

WORLD MEDICAL JOURNAL

55

Vol.

No. 4, December 2009

OFFICIAL JOURNAL OF THE
WORLD MEDICAL ASSOCIATION, INC.



World Medical Association Officers, Chairpersons and Officials

Dr. Dana HANSON

WMA President
Fredericton Medical Clinic
1015 Regent Street Suite # 302,
Fredericton, NB, E3B 6H5
Canada

Prof. Ketan D. Desai

WMA President-Elect
Indian Medical Association
Indraprastha Marg
New Delhi 110 002
I.M.A. House
India

Dr. Yoram BLACHAR

WMA Immediate Past-President
Israel Medical Assn
2 Twin Towers
35 Jabotinsky Street
P.O. Box 3566
Ramat-Gan 52136
Israel

Dr. Edward HILL

WMA Chairperson of Council
American Medical Assn
515 North State Street
Chicago, ILL 60610
USA

Dr Masami ISHII

WMA Vice-Chairman of Council
Japan Medical Assn
2-28-16 Honkomagome
Bunkyo-ku
Tokyo 113-8621
Japan

Dr. Jörg-Dietrich HOPPE

WMA Treasurer
Bundesärztekammer
Herbert-Lewin-Platz 1
10623 Berlin
Germany

Dr. Jens Winther Jensen

WMA Chairperson of the Medical
Ethics Committee
Danish Medical Association
9 Trondhjems gate
2100 Copenhagen 0
Denmark

Dr. José Luiz GOMES DO AMARAL

WMA Chairperson of the Socio-
Medical-Affairs Committee
Associação Médica Brasileira
Rua Sao Carlos do Pinhal 324
Bela Vista, CEP 01333-903
Sao Paulo, SP
Brazil

Dr. Mukesh HAIKERWAL

WMA Chairperson of the Finance
and Planning Committee
58 Victoria Street
Williamstown, VIC 3016
Australia

Dr. Guy DUMONT

WMA Chairperson of the Associate
Members
14 rue des Tiennes
1380 Lasne
Belgium

Dr. Karsten VILMAR

WMA Treasurer Emeritus
Schubertstr. 58
28209 Bremen
Germany

Dr. Otmar KLOIBER

WMA Secretary General
13 chemin du Levant
France 01212 Ferney-Voltaire
France

www.wma.net

Official Journal of The World Medical Association

Editor in Chief

Dr. Pēteris Apinis
Latvian Medical Association
Skolas iela 3, Riga, Latvia
Phone +371 67 220 661
peteris@nma.lv
editorin-chief@wma.net

Co-Editor

Dr. Alan J. Rowe
Haughley Grange, Stowmarket
Suffolk IP143QT, UK

Co-Editor

Prof. Dr. med. Elmar Doppelfeld
Deutscher Ärzte-Verlag
Dieselstr. 2, D-50859 Köln, Germany

Assistant Editor Velta Pozņaka

wmj-editor@wma.net

Journal design and

cover design by Jānis Pavlovskis

Layout and Artwork

The Latvian Medical Publisher
"Medicīnas apgāds", President Dr. Maija Šetlere,
Katrīnas iela 2, Riga, Latvia

Cover painting :

Mural painting in the Cultural Administration
Complex of the University Campus, Caracas,
Venezuela. Painter: Narváez Francisco.
Photographer: Eliseo Sierra.
Date of photograph 2009.

Publisher

The World Medical Association, Inc. BP 63
01212 Ferney-Voltaire Cedex, France

Publishing House

Deutscher-Ärzte Verlag GmbH,
Dieselstr. 2, P.O.Box 40 02 65
50832 Köln/Germany
Phone (0 22 34) 70 11-0
Fax (0 22 34) 70 11-2 55

Business Managers J. Führer, D. Weber

50859 Köln, Dieselstr. 2, Germany
IBAN: DE83370100500019250506

BIC: PBNKDEFF

Bank: Deutsche Apotheker- und Ärztebank,

IBAN: DE28300606010101107410

BIC: DAAEDED

50670 Köln, No. 01 011 07410

At present rate-card No. 3 a is valid

The magazine is published quarterly.

Subscriptions will be accepted by
Deutscher Ärzte-Verlag or
the World Medical Association

Subscription fee € 22,80 per annum (inkl. 7%
MwSt.). For members of the World Medical
Association and for Associate members the
subscription fee is settled by the membership
or associate payment. Details of Associate
Membership may be found at the World
Medical Association website www.wma.net

Printed by

Deutscher Ärzte-Verlag

Köln, Germany

ISSN: 0049-8122



Opinions expressed in this journal – especially those in authored contributions – do not necessarily reflect WMA policy or positions

Editorial

Healthcare and the Economic Crisis

Eastern European countries, especially those that were formerly parts of the Soviet Union, are in the midst of a serious economic crisis. The countries most significantly affected are Lithuania, Latvia, Romania, Bulgaria and Hungary (members of the European Union), as well as Ukraine, Moldavia and Azerbaijan. In these countries the gross national product has fallen from 10% to 25%, the national debt has increased dramatically, the unemployment rate has reached up to 20%, wages have decreased, the budget for health care and welfare have been cut, and money for heating and even subsistence is lacking in some areas.

An economic crisis somewhere in the world is nothing new. In the early 1990s the economies of Eastern Europe overall dropped 32% to 75% of their previous level and medical facilities were faced not only with insufficient funds, but also with a lack of medicines and bandages, while also working in out-dated facilities and with imprecise laboratories. In the 1990s, during the military crisis in Yugoslavia and the Nagorno-Karabakh conflict, the countries involved did not expend any money at all for the health care of its civilians. At the turn of the century the economies of the "Southeast Asian tiger" countries fell by more than 25%, and the health care expenditures of Thailand, Laos and Vietnam were significantly reduced. But, the situation that is most analogous to the current crisis in Eastern Europe occurred in Argentina and other South American countries, whose economies collapsed at the beginning of this decade. It is interesting that almost all these countries that were faced with economic recession and decline in health expenditures have reacted to the crisis with political sensitivity.

To avoid risk of offending colleagues in other countries, I will confine my comments to the situation in Latvia, though I am familiar the way the crisis was handled in Lithuania, Ukraine and Byelorussia. There is a great deal of interest in crises, and how they affect medical care. Conferences have been held to search for solutions on how to prevent economic crises from disrupting health care. For example, the conference "Health in the times of global economic crisis: implications for the WHO European Region" that was held in Oslo, Norway from April 1-2, 2009 came up with recommendations for European countries*. The fifth recommendation stated: "Protect cost-effective public health and primary healthcare services. If spending on health is reduced: a) protect spending on public health programmes; 2) protect spending on primary health care; 3) reduce spending on the least cost effective services. These will normally be found among the most high-technology, high-cost services in hospitals. 4) delay investment plans for high-cost facilities and promote the use of generic drugs.

Unfortunately, this resolution was not heard in Latvia. When health care financing was reduced, the first programmes to be cut were: 1) the Public Health Service which is the only authorized institution in Latvia responsible for disease prevention and prophylaxis. We are not an isolated country, and the potential spread of infectious disease could have an effect on others. 2) The expenditure for medical care in prisons was cut threefold - raising the prospect that our prisons could become a breeding ground for resistant tuberculosis in Europe. (3) Elective surgery, such as arthroplasty, cardiac valve replacement and cataract surgery was severely curtailed because of lack of funding, resulting in the departure of many physicians from the Baltic countries to work in Great Britain, Scandinavia, Canada and New Zealand where they can receive higher wages and better job security. In 1990s almost every hospital in Latvia acquired new technology, such as magnetic resonance imaging and digital angiography. It was easy to make the transition to modern medicine and to achieve a standard comparable to the rest of Europe - going backwards is not so easy. This year, when a true financial deficit hit: the health care budget was cut by 20% in the first half of the year and 40% in the second half. The State could no longer reimburse for expensive diagnostic methods and costly medications. It appears that it is not possible to turn back the clock: doctors would sooner go to work elsewhere than resume using cheap and ineffective treatment methods. The plunge in doctors' salaries has led to depression amongst physicians and their loss of faith in the future. In Europe, physicians have traditionally been respected citizens and role models. Seeing the doctors depressed spills over to the rest of the population.

It is not enough to look at the adverse effects of an economic crisis upon the health care of a nation. We must also look at the fundamental underlying causes of the problem. In Latvia, the money for health care is under the direct control of the politicians. The significance of politicians having direct control over health care expenditures cannot be ignored. If Latvia had introduced a self-governed and contribution-financed social insurance system, this health care disaster might not have happened! Furthermore, the functioning health care sector would be a stabilizing element for the economy instead of a drag on the economy. Unfortunately, in Latvia, health care has become the victim of bad politics.

Respected colleagues throughout the world! An economic downturn can hit any country. Latvia was not ready for these changes. We would like others to learn from our experiences so you do not repeat our mistakes. A WMA conference focusing on how to prevent, prepare for and deal with the health care problems that are associated with economic crises would be an excellent way to achieve this and could be organised in Latvia.

*Peteris Apinis, MD,
Editor in Chief, WMJ*

* "Recommendations of the meeting" available at
http://www.euro.who.int/document/HSM/Oslo_crisis_mtg_rec.pdf

WMA General Assembly, New Delhi 2009

More than 200 delegates from 46 National Medical Associations (NMAs) attended the annual General Assembly held at the LaLit Hotel, in New Delhi, India from 14-17 October 2009.

The four-day event, hosted with Bollywood flamboyance by the Indian Medical Association, was notable for the attendance of the President of India Madam Pratibha Patil, to officially open the Assembly, as well as the unopposed election in his own country of Dr. Ketan Desai, President of the Indian Medical Council, as President Elect of the WMA, and the adoption of no less than 16 new or revised policy statements on issues ranging from climate change and stem cell research, to professionally-led regulation and task shifting.

The ceremonial session of the Assembly was addressed by both the President of India and the Health Minister Mr. Ghulam Nabi Azad. In her welcome address the President Madam Pratibha Patil called on the medical community to work for the ideal of medical care for all.

She said: "The question of equitable medical care to all people is a big human and ethical question. In India, we are conscious of this and through policies and programmes, efforts are underway to reach populations including those in rural areas that face the highest degree of deprivation in terms of health facilities. All governments have responsibilities to take action, but global institutions also have a crucial role. The World Health Organization and other international organizations like yours are major stakeholders in this endeavour. I would call on all of you present here today, to contribute, to further the cause of medical care for all."

Union Health Minister, the Honourable Shri Gulam Nabi Azad, told the Assembly

about the proposed new alternative model for medical education in his country, aimed primarily at rural health manpower. He pointed out that because of the concentration of health care professionals in urban and semi-urban areas there was a huge gap in availability of manpower at the grassroots level.

Dr. Yoram Blachar, in his valedictory address as outgoing President of the WMA, said that Association statements carried great weight in most national and international discussions on health. In recent years the WMA had taken more active roles in promoting health care and had initiated or taken part in a number of projects in the areas of public health, such as an internet course on TB and the project of talking books which enabled information to be brought to parts of the world where there was illiteracy.

The WMA also had an important role in advocacy as the voice of the profession representing millions of doctors around the world. The partnerships and alliances of the Association were vital to its success. Through its relationships the WMA promoted and defended the basic rights of patients and physicians, helped physicians to continuously improve their knowledge and skills, developed public health policy and projects such as tobacco control and immunisation, assisted with human resource planning for health care services and encouraged democracy building for new medical associations, especially in new or developing democracies.

The installation then took place of the new WMA President for 2009-2010, Dr. Dana Hanson, former President of the Canadian Medical Association. In his inaugural speech he criticised Governments of the world for paying too little attention to the effects of



President of India Madam Pratibha Patil

climate change on population health and its huge impact on health services.

"We know that the climate affects local and national food supplies, air and water quality, weather, economics and many other critical health determinants. Climate change represents an inevitable, massive threat to global health that will likely eclipse the major known pandemics as the leading cause of death and disease in the 21st century. Yet why do we hear so little or no discussion by our governments of the effects of climate change on population health and its huge impact on health services?"

Dr. Hanson, a dermatologist from Fredericton, New Brunswick, said he hoped the WMA would be granted observer status in Copenhagen in December when 192 United Nations member states will meet to create a plan of action around the UN Framework Convention on Climate Change.

"There is no other organisation that can bring the message of human health protection and preservation – untainted by national political and economic agendas – to the climate change debates. There is no oth-



Dr. Yoram Blachar

er organisation whose members view each and every citizen as a cherished patient to whom we owe a professional duty and feel a personal commitment.”

Dr. Hanson said that traditionally the WMA's work had focused almost exclusively on the development of its body of policy, as it sought to promote the highest standards of medical ethics, professional responsibility and patient care.

“These standards reflect the cumulative, global experience and understanding of the world's physicians and constitute a rich collection of resources for which the WMA is known among physicians and many of our allied organizations. Some of our policies, such as the Declaration of Helsinki and the Declaration of Tokyo, among others, are known far beyond WMA and our close friends and, indeed, are recognised globally as the gold standard of policy on their respective subjects.”



Dr. Ketan D. Desai

He added: “I believe that our work is relevant - indeed vital – far beyond our own membership and our historic allies and partners and it is time to elevate advocacy to a higher priority for the WMA. With the growth of our membership, the addition of project work to our portfolio, and our professionalised staff structure, the WMA is now positioned to add a stronger, more dynamic advocacy dimension to our work. Ours is a unique advocacy voice in the world today – that of the world's physicians – and it is by activating this voice to its fullest capacity that we will ensure WMA's vision and policies are truly promoted worldwide and that our expertise and experience can be effectively accessed by those whose interests intersect with our own.”

Finally Dr. Hanson spoke of physicians' own well being. “At the same time that we advocate for the health, safety and well-being of our patients, we must also channel our advocacy efforts in support of these qualities for ourselves and our colleagues all over the world. Poor and dangerous working environments, inadequate pay and overwork, institutional and even physical violence are experienced by far too many physicians. And while many persevere, continuing their dedicated service to patients and their communities despite these conditions, many others move on in search of better circumstances – sometimes even leaving medicine entirely for other professions.”

“I think this is a vital component of our ongoing work on health and human resources. It is a subject that is often marginalised in the international medical workforce discussion, but we at the WMA know that it has a profound effect on physicians, patients and entire health systems. The importance of advocacy by the profession for our fellow doctors in this context cannot be overstated and the WMA must and will continue to shine a light on this endemic problem.”

At the plenary session of the Assembly Dr. Ketan Desai was elected unopposed as



Dr. Dana Hanson

President Elect of the WMA. Dr. Desai, President of the Medical Council of India and former National President of the Indian Medical Association, will take up his post at the General Assembly meeting in Vancouver, Canada in October 2010.

The Assembly, under the chairmanship of Dr. Edward Hill, adopted several new and revised policies, many of them the result of the Association's ongoing revision of policies.

Climate Change

A new Declaration was adopted – entitled the Declaration of India – setting out measures to bring health to the forefront of the climate change debate and to mitigate the serious health risks facing the world (*see full text p. 137*). Dr. Ruth Collins-Nakai, from the Canadian Medical Association, who chaired the WMA's climate change working party, said: “We should recognise that most initiatives, which improve the impact of climate change, also improve individual and population health – that what is good for the environment is also good for health.”

Following the meeting an advocacy kit was circulated to NMAs, including a factsheet



on the impact of climate change on health and a model letter to send to health ministers and to the UNFCCC national contact.

Professionally-led Regulation

A rewritten Declaration of Madrid on Professionally-led Regulation was adopted (*see full text p. 140*). The Declaration, a revision of the 2005 Declaration on Professional Autonomy and Self Regulation, resulted from a White paper on Professionalism and the Medical Association, written by Dr. Jeff Blackmer from the Canadian Medical Association.

Child Health

The 1998 Declaration of Ottawa on Child Health was revised and adopted to include new broader guidelines on improving the health of the world's children (*see full text p. 140*). Dr. Ruth Collins-Nakai, who chaired the WMA working group on child health, said: "The world's children are worse off today than they were two decades ago and it is important that in proposing this broader policy we make physicians aware of just how tenuous the status of children is in the world."

Task Shifting

A new Resolution on Task Shifting was adopted, expressing a series of concerns about the global development of task shifting (*see full text p. 141*).

The Resolution prompted lengthy debates both in Council and Assembly following criticism from several delegates that its tone was too negative. However, others argued that this was a document relating to physicians and it was important that it was published. A call to refer back the document was defeated.

Iran

In an Emergency Resolution, National Medical Associations were urged to speak out in support of the rights of patients and physicians in Iran (*see full text p. 143*). This followed a report from the German Medical Association. Dr. Frank Montgomery, from the German Medical Association, said: "Physicians serve people not governments. They must be able to fulfil their duties without government harassment. Physicians will not participate in torture or degrading treatment. They are the "whistleblowers" of such criminal acts committed by governments. I call upon the Iranian Government to reaffirm the position that independent, free medicine is a cornerstone of democracy."

Medical Workforce

The Assembly agreed to amend the 1998 Resolution on the Medical Workforce (*see full text p. 144*).

Inequalities in Health

A Statement was adopted calling on NMAs to influence national policy to reduce health inequalities, advocate for the abolishment of financial barriers to obtaining needed medical care, and to advocate for equal access for all to health care services irrespective of both geographic and economic differences (*see full text p. 145*).

Improved Investment in Public Health

With many countries planning to cut their health budgets as a result of the economic recession, the Assembly revised its Reso-

lution on Improved Investment in Public Health (*see full text p. 146*).

Conflict of Interest and Commercial Enterprises

A Statement on Conflict of Interest was adopted, the first time the WMA has issued guidelines on physicians' behaviour on issues of conflict of interest. The guidelines identify areas where a conflict of interest might occur during a physician's day-to-day practice of medicine, and seek to assist physicians in resolving such conflicts in the best interests of their patients.

The Association's Statement Concerning the Relationship between Physicians and Commercial Enterprises was also revised with advice to physicians on receiving sponsorship or gifts when attending conferences or conducting research and on their affiliations with commercial entities.

Stem cell research

A Statement was adopted expressing support for stem cell research being carried out with appropriate regulation to prevent unacceptable practices. The Statement, initially prepared by the Icelandic Medical Association, declared that regulation according to established ethical principles was likely to alleviate public concerns, especially if associated with careful policing. Whenever possible, research should be carried out using stem cells that were not of embryonic origin. However there would be circumstances where only embryonic stem cells would be suitable for the research model. Research on stem cells, regardless of their origin, must be carried out according to agreed ethical principles.

Dr. Vivienne Nathanson, from the British Medical Association, who chaired the WMA's stem cell working party, said: "This is cutting edge science and may lead to the development of new treatments for chronic illnesses such as diabetes and Parkinson's,



which would enormously lessen human suffering. We must make sure that good, ethical research goes ahead, and see if we can reap the benefits of this exciting science.”

Telehealth

New guiding principles for the use of telehealth for the provision of health care were adopted. Among the areas covered by the Statement were legal responsibilities, communication with patients, standards of practice and quality of clinical care, quality indicators, patient confidentiality and consent.

Nicaragua

An Emergency Resolution called on the Nicaraguan government to repeal legislation criminalising abortion. It said the legislation was having a negative impact on the health of women in Nicaragua and could result in preventable deaths of women and the embryo or foetus. The legislation also placed physicians at risk of imprisonment if they broke this law and at risk of suspension from medical practice if they failed to follow government protocols, which sometimes required treatment of a pregnant woman contrary to the legislation.

The 1997 Declaration on Guidelines for Continuous Quality Improvement in Health Care was revised as part of the WMA's review of policy documents and

amendments were also made to the 1999 Statement on Patenting of Medical Procedures, which was renamed the Statement on Medical Process Patents, and to the 2005 Statement on Genetics and Medicine.

Human Rights

Ms. Clarisse Delorme, the WMA's advocacy advisor, and Dr. Herman Reyes, from the International Committee for the Red Cross, gave a presentation to the Assembly about the role of physicians in the prevention of torture and ill treatment in places of detention. They spoke about the Optional Protocol to the UN Convention against Torture and how national medical associations had an important role in monitoring the National Prevention Mechanisms where they had been set up in their countries.

Dr. Otmar Kloiber, secretary general of the WMA, said this was not a problem for other countries. It was a problem for all countries.

Associates

The Associate Members meeting debated a report from Dr. Masami Ishii, Chair of the Work Group on Reform of Associate Membership. It was agreed that proposals for increasing the merits of membership should be circulated for further discussion.

New Member

The Assembly approved an application for membership from the Society of Medical Doctors in Malawi.

Other Business

The Assembly adopted the audited Financial Statement for the year ended December 2008 and adopted the Budget for 2010.

Open Session

During the “open session”, giving delegates an opportunity to present any profession-specific problem, policy or project they believed the WMA should know about, the meeting heard from several NMA representatives.

Dr. Cecil Wilson, from the American Medical Association, reported on the controversy surrounding America's health care reform proposals. He said the AMA was proud of the health care that was provided to the citizens of the US and proud of the country's dedicated physicians. The problem was that that health care was not universal. Some 46 million Americans or 16 per cent of the population did not have health insurance. The AMA was committed to health care reform and was working very closely with President Obama and with Members of Congress on proposals for reform, but it was not an easy task. He added that the AMA shared the concern about the vitriolic tone of the debate and had called for calm.

Scientific session

The theme of the scientific session was “Multi-Drug Resistant Tuberculosis and Lessons Learned from this Epidemic.” Experts from across the world spoke about guidelines for treatment and infection control, with a particular emphasis on the experience in India.



At the same time, the WMA launched a new online refresher course for physicians, providing basic clinical care information for TB including the latest diagnostics, treatment and information about multidrug-resistant TB. The new course was written for the WMA by the New Jersey Medical School Global Tuberculosis Institute, USA. It incorporates key strategies of internationally accepted strategies for management and control of TB, will link to the WMA's MDR-TB course which has been running for the past two years.

Dr. Julia Seyer, medical adviser at the WMA, said: "When we started an online multidrug-resistant tuberculosis (MDR-TB) training course in 2006, we discovered that many physicians were missing the most basic knowledge about normal TB. With the disappearance of the disease from large parts of the world, many physicians from the developed world had never even seen a case of TB and had no basic training in diagnosing and treating what is a preventable disease. Now that TB has re-emerged as a serious global disease, it is vital that physicians around the world regain the basic knowledge they once had. The course will be useful in developing countries, where the majority of TB cases are, and will serve as a refresher of what physicians may have learned some time ago."

The course is free of charge and can be used by physicians in private practice, as well as in the public. Physicians will be able to

receive credits for completing the course as part of their continuing medical education programme. Although the course is available only in English at the moment, it will be translated into Spanish, French, Russian and Chinese. The new course is being financed by an unrestricted educational grant by the Lilly MDR-TB Partnership, which comprises several other organisations working together to improve tuberculosis control worldwide.

Secretary General's Report

Dr. Otmar Kloiber reported on significant activities and developments during the year.

A **train-the-trainer course in MDR-TB** had been developed to create champions in the field of TB on a local level. Physicians who were experts in TB received training in adult learning and accelerated learning principles in order to better teach their colleagues. The first of a series of workshops took place in Pretoria, South Africa in November 2008 in co-operation with the Foundation of Professional Development. A further workshop was due to take place in New Delhi before the Assembly together with the Indian Medical Association.

The WHO was in the process of developing a **policy on ethics in the TB setting**, with a goal for its adoption at the World Health Assembly in 2010. The WMA was invited to address the issues related to health professionals in the policy.

Given the already critical shortage of health providers and generally weak health systems in the regions most affected by XDR-TB and MDR-TB, anxiety about safety in the health care environment ran high and could dissuade health providers from accepting assignments in these settings. A set of **inter-professional workshops on health care worker safety in the context of drug resistant TB** in low and middle-income countries addressed TB infection protection with the objective of identifying good

practices, implementing joint recommendations for facilities and health workers and establishing a working group with a plan of action to communicate the identified practices and recommendations. The WMA, in collaboration with the South African Medical Association and the ICN, IHF and ICRC, organised the first workshop in Cape Town South Africa in November 2007. The second one took place together with the Brazilian Medical Association in Rio De Janeiro, Brazil in March 2009, and the third one was in Durban, South Africa in June 2009.

The WMA joined the implementation process of the **WHO Framework Convention on Tobacco Control (FCTC)** <http://www.who.int/tobacco/framework/en/>, the international treaty that condemned tobacco as an addictive substance, imposed bans on advertising and promotion of tobacco, and reaffirmed the right of all people to the highest standard of health. The first international treaty negotiated under the auspices of the WHO, the FCTC entered into force in 2005 and was the most widely embraced treaty in UN history, with 168 signatories and 154 ratifications to date.

WHO FCTC held its **Third Conference of the Parties COP3** in Durban from in November 2008 to discuss articles of the treaty and receive reports of the working groups created for specific articles. The WMA was a member of the working groups on Article 12 - Education, Communication, Training and Public Awareness and Article 14: Measures Concerning Tobacco Dependence and Cessation.

The WMA continued its close involvement in the **Positive Practice Environment Campaign (PPE)**. This global five-year campaign - spearheaded by WHPA members together with the World Confederation for Physical Therapy and the International Hospital Federation - aimed to ensure high-quality healthcare workplaces worldwide. The appointment last March of



"Speaking book" opening

a full-time coordinator, in charge of running the campaign on behalf of the organisation members, allowed the PPE to kick off in three selected countries: Uganda, Morocco and Zambia. Taiwan would also be involved in the PPE as a self-funded country. With the support of the PPE coordinator, health professionals' organisations from the selected countries were in the process of setting up national structures (national coordinator and steering committee) for the running of the campaign.

At the invitation of the Iceland Medical Association and WMA Past president, Dr. Jon Snaedal, the World Medical Association convened a **Seminar on Human Resources for Health and the Future of Health Care** from in March, 2009. The seminar was an effort to bring together stakeholders from a range of health professions to focus on these issues and help WMA define some policy priorities in its approach to the subject. The final report of the event included ideas to facilitate WMA policy development in this area. The WMA Advocacy Working Group was considering these proposals and exploring follow-up opportunities, such as mapping relevant work and research undertaken on task shifting.

In early March, the WMA was invited to take part in the planning process of the next **Conference on Workplace Violence in the Health Sector**, scheduled to take

place from 27-29 October 2010 in Amsterdam. The event is supported by the Global Health Workforce Alliance (GHWA), WHO, International Labour Organisation (ILO), the International Council of Nurses (ICN), Public Services International (PSI) and other relevant health organisations.

The WHO was developing **guidelines on retention strategies for health professionals in rural areas**, which should be adopted at the World Health Assembly 2010. The objective was to ensure access to health care for people living in rural areas, thus improving the health outcomes, including those outlined in the Millennium Development Goals (MDGs). The guidelines would be based on three pillars: educational and regulatory incentives, monetary incentives and management, environment and social support. The WMA, as the secretariat of the World Health Professions Alliance, was a member of the core expert group developing the guidelines.

WMA staff, Dr. Julia Seyer, as secretariat of the WHPA, had been invited to join an independent merit review panel organised by the **Global Health Research Initiative**. The panel would review research proposals submitted in response to a competition launched in January 2009 by the "**Africa Health Systems Initiative Support to African Research Partnerships**" program (AHSI-RES). AHSI-RES was a 5-year

research program (2008-2013) that formed one component of the Africa Health System Initiative (AHSI) supported by the Canadian International Development Agency (CIDA). AHSI was a 10-year initiative focused on strengthening national-level health strategies and architecture, ensuring appropriate human resources for health, strengthening front-line service delivery, and building stronger health information systems - all with special attention to equity considerations.

The WMA participated as a member of the steering group in the **Mobility of Health Professionals research project**. The objective of the project was to assess the current trends of mobility of health professionals to, from, and within the European Union, including their reasons for moving. Research would also be conducted in non-European sending and receiving countries, although the focus lay on the EU.

In January 2011 the Global Health Workforce Alliance is organising the **2nd Global Forum on Human Resources in Health (HRH)** in Thailand. The WMA is part of the thematic focus committee for this event. In a first meeting, two main themes is proposed: improving quantity and quality of health workforce for equitable access to primary health care within a robust health system and financing HRH in the light of the global financial crisis.

Counterfeit medicines were drugs manufactured below established standards of safety, quality and efficacy and therefore risked causing ill health and killing thousands of people every year. Experts estimated that 10 per cent of medicines around the world could be counterfeit. The phenomenon had grown in recent years due to increasing sophistication of counterfeiting methods and the increasing amount of merchandise crossing borders. At the last Executive Board Meeting of the WHO in January 2009, the report and draft resolution on counterfeit medical products were



discussed and all member states stressed the importance of protecting public health against risks caused by counterfeit medications. An intense debate took place on the definition of counterfeits versus substandard medicines. So far WHO has focused on counterfeits while largely ignoring the broader - and more politically sensitive - category of substandard drugs.

The **World Health Report from 2008 "Primary Health Care – Now More Than Ever"** - critically assessed the way that health care was organised, financed, and delivered in rich and poor countries around the world. The WHO report documented the failures and shortcomings over the last decades that had left the health status of different populations, both within and among countries, dangerously out of balance. The report urged the importance of an holistic health care approach where primary health care played an important role as a facilitator between prevention, secondary and tertiary care. The report focused health care systems on four pillars: universal coverage, people-centred health care, leadership reform to make health authorities more accountable and to promote and protect public health in general.

The **Executive Board of the WHO** in January 2009 discussed a **draft resolution on primary health care, including health care system strengthening**. On behalf of the World Health Professions Alliance, the WMA made a public statement during the Executive Board session. Further debate took place during the World Health Assembly in May 2009. The WHO invited

the WMA to take part in a global consultation on the **contribution of health professions to primary health care** and the global health agenda in June 2009. As one of the outcomes the WHO was developing implementation guidelines to support governments in setting up primary health care teams in a holistic health care system, which would be sent out soon for comments. The WHO saw physicians as a strong pillar in this approach and was pleased to work closely with WMA.

In May 2008, the World Health Assembly adopted a resolution requiring the WHO to intensify its work to curb the harmful use of **alcohol**. Members States called on the WHO to develop a **global strategy** for this purpose. The resolution also requested the WHO Director-General to consult with intergovernmental organisations, health professionals, nongovernmental organisations, and economic operators regarding ways in which they could contribute to reducing the harmful use of alcohol. In line with the **WMA Statement on Reducing the Global Impact of Alcohol on Health and Society**, the WMA secretariat monitored the drafting process of the WHO strategy, informed WMA members on a regular basis of relevant developments in this area and had developed contacts with relevant WHO officials and civil society organisations to collaborate in the process.

In October 2008, the WMA Advocacy Advisor, Ms. Clarisse Delorme, moderated an **NGO briefing on reducing the global harm caused by alcohol**, organised by GAPA (Global Alcohol Policy Alliance). The objectives of the briefing were to understand the WHO process related to the strategy, to begin discussions on substantive and political proposals to promote an effective, evidence-based global strategy, and, finally, to develop further working relations between civil society actors involved in this area.

In November 2008, Dr. Kloiber, and Ms. Delorme, participated in the **WHO roundtable meeting with representatives of NGOs and health professionals on ways they could contribute to reducing harmful use of alcohol**. This was an opportunity to raise, amongst others issues, the WMA's desire that medical associations and individual physicians be fully involved in the WHO strategy on alcohol.

The World Medical Association had developed, together with the Geneva Social Observatory, a **Workplace Strategy on Diabetes and Wellness**. This was a guideline for employers and employees to educate and raise awareness about diabetes, and provide examples of healthier lifestyles during work. The aim was to mitigate the ill effects of diabetes on personal health, workplace productivity, and health care costs.

The **WMA Workgroup on Health and the Environment**, chaired by the Canadian Medical Association, was established in the summer of 2008. For 2009, the workgroup agreed to focus its attention on health and climate change, in view of the global United Nations conference on this topic in Copenhagen in December 2009. In 2010, the workgroup would focus on environmental degradation and the built environment.

Following the adoption by the 2008 General Assembly of the WMA Statement on Reducing the Global Burden of Mercury, the WMA joined the **UNEP Global Mercury Partnership** to contribute to the partnership goal to protect human health and the global environment from the release of mercury and its compounds.

During the reporting period, the WMA secretariat launched several lobbying actions, based on information from Amnesty international, to support **physicians in distress** worldwide:

- Two Egyptian doctors, Raouf Amin al-Arabi and Shawqi Abd Rabbuh, were sentenced to 15 and 20 years in prison



and 1500 and 1700 lashes respectively in Saudi Arabia for having facilitated the addiction of a patient to morphine after prescribing the medicine for her pain relief following an accident (December 2008). The WMA sent letters calling on the authorities of Saudi Arabia to review the case or send it for retrial and to ensure that any such procedures were undertaken in accordance with international fair trial standards.

- Dr. Arash Alaei and Kamiar Alaei (Republic of Iran) were sentenced to six and three years of imprisonment respectively for “co-operating with an enemy government”, specifically with US institutions in the field of HIV & AIDS prevention and treatment (January 2009). In letters to the Iranian authorities, the WMA expressed its serious concerns on the proceedings falling far short of international standards for fair trial and asked for the immediate release of the two physicians, as their imprisonment appeared to be politically motivated.
- Three government employed doctors, Dr. T. Sathiyamoorthy, Dr. T. Varatharajah and Dr. Shanmugarajah, who had been working in the conflict zone in northeastern Sri Lanka until 15 May 2009, were held under emergency regulations by the Sri Lankan government for providing “false information” to foreign journalists. At the end of May, the WMA sent letters urging the Sri Lankan authorities to give to the three doctors immediate and unrestricted access to lawyers of their choice and that they be promptly brought before an independent court. Access to medical

treatment and permission for family visits were also required. They were released on the 24 August 2009, but with restricted liberty, required to report regularly to the authorities. Amnesty International continued to have serious concerns, given the unclear process for their bail and possible ongoing trial. The WMA Secretariat was in regular contact with Amnesty and was ready to take further actions, if appropriate.

The WMA also intervened on behalf of Majid Movahedi who was sentenced last March in Iran to be blinded in both eyes with acid – a process that would involve medical professionals. Recalling its firm opposition to punishments that constitute cruel, inhuman and degrading treatment amounting to torture, WMA emphasised in letters to Iran authorities that, according to international medical standards, it was unacceptable to involve physicians in this inhuman and degrading treatment.

The WMA was actively involved in developing the “**Right to Health as a Bridge to Peace in the Middle East**” joint seminar, which was due to take place in October 2009 in Turkey. The seminar was being organised by the International Federation of Health and Human Rights Organisations (IFHHRO), the Norwegian Medical Association (NMA), the Human Rights Foundation of Turkey (HRFT), the Turkish Medical Association (TMA) and the WMA. The objectives of the meeting are to discuss what role the medical profession can play in securing equal access to health care for the population and to facilitate the communication among health professionals in the participating nations.

The WMA maintained regular contact with Anand Grover, the **UN Special Rapporteur on Health** in order to increase the role of health professionals in the promotion of the human rights to the highest attainable standard of health.

In August 2008, Clarisse Delorme, WMA advocacy advisor, was elected as independent expert on the **Council of the International Rehabilitation Council for Torture Victims (IRCT)** 2009-2012.

In September 2009, the WMA secretariat together with the Danish Medical Association contacted the Danish permanent Representative in Geneva to discuss potential follow-up from the **resolution on the Role and Responsibility of Medical and other Health Personnel in Relation to Torture**, adopted by the Human Rights Council last March at its 10th session. Based on their concerns that the resolution adopted did not include references to WMA core policies in this area, nor did it highlight the positive role of physicians and other health personnel in preventing and condemning torture and other inhuman treatments, the WMA and DMA suggested that the Permanent Representative work with the Danish government on a further resolution highlighting the positive role of physicians and other health personnel in preventing and condemning torture and other inhuman treatments.

In August 2008, the Commission on Social Determinants of Health published its final report “Closing the Gap in a Generation – Health Equity through Action on the Social Determinants of Health”. In this 200-page report, the Commission addressed global health through social determinants, i.e., the structural determinants and conditions of daily life responsible for a major part of health inequities among and within countries, and proposes a new global agenda for health equity.

On the occasion of the 124th session of **WHO Executive Board (January 2009)**, the WMA – on behalf of the World Health Professions Alliance (WHPA) – presented a statement on this report, with a focus on the health workforce. In this statement, the WHPA welcomed the recommendation directed at national governments and do-



nors to “increase investment in medical and health personnel”, but regretted that the report in general does not give more attention to health professionals as key players in addressing the social determinants of health and to the inequalities health professionals face in their daily work.

Clinical research involving human subjects had proliferated in developing countries in the recent past, increasing concerns about ethical and legal implications of misconduct and violations of subjects’ human rights and welfare due to inadequate scientific and ethical review of protocols or as a result of poor or absent drug regulatory systems. The WMA was invited to the international Round Table - **Biomedical Research in Developing Countries: the Promotion of Ethics, Human Rights and Justice** - to compare and exchange expertise and experiences between national and international institutions, on the issue of protection of human participants in biomedical research. Participants stressed the importance of building capacity in biomedical ethics reviews in developing countries by supporting education and training curricula of health professionals and community health workers, in order to facilitate the creation of institutional Research Ethics Committees.

The **Caring Physicians of the World (CPW) Initiative (Leadership Course)** began with the Caring Physicians of the World book, published in October 2005 in English and in Spanish in March 2007. Regional conferences were held in Latin America, Asia-Pacific and Africa regions.

The CPW Project was extended to include a leadership course organised by the INSEAD Business School in Fontainebleau, France, in December 2007, in which 32 medical leaders from a wide range of countries participated. The second Leadership Course was held at the same place in December 2008 for one-week with 30 participants, with continued successful results and positive feedback. The third Leadership Course at the INSEAD Business School would be held in Singapore, 8-13 February 2010. The curriculum included training in decision-making, policy work, negotiating and coalition building, intercultural relations and media relations. The courses were made possible by an unrestricted education-grant provided by Pfizer, Inc.

The **World Health Professions Alliance** was now a decade old. The context within which it was working had evolved with its continued development, and so had the organisations that made up the alliance. The WHPA had revised its strategy and priorities for the next few years and would focus mainly on human resources in health, patient safety, public health, counterfeit medical products and human rights in health.

The **World Federation for Medical Education (WFME)** brought together medical faculties and the profession. During recent years it had focused on describing global standards for basic and post-graduate education of physicians, as well as for Continuing Professional Development. The WMA General Assembly, Tokyo 2004 endorsed these standards.

Currently, the WFME worked on encouraging and supporting countries and medical schools to further develop, or to improve, their accreditation. Although not itself an accrediting body, the WFME - together with WHO - strongly supported the use of accreditation as a method of documenting and improving the quality of education and achieving comparability in the international arena.

Based on a mutual agreement with the WHO, the WFME together with the University of Copenhagen (which hosted the WFME office), had taken over from WHO Headquarter the register of institutions for higher education in health care. The WFME now developed this register in an online database called Avicenna Directories, which would not only list the institutions as named by their governments, but also provide information about their accreditation status and the accrediting body.

In January 2009, the WMA signed a contract with DGN Services to develop and install a **new web portal for the WMA**. The new web portal, launched in October 2009, would provide the platform for co-operation with the members of WMA, allow online payments for meetings, books and associate membership dues, and, most of all, it would facilitate more timely presentation of content on the public website.

Speaking book on clinical trials

One of the fringe events of the Assembly was an evening presentation of an Indian perspective of the WMA’s Speaking Book on Clinical Trials, aimed at patients and their relatives who do not read and write sufficiently well to understand what a clinical trial is for and how it works. Representatives from the WMA, the Indian Medical Association, the Indian Council of Medical Research and Pfizer, spoke about the launch of the English-Hindi books and Ms. Zane Wilson, from Books of Hope and the South African Depression and Anxiety Group, spoke movingly about the developments of the project.

*WMA Public Relations Consultant
Mr. Nigel Duncan*

Declaration of Delhi on Health and Climate Change

*Adopted by the WMA General Assembly,
New Delhi, India, October 2009*

PREAMBLE

The purpose of this document is to provide a response by the WMA on behalf of its members to the challenges imposed on health and healthcare systems by climate change.

Although governments and international organizations have the main responsibility for creating regulations and legislation to mitigate the effects of climate change and to help their populations adapt to it, the World Medical Association, on behalf of its national medical association members and their physician members, feels an obligation to highlight the health consequences of climate change and to suggest solutions. The 4th Assessment Report of the International Panel on Climate Change (IPCC) contains a full chapter on human health impacts (AR4 Chapter 8 Human Health^{*}), including a range of possibilities regarding the potential effects of climate change. The following introduction includes the most likely effects of climate change from the IPCC report.

INTRODUCTION

The response of world leaders to the impact that humans are having on climate and the environment will permanently alter the livability of this planet.

1. The UN International Panel on Climate Change (IPCC) states "Even the minimum predicted shifts in climate for the 21st century are likely to be significant and disruptive".^{**}

1.1 The minimum warming forecast for the next 100 years is more than twice the 0.6° C increase that has occurred since 1900.

1.2 Extra-tropical storm tracks are projected to move toward the poles, with consequent changes in wind, precipitation, and temperature patterns.

1.3 Sea levels have already risen by 10 to 20 cm over pre-industrial averages, and will continue to rise due to the time scales associated with climate processes and feedbacks.

* Confalonieri, U., B. Menne, R. Akhtar, K.L. Ebi, M. Hauengue, R.S. Kovats, B. Revich and A. Woodward, 2007: Human health. Climate Change 2007: Impacts, Adaptation and Vulnerability. Contribution of Working Group II to the Fourth Assessment Report of the Intergovernmental Panel on Climate Change, M.L. Parry, O.F. Canziani, J.P. Palutikof, P.J. van der Linden and C.E. Hanson, Eds., Cambridge University Press, Cambridge, UK, 391-431.

** United Nations Framework Convention on Climate Change. <http://unfccc.int/2860.php> downloaded 1 September 2008

1.4 Projections point to continued snow cover contraction, and widespread increases in thaw depth over most permafrost regions, now including Antarctica.

1.5 A future of more severe storms and floods along the world's increasingly crowded coastlines is likely.

1.6 Increases in the amounts of precipitation in high latitudes and precipitation decreases in most sub-tropical land regions are predicted.

1.7 Regional / local effects may differ but a reduction in potential crop yields is expected in most tropical / sub-tropical regions – causing further disruptions in global food supply.

1.8 Salt-water intrusion from rising sea levels will reduce the quality and quantity of freshwater supplies, and seawater will become more acidic from dissolved CO₂.

1.9 As many as 25% of mammals and 12% of birds may become extinct within the next few decades. Warmer conditions are altering the ecosystem and human development is blocking threatened species from migrating.

1.10 Higher temperatures will expand the range of some vector-borne diseases, such as malaria, which already kills 1 million people annually, mostly children.

2. The IPCC authors begin with a review of the evidence and provide the following information (confidence levels as determined by IPCC in brackets):

2.1 Climate change currently contributes to the global burden of disease and premature deaths (very high confidence). At this early stage the effects are small but are projected to progressively increase in all countries and regions.

2.2 Emerging evidence of climate change effects on human health shows that climate change has (confidence levels in brackets):

2.2.1 Altered the distribution of some infectious disease vectors (medium);

2.2.2 Altered the seasonal distribution of some allergenic pollen species (high);

2.2.3 Increased heat wave related deaths (medium).

3. In their thorough review, the IPCC authors' project climate change related human health impacts as follows (confidence levels in brackets):

3.1 Increased malnutrition and consequent disorders, including those relating to child growth and development (high).

3.2 Increased numbers of people suffering from death, disease and injury from heat waves, floods, storms, fires and droughts (high).

3.3 Continued change in the range of some infectious disease vectors (high).

3.4 Mixed effects on malaria; in some places the geographical range will contract, elsewhere the geographical range will expand and the transmission season may be changed (very high).

- 3.5 Increased burden of diarrheal diseases (medium).
- 3.6 Increased cardio-respiratory morbidity and mortality associated with ground-level ozone (high).
- 3.7 Increased numbers of people at risk of dengue (low).
- 3.8 Social and health inequalities due to possible desertification, natural disasters, changes in agriculture, feeding and water policy which will have consequences on both human health and human resources in health.

4. The authors note that climate change could bring some benefits to health, including fewer deaths from cold, although these will be outweighed by the negative effects of rising temperatures worldwide, especially in developing countries (high confidence).

5. The WMA notes that climate change is likely to amplify inequalities in health and other existing problems within and between countries.

6. Early research suggests that mitigation of the effects of climate change may have a link with prevention such that mitigation might have significant health benefits for both individuals and populations*

STATEMENT

Given the consequences of global climate change on the health of people throughout the world, the World Medical Association, on behalf of its national medical association members and their physician members supports and commits to the following actions:

1. ADVOCACY to Combat Global Warming

- 1.1 The World Medical Association and National Medical Associations urge national governments to recognize the serious consequences for health as a result of climate change and therefore to strive for an intergovernmental agreement in Copenhagen in December 2009 with the following components:
 - 1.1.1 specific goals for reductions of climate altering emissions (mitigation);
 - 1.1.2 a mechanism to minimize the harms and health inequalities that are globally associated with climate change (adaptation);
 - 1.1.3 because climate change will exaggerate health disparities, WMA recommends that resources transferred to developing

* In the context of this paper, Mitigation describes the actions to reduce human effects on the climate system: principally strategies to reduce greenhouse gas emissions (analogous to primary prevention) while Adaptation is understood to refer to the adjustment in natural or human systems taken in response to actual or expected climate stimuli or their effects, and that moderate harm or exploit beneficial opportunities (analogous to secondary prevention). (See WHO EB122/4, Jan 08)

- countries for climate change must include designated funds to support the strengthening of health systems.
- 1.2 As a profession, physicians & their medical associations will encourage advocacy for environmental protection, reduction of green house gas production, sustainable development and green adaptation practices within their communities, countries/regions, especially for the right of safe water & sewage disposal for all.
- 1.3 As professionals, physicians are encouraged to act within their professional settings (clinics, hospitals, laboratories etc.) to reduce the environmental impact of medical activities, & to develop environmentally sustainable professional settings.
- 1.4 As individuals, physicians will be encouraged to act to minimize their impact on the environment, reduce their carbon footprint and encourage those around them to do so.

2. LEADERSHIP: Help people to mitigate climate damage & adapt to climate change

- 2.1 Support the Millennium Development Goals and commit to work to attain them.
- 2.2 Support and implement the principles outlined in the WHO Commission on the Social Determinants of Health report, Closing the Gap in a Generation and in the World Health Assembly Resolution on climate change and health and work with WHO and others to ensure implementation of the recommendations.
- 2.3 Work to create resilience within health systems to ensure that all health care providers are able to adapt and can fully utilize their capacity to provide care to those in need.
- 2.4 Urge local, national and international organizations focused on adaptation, mitigation, and development to involve physicians and the healthcare community to ensure that unanticipated health impacts of development are minimized, while opportunities for health promotion are maximized.
- 2.5 Work to improve the ability of patients to adapt to climate change and catastrophic weather events by:
 - 2.5.1 encouraging health behaviors that improve overall health;
 - 2.5.2 creating targeted programs designed to address specific exposures;
 - 2.5.3 providing health promotion information and education on self-management of the symptoms of climate-associated illness.

3. EDUCATION & CAPACITY BUILDING:

- 3.1 Build professional awareness of the importance of the environment and global climate change to personal, community and societal health, and recognize that universal equitable education improves health capacity for all.



- 3.2 Physicians have obligations for the health and health care of individual patients. Collectively, through their national medical associations, and through WMA they also have obligations and responsibilities for the health of all people.
- 3.3 Work with others to educate the general public about the important effects of climate change on health and the need to both mitigate climate change and adapt to its effects.
- 3.4 Add or strengthen routine health training on environmental health/medicine and public health for all students in health related disciplines.
- 3.5 The WMA and NMAs should develop concrete actionable plans/practical steps as tools for physicians to adopt in their practices; health authorities and governments should do the same for hospitals and other health facilities.
- 3.6 Incorporate tools such as a patient environmental impact assessment and encourage physicians to evaluate their patients and their families for risk from the environment and global climate change.
- 3.7 Advocate that governments undertake community climate change health impact assessments, widely disseminate the results, and incorporate the results into planning for mitigation and adaptation.
- 3.8 Encourage recruitment of physicians for work in public health and all roles in emergency planning & response to extreme climate change, including the training of other physicians.
- 3.9 Urge colleges and universities to develop locally appropriate continuing medical and public health education on the clinical signs, diagnosis and treatment of new diseases that are introduced into communities as a result of climate change, and on the management of long-term anxiety and depression that often accompany experiences of disasters.
- 3.10 Urge governments to provide training for climate-change-related emergency response to physicians, particularly those living in relatively isolated regions.
- 3.11 Work with policy makers on the development of concrete actions to be taken to prevent or reduce the health impact of climate-related emissions, in particular those initiatives, which will also improve the general health of the population. This would include initiatives to stop the privatization of water.

4. SURVEILLANCE AND RESEARCH:

- 4.1 Work with others, including governments, to address the gaps in research regarding climate change and health by undertaking studies to:
 - 4.1.1 describe the patterns of disease that are attributed to climate change, including the impacts of climate change on communities and households;
 - 4.1.2 quantify and model the burden of disease that will be caused by global climate change;

- 4.1.3 describe the effects of poorly treated wastewater used for irrigation and
- 4.1.4 describe the most vulnerable populations, the particular health impacts of climate change on vulnerable populations, & possible new protections for such populations.
- 4.2 Advocate for the collection of vital statistics and the removal of barriers to the registration of births & deaths, in recognition of the special vulnerability of some populations.
- 4.3 Report diseases that emerge in conjunction with global climate change, and participate in field investigations, as with outbreaks of infectious diseases.
- 4.4 Support and participate in the development or expansion of surveillance systems to include diseases caused by global climate change.
- 4.5 WMA will and encourages all NMAs to collaborate in the collection and sharing of local or regional health information within and between countries in order to encourage the adoption of best practices and proven strategies

5. COLLABORATION: Prepare for climate emergencies

- 5.1 Collaborate with governments, NGOs and other health professionals to develop knowledge about the best ways to mitigate climate change, including those adaptive and mitigation strategies that will result in improved health.
- 5.2 Encourage governments to incorporate national medical associations & physicians into country & community emergency planning & response.
- 5.3 Work to ensure integration of physicians into the plans of civil society, governments, public health authorities, international NGOs and WHO.
- 5.4 Encourage WHO and countries of the World Medical Assembly to review the International Health Regulations and Planning for Pandemic Influenza and obtain the perspective of clinicians in community practice to ensure that there are appropriate responses by practicing physicians to emergency alerts, and to make recommendations regarding the most appropriate education, and tools for physicians and other healthcare workers.
- 5.5 Call upon governments to strengthen public health systems in order to improve the capacity of communities to adapt to climate change.
- 5.6 Prepare physicians, physicians' offices, clinics, hospitals and other health care facilities for the infrastructure disruptions that accompany major emergencies, in particular by planning in advance the delivery of services during times of such disruptions.
- 5.7 Urge physicians, medical associations and governments to work collaboratively to develop systems for event alerts in order to ensure that health care systems and physicians are aware of climate-related events as they unfold, and receive timely accurate information regarding the management of emerging health events.

- 5.8 Call upon governments to plan for environmental refugees within their countries.
- 5.9 In collaboration with WHO, produce locally adapted fact sheets on climate change for national medical associations, physicians, and other health professionals.
- 5.10 WMA will work with others to identify funding for specific research programs on mitigation and adaptation related to health, and the sharing of information/research within and between countries and jurisdictions.

Declaration of Madrid on Professionally-led Regulation

Adopted by the WMA General Assembly, New Delhi, India, October 2009

1. The collective action by the medical profession seeking for the benefit of patients, in assuming responsibility for implementing a system of professionally-led regulation will enhance and assure the individual physician's right to treat patients without interference, based on his or her best clinical judgment. Therefore, the WMA urges the national medical associations and all physicians to take the following actions.
2. Physicians have been granted by society a high degree of professional autonomy and clinical independence, whereby they are able to make recommendations based on the best interests of their patients without undue outside influence.
3. As a corollary to the right of professional autonomy and clinical independence, the medical profession has a continuing responsibility to be self-regulating. Ultimate control and decision-making authority must rest with physicians, based on their specific medical training, knowledge, experience and expertise
4. Physicians in each country are urged to establish, maintain and actively participate in a legitimate system of professionally-led regulation. This dedication is to ultimately assure full clinical independence in patient care decisions.
5. To avoid being influenced by the inherent potential conflicts of interest that will arise from assuming both representational and regulatory duties, National Medical Associations must do their

- utmost to promote and support the concept of professionally-led regulation amongst their membership and the public.
6. Any system of professionally-led regulation must ensure
 - a) the quality of the care provided to patients,
 - b) the competence of the physician providing that care and
 - c) the professional conduct of physician.
 To ensure the patient quality continuing care, physicians must participate actively in the process of Continuing Professional Development in order to update and maintain their clinical knowledge, skills and competence.
 7. The professional conduct of physicians must always be within the bounds of the Code of Ethics governing physicians in each country. National Medical Associations must promote professional and ethical conduct among physicians for the benefit of their patients. Ethical violations must be promptly recognized and reported. The physicians who have erred must be appropriately disciplined and where possible be rehabilitated.
 8. National Medical Associations are urged to assist each other in coping with new and developing problems, including potential inappropriate threats to professionally-led regulation. The ongoing exchange of information and experiences between National Medical Associations is essential for the benefit of patients.
 9. An effective and responsible system of professionally-led regulation by the medical profession in each country must not be self serving or internally protective of the profession, and the process must be fair, reasonable and sufficiently transparent to ensure this. National Medical Associations should assist their members in understanding that self-regulation cannot only be perceived as being protective of physicians, but must maintain the safety, support and confidence of the general public as well as the honour of the profession itself.

Declaration of Ottawa on Child Health

Adopted by the 50th World Medical Assembly, Ottawa, Canada, October 1998 and amended by the WMA General Assembly, New Delhi, India, October 2009

PREAMBLE

Science has now proven that to reach their potential, children need to grow up in a place where they can thrive – spiritually, emotionally,

mentally, physically and intellectually*. That place must have four fundamental elements:

- a safe and secure environment;
- the opportunity for optimal growth and development;
- health services when needed; and
- monitoring & research for evidence-based continual improvement into the future**.

* Irwin LG, Siddiqi A, Hertzman C. "Early Child Development: A Powerful Equalizer. Final Report". World Health Organization Commission on the Social Determinants of Health June 2007.

** WHO Commission on Social Determinants of Health (Closing the Gap in a Generation) 2008



Physicians know that the future of our world depends on our children: their education, their employability, their productivity, their innovation, and their love and care for one another and for this planet. Early childhood experiences strongly influence future development including basic learning, school success, economic participation, social citizenry, and health³. In most situations, parents and caregivers alone cannot provide strong nurturing environments without help from local, regional, national and international organizations.^{***} Physicians therefore join with parents, and with world leaders to advocate for healthy children.

The principles of this Declaration apply to all children in the world from birth to 18 years of age, regardless of race, age, ethnicity, nationality, political affiliation, creed, language, gender, disease or disability, physical ability, mental ability, sexual orientation, cultural history, life experience or the social standing of the child or her/his parents or legal guardian. In all countries of the world, regardless of resources, meeting these principles should be a priority for parents, communities and governments. The United Nations Convention on the Rights of Children (1989) sets out the wider rights of all children and young people, but those rights cannot exist without health.

GENERAL PRINCIPLES

1. A place with a safe and secure environment includes:

- Clean water, air and soil;
- Protection from injury, exploitation, discrimination and from traditional practices prejudicial to the health of the child, and
- Healthy families, homes and communities.

2. A place where a child can have good health and development offers:

- Prenatal and maternal care for the best possible health at birth;
- Nutrition for proper growth, development and long-term health;
- Early learning opportunities and high quality care at home and in the community;
- Opportunities and encouragement for physical activity;

*** Canadian Charter for Child and Youth Health

- Affordable & accessible high quality primary & secondary education.

3. A full range of health resources available to all means:

- The best interests of the child shall be the primary consideration in the provision of health care;
- Those caring for children shall have the special training and skills necessary to enable them to respond appropriately to the medical, physical, emotional and developmental needs of children & their families;
- Basic health care including health promotion, recommended immunization, drugs & dental health;
- Mental health care and prompt referral to intervention when problems identified;
- Priority access to drugs for life- or limb-threatening conditions for all mothers and children;
- Hospitalization only if the care and treatment required cannot be provided at home, in the community or on an outpatient basis;
- Access to specialty diagnostic and treatment services when needed;
- Rehabilitation services and supports within community;
- Pain management and care and prevention (or minimization) of suffering;
- Informed consent is necessary before initiating any diagnostic, therapeutic, rehabilitative, or research procedure on a child. In the majority of cases, the consent shall be obtained from the parent(s) or legal guardian, or in some cases, by extended family, although the wishes of a competent child should be taken into account before consent is given.

4. Research^{****} & monitoring for continual improvement includes:

- All infants will be officially registered within one month of birth;
- All children will be treated with dignity and respect;
- Quality care is ensured through on-going monitoring of services, including collection of data, and evaluation of outcomes;
- Children will share in the benefits from scientific research relevant to their needs;
- The privacy of a child patient will be respected.

**** Proposed WMA statement on ethical principles for medical research on child subjects

WMA Resolution on Task Shifting from the Medical Profession

*Adopted by the WMA General Assembly,
New Delhi, India, October 2009*

In health care, the term "Task Shifting" is used to describe a situation where a task normally performed by a physician is transferred to a health professional with a different or lower level of education and training, or to a person specifically trained to perform a limited task only, without having a formal health education. Task shifting occurs both in countries facing shortages of physicians and those not facing shortages.

A major factor leading to task shifting is the shortage of qualified workers resulting from migration or other factors. In countries facing a critical shortage of physicians, task shifting may be used to train alternate health care workers or laypersons to perform tasks generally considered to be within the purview of the medical profession. The rationale behind the transferring of these tasks is that the alternative would be no service to those in need. In such countries, task shifting is aimed at improving the health of extremely vulnerable populations, mostly to address current shortages of healthcare professionals or tackle specific health issues such as HIV. In countries with the most extreme shortage of physicians, new cadres of health care workers have been established. However, those persons taking over physicians' tasks lack the broad education and training of physicians and must perform their tasks according to protocols, but without the knowledge, experience and professional judgement required to make proper decisions when complications arise or other deviations occur. This may be appropriate in countries where the alternative to task shifting is no care at all but should not be extended to countries with different circumstances.

In countries not facing a critical shortage of physicians, task shifting may occur for various reasons: social, economic, and professional, sometimes under the guise of efficiency, savings or other unproven claims. It may be spurred, or, conversely, impeded, by professions seeking to expand or protect their traditional domain. It may be initiated by health authorities, by alternate health care workers and sometimes by physicians themselves. It may be facilitated by the advancement of medical technology, which standardizes the performance and interpretation of certain tasks, therefore allowing them to be performed by non-physicians or technical assistants instead of physicians. This has typically been done in close collaboration with the medical profession. However, it must be recognized that medicine can never be viewed solely as a technical discipline.

Task shifting may occur within an already existing medical team, resulting in a reshuffling of the roles and functions performed by the members of such a team. It may also create new types of personnel whose function is to assist other health professionals, specifically physicians, as well as personnel trained to independently perform specific tasks.

Although task shifting may be useful in certain situations, and may sometimes improve the level of patient care, it carries with it significant risks. First and foremost among these is the risk of decreased quality of patient care, particularly if medical judgment and decision making is transferred. In addition to the fact that the patient may be cared for by a lesser trained health care worker, there are specific quality issues involved, including reduced patient-physician contact, fragmented and inefficient service, lack of proper follow up, incorrect diagnosis and treatment and inability to deal with complications.

In addition, task shifting which deploys assistive personnel may actually increase the demand on physicians. Physicians will have increasing responsibilities as trainers and supervisors, diverting scarce time from their many other tasks such as direct patient care. They may also have increased professional and/or legal responsibility for the care given by health care workers under their supervision.

The World Medical Association expresses particular apprehension over the fact that task shifting is often initiated by health authorities, without consultation with physicians and their professional representative associations.

RECOMMENDATIONS

Therefore, the World Medical Association recommends the following guidelines:

1. Quality and continuity of care and patient safety must never be compromised and should be the basis for all reforms and legislation dealing with task shifting.
2. When tasks are shifted away from physicians, physicians and their professional representative associations should be consulted and closely involved from the beginning in all aspects concerning the implementation of task shifting, especially in the reform of legislations and regulations. Physicians might themselves consider initiating and training a new cadre of assistants under their supervision and in accordance with principles of safety and proper patient care.
3. Quality assurance standards and treatment protocols must be defined, developed and supervised by physicians. Credentialing systems should be devised and implemented alongside the implementation of task shifting in order to ensure quality of care. Tasks that should be performed only by physicians must be clearly defined. Specifically, the role of diagnosis and prescribing should be carefully studied.
4. In countries with a critical shortage of physicians, task shifting should be viewed as an interim strategy with a clearly formulated exit strategy. However, where conditions in a specific country make it likely that it will be implemented for the longer term, a strategy of sustainability must be implemented.
5. Task shifting should not replace the development of sustainable, fully functioning health care systems. Assistive workers should not be employed at the expense of unemployed and underemployed health care professionals. Task shifting also should not replace the education and training of physicians and other health care professionals. The aspiration should be to train and employ more skilled workers rather than shifting tasks to less skilled workers.
6. Task shifting should not be undertaken or viewed solely as a cost saving measure as the economic benefits of task shifting remain unsubstantiated and because cost driven measures are unlikely

to produce quality results in the best interest of patients. Credible analysis of the economic benefits of task shifting should be conducted in order to measure health outcomes, cost effectiveness and productivity.

7. Task shifting should be complemented with incentives for the retention of health professionals such as an increase of health professionals' salaries and improvement of working conditions.
8. The reasons underlying the need for task shifting differ from country to country and therefore solutions appropriate for one country cannot be automatically adopted by others.
9. The effect of task shifting on the overall functioning of health systems remains unclear. Assessments should be made of the impact of task shifting on patient and health outcomes as well as on efficiency and effectiveness of health care delivery. In particular, when task shifting occurs in response to specific health issues, such as HIV, regular assessment and monitoring should be conducted of the entire health system. Such work is essential in order to ensure that these programs are improving the health of patients.
10. Task shifting must be studied and assessed independently and not under the auspices of those designated to perform or finance task shifting measures.
11. Task shifting is only one response to the health workforce shortage. Other methods, such as collaborative practice or a team/partner approach, should be developed in parallel and viewed

as the gold standard. Task shifting should not replace the development of mutually supportive, interactive health care teams, coordinated by a physician, where each member can make his or her unique contribution to the care being provided.

12. In order for collaborative practice to succeed, training in leadership and teamwork must be improved. There must also be a clear understanding of what each person is trained for and capable of doing, clear understanding of responsibilities and a defined, uniformly accepted use of terminology.
13. Task shifting should be preceded by a systematic review, analysis and discussion of the potential needs, costs and benefits. It should not be instituted solely as a reaction to other developments in the health care system.
14. Research must be conducted in order to identify successful training models. Work will need to be aligned to various models currently in existence. Research should also focus on the collection and sharing of information, evidence and outcomes. Research and analysis must be comprehensive and physicians must be part of the process.
15. When appropriate, National Medical Associations should collaborate with associations of other health care professionals in setting the framework for task shifting. The WMA shall consider establishing a framework for the sharing of information on this topic where members can discuss developments in their countries and their effects on patient care and outcomes.

WMA Emergency Resolution supporting the Rights of Patients and Physicians in the Islamic Republic of Iran

*Adopted by the WMA General Assembly,
New Delhi, India, October 2009*

WHEREAS,

Physicians in the Islamic Republic of Iran have reported:

Unsettling practices of injured persons being taken to prisons, without adequate medical treatment or the consensus of the attending physicians;

Physicians being hindered from treating patients;

Concern about the veracity of documentation related to the death of patients and physicians being forced to clinically inaccurate documentation; and

Corpses and badly injured political and religious prisoners who were admitted to hospitals with signs of brutal torture, including sexual abuse.

THEREFORE, the World Medical Association

1. Reaffirms its Declaration of Lisbon: Declaration on the Rights of the Patient, which states that whenever legislation, government action or any other administration or institution denies patients the right to medical care, physicians should pursue appropriate means to assure or to restore it.
2. Reaffirms its Declaration of Hamburg: 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, which encourages doctors to honor their commitment as physicians to serve humanity and to resist any pres-

sure to act contrary to the ethical principles governing their dedication to this task.

3. Reaffirms its Declaration of Tokyo: Guidelines for Physicians Concerning Torture and other Cruel, Inhuman or Degrading Treatment or Punishment in Relation to Detention and Imprisonment, which:

- prohibits physicians from participating in, or even being present during the practice of torture or other forms of cruel or inhuman or degrading procedures;
- requires that physicians maintain utmost respect for human life even under threat, and prohibits them from using any medical knowledge contrary to the laws of humanity.

4. Reaffirms its Resolution on the Responsibility of Physicians in the Documentation and Denunciation of Acts of Torture or Cruel or Inhuman or Degrading Treatment; which states that physicians should attempt to:

- ensure that detainees or victims of torture or cruelty or mistreatment have access to immediate and independent health care;
- ensure that physicians include assessment and documentation of symptoms of torture or ill-treatment in the medical records using the necessary procedural safeguards to prevent endangering detainees.

5. Refers to the WMA International Code of Medical Ethics, which states that physicians shall be dedicated to providing competent medical service in full professional and moral independence, with compassion and respect for human dignity.

6. Urges the government of the Islamic Republic of Iran to respect the International Code of Medical Ethics and the standards included in the aforementioned declarations to which physicians are committed.

7. Urges National Medical Associations to speak out in support of this resolution.

WMA Resolution on Medical Workforce

Adopted by the 50th World Medical Assembly, Ottawa, Canada, October 1998 and amended by the WMA General Assembly, New Delhi, India, October 2009

PREAMBLE

The health of our countries depends upon keeping the population healthy. Health care is a key right of individuals. This care is dependent upon access to highly-trained medical and other healthcare professionals. Well-functioning health care systems depend upon these sufficient human resources. Comprehensive and extensive planning on a national level is required in order to ensure that a country has a medical workforce in all fields of medicine that meets the present and future health needs of the entire population of that country.

There are currently significant shortages in the area of health human resources. These shortages are present in all countries but are especially pronounced in developing countries where health human resources are more limited.

The problem is made more severe by the fact that many countries have not invested adequately in the education, training, recruitment and retention of their medical workforce. The ageing population in developed countries has also been reflected by an ageing medical workforce. Many developed countries address their medical work-

force shortages by employing health care professionals from developing countries to bolster their own health care systems.

The migration of health care professionals from developing countries to developed countries has, over the past ten years, impaired the performance of health systems in developing countries. Economic realities of insufficient investments in health care and inadequate facilities and support for health care professionals have continued to be responsible for this migration.

The World Health Organization has recognized that the crisis of health workforce shortages is impeding the provision of essential, life-saving interventions. It has therefore established structures such as the Global Health Workforce Alliance, a partnership dedicated to identifying and implementing solutions to the health workforce problems. The WHO is promoting the development of a cadre of medical/clinical assistants who propose to join the medical workforce to partially address these shortages.

RECOMMENDATIONS

Recognizing that health care systems require adequate numbers of qualified and competent health care professionals, the World Medical Association asks all National Medical Associations to participate and be active in addressing these requirements and to:

1. Call on their respective governments to allocate sufficient financial resources for the education, training, development, recruitment and retention of physicians to meet the medical needs of the entire population in their countries.

2. Call on their respective governments to ensure that the education, training and development of healthcare professionals meets the highest possible standards including:

- The training and development of medical/clinical assistants where this is applicable and appropriate and
- Ensuring clear definitions of scope of practice and conditions for adequate support and supervision.

3. Call on governments to ensure that appropriate ratios are maintained between population and the medical workforce at all levels, including mechanisms to address reduced access to care in rural and remote areas, based on accepted international norms and standards where these are available.

4. Take measures to attract and support individuals within their countries to enter the medical profession and also call on their respective governments to take such action.

5. Actively advocate for programs that will ensure the retention of physicians within their respective countries and ensure governments' recognition of this need.

6. Call on governments to improve the health care working environment (including access to appropriate facilities, equipment, treatment modalities and professional support), physician remuneration, physician living environment and career development of the medical workforce at all levels.

7. Advocate for the development of transparent memoranda of understanding between countries where migration of trained health care professionals is an issue of concern and enlist where possible the NMA of origin and receiving NMAs to support these physicians.

WMA Statement on Inequalities in Health

*Adopted by the WMA General Assembly,
New Delhi, India, October 2009*

PREAMBLE

For over 150 years, the existence of health inequality has been acknowledged worldwide. The recently published Final Report of the WHO Commission on Social Determinants of Health has highlighted the critical importance of health equity to the health, economy and social cohesiveness of all countries. It is clear that while there are major differences between countries, especially between the developing and developed countries, there are also substantial disparities within countries with respect to various measures of socio-economic and cultural diversity. Disparities in health can be defined as either disparities in access to healthcare, disparities in quality of care received, or both. The differences manifest themselves in a wide variety of health measures, such as life expectancy, infant mortality, and childhood mortality. Particularly disturbing is evidence of the gradual and ongoing widening of specific disparities.

At the core of this issue is the healthcare provided by physicians. National medical associations should take an active role in combating social and health inequalities in order to allow their physician members the ability to provide equal, quality service to all.

The Role of the Health Care System

While the major causes of health disparities lie in the socio-economic and cultural diversity of population groups, there is a very

significant role for the health care system in their prevention and reduction. This role can be summarized as follows:

- To prevent the health effects of socio-economic and cultural inequality and inequity – especially by health promotion and disease prevention activities (Primary Prevention)
- To Identify, treat and reduce existing health inequality, e.g. early diagnosis of disease, quality management of chronic disease, rehabilitation (Secondary and Tertiary Prevention).

RECOMMENDATIONS

The members of the medical profession, faced with treating the results of this inequity, have a major responsibility and call on their national medical associations to:

1. Recognize the importance of health inequality and the need to influence national policy and action for its prevention and reduction
2. Identify the social and cultural risk factors to which patients and families are exposed and to plan clinical activities (diagnostic and treatment) to counter their consequences.
3. Advocate for the abolishment of financial barriers to obtaining needed medical care.
4. Advocate for equal access for all to health care services irrespective of geographic, social, age, gender, religious, ethnic and economic differences or sexual orientation.
5. Require the inclusion of health inequality studies (including the scope, severity, causes, health, economic and social implications) as well as the provision of cultural competence tools, at all levels of academic medical training, including further training for those already in clinical practice.

WMA Resolution on Improved Investment in Public Health

Adopted by the 50th World Medical Assembly, Ottawa, Canada, October 1998 and amended by the WMA General Assembly, New Delhi, India, October 2009

INTRODUCTION

Each country should have a health system with enough resources to attend to the needs of its population. However today, many countries across the world are suffering wide inequities and inequalities in health care and this is causing problems of access to health services for the poorer segments of society [the weak or underprivileged]. The situation is especially serious in low-income countries.

The international community has attempted to improve the situation. The 20/20 initiative of 1995, the 1996 Initiative for Heavily Indebted Poor Countries (HIPC), and Objectives for Millennium 2000 Development (MDGs) are all initiatives aimed at reducing poverty and dealing with poor health, inequities and inequalities between the sexes, education, insufficient access to drinking water and environmental contamination.

The objectives are formed as an agreement with acknowledgement of the contributions which developed countries can make, in the shape of trade relations, development assistance, reduction of the burden of debt, improving access to essential medication and the transfer of technology. Three of the eight objectives are directly related to health, which has a considerable influence on various other objectives that interact to support each of the others within a structural framework, these are designed to increase human development globally. The eight Millennium Development Objectives (MDO) foresee a development vision based on health and education, thus affirming that development does not only refer (allude) to economic growth.

Various reports from the World Health Organization have underlined the opportunities and skills [or techniques] which are currently involved in bringing about significant improvements in health, as well as helping to reduce poverty and encourage growth. Additionally, the reports highlight the fact that it is of fundamental importance to reduce limitations on human resources, in order to increase the achievements of the public health system, a situation which requires urgent attention. These limitations are related to work, training and payment conditions, and play a substantial role in determining capacity for sustained growth of access to health services.

RECOMMENDATIONS

The World Medical Association urges National Medical Associations to:

1. Advocate that their governments should adhere to and promote the proposals to increase investment in the health sector; and to adhere to and promote initiatives to reduce the debt burden for the poorest countries on the planet.
2. Advocate [defend] the inclusion of public health factors in all fields of policy provision, since health is mostly determined by factors that are external to the area of healthcare, for example, housing and education. [Health is not only medicine, it also depends on living standards].
3. Encourage and support countries in the planning and implementation of investment plans, which invest in health for the poor; guarantee that more resources be used for health in general, with greater efficiency and impact; and reduce limitations for the most effective use of the additional investments.
4. Maintain vigilance to ensure that the investment plans focus maximum attention on generating capacity, that they promote leadership skills and promote incentives to retain and place qualified personnel, whilst it is taken into consideration that the limitations in relation to the previous matter currently constitute the greatest obstacle for progress.
5. Urge international financial institutions and other important donors to: i) Adopt the necessary measures to help the countries that have already organised mechanisms to prepare their investment plans, and provide assistance to those countries that have begun to take the necessary steps, with the support and participation of the international community; ii) Help countries to obtain funds to develop and implement their investment plans; iii) Continue providing technical assistance to the countries for their plans.
6. Exchange information in order to coordinate efforts to change policies in these areas.

Hindi – English bilingual “Speaking Book”

“Speaking Books” launched at the World Medical Association AGM in New Delhi

In a joint collaboration, the WMA together with Pfizer, and South African NGO SADAG (The South African Depression and Anxiety Group) launched the next two books in their ongoing series of “Speaking Books” for vulnerable communities.

The “Speaking Books” first launched in South Africa for rural and least served communities are to help patients gain a basic understanding of clinical trials that they may choose to participate in. The first in this series was field tested in South Africa at TB, and HIV and AIDS facilities. Patients overwhelmingly gained a better understanding of their rights and responsibilities, with results indicating that:

- 93% of patients understood that they would be told how long to take the medicine or vaccination and the duration of the trial;
- 91% understood that they would be allowed to stop the trial at anytime;
- 91% were aware that they must tell their doctor about other medications they were taking;
- 100% knew both that they had rights when participating and that their information would be private.

This hard backed book with 16 pages of culturally appropriate illustrations, has a recorded soundtrack, so that with the push of a button, each page can be read, heard and viewed simultaneously. Each book is customized to meet the needs of the local community, recorded in the required language and read by a well known local personality

The first “Speaking Book” in South Africa was as a result of the collaboration between the South African Medical Association, The Steve Biko Centre for Bioethics, the

World Medical Association and sponsored by Pfizer in the interests of patient education. This “Speaking Book” was produced to support the principles of the Declaration of Helsinki in promoting Good Clinical Practice and protecting the human rights, safety, and well-being of clinical trial participants.

According to Dr. Soeren Rasmussen, Senior Director for Pfizer Inc and responsible for implementing Pfizer’s “Speaking Book” program, “There is a need for informing people with limited literacy skills on how clinical trials work, and by using the “Speaking Book” it has made it possible for us to deliver simple messages that will be seen read, heard and understood. We first introduced the “Speaking Books” with WMA for Africa, followed by India in Hindi and Telugu, and now the next in our series being an anti-smoking “Speaking Book” recorded in Mandarin focusing on Chinese youth”

“Speaking Books” enable patients with little or no literacy skills to understand critical health care messages and to take them home to share with their families so that the clinical trial concept is fully understood by all. The sound tracks are read by local celebrities and in the language of choice for that community. By being battery operated even the most isolated and remote community can be reached with this innovative cost effective tool.

In India the first ever dual language “Speaking Book” was distributed using both Hindi and Telugu for use by clinics, trial centres and hospitals. One clinical trial sister commented that, “The book is a great idea to send home with each person. Sometimes people forget things you have said to them. With the book they can listen over and over again until they understand fully”.

Developed by a small South African mental health NGO, these “Speaking Books” have



Ms. Yoonsun Park

Ms. Anne-Marie Delage

now been distributed globally in 14 languages and on 35 health care topics. www.booksofhope.com

The “Speaking Book” delivers important health information to low-literacy communities. Available free of charge, each book focuses on a single subject, such as a particular disease – or a healthcare assistance program.

This book explains clinical trials to potential participants including goals, possible risks, and patient rights and responsibilities.

Healthcare practitioners request the free “Speaking Books” and give them to their patients. Patients considering participation can take the books home and share them with friends, family, and community members.

After spending a week with the book in their homes, community members who had never taken part in a clinical trial shared their experiences:

- “I like the explanation about clinical trials. It is clear and understandable”
- “I liked the voice... and all the information given. It was really great”
- “I liked how the talking book encourages reading”

Dr. Brian M. Julius (bj@booksofhope.com)

Impact of climate change in Asia and Oceania region and challenges ahead



Dong-Chun Shin

Introduction

The world's greatest health concern in the 21st century is global warming. Warnings against the dangers of future climate change are heralded by every newspaper. Average global temperature has increased by 0.74 °C with a span of 0.56-0.92 °C over the past century, which has resulted in numerous problems such as increasing rainfall, melting glaciers and flooding of low-lying areas around the equator. Decrease in crop yield and higher frequency of nature disasters and communicable diseases also threaten mankind. Many countries have tried to reduce greenhouse gas emission. Even the US House of Representatives drafted a clean energy legislation called the American Clean Energy and Security Act, also known as the "Waxman-Markey Bill" on 26, June 2009.

Climate change threatens to stall economic development in Asia and Oceania and endangers the health and safety of its vast population. Climate change causes temperature, wind and precipitation to vary, with profound effects on natural systems. This,

in turn, has effects on the health, safety and livelihoods of people – especially the disadvantaged. Nowhere in the world are as many people affected by climate change as in Asia and Oceania.

Climate change will intensify typhoons, droughts, heat waves, landslides and other natural hazards in a region which already suffers from more natural disasters than any other part of the world. During the last decade, Bangladesh, India, the Philippines and Viet Nam have topped the list of countries facing serious climate risks. The cumulative losses due to natural disasters have averaged nearly \$20 billion over the same period. Future warming will cause an increase of sea-levels, warmer ocean temperatures and higher sea water acidity, leading to greater coastal erosion and threatening the health of marine ecosystems.

Climate Change in Asia and Oceania

Asia is the most populous continent in the world. Marine and coastal ecosystems in Asia are likely to be affected by sea-level rises and temperature increases. Future climate change is likely to affect agriculture and aggravate the risk of food and water shortages by amplifying climate variability and accelerating glaciers melting [1]. From the Himalayas, which provide water to a billion people, to the coastal areas of Bangladesh, South Asian countries must prepare against the impact of global warming. A moderate rise in temperatures could cause serious changes to the environment in South Asia [2]. A large number of deaths from heat waves have been reported in India [3] and Siberia [4]. An endemic morbidity and mortality of diarrheal disease, closely associated with poverty and hygiene, also have been reported in South Asia [5].

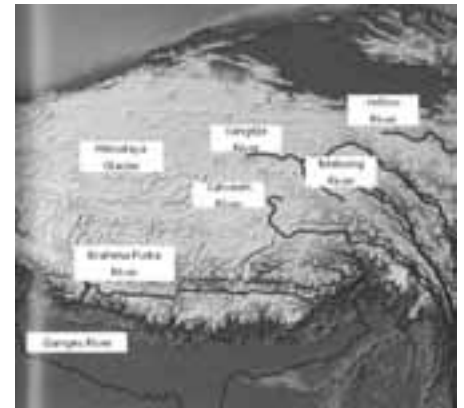


Figure 1.
Himalaya Glacier and Asian rivers

Most Asian countries have already realised their own risk related with climate change, but not all of them are prepared against it. Some leading countries have developed efforts for reducing greenhouse gas emissions and have even started to support other countries in Asia. For example, CarboEast-Asia (China, Japan and Korea) copes with climate change by developing measurements, theory and modelling that helps quantify and understand the global warming mechanism [6].

In December 1993, Korea joined the UNFCCC. It is currently classified as a non-Annex I (industrialized countries) and II (developed countries) country and therefore, has no obligation to reduce emissions during the first commitment period (2008-2012). However, after the first commitment period, the international demand for Korean's participation in the international efforts to tackle global warming will be even stronger [7].

China is also a developing country and does not have an international obligation to cut emissions. But, in the 2007 G8 meeting in Germany, the Chinese government unveiled its first national plan for climate change. This plan contained China's aim to reduce energy use by a fifth before 2010 and to increase the amount of renewable energy production [8].

Table 1. General statistics in Asia by year 2005

Country	Area (x1,000 ha)	Population (thousand)	Pop. Density (per km ²)	Ave. temp. (°C)	Annual precipitation (mm)	CO ₂ emission (million Ton)	GNI (billion \$)
Afghanistan	65,209	29,929	46	10.1	338	0.9	32
Bangladesh	14,400	144,320	1,002	25.8	2,096	38.2	60.5
China	959,809	1,306,314	137	11.9	577	5,126.8	2,254.6
India	328,726	1,080,264	340	25.0	795	1,190.9	805.9
Indonesia	190,457	241,974	126	27.2	1,927	350.1	272.0
Japan	37,791	127,417	338	15.6	1,405	1,249.7	4,659.7
Korea	9,965	48,422	485	11.7	1,369	460.4	790.1
Laos	23,680	6,217	26	26.3	1,635	0.4	2.9
Malaysia	32,974	23,953	81	26.6	2,343	123.6	130.9
Philippine	30,000	87,857	290	25.9	2,777	74.6	106.9
Vietnam	32,931	83,536	253	27.2	1,872	79.7	51.9
Total/Ave. [†]	1,725,942	3,180,203	284 [†]	21.2 [†]	1,558 [†]	8,695.3	9,167.4

* Sources

- Area/Population: UN Statistics Division / "www.nationmaster.com"
- Average temperature/Annual precipitation: World Meteorological Organization
- CO₂ emission: UN Statistics Division / IPCC AR4 report
- Gross National Income: The World Bank

Japan has provided training in developing countries and has promoted monitoring, analysing and interpreting of observational data, as well as sharing climate change data in the Asia-Pacific region with other governments [9].

The Oceania region ranges from the lush tropical rainforests of Indonesia to the interior deserts of Australia. Climate is strongly influenced by the ocean and El Niño. Small island states and the coastal regions – where most of the population is concentrated – are highly vulnerable to increasing coastal flooding and erosion due to a rising sea level. The recent increase in ocean temperatures has damaged many of the region's spectacular coral reefs, one of the world's most diverse ecosystems.

Extreme temperatures have contributed to the deaths of some 1100 people aged over 65 each year in 10 Australian and 2 New Zealand cities. The projected rise in temperature for the next 50 years is predicted to result in a substantial increase in heat-related deaths in all the cities studied, in the absence of adaptive measures. Temperate cities show higher rates of deaths due to heat than tropical cities. Global warming is projected to

reduce the number of cold winter days and a few cities may actually experience fewer annual deaths in the short-term due to this. In the medium to long-term, however, these health gains would be greatly outweighed by additional heat-related deaths.

Extreme rainfall events are expected to increase in almost all Australian states and territories by 2020. Annual flood-related deaths and injuries may also increase by up to 240 %, depending on the region. The situation by 2050 is mixed. As the climate changes, parts of Australia are projected to have substantially less rainfall, and in these places the risk of flooding is predicted to lessen. Most parts of the country, however, are still predicted to be at far greater risk of flood-related deaths and injuries than at present.

The "malaria receptive zone" may expand southwards, to include regional towns like Rockhampton, Gladstone and Bundaberg. However, in the foreseeable future malaria itself is not a direct threat to Australia under climate change, as long as a high priority is placed on prevention via the maintenance and extension of public health and local government infrastructure.

Warmer temperatures and stronger rainfall variability are predicted to increase the intensity and frequency of food-borne and water-borne diseases. Successful adaptation to the projected climate changes will require the upgrading of sewerage systems and safer food production and storage processes. Due to their poor living conditions and limited access to public services, Aboriginal people living in remote arid communities will be exposed to increased risk. The annual number of diarrheal admissions among Aboriginal children living in the central Australian region is predicted to increase by 10 % by 2050.

The number of people exposed to flooding due to sea-level rise in Australia and New Zealand is predicted to approximately double in the next 50 years, although absolute numbers would still be low. For the rest of the Pacific region, however, the number of people who experience flooding by the 2050s could increase by a factor of more than 50 to between 60,000 and 90,000 in an average year. As well as the impact of flooding on settlements, the impact of sea-level rise on freshwater quality and quantity is likely to be a critical threat to Pacific Island health and welfare.

The first detectable changes in human health may well be alterations in the geographic range and seasonality of certain vector-borne infectious diseases. Summer-time food-borne infections (e.g. salmonellosis) may show longer-lasting annual peaks. The public health consequences of the disturbance of natural and managed food-producing systems, of rising sea-levels and of population displacement for reasons of physical hazard, land loss, economic disruption and civil strife may not become evident for several decades.

Reducing the total level of greenhouse gas emissions is a primary preventive health strategy. Because the current levels of greenhouse gases will continue to influence the climate over the next several hundred years,



Table 2. *General statistics in Oceania by year 2005*

Country	Area (x1,000 ha)	Population (thousand)	Pop. Density (per km ²)	Ave. temp. (°C)	Annual precipitation (mm)	CO ₂ emission (million Ton)	GNI (billion \$)
Australia	774,122	20,090	2	13.0	624	367.8	685.3
Fiji	1,827	893	48	25.0	3,000	0.7	1.7
Kiribati	81	103	127	27.0	2,200	0.03	0.03
New Zealand	26,771	4,035	15	12.5	1,267	32.3	10.30
Papua New Guinea	46,284	5,545	11	26.9	1,177	2.4	3.9
Tuvalu	3	12	447	28.0	2,736	0.001	0.008
Total/Ave. ¹	849,088	30,678	108 ¹	22.1 ¹	1,834 ¹	403.2	701.2

* Sources
 • Area/Population: UN Statistics Division / "www.nationmaster.com"
 • Average temperature/Annual precipitation: World Meteorological Organization
 • CO₂ emission: UN Statistics Division / IPCC AR4 report
 • Gross National Income: The World Bank

greater research effort must be devoted to how humans can adapt to these changes.

The health impacts of climate change will be strongly influenced by the extent and rate of warming, as well as local environmental conditions and social behaviours and the range of social, technological, institutional, and behavioural adaptations taken to reduce the threats.

Some individuals and communities will lack the resources required for adequate response. Remote Aboriginal communities, low income households, the elderly and many Pacific Island countries will be most vulnerable [14].

Climate Change and Human Health

We can see some of the health effects that may lie ahead if extreme weather events continue to increase. Heat waves like the one that hit Chicago in 1995, killing some 750 people and hospitalising thousands, have become more common. Hot, humid nights, which have become more frequent with global warming, magnify the effects. The 2003 European heat wave – involving temperatures that were 18°F (10°C) above the 30-year average, with no relief at night – killed 21,000 to 35,000 people in five countries.

But even more subtle, gradual climatic change can quietly damage human health. During the past two decades, the prevalence of asthma in the United States has quadrupled, in part because of climate-related factors. For Caribbean islanders, respiratory irritants are carried by dust clouds from Africa's expanding deserts and then swept across the Atlantic by trade winds accelerated by the widening pressure gradients over warming oceans. Increased levels of plant pollen and soil fungi may also be involved. When ragweed grows in conditions with twice the ambient level of carbon dioxide, the stalks sprout 10 percent taller and produce 60 percent more pollen. Elevated carbon dioxide levels also promote the growth and sporulation of some soil fungi. Diesel particles deliver these aeroallergens deeper into our alveoli and present them to immune cells along the way.

Mosquitoes, which can carry many diseases, are very sensitive to temperature changes. Warming of their environment – within their viable range – boosts their rates of reproduction and the number of blood meals they take, prolongs their breeding season, and shortens the maturation period for the microbes they disperse. In highland regions, as permafrost thaws and glaciers retreat, mosquitoes and plant communities are migrating to higher ground.

Extremely wet weather may bring its own share of ills. Floods are frequently followed by disease clusters: downpours can drive rodents from burrows, deposit mosquito-breeding sites, foster fungus growth in houses, and flush pathogens, nutrients, and chemicals into waterways. Milwaukee's cryptosporidium outbreak, for instance, accompanied the 1993 floods of the Mississippi River and norovirus and toxins spread in Katrina's wake. Major coastal storms can also trigger harmful algal blooms ("red tides"), which can be toxic, help to create hypoxic "dead zones" in gulfs and bays and harbour pathogens.

Prolonged droughts, for their part, can weaken trees' defences against infestations and promote wildfires, which can cause injuries, burns, respiratory illness, and deaths. Shifting weather patterns are jeopardising water quality and quantity in many countries, where groundwater systems are already being overdrawn and underfed. Most montane ice fields are predicted to disappear during this century – removing a primary source of water for humans, livestock, and agriculture in some parts of the world.

And many habitats are not faring well. Coastal zones, for example, are in trouble: coral reefs are suffering from warming-induced "bleaching," excess waste, physical damage, overfishing, and fungal and bacterial diseases. Reefs provide a buffer against storms and groundwater salinisation and offer protection for fish, the primary protein source for many inhabitants of island nations. One reef resident, the cone snail, produces a peptide that is 1000 times as potent as morphine and that is not addictive. We may never know what other potential treatments will be lost as reefs deteriorate.

Climate Change and Influenza

Climate change would almost certainly alter bird migration, influence the AI virus transmission cycle and directly affect virus survival outside the host [12]. Some say that

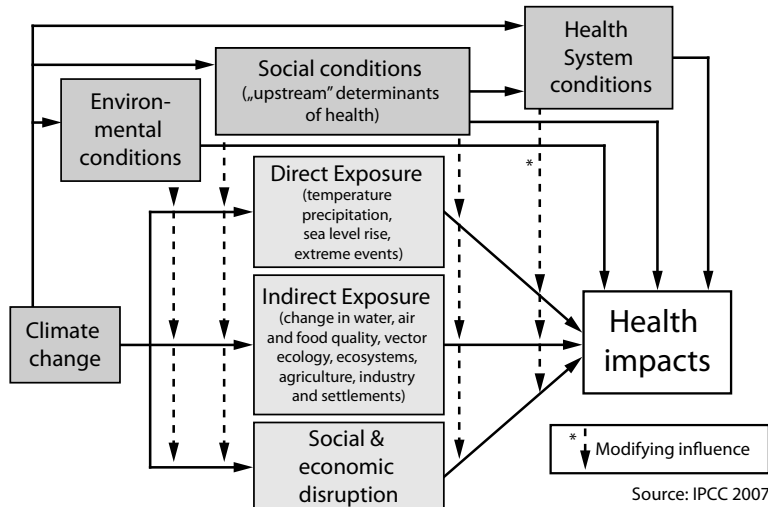


Figure 2. Climate Change and Health Impact Pathways

swine flu (H1N1) and climate change are inextricably related [13]. Tropical Africa is not the only area where deadly viruses have recently emerged. In South-East Asia, severe epidemics of dengue hemorrhagic fever started in 1954 and flu pandemics have originated from China such as the Asian flu (H2N2) in 1957, the Hong-Kong flu (H3N2) in 1968, and the Russian flu (H1N1) in 1977. However, it is especially during the last ten years that very dangerous viruses for mankind have repeatedly developed in Asia. The evolution of these viral diseases was probably not directly affected by climate change, but we cannot simply pass over this pattern.

Mitigation: Black Carbon

The Annex I & II Parties and other countries that have more developed technology and research circumstances must co-operate with developing countries to reduce the damage from climate change. We all need to focus on the newly emerging issues, such as new greenhouse gas pollutants other than classic sources and pandemic health effects amplified by climate change.

Greenhouse causing gases in the Earth's atmosphere are SO₂, water vapour, (about

80%) and carbon dioxide. But nowadays, greater interest is being directed towards black carbon and aerosol. It is reported that a strong radiative heating effect was caused when black carbon (BC) was mixed in atmospheric aerosols [11]. And black carbon is estimated to be the second largest contributor to global warming following carbon dioxide. Today, the majority of black carbon emissions from developing countries in South Asia are from biofuel cooking, whereas in East Asia, coal combustion for residential and industrial uses plays a larger role. Regulating black carbon emissions from diesel engines or local emission sources presents a significant opportunity to reduce black carbon's global warming impact.

Future Adaptation

Considering the magnitude of potential impacts, greater efforts need to be devoted to building climate resilience in sectors and climate-proofing infrastructure of at-risk areas. The impact of climate change may undermine the long-term development of many countries. The poorest people in the poorest countries are likely to suffer most. Climate change is not the only issue on the global agenda, but it requires our greatest

personal and regional attention and commitment.

References

1. Climate Change 2007: impacts, adaptation and vulnerability : working group II to the 4th assessment report of the intergovernmental panel on climate change. [Document on the Internet] [cited 2009 October 7]. Available from: http://www.ipcc.ch/publications_and_data/publications_ipcc_fourth_assessment_report_wg2_report_impacts_adaptation_and_vulnerability.htm.
2. Understanding and responding to climate change in developing Asia. Asian Development Bank, 2009. [Document on the Internet] [cited 2009 October 7]. Available from: <http://www.adb.org/Documents/Books/Climate-Change-Dev-Asia/default.asp>.
3. Lal M. Global climate change: India's monsoon and its variability: final report under "Country Studies Vulnerability and Adaptation". 2002 September. 58 p.
4. Zolotov PA. Human physiological functions and public health ultra-continental climate. In: Proceedings of intl. conf. on Climate Change and Human Health; 2004 Apr 5-6; Moscow, Russia. Moscow: Russian Academy of Sciences, 2004. p. 212-22.
5. Checkley W, Epstein LD, Gilman RH, Figueroa D, Cama RI, Patz JA, Black RE. Effect of El Niño and ambient temperature on hospital admissions for diarrhoeal diseases in Peruvian children. *Lancet*. 2000 Feb 5; 355 (9202): 442-50.
6. A3 Foresight Program CarboEastAsia [homepage on the Internet] [cited 2009 October 7]. Available from: <http://www.carboeastasia.org>.
7. Climate Change Information website [homepage on the Internet] [cited 2009 October 7]. Available from: <http://www.gihoo.or.kr>.
8. National Development and Reform Commission (NDRC) [homepage on the Internet] [cited 2009 October 7]. Available from: <http://en.ndrc.gov.cn>.
9. Ministry of Foreign Affairs of Japan [homepage on the Internet] [cited 2009 October 7]. Available from: <http://www.mofa.go.jp>.
10. Climate Change 2007: synthesis report: summary for policymakers: IPCC Plenary XXVII; 2007 Nov 12-17; Valencia, Spain [document on the Internet] [cited 2009 October 7]. Available from http://www.ipcc.ch/pdf/assessment-report/ar4/syr/ar4_syr_spm.pdf.
11. Jacobson MZ. Strong radiative heating due to the mixing state of black carbon in atmospheric aerosols. *Nature*. 2001 Feb 8; 409 (6821): 695-7.
12. Gilbert M, Slingenberg J, Xiao X. Climate change and avian influenza. *Rev Sci Tech*. 2008 Aug;27(2):459-66.
13. Mawle A. Swine flu and climate change are inextricably related. Voice of the public health movement [document on the Internet] [cited 2009 October 7]. Available from <http://www.ukpha.org.uk/news-and-press/press-releases.aspx>.
14. McMichael A, Woodruff R, Whetton P, Hennessy K, Nicholls N, Hales S, Woodward A, Kjellstrom T. Human health and climate change in Oceania : a risk assessment: 2002. [Document on the Internet] [cited 2009 October 7]. Available from http://nceph.anu.edu.au/Staff_Students/Staff_pdf_papers/Rosalie_Woodruff/Health_Climate_Change_Impact_Assessment_2002.pdf.
15. Epstein PR. Climate change and human health. *N Engl J Med*. 2005 Oct 6; 353 (14): 1433-6. Available from : <http://content.nejm.org/cgi/content/full/353/14/1433>.

*Dong-Chun Shin, MD, PhD
Chair, Executive Committee
of International Affairs,
Korean Medical Association
Professor, Dept. of Preventive Medicine,
Yonsei University College of Medicine*

Anthropedia's initiatives to promote person centered care



Sita Kedia

As the rates of lifestyle and stress-related illness increase worldwide, the Anthropedia Foundation (APF) advances the Science of Well-Being and offers solutions to foster health and happiness that are adapted to the 21st century. APF is a non-profit organization that promotes well-being through health and education initiatives, and is dedicated to empowering individuals of all ages to reach their fullest potential for physical, mental, and social well-being. Anthropedia is led by an institute of professionals from the fields of medicine, psychology, art, education, and public health. Members of the Anthropedia Institute examine effective and scientifically based practices from their fields and design comprehensive strategies to improve physical, mental, and social well-being. Based on the findings of the Institute, the foundation creates resources that teach people ways to cultivate healthy lifestyles, psychological resilience, character development, and self-awareness. Resources are simple, practical, and powerful, and can be used by individuals, professionals, and organizations seeking an effective approach to achieving and sustaining well-being.



Lauren E. Munsch

Existing biomedical approaches to illness prevention and treatment often fail to address the complex relationships between a person's body, mind, and social context [1, 2, 3]. Furthermore, healthcare systems worldwide are limited in their ability to provide opportunities for people to receive the attention, personalized care, health education resources, lifestyle counseling, and support necessary to foster long-term health and happiness. APF aims to prevent disease and promote health by providing healthcare professionals with tools to apply a comprehensive approach that encourages consideration and care for the *whole* person (body, thoughts, and psyche) within their social context.

APF develops and provides multi-media courses in well-being that individuals can use on their own and professionals can offer as a complement to therapy. Anthropedia's *Know Yourself* series is a step-by-step course in well-being designed to help people augment health and happiness, face stressful challenges, and find greater satisfaction in their lives. *Know Yourself* offers an approach to mental and physical well-being that is

based on the latest research in psychiatry, psychology, neuroscience, and mind-body health, including studies on self-awareness, personality, positive thought, and life satisfaction. Specifically, the series builds on the research and clinical work of C. Robert Cloninger, MD [4]. Supplemental materials for each part of *Know Yourself*, including summaries and exercises are also available on Anthropedia's website (www.anthropedia.org). The *Know Yourself* series is received well by individuals and is successfully used in schools, criminal rehabilitation, medical treatments, and therapy settings.

APF also develops and provides evaluation tools for professionals and individuals to gain insight into a person's sense of well-being, emotional outlook, and higher cognitive processes via temperament and character measurements, as well as through positive and negative emotion inventories, and life satisfaction scales. The presence of positive emotions, as well as a person's ability to be resourceful, purposeful, goal directed, controlled, and aware of one's psychological attachments and dependences, are strong positive predictors of health [4]. The Temperament and Character Inventory (TCI) is the most advanced and comprehensive test of personality available to date. Designed by C. Robert Cloninger MD, the TCI identifies the intensity of and the relationships between the seven basic personality dimensions of temperament and character, which interact to create the unique personality of an individual [5]. The TCI provides a profile that can help people understand themselves or another person, such as their child, spouse, friend, or anyone else they know well. Low Self-Directedness is a strong indicator of vulnerability to major depressive disorders [6]. High Self-Directedness is also a predictor of rapid and stable response to both antidepressants and CBT [7].

When a patient or health care professional has a more complete understanding of a person's unique character and temperament traits, and how they help or hinder a per-

son's experience of well-being, they can take a more personalized and targeted approach to treatment. APF has worked to make this test available through our website for both individual and professional use, as well as for clinicians interested in using the test for research. The TCI is a validated assessment in both adolescents and adults offered in several languages [8, 9]. Quantitative scoring of the profiles allows comparison to other people. It also allows for predictions about situations that are difficult or stressful, and ways of dealing with those difficulties.

Anthropedia's initiatives promote person-centered care by providing professionals with tools to learn more about their pa-

tients, and by increasing the availability of educational resources that teach ways to develop and sustain physical and mental health. For more information about the Anthropedia Foundation please visit www.anthropedia.org.

References:

1. Mezzich, J.E. and I.M. Salloum, Clinical complexity and person-centered integrative diagnosis. *World Psychiatry*, 2008. 7(1): 1-2.
2. Mezzich, J.E., Positive health: conceptual place, dimensions and implications. *Psychopathology*, 2005. 38(4): 177-9.
3. Mezzich, J.E., Psychiatry for the Person: articulating medicine's science and humanism. *World Psychiatry*, 2007. 6(2): 65-7.
4. Herrman, H., R. Moodie, and S. SR, Mental Health Promotion, in *International Encyclopedia of Public Health*, K. Heggenhougen and S. Quah, Editors. 2008, Academic Press: San Diego.
5. Cloninger, C.R., *Feeling Good: The Science of Well Being*. 2004, New York: Oxford University Press.
6. Farmer, A., et al., A sib-pair study of the Temperament and Character Inventory scales in major depression. *Arch Gen Psychiatry*, 2003. 60(5): 490-6.
7. Cloninger, C.R., A practical way to diagnosis personality disorder: a proposal. *J Pers Disord*, 2000. 14(2): 99-108.
8. Cloninger, C.R., D.M. Svrakic, and T.R. Przybeck, A psychobiological model of temperament and character. *Arch Gen Psychiatry*, 1993. 50(12): 975-90.
9. Lyoo, I.K., et al., The reliability and validity of the junior temperament and character inventory. *Compr Psychiatry*, 2004. 45(2): 121-8.

Sita Kedia, MD, Lauren E. Munsch, MD

Lack of access to healthcare information is a hidden killer

Healthcare Information For All by 2015

By 2015, people will no longer be dying for lack of knowledge



Neil Pakenham-Walsh

Every day, tens of thousands of children, women and men die needlessly for want of simple, low-cost interventions - interventions that are often already locally available. *A major contributing factor is that the mother,*

family caregiver or health worker does not have access to the information and knowledge they need, when they need it, to make appropriate decisions and save lives. For example:

- **8 in 10 caregivers** in developing countries do not know the two key symptoms of *childhood pneumonia* - fast and difficult breathing - which indicate the need for urgent treatment[1] (only 20% of children with pneumonia receive antibiotics despite wide availability, and 2 million die each year);
- **4 in 10 mothers** in India believed that they should *withhold* fluids if their baby develops diarrhoea (worldwide, 1.8 million children die every year from dehydration due to diarrhoea)[2];
- **3 in 4 hospital doctors** responsible for sick children in district hospitals in Bangladesh, Dominican Republic, Ethiopia, Indonesia, Philippines, Tanzania, and



- Uganda had *poor basic knowledge* of common killers such as childhood pneumonia, severe malnutrition, and sepsis[3];
- **4 in 10 general practitioners** in Pakistan used *tranquilisers* as their standard treatment for hypertension[4].

HIFA2015 is a rapidly growing campaign and knowledge network with more than 2900 professionals from 150 countries worldwide - healthcare providers, librarians, publishers, researchers, policymakers and others committed to improve health care. Every day, members exchange ideas, experience and expertise on ways to enhance the availability of relevant, reliable healthcare information in low-income countries.

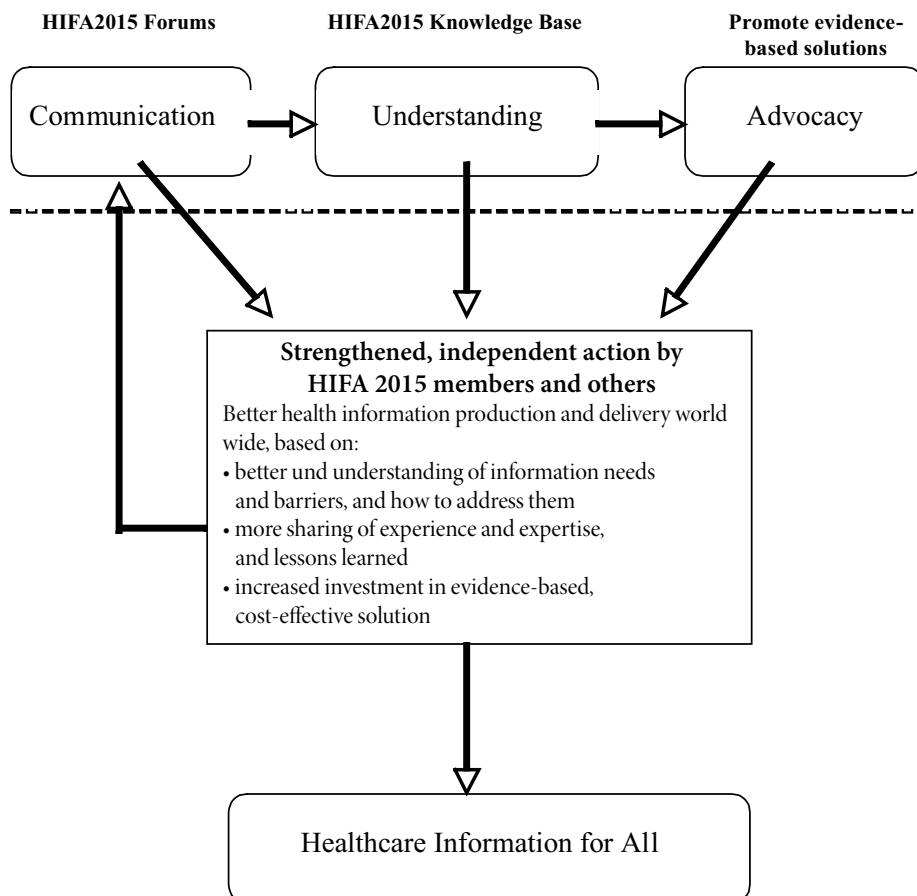


Figure: The HIFA2015 Campaign strategy and how it assists HIFA2015 members and others to achieve our common goal.

Upper section: HIFA2015. All stakeholders are invited to use and contribute to the HIFA2015 Forums and HIFA2015 Knowledge Base. HIFA2015 members share experience and build an understanding of information needs and barriers, and how to meet them. This in turn provides the evidence base needed to identify and promote cost-effective solutions.

Lower section: Independent action by HIFA2015 members and others. HIFA2015 members represent thousands of organisations that produce, exchange and deliver health information. These organisations benefit from their participation in the HIFA2015 Forums and Knowledge-Base. Their collective impact is increased, leading progressively to Healthcare Information For All by 2015, a future where people are no longer dying for lack of knowledge.

Our common goal: *By 2015, every person worldwide will have access to an informed healthcare provider – people will no longer be dying for lack of knowledge.*

Together, we are building a specialised web-based tool, the HIFA2015 Knowledge Base. This harnesses the collective experience and expertise of HIFA2015 members as a basis for a better understanding of the information needs of different groups of healthcare

provider in different contexts, and ways of meeting those needs. A prototype is available at www.hifa2015.org/knowledge-base.

“HIFA2015 is needed as a global forum which provides space for professionals from all parts of the world to exchange views and share knowledge.” Dr Najeeb Al-Shorbaji, Director of Knowledge Management and Sharing, World Health Organization, HIFA2015 Foundation Document 2008

The HIFA2015 Knowledge Base will provide the evidence we need to persuade governments and funding agencies to commit political and financial support for diverse efforts to improve availability and use of healthcare information, especially where it is most needed. For too long, the information needs of healthcare providers in low-income settings have been neglected.

Each year the campaign includes a focus on a particular cadre of healthcare provider. In 2008 the focus was on health students (medical, nursing, midwifery and allied health). The HIFA 2009 Challenge is addressing the information needs of nurses and midwives, in collaboration with the British Medical Association, Global Alliance for Nursing and Midwifery, International Confederation of Nurses, International Confederation of Midwives, Royal College of Midwives, Royal College of Nurses, WHO and others. In 2010 the HIFA2015 membership will turn its attention to Community Health Workers.

The HIFA2015 members have evolved the campaign strategy (see Figure). The strategy focuses on improving interdisciplinary communication (HIFA2015 and CHIL2015 forums), understanding (HIFA2015 knowledge base) and advocacy (see figure, above dotted line). These are the three pillars of the campaign, providing an enabling environment to support and inform independent health information activities by HIFA2015 members and others.



HIFA2015 is administered by the Global Healthcare Information Network (www.ghi-net.org), assisted by the HIFA2015 Steering Group, three Working Groups (HIFA Challenge; Knowledge Base; Fund-raising & Marketing), an International Expert Advisory Panel, and dozens of HIFA2015 volunteers.

Over 70 leading health and development organisations have officially committed to work together towards the HIFA2015 goal. Examples are shown below.

- **HIFA2015 Supporting Organisations** (2009 funders in bold)
- Association for Health Information and Libraries in Africa
- BioMed Central
- Book Aid International
- **British Medical Association**
- eIFL

- European Association of Senior Hospital Physicians
- European Federation of Salaried Doctors
- Faculty of Public Health (UK)
- Hesperian Foundation
- INCLIN
- Institution of Engineering and Technology
- International Council of Nurses
- International Federation of Medical Students' Associations
- International Medical Corps
- London School of Hygiene and Tropical Medicine
- Medical Library Association
- Medsin
- Partnerships in Health Information
- **Royal College of Midwives**
- **Royal College of Nursing**
- Royal College of Obstetricians and Gynaecologists
- Standing Committee of European Doctors
- Teaching-Aids at Low Cost
- Tropical Health and Education Trust
- WHO African Regional Office Library

On 19th November 2009, in Maputo, Mozambique, we are launching HIFA2015-Portuguese in collaboration with the ePOTUGUÊSe network, hosted at WHO headquarters. In 2010 we hope to launch

HIF2015 in French, with other languages to follow.

The HIFA2015 campaign strategy is currently only 20% funded, with thanks to the British Medical Association, Royal College of Midwives and Royal College of Nursing. This means that we are far from reaching our full potential. We welcome additional offers of funding and in-kind support to enable us to achieve our goal.

We also invite all readers to join the campaign as individuals. To find out more, and to contribute your expertise to our efforts, please visit our website: www.hifa2015.org.

References

1. Wardlaw T *et al.* Pneumonia: the leading killer of children. *Lancet* 2006;368:1048-50
2. Wadhvani N. An integrated approach to reduce childhood mortality and morbidity due to diarrhoea and dehydration. <http://hetv.org/india/mh/plan/hetvplan.pdf>
3. Nolan T *et al.* Quality of hospital care for seriously ill children in less-developed countries. *Lancet* 2001;357(9250):106-10
4. Jafar TH *et al.* General practitioners' approach to hypertension in urban Pakistan: disturbing trends in practice. *Circulation* 2005;111(10):1278-83.

*Dr. Neil Pakenham-Walsh,
HIFA2015 Coordinator*

The Medical Women's International Association (MWIA)

The Medical Women's International Association has been in existence since 1919, when it was founded in New York city by a group of medical women from around the world. Dr. Esther Pohl Lovejoy was its first president.

As a non-political, non-sectarian and non-profit association of medical women representing women physicians from all five continents, the Medical Women's International Association's objectives are:

- To offer women in medicine the opportunity to meet, network and discuss issues concerning the health and well-being of humanity.
- To promote the general interest of women in medicine by developing cooperation, friendship and understanding without regard to race, religion or political views.
- To overcome gender-related differences in health and healthcare between women and men, girls and boys throughout the world.



Shelley Ross

- To overcome gender-related inequalities within the medical profession.
- To promote health for all throughout the world with particular interest in women, health and development.

The Association is composed of eight geographical regions: Northern Europe, Central Europe, Southern Europe, North America, Latin America, Near East and Africa, Central Asia and Western Pacific. Each region is represented on the Executive Committee by its regional Vice-President. The President, President-Elect, Treasurer, Secretary-General and the Vice-Presidents are elected by the members for a term of three years. The MWIA Secretariat in Burnaby, Canada, coordinates the interests and activities of the Organization.

Dr. Atsuko Heshiki is the current President and Dr. Shelley Ross is the Secretary-General.

Every three years, the MWIA holds an international meeting. The last meeting was in Accra, Ghana, in 2007 and the next meeting will be in Munster, Germany, in July, 2010. The theme of the 2010 conference will be **"Globalisation in Medicine - Challenges and Opportunities,"** with a focus on four sub-topics: Gender Strategies, Addiction, Epidemic Plagues and Nutrition. Please visit the website at www.mwia2010.net and plan to join us.

MWIA has advocated on numerous for gender and health issues for many years. MWIA wrote a Training Manual on Gender Mainstreaming in Health for physicians and helped the World Health Organization Department of Gender Women and Health develop their gender training modules. MWIA's manual can be accessed on the webpage at www.mwia.net. Numerous workshops on gender and health have been held at regional and national meetings. MWIA has also written a Training Manual on Adolescent Sexuality, which can be accessed on the website.

MWIA has been on the forefront of work on female genital mutilation, with one of our members from Sierra Leone having written a book back in the 1980's on the topic and appearing in the Danish film entitled **The Silent Pain**. MWIA participated recently in a large meeting organized by the WHO on this subject in Kenya.

In many countries, women physicians have been instrumental in developing government-funded programs for prevention of cervical cancer by the use of the HPV vaccines, early detection and treatment. MWIA was represented in October in Lusaka, Zambia, at a meeting of cervical cancer prevention and treatment strategies.

MWIA has recently partnered with the International Osteoporosis Foundation to make women aware that osteoporosis is a silent killer. MWIA participated in a survey conducted in Europe, Mexico and Canada to assess the public's perception of the osteoporotic woman. Much to the surprise of physicians, this is no longer assumed to be a disease of the old and frail, but one that affects women who are active and who want to be in charge of their lives. A second survey was done to see if mothers and daughters were aware of the dangers of osteoporosis.

With an increasingly large proportion of women in medical schools, MWIA has sought to ensure the training of women in leadership roles to ensure that medicine continues to have significant influence on policy decisions in the health field. MWIA feels that medicine must not be allowed to become a Pink Collar Profession.

MWIA is active in primary health care delivery, with several of its members on the front lines of delivering health care in various areas around the world.

In Calcutta, the West Bengal Branch of MWIA runs a Mission Hospital. Dona-

tions are always welcome, as the physicians volunteer their time at the hospital.

MWIA is pleased to attend the annual meetings of the World Medical Association as an observer. MWIA would be pleased to partner with the World Medical Association in projects of mutual interest.

Shelley Ross, MD, Secretary-General, MWIA



A strange form of declaring a health emergency: the case of Venezuela

Introduction

The declaration of a national health emergency in any country in the world is a decision that is adopted by the authorities in the face of unexpected or unusual events that produce a situation that is considered a public health emergency [1] of national or international concern. These diverse events go from natural disasters, armed conflicts, to disease outbreaks or potentially pathogenic events that constitute a threat to the public health of a country and of other States.

This type of declaration is usually accompanied by decisions of a legal and administrative nature, that allow the authorities to adopt dispositions that, amongst other things, temporarily restrict liberties, as in the case of quarantines, and/or temporarily eliminate certain requisites demanded of the national public administrations for the acquisition of the goods and services necessary to protect the health of the population affected by the events that produced the emergency.

The case we are concerned with, the declaration of emergency recently announced by the President of the Bolivarian Republic of Venezuela, Hugo Chavez [2], is *sui generis*. On one hand, it is not the result of an unexpected or unusual event of a kind that is frequently invoked to adopt such a decision; on the other hand, it is not supported by any administrative act. Other kinds of facts are clearly at play here, and revealing their meaning is the purpose of this article, which draws heavily on an open letter addressed to President Chavez by Venezuelan ex-Ministers of Health Blas Bruni Celli, Jose Felix Oletta, Rafael Orihuela, Pablo Pulido and Carlos Walter.

The announcement of the emergency declaration and a question that warrants a different response

"In the social area, we have an emergency at this time: health. Let us state that we are all in a state of emergency (...) Two thousand Barrio Adentro primary health care units have been closed. What happened there? We have all been negligent" [3]. In this case was this declaration of emergency announced to the Venezuelans in an extended Cabinet Meeting held on 19 September.

Venezuelans were surprised that President Chavez asked himself *"What happened there?"* The president seems to have forgotten that both he and the Cuban Government decided to start a progressive transfer of 4500 Cuban doctors from Venezuela to Bolivia by 2006?

Since 2007, various studies as well as statements [4, 5] by the users of the parallel system of Barrio Adentro, have shown serious problems in access and quality of services. This dissatisfaction worsened when the personnel were reduced upon being transferred (without explanation to the Venezuelan people) to other countries.

Of the 8000 buildings scheduled to be built as popular clinics for the Barrio Adentro I network only 2000 have been built, and in the clinics and attention sites that are operative, the tasks of primary health attention

* Barrio Adentro (BA) I is the name that the Venezuelan government uses to designate a network of primary attention in a health system that is parallel to the conventional one, that began operating in 2003. This system is managed by the Cuban Medical Mission in Venezuela outside the rectory of the Ministry of Health.

had to be limited. In addition, many of the "cooperantes" or Cuban health professionals or technicians were moved to work at the "Comprehensive Diagnostic Centres"**. Very soon the provision of services was discontinuous and irregular, the hours of operation were reduced and many modules closed their doors. This resulted in discomfort and frustration among the users and among those that in good faith accepted to get involved in health activities. Finally, the infrastructure has deteriorated due to lack of maintenance and use.

It seems that President Chavez has not found out that on January 2008, the President of The Metropolitan College of Physicians and representative of the National Bolivarian Physicians Front stated: *"Unfortunately, I have to admit that the wonderful plan of Barrio Adentro has collapsed. The centres have been transformed into simple points of reception. The constitutional goal has not been met"* [6].

The abandonment of the 2000 Barrio Adentro centres to which the President referred is not the only problem this system faces. Barrio Adentro generated a new network within the public subsystem, which deepened and broadened the segmentation and fragmentation of the Venezuelan health system. These characteristics were some of the flaws that the Ministry of Health and Social Development (today the Ministry of Popular Power for Health) pointed out about the health system existing in the country before 1999, and that needed to be corrected [7].

From a technical, administrative, and managerial perspective, Barrio Adentro was never integrated into the Public Health System; on the contrary, it was a critical factor in debilitating the existing system. At the same time, this system did not achieve

** The Comprehensive Diagnostic Centers are part of the medical assistance establishments that constitute the network for secondary attention in the parallel health system managed by the Cuban Medical Mission in Venezuela.

the expected coverage. Even though Barrio Adentro increased the coverage of the primary care level, in practice it duplicated the existing coverage. The question is, how efficient, effective and sustainable has this policy been? How much has it contributed to reduce the regional inequities in terms of coverage? In addition, there has never been enough information to evaluate the results, nor transparency in the management and rendering of accounts by those who have led and managed this parallel health system.

For all these reasons, the dismantling of Barrio Adentro is not a "health emergency". It is a fact known for over three years by the President, the health authorities and most Venezuelans, a fact that adds to other ills of the national health system. We regret that the President accepts it as true only when the Cuban Government corroborates this information. It would have been enough for him to listen to the Venezuelan people, those who support him, those who supported him, and those who do not agree with his administration, but particularly, to those people with scant resources that benefited from Barrio Adentro and who now feel deceived and cheated.

Responsibilities of the announced abandonment

The responsibility of the President in this matter is not transferable. He cannot transfer blame to the rest of his Cabinet, his governors and his mayors. He and he alone is responsible for having delegated to a foreign government, the Cuban Government, through the Cuban Medical Mission, the management, supervision and evaluation of this Parallel Health System.

How can the President explain to the country that in January 2008 in his Annual Message to the Nation [8], he stated that 6531 primary health centres were in operation and seven months later, he said 2000 had been abandoned? How can he explain that on 25 January 2006, at the height of Barrio Aden-

tro, 21 745 Cuban health "*cooperantes*" were working, and now with 24 000 "*cooperantes*", 2000 health centres have been closed?

It is the duty of the President and of the State Controller Agencies to promptly order investigations to establish responsibilities in the neglect and abandonment of Barrio Adentro Mission that gave rise to the aforementioned declaration of emergency, and what share of the responsibility belongs to the Cuban Government.

A wrong answer

The solution is not to bring more Cuban doctors and students to join those already here, and who are not showing results in improving the health care in our Nation. This will only compound the errors and will delay the actions to start a systematic approach to improve the Venezuelan health care system.

After 10 years in power, President Chavez does not seem to realise that the severe problems of the Venezuelan health care system are not limited to the appalling neglect of Barrio Adentro. During this decade of President Chavez's government, many critical health system functions were abandoned, deteriorated or improvised. Debilitating policies, such as reorienting the objectives of health campaigns, fragmenting, segmenting and centralising health care services have produced inequity and exclusion, in addition to reducing the coverage and the quality of health care. Never before has so much money been spent in health, in a disorganised, uncontrollable, and non-transparent way. And never before have the results, as measured by health indicators, been so poor.

Fundamental health programs do not show results, epidemiological surveillance is weak and the capacity to respond to endemic diseases, epidemics, emerging and re-emerging diseases is poor and inefficient. There are no integrated plans against new social health

threats such as violence, drug addiction and problems arising from population explosion. Environmental sanitation and the quality of housing is poor. Public hospitals are in ruins, Venezuelan mothers are giving birth on the street, health information has been arbitrarily restricted, all of which weaken the response capacity of the system. In addition, there is a deliberate policy to destroy the national health manpower, which has morally damaged the health workers and their families.

To make matters worse, in these past 10 years of President Chavez and his ruling party in government, despite having an ample majority in the National Assembly, he has been unable to foster a broad debate to approve health legislation that would contribute to make the right to health an effective right for all Venezuelans.

The critical social reality

The problems related to the health sector affect other social policy areas, which in turn decisively affect the health of the population and their quality of life.

We are deeply concerned that the political environment, the democratic shift towards an authoritarian regime, the fragile social peace, the loss of civil liberties and the re-



Unsanitary conditions near an abandoned popular clinic in the "El Hediondito" (The Stinky) neighborhood



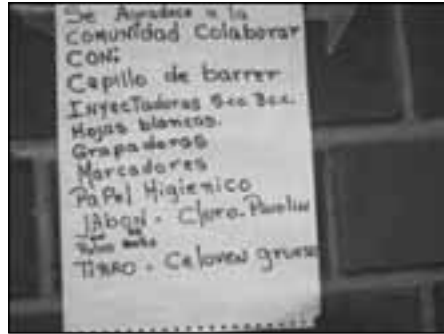
Inside an abandoned popular clinic

cently approved unconstitutional laws that impose a national model stamped with the personal ideology of President Chavez, have all advanced simultaneously with repression and threats to the freedom of speech. The increasingly unsatisfied social demands stimulate conflict and have contributed to a disrupted social dialog, particularly with the public authorities. These conditions fertilise the way towards greater poverty, deeper conflicts, greater insecurity, more exclusion, less health, fewer opportunities for productive work and less development.

Thus, it is critical to enable a space for social dialogue in order to reach fundamental agreements. Amongst these, health is a critical condition for equitable development, and this value is the best drive in combating exclusion and poverty.

The necessary correction

The Venezuelan health system has serious deficiencies. Improving them requires mak-



Poster on the wall of a fully operating popular clinic with a list of materials requested of the community: broom; syringes 5cc, 3cc; white sheets of paper; staplers; magic markers; toilet paper; soap powdered and bathroom; Clorox and masking tape.

ing political decisions sustained by sound technical and scientific criteria. This is a hard reality for all Venezuelans, a reality from which we cannot escape. A shared destiny forces us to humbly offer wise and timely responses.

The construction of Venezuela requires tolerance, respect for personal dignity, willingness to a civilised understanding within our society that cannot continue oscillating between extremes of endless and fruitless confrontation, and indifference or social autism, driven by hatred, resentment and thoughtlessness. There is still time to rectify, to invoke more freedom and more democracy, and in this way call on all Venezuelans

to share the dream of a more just and better country.

References

1. Organización Mundial de la Salud (2006). *Reglamento Sanitario Internacional 2005*, Ediciones de la OMS, Ginebra, Suiza.
2. Chávez declara en emergencia sistema de salud. Available from: http://www.eud.com/2009/09/19/pol_ava_chavez-declara-en-em_19A2760687.shtml
3. Chávez declaró en emergencia la salud en Venezuela. Available from: http://www.eluniversal.com.ve/2009/09/20/pol_art_chavez-declaro-en-em_1574464.shtml
4. Rachel Jones, *Hugo Chavez's health-care programme misses its goals*. *Lancet*. 2008 Jun; 371(9629): 1988.
5. Aceptación de Barrio Adentro descendió pero sigue alta. Available from: <http://www.guia.com.ve/noti/50545/aceptacion-de-barrio-adentro-descendio-pero-sigue-alta>
6. Fernando Bianco: "La misión Barrio Adentro se vino abajo". Available from: <http://www.aporrea.org/misiones/n108067.html>
7. Organización Panamericana de la Salud -OPS (2006). *Barrio Adentro: derecho a la salud e inclusión social en Venezuela*, Caracas, Venezuela
8. Mensaje Anual a la Nación del Presidente de la República. Available from: www.abn.info.ve/mensaje_anual_2009.doc

Carlos Walter V.

Ex-Minister of Health of the Bolivarian Republic of Venezuela

Ex- Institutional Development Advisor of the Pan American Health Organization
Director of the Centre for Development Studies (CENDES) of the Central University of Venezuela.

Caracas, Venezuela

Indian Medical Association: brief report of all projects

IMA's Dedication to TB Care

IMA started perhaps India's first Public Private Mix (PPM) project by joining hands with the Central TB Division (CTD) to aid their Revised National Tuberculosis Control Program (RNTCP) using DOTS funded by GFATM through our IMA-GFATM-RNTCP-PPM Project and with

M/s. Eli Lilly in a separate project. We have sensitised 25 080 private practitioners (PPs) and trained 3334 of them in providing services through 1585 DOT centres in various States of the country. It is planned to be extended to whole of the country soon.

IEC material prepared by us has been circulated to all the members for awareness of

the disease and its control and cure among the masses. Spreading awareness among our own members is a regular feature through the mouthpiece of the Association – The Journal of IMA. A regular news bulletin highlighting the activities of the project is being mailed to all the members to inculcate a feeling of belonging in them for control of the disease.

Also, an Indian Medical Professional Associations' Coalition Against TB (IMPACT) has been formed consisting of 10 specialist Associations other than IMA to promote



Workshop on IMA-GFATM-RNTCP-PPM Project (a project on TB)

treatment of TB by PPs on the guidelines of International Standards for TB Care (ISTC). Endorsements are being received from these Associations.

Stop Sex Selection

Taking serious note of the falling sex ratio in the country, IMA has taken sex selection prohibition as one of its most important activities. Therefore, IMA started a project on sex selection “Cadre of IMA Volunteers strengthened and capacities built for medical community to prevent sex selection” with UNFPA with a goal to prevent sex selection procedures by stopping the unethical practice of intra-uterine gender determination by members of the medical profession and thereby help to restore the natural child sex ratio.

A National Mentoring Group to Stop Sex Selection consisting of 7 permanent members meets quarterly to plan and devise strategies for proper implementation of the project. Federation of Obstetric and Gynaecological Societies of India (FOGSI) and Indian Radiological and Imaging Association (IRIA) are being involved in this activity.

50 eminent members of the Association known for their dedication against sex selective procedures have been nominated as IMA Ambassadors Against Sex Selection (IAASS). They have been sensitised through



Regional Workshop on “Stop Sex Selection – Doctors can make a difference”

workshops and are working for achieving the aims of the project. Guidelines have been formulated and issued to them for formation and working of the Doctors Against Sex Selection (DASS) forums at district levels.

These Ambassadors share their experiences on a regular basis through an IMA e-Group. This helps all of them to plan their strategy and gear up beforehand in their endeavour.

Contraceptive Updates and Safe Abortion Techniques

Being of the view that India’s current contraceptive prevalence rate is just 48.2 %

and unprotected sex and contraceptive accidents account for nearly 13% of unwanted and unplanned pregnancies, the IMA, in partnership with the Ministry of Health & Family Welfare, planned and successfully organised many programmes for sensitisation of the society and also its own members about the various methods of contraception. More than 2000 IMA members have been trained and sensitised to organise sessions in their area on the use of contraception. IMA Family Welfare programme has included emergency contraception and unsafe abortions as an integral part of the programme. Many sessions have been organised in various IMA Family Welfare activities.

IMA also partnered with UNFPA and has organised a Resource Persons’ Workshop on “Contraceptive Updates and Safe Abortion Techniques” which was attended by doctors from some States of India. These trained doctors will be conducting total 150 district workshops in these five States and will further train more doctors. We expect to train nearly 5000 private practitioners in these States in Family Welfare activities.

One more project by the Ministry of Health and Family Welfare wherein we will be organising sensitisation and awareness



Master Trainers Workshop on Avian Flu



Blood Donation camps are being organized from time to time by IMA Branches

programme on the various modes of available contraceptives and their use in most of the States is on the anvil. Further we will identify members who will be interested in taking up training in No Scalpel Vasectomy (N.S.V) and Laparoscopic Sterilization in near future.

Pharmaco Vigilance and Drug Safety

The efficacy and safety of a new drug are generally studied on a few thousand carefully selected and followed up trial subjects. Therefore, only very frequent adverse reactions are observed during its clinical development. Once, the medicine is placed on the market and the population is exposed, its actual safety profile is known. To identify and tackle these risks, the new adverse reactions should be reported immediately as a contribution to an incomplete safety profile.

An IMA Pharmaco Vigilance cell was formed at IMA HQs, IMA House, New Delhi with an Advisory committee to monitor and report such adverse reactions observed by the members of the Association to the competent authorities and related organisations. Nearly 1200 members from all States have been trained and sensitised in the need and procedure of Adverse Drug Reporting (ADR) / Adverse Event (AE) reporting through various sessions during events of IMA at National, State and District levels.



No Tobacco Day Rally organized by various IMA Branches all over the country

An ADR / AE reporting form has been circulated amongst members of IMA on which reports of ADR/AE are being sent to us by them.

Aao Gaon Chalen Project

“India lives in villages”. However, due to various socio-economic and other reasons, the basic healthcare needs of these citizens of the country cannot be looked after due to the poor facilities available to them.

Therefore, IMA considered its first duty to cater to the healthcare needs of the masses living in these villages. Hence, it was decided that every State and local branch of IMA will adopt villages in their area of jurisdiction to provide medical facilities to them at their doorstep.

Under the project implementation plan, creation of health awareness (general health & hygiene, adolescent health, FP, MCH care especially ANC & anaemia, gender sensitization, quackery, sex determination, female infanticide etc.) plays a pivotal role. This is done through Puppet shows; Nukkad nat-aks, School health talks; essay & painting competitions, debates in schools and colleges, social meetings involving pradhans, gram sabha members, community leaders and religious leaders.

We have been quite successful in achieving our expected outcomes from this project.



Laparoscopic sterilization camp

Swine Flu

Despite of the efforts of the Government to control the spread of Swine Flu, it has taken the form of an epidemic in our country. IMA has already sensitised all its members about the Swine Flu epidemic and issued guidelines through its News Letter. General public has been informed and sensitised about the methods to prevent the Swine Flu. An Information Cell at IMA HQs. is working round the clock to respond to various queries of general public and our members.

Tobacco De-addiction and Control

Identifying tobacco as a giant killer with 5.4 million global and around 10 lakhs Indian tobacco related deaths, IMA undertook a nationwide campaign against tobacco. To sensitise health providers about the dangers of tobacco products and generate awareness on tobacco related health issues, IMA organised Public rallies, workshops and lectures on Tobacco Control & De-addiction on 31 May 2009 all over the country on “World No Tobacco Day”.

Blood Donation

Voluntary blood donation is one of IMA's regular activities with IMA running its own state-of-art blood banks all over the country to cater to the needs of patients.

*Dr. Dharam Prakash, Hon. Secretary General
Indian Medical Association*

Changes in the Uruguayan health system

Taking into consideration a recent official publication, we provide a brief overview of the Uruguayan health system in the mid-2000s and the main measures adopted within the framework of this change, organising it around seven issues.



Julio Trostchansky

According to the classic indicators of mortality, the health situation in Uruguay has been comparable to that in various developed countries. However, upon observation of its historical evolution, we maintain that there has been a severe stagnation in regard to health indicators, particularly those that are more specific and closely related to the transitional model. Up until a few decades ago, Uruguay was among the top countries in the Americas for the good results obtained in the health of its population, although the fact that it failed to follow the dynamics created by several countries in the region resulted in slowdown of progress in the field.

It is said that the health system failed to respond to the needs of the Uruguayan population. Demographical, epidemiological and social transformations that took place ultimately define a new needs profile. Increase in life expectancy and decrease in fertility are reflected in an aged population, where

chronic degenerative conditions prevail. In addition to this, a strong process of economic and social inequality experienced in the past decades caused a large sector of society to fall below the poverty line. As a matter of fact, it is in these sectors, deprived of protection, where the highest child mortality rates are found.

1. From the point of view of the organisation of the health care services, it is said that the main problems are grounded on the existence of two service providers' sub-systems that were fragmented and had no connection with one another, unequal in terms of citizen access to them and showing no signs of being complementary. In particular, the State's main provider remained as an entity that had no relation with the Ministry of Health, and thus acted stiffly, evidencing confusion with other tasks carried out by the Ministry.

According to official publications, sectoral measures were geared towards creating a national integrated health system, by strengthening the connection between sub-sectors, favouring greater equality based on the strong contribution of resources and strengthening the main public health care centre, thus aiming to improve access of more vulnerable sectors of population and to encourage complementary bonds between sub-sectors. The State's main health care services provider is decentralised, and through the reinforcement of financial resources, priority was given to the salaries of physicians, which increased substantially. The latter is probably the most relevant change in terms of human resources, an aspect that has not been prioritised in the agenda for change.

2. Likewise, only employees from the formal private sector – without including their relatives – were covered by a social health insurance they paid for together with their

employers via their payroll, it being only possible for them to choose their health care services provider from among private medical institutions and later on losing their right to choose and the said health insurance coverage upon retirement.

The new system is said to have a combined nature in terms of the service providers, including private and public institutions acting within the framework of a complementary and competitive regime, giving a chance to those insured to choose between public and private institutions.

At the same time, the rest of the population had access to health care services under different modalities, ranging from individuals paying for services out of their own pockets to free services being funded by taxes collected by the State for indigents or people lacking enough resources, or else provided by means of a combination of financing modalities for specific sectors of the population, as for instance, the military and police.

As to relatives, they are specifically included in the social insurance health coverage, children are immediately covered, and as from 2010 spouses will be included according to the regulations in force. The system consists in making social insurance into a universal coverage plan that provides for a graded admission of citizens to the system that is funded by the national insurance, turning it into a life insurance, since insurance rights survive upon the beneficiaries retirement.

3. The price reimbursed to providers of health care centres who ensured and rendered health care services was regulated by a single monthly payment by the State. In this way, the social sickness insurance and a large portion of the remaining population paid their insurance via this system, ignoring the risk associated with the covered population and the expected cost differential, thus weakening the sustainability of the health care service system itself. Simultaneously,

the price of important supplies was under no regulation whatsoever.

From the point of view of payment to health care centres, the national health insurance pays according to risk – even partially, as a stage in the transition process – as distinct from single payment reimbursement.

Prior to the process of change, a distortion in the price of co-payments grew stronger (care-order payments, medicine tickets and multiple diagnose and treatment techniques), evolving from a way to regulate demand – under State provisions – into a way to fund the private health care system, and thus creating great barriers for the access of users.

Thanks to modifications introduced into the system, the prices of a number of medicine tickets controlled by the State were mainly brought down, although they still hinder access to consumption by a large portion of users.

High-cost non-frequent techniques, generally associated to high-technology, are covered by the so-called National Resource Fund, a combined fund (public and private) and reimbursement system – according to different modalities – for highly specialised medical institutions.

4. It is believed that the system portrays a health care model that fails to emphasise strategies for primary health care services, and is instead eminently a therapeutic, hospital-centered model.

The official document suggests the transformation of the advanced health care model based on the implementation of strategies for primary health care services, according to regulations that encourage these strategies and additional payments associated with achieving health care goals that need to be carried out by the first level of assistance.

5. The document further explains that the administration and control system is weakened in the different tasks required, there being no management contracts or incentive programs based on goal accomplishment (health/economic-financial goals).

At the official level, the change process is to provide the system with a real administrative and control policy, mainly by means of the execution of management contracts and their enforcement and sanctions framework, whereby institutions providing health care services commit to fulfil the health programs defined as priority programs.

6. The quality and quantity of services that the whole structure commits to render was not clearly defined.

Ministerial authorities reassure that the system has managed to level the quality and quantity of benefits by means of the specific definition of the national integrated health system that becomes an explicit guarantee whose enforcement can be demanded from the health authorities.

7. Finally, reference is made to the fact that historically there has been no social participation in the running of systems or institutional management.

Changes suggest the incorporation of social participation as a system and institutional guideline. In this way, the participation of users and workers of the National Integrated Health System is strongly encouraged at the macro level of the National Health Council, and at the micro level of institutions providing health care services. Private institutions will do it by means of Counselling Consulting Councils, and public institutions will rely on the participation of the board of the main health care services centre.

Ec. Luis Lazarov, Executive Committee Consultant;

Dr. Julio Trostchansky, MD, President SINDICATO MÉDICO del URUGUAY;

Alarico Rodríguez, MD, Head of Foreign Relations

Prescription for a Healthy Planet

Health Care Without Harm (HCWH) and the Health and Environment Alliance (HEAL) are working with the World Health Organisation (WHO) to launch a new platform, the **Prescription for a Healthy Planet**.

Why you should care

Climate change affects health, the environment and economy – but the health community will be picking up the tab as the health impacts of climate change begin making themselves felt.

Yet health is largely missing in climate change discussions.

The health community holds an influential position in society and in policy-making. If its voice were heard then climate initiatives would be significantly stronger and more health-friendly.

Please join our efforts to bring health to climate change negotiations

- Endorse the Prescription
- Promote the Prescription in National Medical Association publications and elsewhere
- Join us in Barcelona for the global launch of the Prescription and Network



The problem

There is increasingly powerful scientific evidence that climate change is not only a reality now but is threatening to become a far more destructive phenomenon much more quickly than even recently predicted.

One of the most disturbing implications of climate change is its potentially dramatic impact on human health around the world. As the Lancet Commission report says: “the effects of climate change on health will affect most populations in the next decades and put the lives and well-being of billions of people at increased risk.”

Overall, the health impacts of climate change will be disproportionately felt by the most vulnerable populations – the poor, the very young, the elderly and the medically infirm.

The World Health Organization predicts that climate change will lead to a series of significant health impacts, including: higher levels of some air pollutants and concomitant increased respiratory disease; the spread of diseases such as cholera, malaria, dengue and other infectious diseases; the compromising of agricultural production and food security in some of the least developed countries leading to greater malnutrition; an increase in extreme weather events like floods and droughts with dramatic impacts especially on the health of people living in coastal communities.

The health sector on the front lines

Healthcare providers and public health practitioners will be on the front lines, confronting and adapting to this changing landscape and shifting burden of disease. Such adaptation will come at a cost: the more severe the health-related symptoms of climate change, the greater the outlay of financial and human resources that will be required to treat them.

The health sector itself also makes a significant contribution to the problem of climate change. Healthcare is a major consumer of energy, water, computers, chemicals, pharmaceuticals, food and other resources. This consumption leaves a significant climate footprint.

A leadership role

Precisely because the healthcare sector’s climate impact is so far-reaching, it must play a leadership role in developing and modeling solutions for the rest of society.

Many healthcare institutions are already employing a diversity of cost-effective climate-mitigation measures including energy efficiency, on-site alternative energy generation, green building design and construction, along with more climate-friendly procurement, transportation, food, waste and water-use policies.

Done correctly, these efforts to reduce our climate footprint and to move healthcare

toward carbon neutrality will also create major benefits for public health. The extent of these benefits is only gradually becoming known.

Reducing our reliance on fossil fuels and moving toward clean, renewable energy can have the added benefit of reducing local pollution generated by the combustion of coal, oil and gas. This in turn would reduce the number of respiratory illnesses related to such energy consumption, thereby improving public health. Visionary action to mitigate climate change now will go a long way toward avoiding major health challenges in the future.

The Prescription for a Healthy Planet, if implemented, would both help mitigate climate change’s most severe impacts while ensuring major benefits to society by protecting public health.

A prescription for a healthy planet

- **Protect Public Health:** Take into account the significant human health dimensions of the climate crisis along with the health benefits of climate change mitigation policies. In conjunction with this, a portion of climate mitigation and adaptation funds should be targeted for the health sector. This is needed to ensure evidence of the health impacts of climate change is continuously updated and brought to policy makers, so that the health sector can adapt to the health impacts of climate change while reducing its own climate footprint. To assure a strong voice in the debate, the health sector should also be adequately represented on all national delegations to Copenhagen.
- **Transition to Clean Energy:** A viable accord must promote solutions to the climate crisis that move away from coal, oil,

- gas, nuclear power, waste incineration and fossil-fuel-intensive agriculture. The Copenhagen treaty should foster energy efficiency as well as clean, renewable energy that improves public health by reducing both local and global pollution.
- **Reduce Emissions:** In order to protect human and environmental health, the world’s governments must take urgent action to drastically reduce world-wide emissions by 2050. Over the next decade, developed countries must significantly reduce their greenhouse gas emissions below 1990 levels. Developing countries must also commit to stabilizing and reducing their emissions.
- **Finance Global Action:** A fair and equitable agreement in Copenhagen should also provide new and additional resources for developing countries to reduce their climate footprint and adapt to the impacts of climate change.

Reducing the health sector's climate footprint

As health professionals and representatives of major healthcare and public health institutions and associations, we pledge to aggressively address climate change in our sector and to promote health-friendly climate policy in all sectors.

We will work together as part of a global network to conduct research, share information and strategies to reduce our climate footprint, adapt our health systems and promote policies for mitigating climate change that also achieve significant benefits for public health.

Ultimately it is up to the leaders of the world to establish a forward thinking framework that transcends immediate political prerogatives to adequately confront this looming threat. Therefore we are calling on all world leaders to take a strong and visionary stand in the Copenhagen negotiations in December, as well as in the national and international policy debates that ensue, by following this simple and clear Prescription for a Healthy Planet.

The clock is ticking. The time for action is now.

For more information about signing up

Please contact Dr. Pendo Maro, Senior Climate Policy Advisor to HCWH Europe and HEAL: pendo@env-health.org

Website: www.climateandhealthcare.org

Regina M. Benjamin, MD, MBA, United States Surgeon General



Dr. Regina M. Benjamin, former board member of the American Medical Association (AMA) and Chair of the AMA Council of Ethical and Judicial affairs was appointed to the position of United States Surgeon General on October 29, 2009. U.S. Dept. of Health and Human Services Secretary Kathleen Sebelius announced the confirmation, noting that Dr. Benjamin's "deep knowledge and strong medical skills, her commitment to her patients, and her ability to inspire the

people she interacts with every day will serve her well as Surgeon General."

Dr. Benjamin is founder and CEO of the Bayou La Batre Rural Health Clinic in Bayou La Batre, Alabama, whose mission is to provide "Health Care with Dignity" to the impoverished residents of Bayou La Batre.

Born in 1956, Dr. Benjamin attended Xavier University in New Orleans, and was a member of the second class of Morehouse School of Medicine. She received her MD degree from the University of Alabama Birmingham, and completed her residency in family practice at the Medical Center of Central Georgia. She returned to her home region of Bayou La Batre (a small shrimping village along the gulf coast of Alabama) to establish a solo medical practice. After several years moonlighting in emergency rooms and nursing homes to sustain her practice open, mean while obtaining an MBA from Tulane, Dr. Benjamin converted her medical office into a small rural health clinic dedicated to serving the large indigent population in her community.

Dr. Benjamin is a member of the National Academy of Science's Institute of Medicine, a Diplomat of the American Board of Family Practice, and a Fellow of the American Academy of Family Physicians. She is the immediate past-chair of the Federation of State Medical Boards of the United States, and was a Kellogg National Fellow and a Rockefeller Next Generation Leader. Consistent with her strong social conscience, Dr. Benjamin spent time doing missionary work in Honduras.

In 1995 she was elected to the AMA Board of Trustees, the first physician under age 40 and the first African-American woman to be elected. She also served as President of the AMA Education and Research Foundation (AMA-ERF). In 2002 she became President of the Medical Association State of Alabama, the first African American female president of a State Medical Society in the United States.

Dr. Benjamin's extraordinary accomplishments and commitment to her medical profession have won international recognition. Dr. Benjamin was previously named by *Time Magazine* as one of the "Nation's 50 Future Leaders Age 40 and Under." She was also featured in a *New York Times* article,



“Angel in a White Coat,” as “Person of the Week” on ABC’s *World News Tonight* with Peter Jennings, as “Woman of the Year” by CBS *This Morning*, and in *People Magazine*. She was featured on the December 1999 cover of *Clarity Magazine*, and on the January 2003 cover of *Reader’s Digest*. Dr. Benjamin received the Nelson Mandela Award for Health and Human Rights in 1998. She received the 2000 National Caring Award which was inspired by Mother Teresa, as well as the papal honor Pro Ecclesia et Pontifice from Pope Benedict XVI. She is also a recent recipient of the MacArthur Genius Award.

President Barack Obama praised Dr. Benjamin’s dedication to providing health care for her rural community in the face of adversity, naming her a “relentless promoter of prevention and wellness programs” who “represents what’s best about health care in America -- doctors and nurses who give and care and sacrifice for the sake of their patients”. Dr. Benjamin explained that as Surgeon General she hopes “to be America’s doctor, America’s family physician” and she promised to “communicate directly with the American people to help guide them

through whatever changes may come with health care reform”.

Dr. Benjamin is worthy of recognition among the World Medical Association’s *Caring Physicians of the World*. She too, exemplifies the three enduring traditions of the medical profession, caring, ethics and science, which inspire hope and trust.

Yank D. Coble, MD. Director and Distinguished Professor Center for Global Health and Medical Diplomacy

Standing Committee of European Doctors – 50

The CPME celebrated its 50th Anniversary in Winchester (United-Kingdom, the home town of Dr. Wilks the CPME President) on October 23rd and 24th 2009. 4 past Presidents and the current President thanked all those people that played a role in the past 50 years.

Dr. Alan Rowe is currently retracing the history of CPME in the context of EU- and international health policy. In the introduction he gave of this upcoming description of 50 years CPME he concluded that CPME can be proud of its accomplishments.

This CPME anniversary meeting was also directed towards the future. The General Assembly envisaged, and adopted, a change in its functioning.: From 2010, the 4 CPME subcommittees will be replaced by working groups, dedicated to specific policy topics. Along with an increased use of electronic communication instead of face-to-face meetings, this shift will allow a more flexible and cost-effective decision-making process.

At the Winchester meeting the following policies were adopted:

“Use of Health Related Genetic Information outside the Health Service”
(http://cpme.dyndns.org:591/adopted/2009/CPME_AD_Brd_241009_170_final.EN.pdf)

ME calls national governments to enact legislation which should prohibit the use of health related genetic information outside the area of direct patient care and health service, such as for insurance or pension funds purposes.

“Vitamin D nutritional policy in Europe”
(http://cpme.dyndns.org:591/adopted/2009/CPME_AD_Brd_241009_179_final.EN.pdf)

CPME believes Vitamin D supplementation (600-800 IU D3) and a good calcium intake (about or above 1 g/d) should be considered (especially) for elderly people. CPME calls on the EU Institutions to include vitamin D deficiency in the health agenda.

Prescription for a Healthy Planet

CPME co-signed the Prescription for a Healthy Planet, calling for better represen-

tation of the health sector into the negotiations, which must lead to a strong, binding Copenhagen Treaty that promotes a healthy climate.

CPME Response to the Commission proposal for Council Recommendation on Patient Safety (http://cpme.dyndns.org:591/adopted/2009/CPME_AD_EC_160909_075_final.EN.pdf)

CPME welcomes the European Commission’s proposal, which recognizes the urgency of joint actions with regard to patient safety. CPME welcomes the recommendation that Member States establish reporting systems that are fair, open and non punitive. In addition, CPME urges the Council to give due consideration to the future organization of EU patient safety work and to the creation of a European Center for Patient Safety.

Lisette Tiddens-Engwirda, Secretary General

Average of one doctor per 64 000 inhabitants

Medical delegation from Malawi as guests of the German medical community

A delegation of doctors from Malawi visited Berlin at the beginning of September. In just under a week, three Malawian doctors were given an insight into the German health sector and the system of medical self-administration. They had accepted an invitation from the German Medical Association (Bundesärztekammer – BÄK) and the German Agency for Technical Cooperation (Gesellschaft für Technische Zusammenarbeit – GTZ).

Dr. Douglas Lungu is 43 years old, a surgeon and Director of the Presbyterian Hospital in Lilongwe, the capital of Malawi. Dr. Bridget Msolomba (26) and Dr. Andrew Likaka (29) both work in hospitals as general practitioners. The three doctors represent Malawi's "Society for Medical Doctors" (SMD), which was only founded in 2008.

The visit focused on various players in the German health system, such as the German Medical Association and the German Association of Hospital Doctors ("Marburger Bund").

The guests from Malawi gathered numerous ideas and suggestions that they said would help them promote the development of their medical organisation. They explained that they had set up their organisation only recently because there were very few doctors working in Malawi. In statistical terms, an estimated 64 000 inhabitants are served by one doctor. Accordingly, there are roughly 200 practising doctors in Malawi with its population of 13 million, and a single university has to cover the demand for junior medical staff. To guarantee at least a minimum of healthcare, graduates in medicine have to agree to work in their home country for two years after completing their studies.

Medical care is free of charge for patients in Malawi. At the same time, the country is facing massive financial challenges, particularly in the health sector: infant mortality is

in the region of eight percent of all births, the high AIDS rate of 11.9 percent of the total population causes serious problems, and the average life expectancy is just 46 years. Although the doctors and medical assistants make a major effort to effectively counteract the numerous problems in the healthcare sector, the available budget needs to be utilised more efficiently in practice. In the view of the doctors from Malawi, however, the distributed structure of the healthcare system is in principle sensible and will continue to be viable in the future.

General practitioners like Dr. Likaka and Dr. Msolomba are most in demand, because broad-based knowledge is needed in a hospital. "If you're not familiar with a disease, you look up the treatment in a textbook," said Dr. Lungu, describing the pragmatic approach of his hospital doctors. What the three are very knowledgeable about, is tropical medicine. Given the wealth of tropical diseases that are the daily bread of Malawian doctors, colleagues from abroad were always amazed, they said with a grin. Consequently, it would be interesting and instructive for international doctors to spend some time working at a tropical hospital in Malawi.

"As far as the equipment of the hospitals is concerned, the main thing missing is beds," said Dr. Lungu. In addition to which, however, the quality of the products they could afford often left a lot to be desired. For that reason, they would very much like to equip their hospitals with sturdy, second-hand beds from Europe, for example – if the funds for the transport were available.

The three Malawian doctors subsequently experienced what the equipment of a German hospital can look like during a tour of the eye clinic of the Charité hospital in Berlin. The one-and-a-half-hour visit introduced them to the procedures for dealing with eye patients. Senior physician Dr. Miriam Doblhofer not only explained the ex-



From left to right: Armin Ehl (Secretary General of Marburger Bund), Johanna Janotta (Marburger Bund), Domen Podnar (GMA), Dr. Andrew Likaka (SMD), Elisabeth Jibikilayi (GMA), Dr. Douglas Lungu (President of SMD), Dr. Bridget Msolomba (SMD)

amination and treatment methods, but also demonstrated the workflows in patient administration, from admission and the course of the operation, all the way to collaboration with other specialist clinics.

The exchange between the representatives of the Malawian and German medical communities was a first step towards closer cooperation. Although the conditions under which doctors work around the globe appear to be very different on the surface, it can be seen time and again that all doctors have to contend with many very similar problems. Unfortunately, their wish to engage in their curative activity often has to take a back seat to political, bureaucratic or financial targets. In this respect, closer contacts help to further strengthen the self-image of the medical community worldwide.

Therefore, the World Medical Association received the SMD from Malawi as a new member at this year's General Assembly in Delhi/India. Although the new association joining the WMA is only small, its dedicated members will no doubt help to strengthen the medical community, especially in Africa.

More information on the "Society for Medical Doctors" in Malawi can be found on the website at www.smdmalawi.org.

*Johanna Janotta, Marburger Bund;
Domen Podnar, German Medical Association*

WMA General Assembly, New Delhi 2009



Contents

WMA General Assembly, New Delhi 2009	128	Anthropedia's initiatives to promote person centered care.	152
Declaration of Delhi on Health and Climate Change.	137	Lack of access to healthcare information is a hidden killer	153
Declaration of Madrid on Professionally-led Regulation	140	The Medical Women's International Association (MWIA)	155
Declaration of Ottawa on Child Health	140	A strange form of declaring a health emergency: the case of Venezuela	157
WMA Resolution on Task Shifting from the Medical Profession	141	Indian Medical Association: brief report of all projects	159
WMA Emergency Resolution supporting the Rights of Patients and Physicians in the Islamic Republic of Iran	143	Changes in the Uruguayan health system	162
WMA Resolution on Medical Workforce.	144	Prescription for a Healthy Planet	163
WMA Statement on Inequalities in Health	145	Regina M. Benjamin, MD, MBA, United States Surgeon General.	165
WMA Resolution on Improved Investment in Public Health	146	Standing Committee of European Doctors – 50	166
Hindi – English bilingual “Speaking Book”.	147	Average of one doctor per 64 000 inhabitants	167
Impact of climate change in Asia and Oceania region and challenges ahead	148		