it was important to keep this proposal as the risk of health professionals losing their independence was real because there were major pressures on professional to breach medical ethics. This view was endorsed by *Dr. Gallard (France)*, who commented that the reasons for the original statement had not gone away, there was a need for a special rapporteur. The Committee recommended that the Statement undergo minor editorial revision by the British Medical Association and then be returned to the council with the committee's recommendation that it be reaffirmed.

Declaration of Hamburg

During consideration of the Declaration of Hamburg on Torture, *Dr. Reyes (ICRC)* stressed that this Declaration needed to be better known and the committee recommended it be *reaffirmed*. This was later *approved* by the Council, at which the *Editor* indicated that it would be published in the Journal and NMAs were invited to give it greater publicity.

Licensing of Physicians fleeing Prosecution for Serious Criminal Offences

The committee also recommended that the WMA Statement on Licensing of Physicians Fleeing Prosecution for Serious Criminal Offences, be *reaffirmed*. This was later *adopted* by Council.

Human Rights

The *Secretary General* gave an oral report on Human Rights noting that the issue of human organ transplantation in China had been discussed earlier by the Council (*see above*). *Dr. Snaedall (Iceland)* reminded the committee that WMA had participated in the first phase of activity in relation to the Istanbul Protocol visiting and teaching in five countries. He reported that WMA had been asked to participate also in phase 2 of this activity- financed by the European Union. Meanwhile *Dr. Snaedall* had visited Egypt where he had been able to visit three ministries as well as NGOs. Although the authorities were reluctant, there was a project for training later this year in which he felt that WMA should participate. There was a need for ethical input into this training. He also noted that the Declaration of Hamburg was always on the table during these discussions. In response to the Chair's question as to what was being proposed, *Dr. Snaedall* commented that in the first project we had been full partners with ICRC, while in the second project, formal participation would depend on reimbursement of expenses.

Prof. Nathanson (BMA), echoing these views, commented that documentation of the effects of torture is very important. A bigger issue was abuse – interrogational torture – which is extraordinarily pervasive. It would be worthwhile for WMA to participate in this work and doctors who try to deal with this would appreciate support. She referred in particular to Zimbabwe members being involved in assisting doctors observing that the Zimbabwe representative on the ICRC had to take refuge in an Embassy. She mentioned that Dafur was the 1st project and there would be a report on an Iraq project next time.

Prof. Nathanson reported on a visit with ICRC to India to a conference on "Health of Detainees and Prisoners" at which there were participants from all over India. Participants reported that torture before trial and in prison was common, but it was difficult to document torture during interrogation. Both HIV/AIDS and MDR-Tb were major problems. The Indian Medical Association had agreed to support doctors

both at regional and national level. She commended NMA Prison doctors in India. *Dr. Kumar (IMA)* commented on the importance of the issue of the health of doctors who may have psychological / mental torture. *Dr. Kloiber* commented that the Prison Doctors Course continues and he particularly thanked the ICRC and *Dr. Reyes* for their work.

Proposed Statement on Stem Cell research

The Committee considered a proposed WMA Statement on Stem Cell Research from the Icelandic Medical Association where this issue had been discussed, but progress had been delayed by Parliament.

At the suggestion of the Chair the committee agreed to recommend that the statement be circulated to NMAs for comments and that these be referred to a small working group to prepare revision for the next meeting, a recommendation *accepted* by council.

Proposed Statement on Telemedicine

Dr. Jensen suggested that a proposed Statement on Telemedicine be referred to NMAs for comment. *Dr. Williams* reminded the committee of the long history of this subject and that this had been twice to NMAs. The option would be to consider the document as it is. The committee recommended that the document on the table be referred to NMAs. This was later *agreed* by council.

Proposed Statement on Human Tissue Transplantation

Germany introduced a proposal for a statement on Human Tissue for Transplantation, referring to discussions in council and work done by the working group chaired by *Dr. Vilmar* resulting in the document now before the committee. The new document



supplements existing policy on organ transplants. It covers not only issues but also human cells which may be turned into final products, in which there were large financial interests. The committee *recommended* that the document be circulated for comments to NMAs. This was later *accepted by council*.

Future Work

A paper on priorities which listed a number of possible topics for future work provoked considerable debate. *Dr. Davis* (AMA) felt the list to be a good start and should be the basis for reflection before the Copenhagen meeting later in the year. Concerning a suggestion that WMA should develop the ethics unit into an Ethics Institute and stating that the AMA also had a goal of developing an ethics institute, using an analogy with the WHO's work with Collaborating Centres he suggested that consideration should be given to WMA working with NMA Institutes of Ethics. *Prof. Nathanson* (BMA) agreed with the principle of working with NMA Ethics committees. Turning to specific topics she noted that there was no mention of policy on "Dual Responsibility", also commenting in general that statements should deal with broad issues.

Dr. Jensen (DMA), felt that there was a need to discuss ethical aspects of cooperation with the Pharmaceutical Industry, moving that a paper on this topic should be prepared for Copenhagen and that there should be exploration of an agreement with the industry. The *Secretary General* observed that there had been an agreement with the industry two years ago and appealed for suggested amendments or a new proposal on relations with the Pharmaceutical Industry. The *Chair* pointed out that the CPME had guidance on this topic. The issue was not about ethics it was about collaboration, to which *Dr. Kloiber* commented that WMA had had an offer from the industry to do this which Council had rejected. It had also commented on the CPME/IFPMA document and stated that shared governance was not acceptable. After further support for *Dr. Jensen's* views and information about the experience of other NMAs, the

committee proposed that: "The Danish Medical Association prepare a discussion document which would be discussed at the next meeting of the MEC and that the topic of elaborating common guidelines between the WMA and the industry should be placed on the agenda of the next Ethics Committee." This proposal was *adopted*.

It was reported that a paper on "medical professionalism" was in preparation and it was *agreed* that this would be updated and the topic of medical professionalism from the perspective of NMAs would be on the agenda for the next meeting.

Dr. Williams raised the question of the importance of promoting WMA policies and how this was to be done. *Dr. Kloiber* responded that the office is planning to reintroduce a printed Handbook as a loose leaf binder which NMA would then be able to keep up to date. It was hoped that this would be ready in October. Whether the material should be sent by mail or e-mail had yet to be decided and discussions were taking place with international organisations to promote WMA policies. He appealed to NMAs to take WMA policies to their Annual meetings so that they could be discussed there, as happens in the AMA. Such actions were important to enhance the global image of the WMA.

Prof. Nathanson suggested asking Council how they had found policy useful in the past year and *Dr. Haikerwal* (Australia) reported that the Australian Medical association had formally adopted WMA policy. The *Editor* referring to the policy of publishing important statements in the WMJ, appealed to NMAs to publicise policy in their Journals and *Dr. Kloiber* emphasized the importance of ensuring that NMAs' members understood what was actual WMA policy.

Declaration of Helsinki

In discussion of a document on the advantages/disadvantages of updating the Declaration of Helsinki (DoH), *Dr. Williams* suggested that any review should consider an open approach to take account of all stakeholders, and decide a course of action. Even if there are no changes, a

review would remind all interested parties that the DH exists. One should try to convince them that all other declarations in this field are secondary to the Helsinki Declaration. He suggested that the process of review could be done quickly and that each NMA should be responsible for consultation within its own country; the WMA could deal with International organisations.

Dr. Kloiber said that the document was part of the Strategic Plan. There were major discussions before the last revision, and numerous conferences worldwide. At the time there was difficulty in deciding the direction i.e. to protect the subject of research. In Edinburgh it was recognised that some things were not dealt with such as the position of pregnant women in research. We were now in 2007 and we should start preparation for a review in 2009/10, e.g. look at epidemiological and psychiatric research. We need to keep working if we want to keep ownership, look at document, decide the problems and make proposals.

Dr. Snaedall (IMA) thanking *Dr. Williams* for his paper agreed that the DoH remained important. The research community was catching up with new problems and we need to *decide on new topics which need to be included*.

Prof. Nathanson (BMA) reminded the committee how difficult it was to get the DH revised. Edinburgh was a compromise. Did we really want to open this up now? She felt that we should not decide on new topics today.

Dr. Letlape (Past President) proposed that a work group be formed to review the Declaration of Helsinki with the goal of identifying lacunae without opening basic issues. The committee made this *recommendation* which was later *approved by council*.

Other business

Dr. Kloiber introduced Professor Julian Mezzich, President of the World Psychiatric Association (WPA), who explained that the WPA incorporated 151 national associations, and stressed that ethics were of para-



mount concern to the Association. It had taken the decision to approach WMA with a view to collaboration on ethical issues, including the Madrid Declaration which was undergoing a three year review. It would also like to collaborate on broader issues, such as a holistic approach "Psychiatry with and for the Person." He hoped that it would be possible for this collaboration to occur.

Zimbabwe

Dr. Letlape spoke about the challenges being faced in Zimbabwe. Reporting doctors detained and tortured he said that SAMA had been asked to act and needed guidelines.

Dr. Kloiber commented that he had tried to get reactions to these events from the Zimbabwe Medical Association (ZMA) but had failed to get any response. He asked for guidance from SAMA on strategies for outreach to the ZMA and getting credible information. In response to a suggestion that a safe approach would be to look at any relevant existing policy he agreed but said that we didn't have information and we don't want to add to the problems of the ZMA.

SOCIO-MEDICAL AFFAIRS COMMITTEE

The Chair of Council opening the meeting and following adoption of the minutes of the Pilansberg meeting 2006, called for nominations for the Chair of the Social Affairs Committee to which *Dr. Gomes do Amiral* was elected by acclamation.

Proposed major revision of policies.

Antimicrobial Drugs

Discussion of the proposed major revision of the statement on Anti-microbial Drugs was introduced by the AMA and the committee agreed that this be circulated to NMAs for comments.

Family Planning and the right of a woman to contraception

After a number of comments were made including one that access to contraception for minors especially in emergency situations be added to the proposal. It was pointed out that this was a sensitive and difficult issue to address. It was agreed that the Statement on Family Planning and the Right of a Woman to Contraception be circulated to NMAs for comments.

Noise Pollution

After discussion and minor editorial amendment, the committee recommended that the statement be forwarded to the General Assembly for adoption. This was approved by council.

Economic Embargoes and Health.

The committee recommendation that this statement be reaffirmed, was later approved by council.

The committee recommended that the Israeli Medical Association undertake responsibility for major revision of the Declaration on Continuous Quality Improvement in Health Care.

Health hazards of Tobacco products.

After some discussion, it was agreed to recommend that the current paper be circulated to NMAs for comments and that major revision be undertaken by the AMA.

Prohibition of Access of Women to Health Care and prohibition of Practice by Femal Doctors in Afghanistan

The committee recommended that this document undergo major revision by MASA

with the aim to make it more global in scope.

New business

Dr. Davis presented an AMA proposal for a Statement on Reducing Dietary Sodium Intake, pointing out that most intake of sodium was from processed foods. There is a need to achieve major changes in this and therefore the documents ends with recommendations, in particular, a stepwise approach to a 50% reduction of sodium in processed foods. Pointing out that industry was not interested, he said the last recommendation was to engage in discussion of the issue with governments, regulators and other stakeholders.

The committee recommended that the proposal be circulated to NMAs for comments.

Future Priorities

The committee considered a paper on future priorities and *Dr. Williams* pointed out that unlike the MEC whose remit was limited to Medical Ethics, SMAC had a very wide remit. Suggested areas had therefore been grouped in the paper before the committee. Under headings such as medical education, professional policies, public health and the committee had to decide on focus areas. We already had some problems with the promotion of WMA policies and had had some discussion on this with WHO.

Dr. Hill, the Chair of Council, said consideration was being given to having a small group to develop Advocacy Agenda and Policy before the October meeting. We now have two programmes on Education and consideration could be given to programmes for pandemic control and for "antimicrobial" education. *Dr. Hansen* (CMA) strongly supported the suggestion of supporting work on Advocacy and the role of NMAs in influencing health policies etc. *Prof Nathanson* (BMA) supporting *Dr. Hill*, pointed out that this was a very complex issue. The Secretary General referring to earlier discussions on participatory roles discussed at the World Health Assembly, felt that advocacy was an item which must



Chair of Council, Secretary General reflecting.

be on the committee's agenda regularly. Commenting on education he referred to the fact that education had been a very active area of WMA's work in the '70s at a time in which World Federation on Medical Education had been formed. As Secretary General he was now on the Council of WFME whose papers WMA normally endorse. This does not however place a bar on WMA activity in education. Amongst other issues raised during the debate an appeal, supported by Germany and Korea, was made to NMAs to bring forward environmental health issues, an area in which the AMA had done a lot of work. France raised the issue of both protection of patients and the important issue of the health of physicians and the need to examine doctors physical fitness to practice and it was pointed out that the AMA included this its ethical code.

Approving a motion that its agenda should include a standing item on Advocacy, the committee also *recommended* that a small working group develop an advocacy agenda and a process for handling the various WMA advocacy issues to be presented to SMAC at its meeting in October. This was later *approved* by council.

Resumed Council session

In consideration of the Secretary General's report part two, Council engaged in a dis-

cussion of relationship with the WHO. It took note in particular of two items which figured in the agenda of the World Health Assembly, namely Alcohol and Epidemic preparedness. Attention was also drawn to the inclusion of NMAs in official delegations of some countries and Council was reminded that WMA was now back in official relationship with WHO. This carried with it the obligation to support WHO policies. It was therefore essential that we were represented and present throughout the World Health Assembly meeting. It was equally important that NMA's should bring WMA policy to the attention of their national delegations. The *Secretary General* said that in the past two years there had been a trend to be part of the activities with WHO, notably in Tobacco control but also liaising with WHPA in the Patient Safety initiative. However, while we were quoted as participants none of the health professions Association was in the Strategic Planning Group of the Global Alliance for Patient Safety. He stressed the importance of the IMPACT Group on Counterfeit medicines. Then referring to the World Health report 2006 "Human resources for Health", *Dr. Kloiber* pointed out that in the context of the Global Alliance for the Workforce while there was reluctance to include the health professions, eventually we were asked to be a participant. But again, none of the health professions associations was placed in the governance body which includes govern-

ments and Global funds such as the Gates Foundation etc. In fact there was an opportunity for partnership but no role in decision making bodies.

The donors currently follow the paradigm of "task shifting" and the need to employ a lay workforce. He was concerned that in this context while this might have adverse effects on retaining physicians and other health professionals, an economist during a technical discussion at WHO had expressed welcome for this as he regarded them too expensive. He then referred to Primary care, the Alma Ata Declaration of WHO (1978) and the concept of Targets. Primary Care was not only important in Emergency situations but was an essential part of all Health care systems. However there was a feeling that one cannot focus only on primary care for a long time.

In some rich countries where there have been moves from an Agricultural to a Service Society over at least three decades, in the service industries health care always is the biggest segment. The poor countries of this world are now forced to do the change from agricultural economies to service economies in one step and in a very short time. However forcing them to stay with primary care only produces effective blockade to build a viable service society.

Dr. Kloiber referred to the forthcoming Primary Care document which would need to be studied with care and *Dr. Letlape* (immediate past President) commented with reference to ARVs, etc. that Primary Medical Care documents should be for everyone and be equitable.

The view was expressed that what was needed was the ability to advocate for physicians to be able to work with WHO and help to resolve problems both at first and third country level. There was a plea for better advocacy policy.

Dr. Kloiber responding said it was not a black or white picture. There are committed technical staff at WHO who need to share their frustration with you. At the same time he is optimistic about the new Director General, Dr. Chan. "The opening issue of Primary Care will have to deal with concerns about its role. Referring to the fact that the UN system has to undergo change



and this includes the WHO”, he said, “Dr. Chan seems open to this. There should not be a crusade against WHO. We need to convince them to help people and be careful about policies set up by politicians.”

Dr. de Leon (Uruguay) expressed concern about the threat to physicians from WHO. He congratulated *Dr. Kloiber* on his remarks and agreed that task shifting could be a considerable threat to physicians. He considered that the primary care team should always be led by a physician. At the same time there was a threat with the primary care focus. WHO needs to look at every aspect of care. However Primary Care was needed in underdeveloped countries.

Dr. Haikerval (Australia) referred to a major battle with the Registration body in Australia. One needs to be careful with words. “Task Substitution” is not the same as “Task shifting”. He also stressed that there must be someone who is responsible for taking over care and prevention.

Dr. Bagenholm (SwMA) posing the question how do we influence WHO, said that some policies were good and some bad. We should not be too negative. We should try to have some technical input e.g. in the Interministerial conference on Alcohol.

Referring to the USA *Dr. Davis* said they had problems of task shifting with Nurses and Optometrists, Midwives and Anaesthetist assistants. He referred to seeking legal authority to do formal surgery with a scalpel and also problems associated with the Physicians Assistants stating that we can effectively protect care and quality if our own house is in order.

Dr. Williams reported that the Canadian Medical Association has a policy on task delegation with appropriate training; he further commented that WHO staff say that the Executive Board makes policy and staff carry it out. NMAs need to work with governments. Nationally there was a need to distinguish the level at which decisions were made. *Dr. de Leon* (Uruguay) agreed that we should follow WHO moves and trends and try to be present as observers at Ministerial Conferences. *Dr. Lemye* (Belgium) was concerned about the relation of WMA with WHO, seeking a more loose contact with the WHO:

Emergency Resolution

The Council discussed a proposal for an Emergency Council Resolution on the situation in certain Latin American and Caribbean states concerning the supply of Cuban physicians and the by-passing of systems set up to verify physicians’ credentials and competence. It was reported that the substance of this resolution had already been subscribed to by all the Latin American States.

After a lengthy discussion the Resolution was *adopted* (see box on right).

Dafur

Dr. Blachar, expressing his concern that the situation in Dafur, on which the council had adopted a Resolution in 2005, had continued to deteriorate, proposed that the Council as an Emergency Resolution reaffirm its condemnation, which the council *adopted*.

WMA Council resolution in support of the Medical Associations in Latin America and the Caribbean
Berlin 10-12 May 2007

There are credible reports that arrangements between the Cuban government and certain Latin American and Caribbean governments to supply Cuban Physicians to these countries are bypassing systems, established to protect patients, that have been set up to verify physicians’ credentials and competence.

The World Medical Association is significantly concerned that patients are put at risk by unregulated medical practices.

There exist already duly constituted and legally authorised medical associations within this region that are charged with the registration of physicians and which should be consulted by their respective Ministries of Health.

Therefore, the WMA:

- 1. Condemns any actions by governments in policies and practices that subvert or bypass accepted standards of medical credentialing and medical care;**
- 2. Calls upon the governments in Latin America and the Caribbean to work with the medical associations on all matters related to physician certification and the practice of medicine and to respect the role and rights of these medical associations and the autonomy of the medical profession.**
- 3. Urges, as a matter of utmost concern, that the governments in Latin America and the Caribbean Region respect the WMA International Code of Medical Ethics and the Declaration of Madrid, that guide the medical practice of physicians all over the world.**

11.5.2007

Secretary General's report to the 176th WMA Council Session

Extracts from Secretary General's report to the 176th WMA Council meeting.

The extracts from the Secretary General's written report below are largely those not included in his oral report to council given in two parts. These are to be found in the report of the 176th Council meeting on pages 34 and 35)

Consolidation of Finances

In continuing the efforts of the year 2005 it was possible to foster the consolidation of the WMA finances throughout the year 2006. A further significant improvement of the situation was made possible by a rigid application of the measures we had initiated the year before.

- Financial control: This has been maintained with the counsel of the Treasurer, the Chair of the Finance and planning Committee and the help of the executive treasurer.
- Priority setting: The World Medical Association has initiated and continued only such activities which we were able to carry out without losses or where the immediate value for the association was obvious (e.g. the Ethics Unit).
- Reviewing contracts and business relations: Economic awareness remains an important principle for all of our business activities. However, most contracts had been revised or renewed in 2005.
- Rebuilding internal staff: Due to the ongoing consolidation process, the priority for 2006 was on financial stability. The regained financial security will allow for re-staffing in 2007.
- Application of rules: Counseling with the executive committee, the financial officers or the Sponsorship advisory Committee led to clear governance and to financially sustainable partnerships and sponsorship arrangements, thus reducing

the risk of financially non-sustainable engagements or ethically questionable liaisons.

Caring Physicians of the World Initiative

Spanish Edition of the Caring Physicians of the World Book

When we first introduced the Caring Physicians of the World Book in October 2005 we found a very friendly and warm reception in Santiago de Chile right before our General Assembly. The Latin physicians' community particularly embraced the book as a document for their work and gave it a very warm welcome. Unfortunately, the only thing we had to offer at that point in

time was an English edition. On March 27th 2007 we were able to present a Spanish version of the book to the Inter-American College in Miami, Florida. Like the original English version, the Spanish edition is now widely available.

After concluding a successful series of regional leadership conferences, we have looked for models to implement a strategic option to support the development of international medical leadership. Some of our constituent members already offer leadership courses to their members or to their officers, while others do not. The WMA is positioned as a global organization and has its own particular challenges when addressing the development of medical leadership in that it has a multinational, multi-cultural structure. We have taken this as a challenge for developing a service that can be offered in principal to all constituent members.

World Health Organization

Status of the WMA

As do other United Nations organizations, the WHO allows international Non-

Governmental Organizations (NGOs) a special status called "NGOs in official relations with WHO". Under this status, an NGO may receive an invitation to make a short intervention during the Executive Board Meeting or the World Health Assembly. The exact spoken text has to be handed in before permission will be given.

The WMA will be invited to expert meetings covering all the different topics the WHO is currently dealing with. The participating experts are always requested to hand in a detailed submission regarding potential conflicts of interest, including possible possession of shares from tobacco or pharmaceutical companies by the expert, the sending organization or his/her spouse.

The WMA has held this status with the WHO since 1992 (again) and has to renew it every third year. The renewal process includes detailed information from the financial statement and the sources of income. A common work plan has to be set up for the following three years.

The Executive Board Meeting of WHO has reaffirmed the status of the WMA as an NGO in official relations with the WHO in its January 2007 meeting.

Human Resources

The World Health Report 2006 dealt with the question of human resources for health. The authors believe that the extreme shortage of health professionals necessitates a strengthening of the lay workforce for health. "Community health workers" in many poor countries of the world are being charged with medical tasks to fulfill medical and nursing roles especially in programs targeting HIV/AIDS, Tuberculosis and Malaria.

While there is certainly a demand for immediate action and for the inclusion of the informal workforce in some capacity, the overall consequences for the health care systems in general have not been thoroughly considered.

Together with large donors like the Gates Foundation, the Global Fund, the US President's Emergency Plan for AIDS relief (PEPFAR), the World Bank and the World Monetary Fund, the WHO is following the



paradigm of “task shifting” to transfer competencies from health professionals to lay persons. This is of significant concern to the WMA, particularly as it relates to issues of quality of care and patient outcomes and the overall development of the health care systems.

Global Alliance for the Workforce for Health

Under the leadership of the WHO, the Global Alliance for the Workforce for Health was founded in May 2006. During the preparation of this Alliance, the President of the World Medical Association requested a formal participation of the health profession in the construction of the Alliance, which was denied. In the fall of last year we received an invitation to join as partners, which we accepted. However, as of April 2007 we still have no access to the governing bodies of this alliance.

International Medicinal Products Anti-Counterfeiting Taskforce – IMPACT

Counterfeit medical products produce multiple risks for medical safety:

- Their non- or sub-standard composition may lead to low or non-existing levels of active ingredients or their bioavailability. Their production is not controlled and quality is by no means guaranteed. They may even contain toxic components.
- Counterfeits may lead to completely erroneous medical judgments about the real drugs, as adverse effect or non-effectiveness may be attributed to the original medication thereby leading to treatment changes or discontinuation.
- If added to a current treatment scheme (e.g. for the therapy of tuberculosis or HIV infection) they may produce extremely dangerous drug resistance.
- By reducing revenues for the legitimate producers of a drug, counterfeits reduce the ability to re-invest in research and development.

- Counterfeits produce distrust in medical treatments and reduce compliance.

Together with national governments, industry, patient groups, Interpol and the World Health Professional Alliance, WHO initiated the International Medicinal Products Anti-Counterfeiting Taskforce (IMPACT). This group has been formally installed in October 2006 on invitation of the German Government and tries to find political, juridical, technological and informational means to combat counterfeits in medicine. The health professions participate especially in the field of providing and encouraging information and communication about counterfeit medicines and avoidance of counterfeit products.

International Labor Organization – ILO

Together with other healthcare organizations and the WHO, the World Medical Association participated in a series of roundtables on Diabetes and Social Responsibility initiated by the Geneva Social Observatory and the ILO. The roundtables discussed the role of employers, employees and their organizations in the prevention and detection of diabetes. There was particular interest in models of good practice for healthy nutrition and life style support in the work environment. A special focus was also given to the roles of schools in shaping nutritional habits and patterns of physical activity.

Online Course on treatment of multi-Drug-resistant tuberculosis (MDR-TB)

The development of an online course on the treatment of multi-drug-resistant tuberculosis is a joint initiative with the Foundation for Professional Development of the South African Medical Association and the Norwegian Medical Association. It was made possible by a grant from Eli Lilly, Inc.

The course has been completed and is available over the Internet under: <http://lupin-nma.net/tb.html>

It is currently undergoing field-testing in South Africa. Field tests with selected groups of physicians are also planned for the Philippines and Estonia. Further funds have been secured for translation of the course materials into Russian, Chinese and Spanish.

World Health Professions Alliance (WHPA)

In 1999 the International Council of Nurses (www.icn.ch), the International Pharmaceutical Federation (FIP) (www.fip.org) and the WMA founded the World Health Professions Alliance. The aim of the alliance is to foster the cooperation of the professional organizations and to augment our advocacy work with the relevant international organizations, particularly the WHO, and the general public.

Since its inauguration, the WHPA has taken an active role in the anti-tobacco initiative, the fight to protect human rights, the recognition of the HIV/AIDS pandemic and against discrimination of the mentally ill. In a recent project the WHPA has drafted guidelines for the competencies of international health consultants. It has promoted awareness on issues like antimicrobial resistance, nutrition and health care for the elderly. The WHPA has engaged in leadership issues and has often overcome objection of officials to speak with a “single” health profession.

The WHPA intensively cooperates with the International Alliance of Patient Organizations, IAPO (www.iapo.org), and the Global Alliance for Patient safety, which is led by the WHO.

The WHPA serves as a platform for various discussions and initiatives in health care. It:

- Cooperates closely with the WHO and industry to combat counterfeit drugs and materials, and it is part of the **International Medicinal Products Anti-Counterfeiting Taskforce – IMPACT**
- Discusses overlapping educational issues
- Serves as a common platform on health professional issues with the WHO

- Bundles the interests of health professions in relation to the **Global Health Workforce Alliance**

During the last few years, human resources have been a constant point of interest in the international health debate. In poor countries as well as in rich countries, bad working conditions are strong reasons for health professionals to quit or migrate. Reports about stressful, often dangerous and under-resourced working places do not increase the attractiveness of the health professions. The WHPA together with other partners wishes to promote "Positive Practice Environments". We wish to show that workplaces in the health care field can be made safe and attractive by following the good examples that already exist.

European Forum of Medical Associations and WHO – EFMA Lisbon, 20-21 April 2007

The EFMA is the common forum of Medical Associations of the WHO-Region "Europe" and the WHO Euro in Copenhagen. This year's forum gained considerable political attention as the President of the European Commission, Dr. J.M. Barroso, and the regional director of the World Health Organization, Dr. M. Danzon, opened the forum. This has been a remarkable change as during the last years the forum did not receive the necessary attention of international politics and the WHO.

The forum discussed among other issues:

- Health and Migration
- Obesity
- Disaster preparedness
- Anti-Tobacco Activities of EFMA/WHO
- Health Systems and Policies and investments in health
- Country reports

The WMA legal advisor and Secretary General of the Israeli Medical Association, Adv. Leah Wapner, has been appointed as the new Secretary General of the Forum.

Joint Commission International – Hospital of the future roundtable

The Joint Commission International is the international arm of the American Joint Commission (<http://www.jointcommission.org/>), describing itself as the "nation's predominant standards-setting and accrediting body in health care". JCI offers mainly accreditation and certification to health care institutions and is without doubt one of the most important institutions in the world in the field of health care quality.

While its main focus is still on hospitals, the JCI has started a dialogue on the hospital of the future, trying to analyze and describe international trends in hospital development. In a series of three roundtables, a group of experts from various fields involving hospital care tried to outline the developmental aspect from architectural designs, work flows, social functions and interactions, globalization and migration of health professionals, to the core of the hospital function, the provision of care and medical services. The roundtables served as preparation for an international conference debating the future trends in hospital development.

Microbial Resistance Policy Seminar

Together with the AMA, the International Society for Microbial Resistance and the George Mason University School of Public Policy, the WMA co-hosted a conference on Microbial Resistance Policy. With a group of experts on microbial resistance, the conference analyzed the need for policy development in the field on October 23, 2006. The Conference started off with a review of the 1997 WMA policy on Microbial resistance and resulted in suggestions for development, which were taken up by the AMA and are before the WMA Council now as a redraft of the 1997 WMA policy.

In addition, the George Mason School of Public Policy and the International Society

of Microbial Resistance are seeking the participation of the WMA in developing a certificate course for *medical policy*. This offer is currently under consideration by WMA.

Other national or regional meetings:

The Secretary General attended national meetings of the following WMA member associations or their regional groups:

- Standing committee of European Doctors (CPME), Luxembourg 27. – 28.10.2006 and Warsaw 16. – 17.03.2007
- International Union against Tuberculosis and Lung Disease, Paris 01. – 02.11.2006
- European Conference on Environment and Health, Paris 09.11.2006
- American Academy of Endocrinologists, Phoenix 10.02.2007
- German-Russian Health Dialogue, Sochi 19. – 21.03.2007

Administrational Issues

Consolidation of Standing Documents

The constitution and regulations of the WMA are spread over 6 basic documents. While there are good reasons to keep some of the rules separated there is also a lot of historical and non-logical separation in the documents. Fractional amendments led to inconsistencies and did not add transparency to our rules.

With the help of our legal advisors, Mrs. Leah Wapner and Mrs. Malke Borrows, a first draft of the consolidated Articles and Bylaws has been produced. The purpose of this consolidation is to enhance readability and clarity, to reduce length and to eliminate possible contradictions and illogical rules.

Furthermore, the draft will provide suggestions that will allow for the adaptation of rules to recent developments and to the necessities of the work of the Association (see also p. 35).

Dr. Otmar Kloiber



From the Secretary General's Desk

About Changing the Scope of Practice, Task Shifting and the Proper Use of Words

We all have been driven through selection processes in school, admission tests, state and board exams, audits, appraisals, recertification etc. There certainly is a high expectation by the public and our patients concerning the level of our knowledge, competency and skills. Yet more and more tasks are being transferred or delegated to non-physicians, to persons with significantly less or no qualifying training at all.

This trend started decades ago with nurse practitioners providing primary care instead of GPs. It extended gradually to prescribing by pharmacists, optometrists, psychotherapists and other health professions. The most recent model is the most radical. The so-called Task Shifting is mainly used in HIV/AIDS, tuberculosis and malaria care. Laypersons are being deployed to initiate and maintain complex treatments especially in African countries, but also in other parts of the world.

These laypersons called “community health workers” are often used in programmes by the big donors who finance treatment in poor populations.

Sometimes there are good reasons to change the scope of practice, to share competencies and to use lay help. Over time many medical processes became very simple often automated and safe so that neither the provision by nor the attendance of a physician is necessary any more.

On the other hand in many African countries the physician to patient ratio is less than a tenth of the relation in the rich countries of this world. That means access to continuing competent medical care is practically impossible for the majority of the population. The use of nurses, midwives and other health professions for medical treatment is necessary. But in reality, even those health professions are being seen as too

expensive and donors want to rely on laypersons instead.

It would be too easy to describe this change in scope of practice as just the result of a change in technology or as a result of a growing and unsatisfied demand for professional medical care. We ourselves have been adding to this driving this change by

- the unwillingness by family practitioners and other medical primary care givers to provide medical care during nights and on holiday. Our unwillingness to make home visits or to settle in rural areas opened the window for primary care nurses. It also allowed practice structures to develop which in many regions or countries tended to endanger the patient/physician relationship, already quite impersonal. This is especially the case when patients can no longer choose their physician. In those settings the traditional binding between a family and “their” family physician does not exist anymore.
- the unwillingness to perform repetitive tasks ourselves have led to the emergence of many paramedical professions like anesthesiology technicians or nurses, ultrasound imaging assistance and others.
- the tendency to hyper specialize and at the same time to negate our general capacity as physicians leaves ample space for others to fill this gap.

Of course many of these developments have taken place because of ridiculous payment schemes or because work loads just did not allow us to do what we would have considered as being good practice. Of course it may sometimes be correct to charge a less qualified person with tasks that don't necessarily need to be performed

by a physician. But where does the limit lie and who drives it?

We also have to note how just words change our world. Our willingness to adopt new language when it comes under the veneer of political correctness becomes a trap for our profession:

- We are called “**service providers**”. That is fine for those who wish to make us dependent repair technicians. These people believe that we just have to do what we are being told (by our government, hospital owner, insurance or managed care organization). Of course we serve our patients, but we are caregivers and not just technicians. We need and have to demand professional autonomy or at least clinical independence – something service providers don't have.
- We are being submerged under the term “**health workers**”. This produces the illusion of exchangeability and the unimportance of learned professions.
- We speak about “**customers**” and “**clients**”, but indeed we have to serve patients. Patients do not have the autonomy of a customer (at least not when they are really sick or injured) nor do we have the right to do business with them as a merchant can with his or her clients.
- We proudly call ourselves **doctors**, but others in the health care arena carry this title also and suddenly a doctor of optometry, podometry or a PhD in nursing may say to a patient: “I am your doctor”. The six-year medical training makes us all to physicians and that is the common denominator. Even surgeons will have to live with it.
- We have allowed our governments to **abuse the term physician** for other health care professionals. Why do we tolerate this?

The political strategy behind this is simple and clear. It is to make physicians dispensable, to suggest that others can do the same and to reduce access to high quality care. It works so well, because we ourselves are the best adapters to this type of language.

We will have to carefully define what is the medical domain and what can and should be done by others. We will have to find out who is best suited to take over certain functions and we will have to make sure that responsibility goes with it.

What we define to be in the medical domain and we are sure that it has to be done by physicians (not “doctors“!) we will have to fight for. it.

We will have to lift the curtain on “recertification“ and “revalidation“. With health politicians demanding on one hand stricter controls on physicians and on the other to implementing task shifting, nothing other than hypocrisy may be left.

This is not about payment and status. It is about the quality of medical care that is given to our patients. It is about safety and

access to real medical care and not a substitute for it. Changing the scope of practice sometimes reflects the progress in technology and methods, but sometimes the shortage of resources. But more and more it becomes a silent technical approach of rationing care.

In a recent article from *Médecins Sans Frontières* website entitled “Coping with health worker shortages: lessons and limits“, Joseph Ramokoatsi from Lesotho wrote “*Task-shifting for rapid scale-up must be balanced against the need to provide quality care and should not become an alibi for accepting shortages of skilled staff.*”

Donors are quick to support initiatives involving lay health workers, but often refuse to fund measures to recruit and retain health professionals.“

seek high-level political backing for its recommendations.

A recent study¹ has shown that the number of foreign-trained doctors has tripled in several OECD countries over the past three decades. The number of foreign-trained doctors from countries with chronic shortages of health workers is relatively small (less than 10% of the workforce) in developed countries. However, for some African countries, the migration of a few dozen doctors can mean losing more than 30% of their workforce, even as basic health needs remain unmet.

Other health professions are also affected by this phenomenon. The study showed that from Swaziland, 60 to 80 nurses migrate to the United Kingdom each year, while fewer than 90 graduate from Swazi schools. GHWA partner and member Save the Children UK estimates that the United Kingdom saved £65 million in training costs between 1998 and 2005 by recruiting Ghanaian health workers.

Ms. Robinson summarized the need for urgent action: “We cannot stand alone as individual countries continue to address their own increased needs for health workers without looking beyond their shores to the situation these migrating workers have left behind in their homelands. We cannot continue to shake our heads and bemoan the devastating brain drain from some of the neediest countries on the planet without forcing ourselves to search for – and actively promote – practical solutions that protect both the right of individuals to seek employment through migration and the right to health for all people.“

One of the initiative’s first priorities will be to support WHO in drafting a framework for an International Code of Practice on Health Worker Migration, as called for by a resolution of the World Health Assembly in 2004. This framework will promote ethical recruitment, the protection of migrant health workers’ rights and remedies for addressing the economic and social impact of health worker migration in developing countries. The Code of Practice will be the first of its kind on a global scale for migration.

Medical Manpower

Practical solutions to tackle health worker migration

15 MAY 2007 | GENEVA – The Health Worker Migration Policy Initiative held its first meeting at the WHO headquarters in Geneva. The initiative, led by Mary Robinson, President of Realizing Rights: the Ethical Globalization Initiative, and Dr. Francis Omaswa, Executive Director of the Global Health Workforce Alliance (GHWA), is aimed at finding practical solutions to the worsening problem of health worker migration from developing to developed countries.

WHO Director-General Dr. Margaret Chan said, “International migration of health personnel is a key challenge for health systems in developing countries.“ The new initiative has a Technical Working Group housed at WHO.

The Health Worker Migration Policy Initiative is made up of two groups that will work closely together over the coming months to develop recommendations. The Migration Technical Working Group, which is being coordinated by WHO, brings together the International Organization for Migration, the International Labour Organization, professional associations, experts and academics.

The Health Worker Global Policy Advisory Council, under the leadership of Ms. Robinson and Dr. Omaswa and with Realizing Rights serving as its secretariat, is made up of senior figures from developed and developing countries. It will develop a roadmap and a framework for a global code of practice for health worker migration and



The initiative will also promote good practices and strategies to enable countries to increase supply and retain their health workers more effectively. The new tools and policy recommendations developed by the initiative will support better management of migration through North-South collaboration.

Dr. Omaswa emphasized the importance of addressing both the ‘push’ and ‘pull’ factors simultaneously. “Health workers are a valued and scarce resource. Demand is increasing worldwide, but not enough are being trained – in the developed or the developing world. Developing countries must prioritize health and health workers, with better working conditions and incentives so its workforce can stay and be more efficient, while developed countries must train more of their youth and try to be self-sufficient.”

The Health Worker Migration Policy Initiative is due to make initial policy recommendations by the end of 2008. Its operations are co-funded and coordinated by Realizing Rights, the Global Health Workforce Alliance, and the MacArthur Foundation.

List of members

Health Worker Global Policy Advisory Council

Co-Chairs

- Hon. Mary Robinson, President, Realizing Rights
- Dr Francis Omaswa, Executive Director, GHWA

Members

- Hon. Major Courage Quarshie, Minister of Health, Ghana
- Hon. Erik Solheim, Minister of International Development, Norway
- Hon. Patricia Aragon Sto Tomas, Minister of Labor and Employment, the Philippines
- Hon. Rosie Winterton, Minister of State for Health Services, United Kingdom
- Dr Lincoln Chen, Director, Global Equities Initiative, Harvard University

- Dr Anders Nordström, Assistant Director-General, Health Systems and Services, WHO
- Ms Janet Hatcher Roberts, Director, Migration Health Department, IOM
- Mr Ibrahim Awad Director, International Migration Programme, ILO
- Lord Nigel Crisp, Co-Chair, GHWA Task Force on Scaling up Education & Training
- Dr Percy Mahlati, Director of Human Resources, Ministry of Health, South Africa
- Huguette Labelle, Chancellor, University of Ottawa
- Dr Titilola Banjoko, Managing Director, Africa Recruit
- Prof. Ruairi Brugha Head, Department of Epidemiology & Public Health, Ireland
- Ms Sharan Burrow, President, International Confederation of Free Trade Unions
- Ms Ann Keeling, Director, Social Transformation Programs Division, Commonwealth Secretariat

- Mr Markos Kyprianou, Director General, Health & Consumer Protection, European Commission
- Mr Peter Scherer, Directorate for Employment, Labour and Social Affairs, OECD
- Prof. Anna Maslin, Nursing Officer, International Nursing & Midwifery Health Professions Leadership Team, Department of Health, United Kingdom
- Dr Mary Pittman, President, Health Research & Education Trust, American Hospitals Association
- Dr Jean Yan, Chief Scientist for Nursing & Midwifery, WHO, chair of the Migration Technical Working Group

Health Worker Global Policy Advisory Council Secretariat:

- Ms Peggy Clark, Managing Director, Realizing Rights
- Dr Ita Lynch, Health Advisor, Realizing Rights

International Health Regulations enter into force

New opportunity to respond to international public health threats

GENEVA – The revised International Health Regulations (IHR) entered into **force on Friday, 15 June 2007**. The Regulations consist of a comprehensive and tested set of rules and procedures which will help to make the world more secure from threats to global health. They were agreed by the World Health Assembly in 2005 and represent a major step forward in international public health security.

The Regulations establish an agreed framework of commitments and responsibilities for States and for WHO to invest in limiting the international spread of epidemics and other public health emergencies while minimizing disruption to travel, trade and economies. Under the revised IHR, States

will be required to report all events that could result in public health emergencies of international concern, including those caused by chemical agents, radioactive materials and contaminated food.

In the early 21st Century, demographic, economic and environmental pressures have created a unique combination of conditions that allow new and re-emerging infectious diseases to spread as never before. The experience of recent decades shows that no individual country can protect itself from diseases and other public health threats. All countries are vulnerable to the spread of pathogens and their economic, political and social impact.

The emergence of SARS in 2003 demonstrated as no previous disease outbreak ever had, how interconnected the world has

become and how rapidly a new disease can spread. This shared vulnerability has also created a need for collective defences and for shared responsibility in making these defences work. This is the underlying principle of the International Health Regulations.

“SARS was a wake-up call for all of us. It spread faster than we had predicted and was only contained through intensive cooperation between countries which prevented this new disease from gaining a foothold,” said Dr. Margaret Chan, Director-General of the World Health Organization. “Today, the greatest threat to international public health security would be an influenza pandemic. The threat of a pandemic has not receded, but implementation of the IHR will help the world to be better prepared for the possibility of a pandemic.”

The Regulations build on the recent experience of WHO and its partners in responding to and containing disease outbreaks. Recent experience shows that addressing public health threats at their source is the most effective way to reduce their potential to spread internationally. The Regulations will help to ensure that outbreaks and other public health emergencies of international concern are detected and investigated more rapidly and that collective international action is taken to support affected States to contain the emergency, save lives and prevent its spread.

WHO has already developed and built an improved events management system to manage potential public health emergencies. WHO has also built strategic operations centres at its Geneva Headquarters and in Regional Offices around the world, which are available round-the-clock to manage emergencies. WHO has also been working with its partners to strengthen the Global Outbreak Alert and Response Network (GOARN), which brings together experts from around the world to respond to disease outbreaks.

“Implementing the IHR is a collective responsibility and depends on the capacity of all countries to fulfil the new requirements,” said Dr. David Heymann, WHO Assistant Director-General for

Communicable Diseases. “WHO will help countries to strengthen the necessary capacities to fully implement the Regulations. This is our responsibility and we expect that the entire international community is committed to the same goal of improving international public health security.”

WHO exercise to test global system

In June also, WHO will hold the first exercise to sharpen its preparedness under the terms of the revised International Health Regulations. The exercise will verify new procedures for receiving, analysing and responding to information about potential public health emergencies. It will also ensure the effectiveness of policy direction and coordination, information management and risk assessment capacity and communications between the Regional and Country Offices and Headquarters of WHO.

The exercise will be the first of a series meant to test and improve the mechanisms in place in and between Member States and at different levels of WHO.

The revised IHR requirements include

- **Notification. Greater openness demanded by a world in which serious disease events are increasingly visible.** The Regulations recognize that media and other unofficial reports often appear in advance of official notification of a public health emergency of international concern. To expedite the flow of timely and accurate information, countries are required to notify all events that may constitute a public health emergency of international concern within 24 hours of assessment.
- **Designation of National IHR Focal Points: world on 24-hour alert.** Under the IHR every country is required to designate a National IHR Focal Point, charged with providing to and receiving

information from WHO on a 24 hour basis, seven days a week.

- **Establishment of core public health capacities to maximize surveillance and response.** Under the IHR, each country is committed to develop and maintain core public health capacities for surveillance and response. These capacities also include outbreaks of chemical, radiological and food origin. States are required to establish such core capacities as soon as possible, with a deadline of five years after entry into force of the revised IHR.
- **New recognized rights for international travellers.** The IHR for the first time include express requirements that international travellers be treated with respect for their dignity, human rights and fundamental freedoms when health measures are applied. At the same time, they provide for examinations and other health measures as necessary to protect against the international spread of disease.
- **Cross-sectoral international collaboration key to implementing IHR.** WHO needs the support of all stakeholders to ensure international public health security. The IHR foster multi-sectoral global partnership to respond collectively in the face of epidemics and other major health emergencies.
- **Threat-specific international programmes to improve international health security.** The IHR provide for strengthening existing international disease control programmes, addressing infectious diseases, food safety and environmental safety. These programmes make a vital contribution to the global alert and response system as they allow development of generic and threat-specific capacities.

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Experts recommend innovation for children's medicines

WHO 15th essential medicines list published

Following recommendations from the Expert Committee on Essential Medicines, the World Health Organization has begun work to create a medicines list specifically tailored to children's needs. A group of experts met in July 2007 to produce the first international list of medicines to tackle diseases with high mortality and morbidity rates in children.

The Expert Committee made the recommendation while meeting in Geneva to update the general WHO Model List of Essential Medicines. The list is published and already includes some child specific medicines.

Children suffer from the same illnesses as adults but they are more seriously affected – particularly in developing countries – by certain conditions such as respiratory tract infections, malaria and diarrhoeal diseases. An estimated 10.6 million children under five die every year, many from these treatable conditions. In 2005, 2.3 million children under 15 years were HIV positive – 700 000 new infections had occurred over the twelve months.

In spite of the huge need, there are few medicines made to measure for children or that can be easily consumed by a child. At present, children must often take portions of adult tablets in a crushed form, with little evidence of the efficacy and safety of the dose. When medicines do exist in the right dosage they are usually in syrup form, which may pose supply, storage and pricing problems in developing countries.

The challenge for children becomes more acute when they are affected by a condition requiring combination therapy (several medicines rather than one) such as for HIV/AIDS and malaria. In these cases, fixed dose combination tablets are required (two- or three-in-one pills). While production of adult fixed-dose-combinations is increasing, it is sorely lacking for children. In addition, antiretrovi-

als for children are currently three times more expensive than the adult versions.

The recommendation made by the Expert Committee for an essential medicines list for children will see WHO working with partners to advocate innovation and research into children's medicines, the manufacture of new dosage forms and new formats, and ways in which information about children's medicines can be conveyed to countries in a rapid, effective way.

The plan to work on better medicines for children was backed by Member States at WHO's Executive Board meeting in January this year and was on the agenda of the World Health Assembly in May.

The Expert Committee made a number of important updates to the WHO Model List

of Essential Medicines. Five fixed-dose-combinations for adults were included for HIV/AIDS. Two of these come from the generic industry while the remaining three are produced by brand name companies. All WHO recommended antimalarials were also added.

Five oral liquid formulations were included for children – three for epilepsy, one for children born prematurely, and one new medicine for HIV/AIDS, although in single dose. Three other epilepsy medicines were included in the form of chewable, dispersable tablets, a format which evidence increasingly shows to be effective for children.

The WHO List of Essential Medicines provides a model for countries to select medicines addressing public health priorities according to quality, safety and efficacy standards. It helps governments address problems of cost and availability and provides guidance to the pharmaceutical industry on medicines needs globally.

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The Regulations establish an agreed framework of commitments and responsibilities for States and for WHO to invest in limiting the international spread of epidemics and other public health emergencies while min-

imizing disruption to travel, trade and economies. Under the revised IHR, States will be required to report all events that could result in public health emergencies of international concern, including those caused by chemical agents, radioactive materials and contaminated food.

In the early 21st Century, demographic, economic and environmental pressures have created a unique combination of conditions that allow new and re-emerging infectious diseases to spread as never before. The experience of recent decades shows that no individual country can protect itself from diseases and other public

health threats. All countries are vulnerable to the spread of pathogens and their economic, political and social impact.

The emergence of SARS in 2003 demonstrated, as no previous disease outbreak ever had, how interconnected the world has become and how rapidly a new disease can spread. This shared vulnerability has also created a need for collective defences and for shared responsibility in making these defences work. This is the underlying principle of the International Health Regulations.

“SARS was a wake-up call for all of us. It spread faster than we had predicted and was only contained through intensive cooperation between countries which prevented this new disease from gaining a foothold,” said Dr. Margaret Chan, Director-General of the World Health Organization. “Today, the greatest threat to international public health security would be an influenza pandemic. The threat of a pandemic has not receded, but implementation of the IHR will help the world to be better prepared for the possibility of a pandemic.”

The Regulations build on the recent experience of WHO and its partners in responding to and containing disease outbreaks. Recent experience shows that addressing public health threats at their source is the most effective way to reduce their potential to spread internationally. The Regulations will help to ensure that outbreaks and other public health emergencies of international concern are detected and investigated more rapidly and that collective international action is taken to support affected States to contain the emergency, save lives and prevent its spread.

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“Implementing the IHR is a collective responsibility and depends on the capacity of all countries to fulfil the new requirements,” said Dr. David Heymann, WHO Assistant Director-General for Communicable Diseases. “WHO will help coun-

tries to strengthen the necessary capacities to fully implement the Regulations. This is our responsibility and we expect that the entire international community is committed to the same goal of improving international public health security.”

Global health partners mobilize to counter yellow fever

US\$ 58 million GAVI contribution to prevent highly contagious disease in 12 West African nations

16 MAY 2007 | GENEVA – The effort to contain deadly yellow fever disease has received a boost with the launch of a Yellow Fever Initiative backed by a US\$ 58 million contribution from the GAVI Alliance. Launched during the World Health Assembly currently meeting in Geneva, the new initiative will support special immunization campaigns in a dozen West African countries at high risk of yellow fever epidemics.

Between the 1940s and 1960s, widespread mass vaccination campaigns in some African countries had resulted in the almost-complete disappearance of yellow fever. However, as immunization campaigns waned, a generation of people grew up with no immunity to the disease, and by the 1990s the number of annual cases had risen to an estimated 200,000 per year, with 30,000 deaths, and urban outbreaks were starting to occur.

Yellow fever had returned as a major scourge and, as urbanization progresses across Africa, the threat of a major epidemic looms ever larger. WHO estimates, for example, that this highly transmissible disease could infect around one third of the urban population, or up to 4.5 million people, in Lagos, Nigeria alone.

Now, thanks to the US\$ 58 million GAVI Alliance grant, immunization against yellow fever will be kick-started. Over the next four years, the world's 12 highest-burden countries, all of which are in West Africa, will be able to implement special vaccina-

tion campaigns to immunize more than 48 million people.

Groundbreaking initiative

“The Initiative is a groundbreaker from many perspectives. Existing routine immunization programmes target children. If we were to do only routine child immunization for yellow fever, we would need decades to reduce the risk of epidemics and the international spread of the disease,” said Dr. David Heymann, WHO Assistant Director-General for Communicable Diseases.

“Now, however, thanks to the generous grant from GAVI, the Yellow Fever Initiative will be able to vaccinate at-risk populations and thus quickly reduce the risk of devastating outbreaks that could otherwise threaten the region and the world. With this initiative, we will be working in the short and long term to strengthen primary health care systems in the world's most vulnerable region – Africa,” added Dr. Mike Ryan, Director of the WHO Department of Epidemic and Pandemic Alert and Response (EPR) in Geneva.

“Yellow fever is a particularly dangerous disease which kills up to 50% of those with severe illness. Every age group is at risk, and vaccination is our crucial weapon to prevent cases and epidemics. With the GAVI Alliance contribution, affected countries have an exceptional opportunity, and responsibility, to protect their populations,” said Michel Zaffran, Deputy Executive



Secretary at the GAVI Alliance, in announcing the GAVI contribution. "GAVI is committed to working with all our partners, both globally and in the field, to ensure the success of the Yellow Fever Initiative in Africa."

Vaccine too expensive

Until now, vaccine has often been too expensive for countries to afford when faced with a host of competing health problems and coverage rates in some West African countries are critically low. In Nigeria, for example, the coverage rate in 2005 was an estimated 36%. However, it is recommended that, to stop yellow fever infections from spreading into an epidemic, immunization coverage must be at least 60–80%.

"Immunization against yellow fever is all the more critical now because of increased population movements in Africa. As we see more people moving to cities for work, but returning to their rural villages from time to time, we also see the possibility of yellow fever epidemics multiplying," said Dr. Sylvie Briand, Project Manager of the Yellow Fever Initiative in WHO's EPR Department.

A recent vaccination campaign in Togo has shown how, under the umbrella of the Yellow Fever Initiative, it is possible to quickly and effectively reach even remote populations and consequently prevent isolated cases from spreading into an epidemic. In December 2006, WHO received notification of three cases of yellow fever in northern Togo. As the last mass vaccination there had taken place in 1987, the population was considered to be highly susceptible. By February 2007, the Togo Ministry of Health and WHO, with financial support from GAVI and from the Humanitarian Office of the European Commission (ECHO), and with the technical support of UNICEF and various NGOs, had vaccinated more than 1.5 million people. A similar campaign was then conducted in two districts in southern Togo after two cases of yellow fever had been reported there at the end of January.

GAVI's grant to the Yellow Fever Initiative will cover the 12 countries which are at the

highest risk from the disease – Benin, Burkina Faso, Cameroon, Côte d'Ivoire, Ghana, Guinea, Liberia, Mali, Nigeria, Senegal, Sierra Leone and Togo – and will help create a stockpile of 11 million doses of vaccine. Within the framework of the Initiative, the 12 Member States and WHO will identify specific target populations to vaccinate, with the aim of both preventing outbreaks and managing epidemics, and consequently increasing immunization coverage.

Background

The 12 countries taking part in the Yellow Fever Initiative are Benin, Burkina Faso, Cameroon, Côte d'Ivoire, Ghana, Guinea,

Liberia, Mali, Nigeria, Senegal, Sierra Leone and Togo.

The Ministries of Health of these 12 countries are being supported financially and technically by a Yellow Fever partnership which was launched in February 2006 and now includes WHO, UNICEF, GAVI, Médecins Sans Frontières, the International Federation of Red Cross and Red Crescent Societies, the Association pour la Médecine Préventive (AMP), the Programme for Appropriate Technology (PATH), the European Union Humanitarian Aid Office (ECHO), the United States Centers for Disease Control and Prevention (CDC), the Global Outbreak Alert and Response Network (GOARN) and the Institut Pasteur. The partnership continues to take on new members.

2.5 million people in India living with HIV, according to new estimates

Improved data from more sources gives better understanding of AIDS epidemic in India

6 JULY 2007 | NEW DELHI – The new 2006 estimates released today by the National AIDS Control Organization (NACO), supported by UNAIDS and WHO, indicate that national adult HIV prevalence in India is approximately 0.36%, which corresponds to an estimated 2 million to 3.1 million people living with HIV in the country. These estimates are more accurate than those of previous years, as they are based on an expanded surveillance system and a revised and enhanced methodology.

As part of its continuing effort to know its epidemic better, the Indian Government has greatly expanded and improved its surveillance system in recent years and increased the number of population groups covered. In 2006, the government created 400 new sentinel surveillance sites and facilitated National Family Health Survey-3, which is a population-based survey.

Launching the third phase of the National Programme, Dr. Anbumani Ramadoss, Union Minister for Health and Family Welfare said, "Revision of estimates based on more data and improved methodology marks a significant improvement in systems and capabilities to monitor the spread of HIV, a sign of the progress we have made in understanding the epidemic better. This is welcome progress. Unfortunately, the new figures still point towards a serious epidemic with potential to expand if the prevention efforts identified in the NACP III are not scaled up rapidly and implemented in the desired manner. We must remember that India has nearly 3 million people living with HIV. These are people facing stigma, discrimination and irrational prejudice everyday of their lives and need all our support and understanding." The Minister called upon his colleagues in the medical profession and civil society organizations to fight stigma and discrimination.

Resulting from a more robust and enhanced methodology, the revised estimates will be used to improve planning for prevention, care and treatment efforts. “While it is good news that the total number of HIV infections is lower than previously thought, we cannot be complacent. The steady and slow spread of the HIV infection is a worrying factor. The better understanding of India’s epidemic has certainly enabled us to have more focused HIV prevention and treatment strategies and more effective deployment of resources,” said Mr. Naresh Dayal, Secretary of Health and Chair of the National AIDS Control Board.

The new methods developed for the revised estimates have also been used to “back-calculate” the prevalence for years since 2002 based on the new set of assumptions and measures. These figures allow a fair comparison of year-on-year trends in HIV prevalence. They show an epidemic that is stable over time with marginal decline in 2006.

Commenting on the new estimates and guarding against their misinterpretation, Sujatha Rao, Additional Secretary and Director General, National AIDS Control Organization said, “The calculation of figures for several years using the new model helps us understand that the new lower estimates do not mean a sharp decline in the epidemic.” Cautioning against an easing-off the momentum of the HIV response she added, “Using a similar methodology led to downward revision in estimates in some countries such as Zambia and Rwanda. We will convince all stakeholders to stay energized and to retain the hard-fought gains of the last decade.”

Showing confidence in the commitment of the Indian leadership, Dr. Denis Broun, UNAIDS Country Coordinator said, “The trends evident from the latest estimates validate India’s national AIDS strategy. Taking encouragement from the new lower estimates, the national authorities should increase the strength of their HIV programmes. We must scale up efforts to reach universal access to HIV prevention, care and treatment. Though the proportion of people living with HIV is lower than previously estimated, India’s epidemic continues to be substantial in numbers. Despite the

lower prevalence estimate, the cost of prevention efforts required to control the epidemic remains the same.”

WHO Representative, Dr. Salim Habayeb commended the vision of the Government of India in the last 15 years for addressing the HIV epidemic. He also commended the efforts of the states, civil society, partner agencies as well as the valuable role of the media in facilitating the creation of an enabling environment. “The HIV burden remains substantial. India’s efforts, especially those in prevention, are noteworthy and should be further scaled up along with provision of universal access to treatment for those who need it.”

HIV prevalence shows signs of slight decline among general population

While overall the HIV epidemic shows a stable trend in the recent years, there is variation between states and population groups. The good news is that in Tamil Nadu and other southern states with a high HIV burden, where effective interventions have been in place for several years, HIV prevalence has begun to decline or stabilize.

New pockets of high HIV prevalence identified

HIV continues to emerge in new areas. The 2006 surveillance data has identified selected pockets of high prevalence in the northern states. There are 29 districts with high prevalence, particularly in the states of West Bengal, Orissa, Rajasthan and Bihar.

HIV prevalence continues to be high among vulnerable groups

The 2006 surveillance figures show an increase in HIV infection among several groups at higher risk of HIV infection, such as people who inject drugs and men who have sex with men. The HIV positivity among injecting drug users (IDU) has been found to be significantly high in cities of Chennai, Delhi, Mumbai and Chandigarh. In addition, the states of Orissa, Punjab, West Bengal, Uttar Pradesh and Kerala also show high prevalence among this group.

While data does suggest that HIV prevalence levels are declining among sex workers in the southern states, overall prevalence levels among this group continue to be high, necessitating a scaling-up of focused prevention efforts among these groups. “Only by controlling the epidemic among the vulnerable groups can the dynamic of the epidemic be broken,” said Sujatha Rao, Additional Secretary and Director General, NACO.

Regulatory authority on safe blood being established

Underscoring the priorities, the Minister of Health called for strong measures to regulate the blood collection and distribution system in the country to make it world class. He stated that the Ministry of Health is establishing a regulatory authority which will regulate access to safe blood at affordable prices.

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WHO publishes key world health statistics

18 MAY 2007 | GENEVA – WHO has published *World health statistics 2007*, the most complete set of health statistics from its 193 Member States. This edition also highlights trends in 10 of the most closely watched global health statistics. It is the authoritative annual reference for a set of 50 health indicators in countries around the world.

In her speech to the World Health Assembly, the WHO Director-General, Dr.

Margaret Chan, focussed on the need for accurate evidence and up-to-date statistics as the basis for policy decisions. “Reliable health data and statistics are the foundation of health policies, strategies, and evaluation and monitoring,” she said. “Evidence is also the foundation for sound health information for the general public... I regard the generation and use of health information as the most urgent need.”



This volume, also available as an online database, should be on the shelves or the desktop of every health policy maker, researcher and journalist. It shows:

- How much money is currently spent on health in comparison to regional burdens of disease;
- Projected patterns of major causes of death for 2030;
- Gaps in reliable information, and how estimates of maternal mortality are made;
- The diseases that are killing people, and those that make them sick;
- The extent to which people can access treatment, the major risk factors for ill-health, the human resources underpinning health systems; and

- Health outcomes in the context of demographic and socioeconomic status of individual countries.

World health statistics 2007 is the official record of data produced by WHO's technical programmes and regional offices. In publishing these statistics, WHO provides the global evidence base for improvements and continued challenges in global public health.

World Health Statistics 2007 can be accessed online at <http://www.who.int/whosis>.

Road traffic crashes are the leading cause of death for 10-24 olds

New WHO report marks First UN Global Road Safety Week

GENEVA – Road traffic crashes are the leading cause of death among young people between 10 and 24 years, according to a new report published by World Health Organization. The report, *Youth and Road Safety*, says that nearly 400 000 young people under the age of 25 are killed in road traffic crashes every year. Millions more are injured or disabled.

The vast majority of these deaths and injuries occur in low- and middle-income countries. The highest rates are found in Africa and the Middle East. Young people from economically disadvantaged backgrounds are at greatest risk in every country. Young males are at higher risk for road traffic fatalities than females in every age group under 25 years.

Unless more comprehensive global action is taken, the number of deaths and injuries is likely to rise significantly. Road traffic collisions cost an estimated US\$ 518 billion globally in material, health and other expenditure. For many low- and middle-income countries, the cost of road crashes represents between 1-1.5% of GNP and in some cases exceeds the total amount the countries receive in international development aid.

Youth and Road Safety stresses that the bulk of these crashes are predictable – and preventable. Many involve children playing on the street, young pedestrians, cyclists,

motorcyclists, novice drivers and passengers of public transport.

The report points out that children are not just little adults. Their height, level of maturity, their interests, as well as their need to play and travel safely to school, mean that they require special safety measures. Also, the report says, protecting older youth requires other measures such as lower blood alcohol limits for young drivers and graduated license programmes.

As part of the *First United Nations Global Road Safety Week* (23-29 April 2007), WHO launched the report to draw attention to the high global rates of death, injury and disability among young people caused by road traffic crashes. Youth and Road Safety highlights examples in countries where improved measures such as lowering speed limits, cracking down on drink-driving, promoting and enforcing the use of seat-belts, child restraints, and motorcycle helmets, as well as better road infrastructure and creating safe areas for children to play have significantly reduced the number of deaths and injuries.

“The lack of safety on our roads has become an important obstacle to health and development,” said Dr. Margaret Chan, WHO Director-General. “Our children and young adults are among the most vulnerable. Road traffic crashes are not ‘accidents’. We need to challenge the notion that they

are unavoidable and make room for a proactive, preventive approach.”

Youth and Road Safety is accompanied by a second and more personal document, *Faces behind the figures: voices of road traffic crash victims and their families*. Developed jointly by WHO and the Association for Safe International Road Travel, this book presents first-hand accounts of the experiences of victims, their families and friends following road crashes. The stories place a highly moving human face on the statistics provided by many road safety reports around the world. They reveal the physical, psychological, emotional and economic devastation that occurs during the aftermath of road traffic deaths and injuries. In particular, these accounts deepen our understanding of the enormous suffering that occurs behind each death and injury every year. They also highlight some of the initiatives undertaken by groups and individuals to improve road safety by sharing their concern, frustration and anger in order to prevent the same from happening again.

Faces behind the figures include:

- On 16 September 2002, Jane Njawe, 42, was travelling by car with two other people from Yaounde, the capital of Cameroon, to Douala in the north. An hour into the journey, a bus driving in the opposite direction tried to overtake a truck on a curve at high speed. Unable to see

any oncoming traffic, the driver smashed into the car, injuring everyone in it. While Jane's companions were taken to a nearby hospital, she was inexplicably driven to a poorly equipped bush clinic. A mother of four children, including a three-year-old son, Jane died five hours later from lack of blood. Jane's husband, Pius Njawe, formed an organization called Justice and Jane to keep her memory alive and to promote road safety.

- On 29 August 2003, Balazs Geszti, a 24-year-old Hungarian butcher, returned home with his step-brother, Peter, in the early hours of the morning from a wedding. Both had been drinking heavily. Shortly after arriving home, Balazs received a phone call from his girlfriend asking him to attend another party. Racing over in his car, he smashed into a concrete

barrier at 140 km an hour in a 50 km zone. Balazs was killed on impact. Peter is now a volunteer coordinator for Habitat for Humanity. He believes that if Balazs had not been drinking – or speeding – he might still be alive today.

- In May 2002, Sateni Luangpitak, a motorcycle taxi driver in Thailand, collided into another vehicle. Sateni, now 28, was driving at 80 km per hour. The collision threw him on to the pavement, where he hit his head and left shoulder. Despite wearing a helmet, Sateni lost consciousness. When Prayoon Muangme, a friend, realized it would take too long for the emergency services to come, he evacuated Sateni to a nearby hospital. On arrival, however, he learned that no trauma facilities were available. Prayoon took his friend to yet another clinic. Sateni was lucky his helmet

had protected his head and had suffered only light injuries. Nevertheless, his collision kept him out of work and reduced his ability to earn a living.

The First United Nations Global Road Safety Week was organized by WHO, the UN Regional Commissions and partners in a bid to promote greater awareness of road traffic incidents and to give young people a voice. Spearheading the global campaign, a World Youth Assembly will be held in Geneva, Switzerland, where young delegates from over 100 countries will gathered on to share their experience and plan joint activities for better road safety. World leaders including the UN Secretary-General Ban Ki-moon, the British Prime Minister Tony Blair and stars including Moby gave messages to the opening of the World Youth Assembly.

WHO and UNAIDS issue new guidance on HIV testing and counselling in health facilities

New recommendations aim for wider knowledge of HIV status and greatly increased access to HIV treatment and prevention

LONDON – WHO and UNAIDS have issued new guidance on informed, voluntary HIV testing and counselling in the world's health facilities, with a view to significantly increasing access to needed HIV treatment, care, support and prevention services. The new guidance focuses on provider-initiated HIV testing and counselling (recommended by health care providers in health facilities).

Today, approximately 80% of people living with HIV in low- and middle-income countries do not know that they are HIV-positive. Recent surveys in sub-Saharan Africa showed on average just 12% of men and 10% of women have been tested for HIV and received their test results.

Increased access to HIV testing and counselling is essential to promoting earlier diagnosis of HIV infection, which in turn

can maximize the potential benefits of life-extending treatment and care, and allow people with HIV to receive information and tools to prevent HIV transmission to others.

“Scaling up access to HIV testing and counselling is both a public health and a human rights imperative,” said WHO HIV/AIDS Director Dr Kevin De Cock. “We hope that the new guidance will provide an impetus to countries to greatly increase availability of HIV testing services in health care settings, through realistic approaches that both improve access to services and, at the same time, protect the rights of individuals. Without a major increase in HIV testing and counselling in health facilities, universal access to HIV prevention, treatment and care will remain just a noble goal.”

Additional approaches needed to expand access

Until recently, the primary model for providing HIV testing and counselling has

been client-initiated HIV testing and counselling – also known as voluntary counselling and testing (VCT) – in which individuals must actively seek an HIV test at a health or community-based facility. But uptake of client-initiated HIV testing and counselling has been limited by low coverage of services, fear of stigma and discrimination, and the perception by many people – even in high prevalence areas – that they are not at risk.

Current evidence also suggests many opportunities to diagnose HIV in clinical settings are being missed, even in places with serious HIV epidemics. While, therefore, expanded access to client-initiated HIV testing and counselling is still necessary, other approaches are also required if coverage of HIV testing and counselling is to increase and, ultimately, universal access to HIV prevention, treatment, care and support is to be achieved.

The new WHO/UNAIDS guidance was prepared in the light of increasing evidence



that provider-initiated testing and counselling can increase uptake of HIV testing, improve access to health services for people living with HIV, and may create new opportunities for HIV prevention. Provider-initiated HIV testing and counselling involves the health care provider specifically recommending an HIV test to patients attending health facilities. In these circumstances, once specific pre-test information has been provided, the HIV test would ordinarily be performed unless the patient declines.

Provider-initiated HIV testing and counselling has already been implemented in a range of clinical settings in several low- and middle-income countries, including Botswana, Kenya, Malawi, Uganda and Zambia, as well as in pre-natal settings in parts of Canada, Thailand, the United Kingdom, and the United States.

“If we are going to get ahead of this epidemic, rapidly scaled up HIV treatment and prevention efforts are critical – and increased uptake of HIV testing will be fundamental to making this a reality,” said Dr Paul De Lay, Director of Monitoring and Evaluation, UNAIDS. “At the same time, and in all cases of HIV testing and counselling, the 3 Cs – that is consent, confidentiality and counselling – must be respected,” he added.

Guidance tailored to different types of epidemics and health facilities

The new WHO/UNAIDS guidance advises that health care providers globally should recommend HIV testing and counselling to all patients who present with conditions that might suggest underlying HIV disease.

Additional guidance is tailored to local circumstances. **In generalized HIV epidemics¹**, HIV testing and counselling should be recommended to all patients attending all health facilities, whether or not the patient has symptoms of HIV disease and regardless of the patient’s reason for attending the health facility. **In concentrated² and low-level³ HIV epidemics**, depending on the epidemiological and

social context, countries should consider recommending HIV testing and counselling to all patients in selected health facilities (e.g. antenatal, tuberculosis, sexual health, and health services for most-at-risk populations). The guidance also includes special considerations for HIV testing and counselling for adolescents and children.

WHO and UNAIDS recognize that resource and other constraints may prevent immediate implementation of the guidance. The document therefore provides advice about how to prioritize implementation in different types of health facilities.

The new guidance builds on previous policy positions of WHO and UNAIDS and responds to a growing demand from countries for more detailed policy and operational advice in this area. Its recommendations were developed following a review of available evidence and a broad consultative process with experts and implementers, including submissions received from over 150 organizations and individuals.

Other key recommendations

Other key WHO/UNAIDS recommendations for provider-initiated HIV testing and counselling in health facilities include:

- All HIV testing must be voluntary, confidential, and undertaken with the patient’s consent.
- Patients have the right to decline the test. They should not be tested for HIV against their will, without their knowledge, without adequate information or without receiving their test results.
- Pre-test information and post-test counselling remain integral components of the HIV testing process.
- Patients should receive support to avoid potential negative consequences of knowing and disclosing their HIV status, such as discrimination or violence.
- Testing must be linked to appropriate HIV prevention, treatment, care and support services.
- Decisions about HIV testing in health facilities should always be guided by what

is in the best interests of the individual patient.

- Provider-initiated HIV testing and counselling is not, and should not be construed as, an endorsement of coercive or mandatory HIV testing.
- Implementation of provider-initiated HIV testing and counselling should be undertaken in consultation with key stakeholders, including civil society groups, acknowledging that what works and is ethical will inevitably differ across countries.
- When implementing provider-initiated HIV testing and counselling, equal efforts must be made to ensure that a supportive social, policy and legal framework is in place to maximize positive outcomes and minimize potential harms to patients.
- A system that monitors and evaluates the implementation and scale-up of provider-initiated testing and counselling should be developed and implemented concurrently.

As countries work towards universal access to HIV prevention, treatment, care and support, the new guidance on provider-initiated HIV testing and counselling offers an important opportunity to introduce new approaches and improve the standards of HIV testing and counselling in both public and private health facilities. Together with their partners, WHO and UNAIDS will continue to help countries expand access to the full range of HIV testing and counselling services, as well as to other needed health sector interventions against HIV/AIDS.

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