

# WORLD MEDICAL JOURNAL

# 51

Vol.

No. 2, JUNE 2005

## CONTENTS

### EDITORIAL

HUMAN HEALTH RESOURCES AND MORAL RESPONSIBILITIES 29

SAVING THE LIVES OF SIAMESE TWINS 30

### MEDICAL ETHICS AND HUMAN RIGHTS

THE WORLD MEDICAL ASSOCIATION –  
DECLARATION OF GENEVA 31

COUNCIL OF EUROPE 32

### WMA

170TH WMA COUNCIL MEETS IN DIVONNE 33

COUNCIL RESOLUTIONS ADOPTED AT THE 170TH  
WMA COUNCIL SESSION, MAY 2005 38

WMA DUES REFORM PROPOSAL 40

### WMA SECRETARY GENERAL

„DANGER ON THE SAFE SIDE“ 42

### MEDICAL SCIENCE, PROFESSIONAL PRACTICE AND EDUCATION

PATIENT SAFETY HIGHLIGHTED AT WORLD  
HEALTH PROFESSIONS' RECEPTION 43

THE SWEDISH PATIENT INSURANCE SYSTEM –  
A NO-FAULT SYSTEM 44

NEW ONLINE TOOL KIT ON HIV/AIDS  
PREVENTION FOR SEX WORKERS 46

TWIN STUDY REVEALS ROLE IN FEMALE INFIDELITY 47

THE NATIONAL UK MULTIPLE SCLEROSIS TISSUE BANK  
CO-ORDINATES THE COLLECTION OF DONATED TISSUE  
AND DISTRIBUTES SAMPLES TO SCIENTISTS CONDUCTING  
RESEARCH INTO THE CAUSES AND TREATMENT OF MS 47

### WHO

DR. LEE ADDRESSING THE WORLD HEALTH ASSEMBLY:  
ENDS WITH CONCERN WITH PREPARATION BEFORE AVIAN  
INFLUENZA STRIKES 48

REMARKS OF MR BILL GATES AT THE WORLD HEALTH  
ASSEMBLY 50

STRENGTHENING HEALTH INFORMATION SYSTEMS TO BETTER  
ADDRESS HEALTH NEEDS WORLDWIDE 52

THE WORLD HEALTH REPORT 2005 – „MAKE EVERY MOTHER  
AND CHILD COUNT“ 53

AN INNOVATIVE APPROACH TO HEALTH SYSTEMS RESEARCH 54

VACCINATING AFRICAN CHILDREN AGAINST  
PNEUMOCOCCAL DISEASE SAVES LIVES 55

### REGIONAL AND NMA NEWS

FIGURES AND FACTS FROM AFRICA 56

BMA „CALL FOR ACTION“ 56



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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, Postal Cheque Account: Köln 192 50-506, Bank: Commerzbank Köln No. 1 500 057, Deutsche Apotheker- und Ärztebank, 50670 Köln, No. 015 13330.  
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 (incl. 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](http://www.wma.net)

Printed by  
Deutscher Ärzte-Verlag  
Köln — Germany

ISSN: 0049-8122

**Editorial**



## **Editorial**

# **Human health resources and moral responsibilities**

Since the beginning of the 21<sup>st</sup> century there has been increasing concern, both nationally and internationally, about the distribution and shortages of human health resources—doctors, dentists, nurses, pharmacists and all other varieties of paramedical professions. In the '70s. and even in the '80s. physicians were gloomily predicting an excess number of physicians, and there were even calls for the reduction of the number of medical students in some countries. Suddenly all changed, and from a projected excess which had been predicted there was concern about a shortage of doctors and nurses, first at national level and more recently at global level. Over the past five years there have been a number of demographic studies of the distribution and future needs of the various categories of health workers – not least physicians.

By the year 2003 international bodies were beginning to be concerned not only about the shortage, but also with the effects of efforts to recruit doctors and nurses from countries with limited economic resources and which already had serious under supply of health-care professionals. In 2001, the Commonwealth Ministers of Health considered a paper prepared by its secretariat and at a pre-World Health Assembly meeting in 2003, the Ministers adopted a Commonwealth Code of Practice for the International Recruitment of Health Workers. The World Medical Association considered the issue and adopted a Statement on this topic in 2003. At this time the World Health Assembly, noting the Commonwealth Code, requested the Director-General to explore possible ways forward to improve the situation concerning international recruitment (including the possibility of a Code of Practice on international recruitment of health personnel, in particular from developing countries)

The key issues have been concerns that migration of health workers, notably doctors and nurses from undeveloped and developing countries were not only consuming substantial numbers of professionals from these countries, but were diminishing the national workforce in these countries to even more dangerous levels, from their already overstretched and understaffed position. In the columns of this journal we have already drawn attention to this situation (*see Orvil Adams, WMJ50(3)pp 60-64,2004*).

In the early part of this year the concerns were such that the British Medical Association issued a "Call for Action" and held an international conference at which Medical Associations notably from America, several African States, Canada and other interested bodies such as the Commonwealth Secretariat, The World Health Organisation, MEDACT and the Royal College of Nurses were represented. The resulting statement, together with the Four Key Points which were identified (see p. 56), were drawn to the attention of the Commonwealth Conference and other international bodies meeting this summer. Concern this year has been reflected in the adoption in May of a Council Resolution (reinforcing its earlier Statement in 2003) by the World Medical Association, by the consideration of this issue at the WHO World Health Assembly and WHO's designation of "Human Resources for Health" as the topic for next year's Annual WHO Health report and of the year 2006 as the beginning of a decade of action on this topic.

That there is a moral issue underlying all this activity is understandable in the light of the concern about the pattern of affluent countries recruiting health professionals from less developed and economically weak countries, not only depriving them of healthcare resources, but also having indirect economic consequences. The cost of training healthcare professionals, especially physicians, is a considerable burden in any society, let alone those whose economies are already weak. When as much as 50% or more of the graduates from such countries migrate (often not returning), this spells disaster for care in developing countries who are economically weak but have already borne the cost of their professional training.



This expenditure is a complete loss to the poorer economies which are not in any way compensated for this loss either financially or in terms of the professional resources of which they have been deprived.

Migration for higher training is of course essential, especially when it is not available in the home country, and the basic human right to migrate, whether for better working conditions or other reasons, is that of everyone, including physicians. However, while regard must be paid by health professionals themselves to the community in which they have been trained to carry out their professional responsibilities, it is also the duty of more affluent communities to have regard to the more impoverished and deprived communities in other countries.

Is it morally defensible to recruit health personnel from deprived communities?

Is it morally acceptable to offer posts where work and training are accessible to migrants who lack facilities for such training in their own country and then actively seek to retain them, rather than encourage their return to their own country which desperately needs their skills?

Is any recruitment of this nature justifiable for affluent countries who have simply not trained enough health professionals to meet their need, preferring rather to depend on migrant professionals to make up the short fall? At a time when affluent developed countries are beginning to recognise the poverty in some parts of the world as unacceptable and requiring positive action (such as has led to the Millennium Goals), is there not a duty to address these problems in a practical way?

In the next month the G8 Group will meet. It has many problems to address, including that of Poverty – and the link between Poverty and Health is clearly undeniable. It is therefore not surprising that the attention of this powerful group is being drawn to the fundamental importance of the need for international agreement to a positive international discipline in the field of health professionals' recruitment, and to individual governments' duties to provide facilities for training enough healthcare professionals for their own needs, as well as working

conditions which will retain these professionals in their own countries. Where necessary this debate must take account of the need for some countries to assist others to meet the latter where their resources are inadequate to fulfil their requirements.

The USA calculate that by the year 2020, it will require an additional 200000 physicians and at present it apparently foresees no alternative but to continue recruiting as before. The distribution of physicians in the USA in 1996 per 10000 population was 26.5 (www consulted June 05) and in Ghana it is currently 0.75 per 10000 i.e.1500 physicians for a population of 20 million population i.e. (personal communication). As an illustration of disparity in migrant physician usage, an OECD study in 2002 (Bourassa-Forcier M & Giuffrida A "International Migration of Physicians and Nurses..." - OECD Human Resources for Health Care Project 2002), showed that the

percentage of workforce varied from the UK and New Zealand 34.5% (in 2000), compared with that Canada 25% (in 1998) and in Austria which was 1.9% (in 1998).

Clearly physicians and other health professionals need to be aware of principles behind Codes and Guidelines on Migration and Recruitment in addition to their individual responsibilities as members of their professions. Of vital importance however, the situation also calls for a radical re-thinking of political attitudes in developed countries concerning both their responsibilities to developing and deprived communities, the duty of countries to provide adequate resources to train and retain enough physicians and other health professionals to meet their own country's needs, and also to assist, where necessary, the desperate needs of others elsewhere in the world.

Alan Rowe

## Saving The Lives Of Siamese Twins

Siamese twins are exceedingly rare, approximately one in a million live births. In the 16th and 17th centuries they were displayed as circus freaks, which has evolved at the present day into intense media interest.

Professor Lewis Spitz, Head of Paediatric Surgery at Great Ormond Street Children's Hospital since 1979, has carried out 24 conjoined Siamese twin separations in his 25-year surgical career prior to retirement. In order to ensure that both twins survive, where one may be a parasite on the other, the surgery involved can be complex and difficult, with conglomerate masses representing fused organs. „Nothing is quite where you expect it to be“ he says.

Every support is given to ensure survival, with two surgical teams, one for each twin, of about 15 nurses, surgical registrars and theatre assistants under the two leading paediatric surgeons, Mr Ed Kylie and Professor Spitz.

The chances that one twin will die on separation are nevertheless around 1 in 5. Major organs like the heart can be fused together making separation impossible.

At the start of the operation, the skin is incised down to the level of the bone – barn-door surgery as Professor Spitz puts it, rather than keyhole surgery. Skin flaps remain essential to provide cover later on against hospital-acquired infection such as MRSA. It is essential to make sure that each affected organ has its own survival line in place, which can be very tricky when the stage is reached for the body to be turned over before separation.

Blood loss from dissecting out the liver, which has a particularly rich blood supply, can be fatal. Also, the twins may share a common bile duct, which can lead on to obstructive jaundice. The dilemma for the surgeon whether nature be allowed to take its course or should the surgeon terminate early? The surgical ethical view is that



Siamese twins being stuck together for life in this age of modern medicine is intolerable. With such a good outlook, there is every reason for these patients to lead a normal, independent life-with a normal lifespan.

### **Aetiology & future treatments**

If the Siamese twins present as an emergency, the survival rate is comparatively low at 13%, but where the surgery can be planned in advance, with MRI scans and the construction of models of affected organs, then survival is much higher at around 80%. The surgery is the product of very difficult decisions, where the mass of tissues have to be separated out and re-wired before being put back together again in order as intact re-connections. This can take 18 hours or even longer for, a complex operation.

### **Causation**

At present there are two theories of causation. The first suggests that at 13 days gestation or thereabouts, the dividing mass of embryonic cells in a single pregnancy fails to separate properly. The second hypothesis places the emphasis on parts of the developing embryo which fuse together. Given the choice, the optimal time to operate for successful separation is about 7 months, when the patients are still very tiny babies, although every case is different and must be evaluated on an individual basis.

### **The future**

At the present rate of progress in terms of medical advances in liver transplant research, conjoined livers will soon be operable provided that there is no excessive blood loss from the rich blood supply. With enhanced powers of cellular regeneration, re-wired and re-connected twinned livers are expected to respond very well to treatment in addition to the present successes of trans-formed bowels and urinary systems.

Ivan M. Gillibrand

*Amongst the Declarations to which minor editorial changes were approved at the 170<sup>th</sup> Council meeting was the Declaration of Geneva. This was one of the earliest and fundamental declarations of the World Medical Association and in view of its importance and worldwide use, the revised text is reproduced below.*

## **The World Medical Association Declaration of Geneva**

**Adopted by the 2<sup>nd</sup> General Assembly of the World Medical Association, Geneva, Switzerland, September 1948 and amended by the 22<sup>nd</sup> World Medical Assembly, Sydney, Australia, August 1968, the 35<sup>th</sup> World Medical Assembly, Venice, Italy, October 1983, the 46<sup>th</sup> WMA General Assembly, Stockholm, Sweden, September 1994 and editorially revised at the 170<sup>th</sup> Council Session, Divonne-les-Bains, France, May 2005.**

### **AT THE TIME OF BEING ADMITTED AS A MEMBER OF THE MEDICAL PROFESSION:**

I SOLEMNLY PLEDGE to consecrate my life to the service of humanity;

I WILL GIVE to my teachers the respect and gratitude that is their due;

I WILL PRACTISE my profession with conscience and dignity;

THE HEALTH OF MY PATIENT will be my first consideration;

I WILL RESPECT the secrets that are confided in me, even after the patient has died;

I WILL MAINTAIN by all the means in my power, the honour and the noble traditions of the medical profession;

MY COLLEAGUES will be my sisters and brothers;

I WILL NOT PERMIT considerations of age, disease or disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation, social standing or any other factor to intervene between my duty and my patient;

I WILL MAINTAIN the utmost respect for human life;

I WILL NOT USE my medical knowledge contrary to the laws of humanity, even under threat;

I MAKE THESE PROMISES solemnly, freely and upon my honour.



### Medical Ethics and Human Rights

## Council of Europe

### Additional Protocol To The Convention On Human Rights And Biomedicine Concerning Biomedical Research

The Committee of Ministers of the Council of Europe (CoE) opened on January 25th, 2005 the Protocol concerning Biomedical Research for signature.

This Protocol, already signed by 14 member states, is the first international legally binding instrument to regulate research on man. This framework defines the legal limitations of research on man which need to be incorporated in law, unlike the Declaration of Helsinki or recommendations of CIOMS (see "Biomedical Research in Europe" WMJ, Vol. 50, 64-66, 2004) etc.

Special attention should be paid to some very important protective provisions which are dealt with in a different manner, often without regulation. These points are

- a) research on persons not able to consent and
- b) use of placebo.

For information, these original articles are printed below. Readers who are especially interested in accessing the whole protocol will find this on the CoE website:

[http://www.coe.int/T/E/Legal\\_Affairs/Legal\\_co-operation/Bioethics/](http://www.coe.int/T/E/Legal_Affairs/Legal_co-operation/Bioethics/)

### CHAPTER V Protection of persons not able to consent to research

#### Article 15 – Protection of persons not able to consent to research

1. Research on a person without the capacity to consent to research may be undertaken only if all the following specific conditions are met:
  - i. the results of the research have the potential to produce real and direct benefit to his or her health;

- ii. research of comparable effectiveness cannot be carried out on individuals capable of giving consent;
  - iii. the person undergoing research has been informed of his or her rights and the safeguards prescribed by law for his or her protection, unless this person is not in a state to receive the information;
  - iv. the necessary authorisation has been given specifically and in writing by the legal representative or an authority, person or body provided for by law, and after having received the information required by Article 16, taking into account the person's previously expressed wishes or objections. An adult not able to consent shall as far as possible take part in the authorisation procedure. The opinion of a minor shall be taken into consideration as an increasingly determining factor in proportion to age and degree of maturity;
  - v. the person concerned does not object.
2. Exceptionally and under the protective conditions prescribed by law, where the research has not the potential to produce results of direct benefit to the health of the person concerned, such research may be authorised subject to the conditions laid down in paragraph 1, subparagraphs ii, iii, iv, and v above, and to the following additional conditions:
  - i. the research has the aim of contributing, through significant improvement in the scientific understanding of the individual's condition, disease or disorder, to the ultimate attainment of results capable of conferring benefit to the person concerned or to other persons in the same age category or afflicted with the same disease or disorder or having the same condition;

- ii. the research entails only minimal risk and minimal burden for the individual concerned; and any consideration of additional potential benefits of the research shall not be used to justify an increased level of risk or burden.
3. Objection to participation, refusal to give authorisation or the withdrawal of authorisation to participate in research shall not lead to any form of discrimination against the person concerned, in particular regarding the right to medical care.

#### Article 16 – Information prior to authorisation

1. Those being asked to authorise participation of a person in a research project shall be given adequate information in a comprehensible form. This information shall be documented.
2. The information shall cover the purpose, the overall plan and the possible risks and benefits of the research project, and include the opinion of the ethics committee. They shall further be informed of the rights and safeguards prescribed by law for the protection of those not able to consent to research and specifically of the right to refuse or to withdraw authorisation at any time, without the person concerned being subject to any form of discrimination, in particular regarding the right to medical care. They shall be specifically informed according to the nature and purpose of the research of the items of information listed in Article 13.
3. The information shall also be provided to the individual concerned, unless this person is not in a state to receive the information.

#### Article 17 – Research with minimal risk and minimal burden

1. For the purposes of this Protocol it is deemed that the research bears a minimal risk if, having regard to the nature and scale of the intervention, it is to be expected that it will result, at the most, in a very slight and temporary negative impact on the health of the person concerned.





2. It is deemed that it bears a minimal burden if it is to be expected that the discomfort will be, at the most, temporary and very slight for the person concerned. In assessing the burden for an individual, a person enjoying the special confidence of the person concerned shall assess the burden where appropriate.

#### Article 23 – Non-interference with necessary clinical interventions

1. Research shall not delay nor deprive participants of medically necessary preventive, diagnostic or therapeutic procedures.

2. In research associated with prevention, diagnosis or treatment, participants assigned to control groups shall be assured of proven methods of prevention, diagnosis or treatment.
3. The use of placebo is permissible where there are no methods of proven effectiveness, or where withdrawal or withholding of such methods does not present an unacceptable risk or burden.

Prof. Elmar Doppelfeld, MD

Chair of the Steering Committee on “Bioethics” of the Council of Europe

Following the adoption of the Minutes of the 169th Council meetings in Tokyo, the President then reported on his activities during the past months following the Tokyo General Assembly.

#### President’s interim report

Dr. Coble reported that he had the privilege of visiting the Hungarian, Portuguese, Israel, Indian, Taiwan, China the UK and many other NMAs during the past year. All his contacts with physicians had confirmed his previous impressions that NMAs were concerned with the care of patients, quality of care, patients’ access to healthcare and activity as advocates for patients for whom freedom to choose their physicians was fundamental. There was also concern about physicians’ autonomy. He also referred to his contacts with and the work of WONCA, the Society of Internal Medicine and other global groups in all aspects of medicine. Dr. Coble also referred to important contacts with the other health professions, in particular through the World Health Professions Alliance, emphasizing especially the value of relationships with the Nursing Profession.

In referring to the major role of WMA in Medical Ethics since its foundation in 1948, he stressed the wider role of WMA as set out its mission, and stressed that WMAs activities were more and more having to be extended into other fields such as improving health care provision and the quality of healthcare.

Relevant to this was the World Ocean Forum, which the WMA had founded to discuss the vital health topic of potable water. This had been a particular success involving a large number of interested bodies including the UN, WHO, and the World Bank. Mentioning especially the non-governmental bodies, he referred to International Rotary who had played a notable role in the provision of potable water. This Forum illustrated the strength and real value of public/private initiatives.

He paid a special tribute to the Japanese Medical Association for their hospitality in hosting the highly successful General Assembly in Tokyo.

## WMA

### 170th WMA Council meets in Divonne

Dr. Otmar Kloiber opened the meeting, welcoming especially the seven new members of Council, and introduced Dr. Johnson (USA) Past President of the WMA who gave an introductory talk for new members on the structure and functions of Council and its committees. He stressed the importance of input into debates, the importance of always remembering the diversity of cultures and languages and explained the procedures used by council and committees. This was warmly appreciated by Council.

The Secretary General called for nominations for the Chair. **Dr. Y. Blachar** (Israel) was elected, with **Dr. N. Hashimoto** (Japan) as Vice-Chair, both by acclamation. Dr. Blachar after expressing his thanks both to council and all the officers who had supported him during the past two years continued with the elections. **Dr. J. D. Hoppe** (Germany) was elected Treasurer.

**Dr. K. Vilmar** (Germany) was granted the honorary title of Treasurer Emeritus.

The following were elected as members of the Ethics Committee:

Dr. P. Anttila (Finland), Dr E. N. Bagenholm (Sweden), Dr. H. Haddad (Canada), Dr. N.

Hashimoto (Japan), Dr. J. D. Hoppe (Germany), Dr. H. Miyazaki

(Japan), Dr. J. C. Nelson (America), Dr. D. J. Palmisano (America), Dr. B. Selebano (South Africa), Dr. Viera de Paiva (Brazil), Dr. Y. T. Wu (Taiwan).

The following were elected members of the Socio-Medical Affairs Committee:

Dr. J. Haddad (Canada), Dr. L. J. Callo’h (France), Dr. N. Hashimoto (Japan), Dr. J. E. Hill (USA), Dr. J. Johnson (USA), Dr. D. J. Palmisano (USA), Dr. B. Selebano (south Africa), Dr. K. Vilmar (Germany), Dr. E. Viera de Paiva (Brazil), Dr. Y. T. Wu (Taiwan).

Advisers to the committees were also appointed

The following were elected members of the Finance and Planning Committee

Dr. J. Nelson (USA), Dr. Antilla (Finland), Dr. E. N. Bagenholm (Sweden), Dr. J. Calloc’h, Dr. J. E. Hill (USA), Dr. J. D. Hoppe (Germany), Mr. J. J. Johnson (U. K.), Dr. H. Myazaki (Japan), Dr. K. Vilmar (Germany).



Dr. Coble also paid particular tribute to Dr. Myllymaki and Dr. Appleyard, his predecessors for all their work and support.

Turning to the change of Secretary General, he outlined the process of change. The Search Committee who considered the numerous applications for the post eventually resulting in the appointment of Dr. Otmar Kloiber, and said that the process of the transition and hand-over had been smooth and successful. In the course of this, earlier in the year both Dr. Human and Dr. Kloiber had met with him on a number of occasions, notably on two of them to consider the responses of NMAs on governance and their co-ordination into a single document. During these periods there had also been the opportunity to attend the Executive meeting of WHO which received Dr. Nabarro's initial report on the tsunami, and to meet Dr. Nabarro on a further occasion which promised fruitful Opportunities for further collaboration.

Turning to the "Caring Physicians" project he gave some details of the project and its progress. This was a project responding to the NMAs indication that there was a need for greater transparency to be given to the "caring role" of physicians which was not as widely known as it should be. Hence the project asked individual NMAs to identify examples of physicians whose work demonstrated these qualities, with the intention of publicising this in book form which he felt would go some way to emphasise these values. He had approached the Pfizer Humanities Division, which felt this to be this worthy of support and a committee representative of the six regions was appointed to advise on the project. NMAs from 55 countries made a very good response on a very tight time scale, to an approach to identify physicians from their own countries who illustrated these qualities. Following a meeting of the judges in London, appropriate candidates were identified and this publication would be released at the General Assembly in Santiago.

Referring to the regions, he reported that he had had contact with the Council of the Indian Medical Association and there was an increase in their participation in WMA. The Chinese Medical Association was more

active and he would be attending a Bio-ethic Conference there later this year at which the ethics of transplantation would be on the agenda. He gave further details of regional meetings including one which had taken place, involving 8 of the Sub-Saharan countries. He had met with and assisted the Iraq Medical Association concerning the re-establishment of their Medical Association which had been illegal under the previous regime, and attended a number of Regional meetings.

For the future, much would depend on the Strategic plan but he stressed that his contacts were very positive for further Regional meetings in various parts of the world, mentioning South America and South East Asia in particular, and expressed his concern at the few members in the Middle East.

Finally he thanked those who had been particularly helpful with the problems of the Regional meetings and expressed his thanks to the Chair and to the new Secretary General.

Dr. Blachar acknowledged Dr Coble's extensive work and called for the Secretary General's report.

## Secretary-General's report

Dr. Kloiber commented on the transition from Dr. Delon Human who had held the office for nearly eight years, finishing his work with three major projects to be introduced or finalised.

The first was the launching of the initiative by the President in Tokyo of the "Caring Physicians of the World" referred to in the President's report.

The second was the Ethics Manual which had been prepared by the Director of Ethics, Dr. J. Williams, assisted by a committed team of advisers. This was released at a successful launch in January 2005 and has received considerable attention. French, Spanish and German translations are nearly complete, and other translations under consideration.

The Third was the World Ocean Forum held in New York 15-16 November 2004. This was a common endeavour of the World Ocean Observatory, the Pfizer Medical Humanities Initiative and the World Medical

Association. It was well attended by scientists and activists from water ecology interests, and high officials of the UN Development programme, the UN, national (USA, Canada, Australia) authorities as well as the Executive Director of the WHO Environmental Division, Dr. Kerstin Leimer. This successful event tragically just preceded the tsunami disaster, following which the water and ocean related issues discussed during the meeting were illustrated in a most dramatic fashion (The full report is available at [www.worldoceanforum.org](http://www.worldoceanforum.org)).

Dr. Kloiber commented "these three projects are just a few examples of the outstanding service provided by Dr. Delon Human as the Secretary General over nearly eight years. We owe him our gratitude and appreciation for his work."

Dr. Kloiber used the time between his appointment in Tokyo and his assumption of duties as the Secretary General on 1st February 2005 for the hand-over, including his introduction to regional organisations, to the WHO Executive Board meeting and his participation in the World Ocean Forum. Reporting on these meetings he expressed hopes for further co-operation with all such bodies in the future.

The Governance Working Group continued as the highest priority, in several meetings and telephone conferences proposals were analysed and collated into one report referred back to Council. The implementation of the decisions of Council and the General Assembly would be a major task for the secretariat.

Reporting on the First Global meeting of the International Alliance of Patients' Associations (IAPO) in February 2005, he reported that representatives of the World Health Professions Alliance (WHPA) had addressed the question of collaboration between the two bodies, this had been warmly welcomed by IAPO. Such discussions will be of importance not only at global but also at national level ([www.iapo.org](http://www.iapo.org)).

The Secretary General reported on the work of the European Forum of Medical Associations and WHO at its meeting in March (see pp **WMJ 51(5)28**), on the initiative of the Standing Committee of European Doctors



(CPME) on Patient Safety and on their identification of key problems in common with WHO Regional Scientific Session. In this connection, systems to identify or report hazards in patients safety net need to be set up; a safety culture has to be built up that departs from the blame and shame approach and provides a blame-free procedure to handle mistakes, accidents and “close calls”. The use of telematics (e-health) should be promoted. It will allow health care to be made safer, as demonstrated in the field of drug prescription. Senior officials including the Mr Markos Kyprianou, European Commissioner for Health, the current Chair of the Council Health Ministers, and the Director of Public health of the European Commission, all committed themselves to EU support for research and development in the field of patient safety.

He reported his attendance at several Assemblies of National Medical Associations. Dr. Kloiber detailed the objectives for the future incorporated in the Strategic Plan 2003-2007 namely, to increase visibility of the WMA at all levels, to increase both membership and associate membership by 20%, to focus on agreed objectives and not pursuing all possible opportunities, and create a stable financial position. He detailed the main activities needed in

- the improvement of medical care and health in general;
- medical ethics
- human rights
- advocacy
- networking and management
- non-dues revenue,

and the problems associated with achieving these.

Finally he reported that action had already been taken on consolidation of the bank accounts of the Association and the investment of liquid assets, on a cost analysis of daily business processes and subsequent cost reduction, and outsourcing the position of one translator.

Dr. Masson inquired whether the Chinese Medical Association adhered to the ethical standards of WMA, in particular in relation to

Transplantation of organs, and the involuntary donation of organs?

Dr. Kloiber responded by indicating that he repeatedly had contacts with CMA. There should not be preconditions, but transplanting of Organs will be in the agenda. The President commented that talking continues with the Chinese, and there was cosponsoring for a meeting in the period June- August.

**Following the decision to refer several motions respectively to the Ethics and Medico-Social Committees, Council adjourned until Sunday 15th May.**

## Medical Ethics Committee

The committee met on 13th May under the Chairmanship of Dr. Bagenholm, who paid tribute to the stalwart work of her predecessor Dr. Snaedel.

Following the adoption of the minutes of the last meeting in Tokyo, Dr. John Williams, in presenting his report on the work of the Ethics unit, thanked Dr. Snaedel for all the work he had done during his Chairmanship of the committee. He continued by stressing that the key objective of the unit had been to make the WMA Ethics activities better known. The Ethics Manual had been distributed widely to 125 Medical journals. There had been many positive reviews of the manual, which had been well received. In addition to the French and Spanish version being prepared, there had been offers for Japanese, Chinese, Armenian, German, Macedonian and many others Funds were not, however, available to publish in all these languages, but he hoped that NMAs who translate will be able to distribute the version by e-mail, web, CD ROM etc. Turning to future activities, these would include continuing the policy review, promotion of the manual -possibly web based, and it was hoped that an ethics education course would be available in March. Dr. Haddad enquired whether assistance was needed either in terms of finance or other NMA assistance, to which Dr. Williams replied that money was needed especially to produce hard copies and Dr. Kloiber made clear that funds were not available for distribution of copies.

## Policy Review

The committee then considered the recommendations on policies for minor review following consultation with NMAs, and decided on the following categorisations

Declaration of Tokyo **Approved with minor amendment**

Declaration of Oslo - **Major review**

In discussion, Estonia felt that the document was too narrow and Bolivia also felt a **major review** was **required**.

The Statement on Human Rights and Individual Freedom of Medical Practitioners: following amendment of the title to “Non-discrimination in professional membership, and activities of physicians” the statement was **adopted as revised**.

Declaration of Madrid on Professional Autonomy and Self- Regulation, was **adopted**, with minor amendments.

The Madrid declaration on Euthanasia was **approved**, unamended.

The Resolution on Academic Sanction or boycotts was **approved** with minor amendments

The Marbella statement on Physician-assisted Suicide, was **approved**, unamended.

With minor editorial changes, the revised statement on Body Searches of prisoners was **approved**.

The proposed revised Declaration of Geneva, with minor changes, was approved (see p 31).

## Statements for major revision:

Dr. Snaedel reported that work on the International Code of Medical Ethics on which the Working group established in Tokyo would continue, and it was noted that sections on patient autonomy and freedom of choice, the duties of physicians to keep up to date, to teach, dual responsibility (e.g. when a physician acts for a third party), and the duties of physicians to themselves, would be proposed as additions to the redraft.



Adv. Malke Borrow introduced the proposed statement on Genetics and Medicine on which NMA comments had been received. The draft produced considerable discussion, in particular in relation to the use of the word “regulated” in relation to developments in the field of Gene therapy and genetic research. It was finally decided that this word was not appropriate and the relevant sentence introducing guidelines should read “However, with the continuing development of this field (Gene therapy and genetic research) it should proceed, according to the following guidelines...”. A number of other texts and amendments were introduced and the text **adopted** as amended Organ donation and transplant. The working group would continue its work.

The proposed statement on HIV/AIDS was **referred to NMAs**; as was a document on Telematics, and the Venice Declaration on Terminal illness.

Although the Statement on Human Organ and Tissue Donation and Transplant was a relatively new one, the Danish Medical Association had proposed an addition in January 2005. Having received comments on this from NMAs, it was **agreed that this should undergo general review**.

Of the pre- 1995 documents, it was agreed that the Declaration of Sydney (determination of Death), the Statements on Freedom to attend medical meetings (Singapore), the Statements on Foetal Tissue (Hong Kong), on Patient Advocacy (Budapest), on Medical Ethics in the event of Disaster (Stockholm), and on Animal use in Medical Research (Hong Kong) **should all have major revision**.

The following should be rescinded and archived:

Statement on Physician Independence and Professional freedom (Rancho Mirage) which was largely covered by Madrid, the Statement on Genetic Counselling and Engineering, the Declaration on the Human Genome Project and the Resolution on Cloning.

Concerning post 1995 documents, the Statements on Ethical Aspects of Embryonic Reduction (Bali), and that on Child Abuse and Neglect (Singapore) required **major revision**.

The Statement on Patients’ rights (Lisbon) required **minor amendment** and those on Mental Illness (Bali), Human Rights (Rancho Mirage) **should be archived**.

## Human Rights

Dr. Williams referring to his Report on Human Rights stated that the education programme on Doctors and Prisons had been a great success. The CD-ROM was now available in Spanish. Members of Council had participated in the pilot projects on the Istanbul Protocol. Dr. Appleyard commented on the importance of ICRC participation and the support of the European Union. He spoke about his visit to Uganda where there had been a conference with participants from 5 countries and training (which included lawyers) on support and identification of victims.

Concerning Zimbabwe, both Drs Appleyard and Letlape stressed the problems and appealed for help for colleagues in Zimbabwe. An attempt to organise a regional meeting including Zimbabwe eventually took place after some delay. Speaking of the crisis there, one in eight children die and one in five children are orphans. Concerning emigration of healthcare workers it was pointed out that the number of physicians had dropped from 1400 to 800 for a population of 11 million. Harare Hospital, the largest in the country, was literally breaking up and there was institutionalised violence and torture. CME in Zimbabwe was now obligatory, and we must try to connect with colleagues through this.

Dr. Letlape commented on the silence from the Zimbabwe Medical Association on Human Rights. There had been a meeting of the two organisations and there was no call for help from ZMA. Thus it was not possible to intervene without a request from the ZMA. Their autonomy must be respected but he said, “we therefore must respond to any call. We want to establish a regional meeting and he hoped to report further in Chile”.

The committee had further discussion on the human rights issues in Zimbabwe.

Two members referred to the absence in certain WMA statements of reference to physicians’ participation in torture, actively or pas-

sively. Dr. Nathansen referring to this pointed out that this had been highlighted in the New England Journal of Medicine and commented that the “Dual issues” concerning loyalty was important in this context...

Professor Blahos who had twice been in Ethiopia spoke of the situation in the Fistula Hospital in Addis Ababa and said that the situation was terrible outside Addis Ababa. Dr. Haddad felt it important to establish a working group to inquire into whether there was a need for additional wording in the Declarations of Geneva or Tokyo, and this **was agreed**.

The Danish Medical Association raised the issue of removal of organs for sale from prisoners in China on which it had received a report. It would produce a motion for the General Assembly. Following a lively debate the Secretary General was asked to look into this matter.

The Israeli Medical Association proposed a Council resolution on the situation in Darfur, where there were 300,00 deaths and over a million displaced persons. Dr. Blachar said that “The WMA as an international medical organisation committed to the protection of health and human rights for all, has frequently expressed its support for human rights in statements, and today we are urging national medical associations around the world to press their governments to intervene now to stop the mass killings and to protect the health and safety of refugees in the region”. This was approved and subsequently adopted by Council.

*All the recommendations of the committee listed above were subsequently agreed by Council in adopting the report of the Ethics committee.*

## Socio-Medical Affairs Committee

The committee met on 13 May and Dr. Haddad was elected Chair of the Committee.

Following the approval of the minutes of the Tokyo meeting in October 2004, the Committee considered NMA views on pro-

posed policy changes designated in Tokyo as requiring minor revision.

The committee recommended **approval** of the revision to the Boxing Statement and the Statement on female Genital Mutilation and the Declaration on the Abuse of the Elderly (Hong Kong).

However, it recommended that the Statement on Adolescent Suicide undergo major revision.

Concerning those policies requiring major revision, the committee next considered reports on the progress, which had been made.

Dr. Calloc'h reported that in relation to the Statement on the Role of Physicians in Environmental and Demographic issues, the French Medical Association felt that a major issue needed to be addressed, namely the need for WMA to adopt policy on achieving a balance between informing the public and avoiding public alarm on environmental and preventive issues, citing Pollution and Asthma as an example. At the Chairman's suggestion the FMA would prepare an appropriate document.

Dr. Letlape reported that the South African Medical Association had decided to delay revision of the Statement on Access to Health Care until after the General Assembly discussion of this issue later in the year.

Following considerable discussion and some amendment, the proposed **Statement on Drugs Substitution** was recommended for **approval and forwarding to the General Assembly for adoption**, and that the Statement on Generic Drug Substitution and the resolution on Therapeutic Substitution be **rescinded and archived**.

A proposed WMA Statement on Medical Education as amended was recommended to be forwarded for NMA comment.

Turning to a proposed statement on Medical Liability Reform, Dr. Palmisano stressed the seriousness of the situation in the USA where, in the previous week, awards of 20 and 30 million US\$ had sent a chill through the profession. The Swedish delegation stated that the document as written was unacceptable to them as they had a "no-fault system", and there was a contribution from Spain which

pointed out that both criminal and civil courts may consider liability cases where appropriate. "There was however a need to fight against the criminalisation of liability." Following a discussion on these issues a suitable form of words was agreed and the proposed **WMA Statement on Medical Liability Reform as amended was recommended for approval and transmission to the General assembly for Adoption**.

Turning to six policies which had not been classified; the following decisions were made:

Recommendations concerning Medical care in Rural Areas - be **rescinded and archived**

The Statement on Use and Misuse of Psychotropic Drugs to **undergo major revision**

The Statement on Persistent Vegetative State **be rescinded and archived**

The Statement on traffic Injury **undergo major revision**

The Statement on Noise Pollution, to **undergo major revision**.

The Statement on Alcohol and Road Safety to **undergo major revision** (also to include consideration of drugs and road safety).

Concerning 1995 Socio-medical policies, the committee recommended the following

The Statement on the Prescription of Substitute drugs in the Outpatient Treatment of Addicts to Opiate Drugs to **undergo major revision**

The Statement on Health Promotion to **undergo major revision**

The Resolution on Testing of Nuclear Weapons to **be rescinded and archived**.

Various NMAs accepted responsibility for revision of some of these policies and the secretariat for two others.

The Irish delegation reported on the progress of the workgroup on a Statement on Obesity. Dr. Calloc'h reported that the CPME were also working on this topic and he called for something from WMA on Lipids, carbohydrates etc.

The Secretariat reported on the development of an *On-line Course on the Treatment of*

*Drug- Resistant TB*, and the South African Medical Association gave a report on their progress in co-operation with WHO on this issue.

The Committee proposed that a statement on reducing the Global Impact of Alcohol on Health and Society be forwarded for NMA's for comment.

In the discussion of a proposed Council Resolution on *the Healthcare Skills Drain*, The UK reported on the conclusions of a successful Conference recently held at the BMA which included amongst those attending, various Commonwealth countries as well as others including Africa, WHO, the Commonwealth Secretariat, Nurses and other interested bodies.

The Canadian Medical Association commended WHO for taking a leadership role in facing the global challenges of Human Health Resources. It concluded by stressing the major ethical implications for health care, the problem of the northern countries "siphoning off" resources, and stressed that in the discussions the financial cost of medical studies should not be overlooked. There was an impassioned plea from South Africa that doctor substitution was not the only answer, but it was vital to produce doctors to meet needs (see page 56).

The Committee was informed that an invitation had been received from WHO to contribute to the WHO Annual report for next year, which would be on Human Resources for Health.

The Proposed Council Resolution on Healthcare Skills Drain was **recommended for approval by Council** and NMAs offered to participate in the work group called for in the resolution. Council *subsequently adopted the Resolution (see box)*.

The Committee also recommended that the proposed Council Resolution on observer Status for Taiwan to the WHO and its inclusion as a participating party to the International Health regulations **be approved**.

A Proposed Council Resolution on Implementation of the WHO Framework convention on Tobacco Control was **recom-**



## Council Resolutions adopted at the 170th WMA Council Session, May 2005

### WMA Council Resolution on genocide in Darfur

Adopted at the 170th WMA Council Session, Divonne-les-Bains, France, 15 May 2005

**WHEREAS**, a reported 300,000 Darfurians have been killed and one million refugees displaced since early 2003, on the basis of racial or ethnic origins; and

**WHEREAS**, there have been official reports of savage killing, torture, rape and mutilation of men, women and children by the Government of Sudan and its allied militia; and

**WHEREAS**, many of these reports, including that of the UN Commission of Inquiry on Darfur, have only recently been publicized; and

**WHEREAS**, genocide, as defined by the 1948 UN Convention on the Prevention and Punishment of the Crime of Genocide, is the killing or destroying of populations on the basis of their racial or ethnic identity; and

**WHEREAS**, the WMA, as an international medical organization committed to the protection of health and human rights for all, has expressed its support for human rights in statements and resolutions, among them the Resolution on Human Rights, adopted by the WMA in Rancho Mirage during the 42nd General Assembly and amended by the 45th, 46th and 47th General Assemblies,

**THEREFORE, BE IT RESOLVED**, that the WMA condemns the genocide in Darfur and calls upon its member NMA to urge their governments and the international community to take immediate action to stop the mass killings, expulsions, rape and destruction in Darfur and to protect the health and safety of refugees in the region.

### WMA Council Resolution on the healthcare Skills Drain

Adopted at the 170th WMA Council Session, Divonne-les-Bains, France, 15 May 2005

**Recognising** that the lack of healthcare workers in developing countries, particularly those in sub-Saharan Africa, is one of the most serious global problems of today and that the impact of healthcare worker migration from developing to developed countries is a significant component in the crisis,

Therefore, **be it resolved:**

1. That the WMA reaffirms its 2003 Statement on Ethical Guidelines for the International Recruitment of Physicians, particularly para. 14: "Every country should do its utmost to educate an adequate number of physicians, taking into account its needs and resources. A country should not rely on immigration from other countries to meet its need for physicians"; and para. 15: "Every country should do its utmost to retain its physicians in the profession as well as in the country by providing them with the support they need to meet their personal and professional goals, taking into account the country's needs and resources."
2. That developed countries must assist developing countries to expand their capacity to train and retain physicians and nurses, to enable developing countries to become self-sufficient.
3. That action to combat the skills drain in this area must balance the right to health of populations (Universal Declaration of Human Rights (1948), Article 25.1; International Covenant on Economic, Social, and Cultural Rights (1976), Article 12.1.) and other individual human rights.

4. That the WMA reconvene the expert working group on physician resources to coordinate development of WMA input to WHO preparations for the decade on human resources for health.
5. That the WMA commend WHO for taking a leadership role in the global challenges of human resources for health; commend to WHO the afore-mentioned principles (1, 2 and 3); and call upon WHO to convene a global roundtable to discuss HHR issues.

### WMA Council Resolution on observer Status for Taiwan to the World Health Organization (WHO) and inclusion as participating party to the International Health Regulations (IHR)

Adopted at the 170th WMA Council Session, Divonne-les-Bains, France, 15 May 2005

#### Preamble

1. The ethical obligation of health professionals is to serve all human beings irrespective of their political or religious affiliation or any other factor. The goal of all nations must be the protection of health of all human beings without any discrimination. Protection of human health can only be achieved if all people and health care systems collaborate. WHO must be able to invite all people and health care systems to participate in the fight against disease and premature death. Protection of human health must be separated from politics.



2. A burning example of discrimination in the recent years has been Taiwan. There are 23 million people living in Taiwan, of which a significant number required medical assistance or help from international relief organizations in the aftermath of the 1999 earthquake. In addition, Taiwan was significantly affected and suffered several deaths due to the SARS epidemic during 2002 and 2003 and is under threat by the current outbreak of Avian Flu in South East Asia.
3. There are 23 million people who are willing and take pride in contributing to international relief efforts when other people are in need, as demonstrated again by generous donations and significant humanitarian aid support in the aftermath of the tsunami disaster during 2004.
4. 23 million people should not be excluded from the work of the World Health Organization, but without taking a stand as to the legal status of Taiwan.

#### Resolution

5. The World Medical Association (WMA), as a non-governmental organization in official relations with WHO, calls on WHO to grant Taiwan observer status to WHO;
6. The WMA calls on WHO and all its Member States to ensure that Taiwan is included as a participating party to the WHO International Health Regulations;
7. The World Medical Association further urges its members to call on their national governments to advocate for observer status for Taiwan at WHO, as well as inclusion as a participating party to the WHO International Health Regulations.

### WMA Council Resolution on implementation of the WHO Framework Convention on tobacco control

Adopted at the 170th WMA Council Session, Divonne-les-Bains, France, 15 May 2005

The World Medical Association

**Welcomes** the recognition of the essential role of health professionals in tobacco control as the focus of World No Tobacco Day, 31 May 2005;

**Recognises** the importance of the WHO Framework Convention on Tobacco Control (FCTC) in furthering the campaign to protect people from exposure and addiction to tobacco;

**Encourages** national medical associations to work assiduously and energetically to get their governments to ratify and implement the FCTC;

**Urges** governments to introduce regulation and other measures as set out in the FCTC. Governments should also introduce a ban on smoking in enclosed public places and work places as an urgent public health intervention;

**Recognises** the vital role of health professionals in public health education and in support for smoking cessation;

**Commits**, with the other members of the World Health Professions Alliance, to mobilise health professionals in the fight to implement the FCTC and to reduce the human cost of tobacco.

**mended for Approval, and was subsequently adopted by Council.**

Dr. Appleyard drew attention to a report on the Prevention of Chronic Disease in Children, which would be launched in London in October. He urged that NMAs promoted this and stressed the importance of how best to ensure successful interventions in schools the report should be distributed to all NMAs when it was available.

Dr. Letlape suggested that the workgroup on Human Healthcare Resources should be reconstituted. i.e. members from AMA, BMA and CMA, together with representation from the East.

### Finance and Planning Committee

Dr. Nelson was elected to the Chair of the Committee by acclamation. He thanked the committee for its confidence and stated what a pleasure it had been to work with the Secretary General and Dr. Vilmar. The work had been considerable, involved lots of telephone consultation and had been done well and accurately.

The minutes of the meeting in Tokyo 2004 were **approved**

Dr. Kloiber spoke about the question of Dues (see p. 40) and the problem of the non-payers, some for as long as 2 years. The Statutes required erasure of the member association after this period. A solution was needed for Santiago.

After a considerable debate the committee recommended **that WMA waive all dues in arrears prior to 2005.**

The Committee also considered a report on WMA Dues Structure Reform Proposal (see p. 40) and **recommended that it be sent to NMAs for comment, the Secretary General to report to the next Committee meeting.**

After presentation and detailed discussion it was **recommended that the Preliminary Financial Statement for 2004 be approved**

The Committee then engaged in a lengthy and detailed debate on the report of the



Governance Committee. Dr. Coble, in introducing the report commented that the working group had representation from all regions and there had been very good input into the report. They had divided the issues into three groups, namely (a) those for which the was general agreement on, (b) those on which there appears to be no answer and (c) those which were rejected by consensus. There was also the need to look at the Bye-laws and other standing documents which needed to be consolidated. Finally he referred to Council reports which had not been put into policy.

In the opening discussions the need for the governance review was expressed forcibly by several members, in particular stressing the need for a clear structure setting out where authority lies and likewise where responsibility lies. The Secretary General pointed out that there was a clear understanding that governance was being worked on urgently. Other speakers urged that the work go forward and the committee then engaged in a detailed debate on the report before them, as a result

of which the following Recommendations were made and **later adopted by Council:**

*That an Executive Committee with an advisory role, be established, comprising the Chair and Vice-Chair of Council and the Chairs of the three Standing committees, the Secretary General being a non-voting member. This committee would also undertake the Chief Executive Officer review process.*

*The Chair of Council to establish an "ad hoc" committee to review, consolidate and update WMA bye-laws, rules of procedures and operating policies.*

*One committee should make a trial of the use of a "consent calendar".*

*A proposal for the possible consolidation of the positions of Treasurer and Chair of Finance and Planning Committee be circulated to NMAs for comment.*

*A proposal for the timing of leadership transition be circulated to NMAs*

*That approval be given for a proposal to restrict the term of office of all Chairs of*

*Council and Standing Committees and Treasurer to three two year terms (6 years "in toto") for each position.*

*Council later endorsed all the recommendations of the Finance and Planning Committee.*

**Council**, in addition to endorsing the reports listed above from the committee **agreed** that a proposed statement on reducing the Global impact of Alcohol on Health and Society be referred to NMAs for comment. Council, also discussed possible dates and venues for future meetings of the General Assembly and Council, and other many other internal issues. It received reports on the forthcoming General Assembly in Santiago and a presentation on the 2006 Assembly in South Africa at Sun City.

At the end of the Council meeting tributes were paid to Drs Aarima and Palmisano who were attending their last Council meeting and to Dr. Moon and Dr. Vilmar for their contributions during their many years as Officers of the WMA.

## WMA Dues Reform Proposal

*This paper sets out a proposal for reforms of the WMA Dues and has been circulated to all NMAs. It was prepared by the Treasurer Emeritus, Dr. K. Vilmar and endorsed by Dr. J.-D. Hoppe, the Treasurer.*

### Introduction

The current dues structure is based on a membership fee per physician represented by the member organisation. Thus, organisations representing more physicians pay higher dues than those representing lower numbers of physicians. In turn, voting rights are coupled to the number of physicians represented. Currently, 10,000 physicians equal one vote in the General Assembly, while 50,000 give entitlement to one seat in the Council for a term of two years. Smaller countries can also have a seat on council if their votes from other countries support them on the occasion of the Regional Elections of the WMA Council. This mechanism in principle pro-

vides proportional representation of the physicians of the world in the WMA through their national medical associations.

According to the statutes, the most representative physicians' association of a country is eligible for membership in the WMA. Depending on the national situation, the degree of representation of the different national medical associations varies considerably: while membership of the national medical association is obligatory in some countries (100% membership), private associations with voluntary membership can represent only a share of the physicians in their countries

Moreover, membership status in the constituent organisations varies as well, with

some associations having only one membership level, while others have several membership levels, with different contributions. Overall, physicians' contributions to their national associations vary even more: not only is there a vast difference in the contributions between poorer and richer countries, but the service package constituent organisations deliver to their members is also not comparable. Some are not only associations, but also unions, some provide retirement funds, some have extended membership perks that others do not provide. For these reasons, strict coupling of the WMA dues to the number of enlisted members of constituent organisations would not only be unfair, it would also make it impossible for poorer medical associations to participate in the WMA. The national membership organisations are therefore free to determine the number of physicians they wish to notify to the WMA as their represented membership.





## Criticism of the current situation

Due to the fixed contribution rate per notified member physician of the constituent organisation, smaller and poorer nations have less voting power in the General Assembly and fewer seats to occupy in the Council. While the first reflects the general idea of a representational democracy, the latter is indeed challenging the democratic understanding of the institution.

A more transparent system with a higher degree of fairness should allow the financially less potent medical associations the same chance of representing their physicians as the richer ones.

Furthermore, the potential unfairness of the dues structure in relation to poorer associations and the fact that Council membership is determined only every two years, has led to disappointments and concern, as some constituent organisations pay a higher share in the year the Council seats are determined, reducing it significantly in the following year, thereby remaining in the Council without contributing the proper dues.

## Previous attempts at change

During the last fifteen years, major changes in the dues structure were attempted twice. They aimed both to increase the dues income and to improve the fairness of the dues structure and representation. (The free-rider effect mentioned above was not addressed.) A first task force in the late 80s delivered a moderate change, when the number of votes in the General Assembly was changed from one vote per 5,000 notified members to one vote per 10,000 notified members. Although especially the question of unfairness was addressed at that time, it was neither changed then nor by a later working group in the late 90s.

Several models for a new dues structure were analysed in these attempts:

- A one-country-one-vote principle would fail, as stronger medical associations were not prepared to pay a higher share than others with the same voting rights.

On the other hand, an equal (flat-rate) contribution of all constituent organisations would have clearly overcharged the smaller organisations. Therefore, and for lack of proportional and adequate representation, the one-country-one-vote principle was not followed up. (It existed before in the 70s and was abandoned, because large associations decided to move out or reduce their commitment.)

- A contribution based on the membership and economic strength of the country appeared neither possible nor truly fair for several reasons: the economic data are not reliable. During the last decade, some countries changed their reported gross domestic product (GDP) following political changes or new calculations. Moreover, poorer countries in particular have huge differences in individual income. While people in general may have a very low income, thus yielding a small GDP, physicians may live as relatively wealthy people, meaning that assessment of the WMA dues solely in relation to the GDP would be unfair compared to other nations with more balanced national wealth.
- A stratified model of flat-rate dues based on a rough economic stratification model was not followed, because it would not have allowed proportional representation and would have overcharged smaller associations.

## Conditions for change

Although increasing the dues income of the WMA will be important in the future to maintain the independence and functional capacity of the WMA, a first step must be taken to make the dues structure fairer and stable. Many national member associations may find that a dues structure of the WMA that fails to give adequate consideration to their financial situation or capabilities deters them from applying for membership or paying a higher contribution. Therefore, a solution to this problem may be a door-opener for new constituent organisations and for fairer representation of financially less powerful organisations.

On the other hand, a change in the dues structure must not lead to a drop in overall dues. What is more, it should not reduce the willingness of each single constituent organisation of the WMA to contribute its own dues.

Furthermore, a new dues structure or the distribution of voting rights should not encourage the free rider phenomenon in the Council mentioned above.

## Solution

### A. Access and fairness

In order to maintain the dues income of the WMA and the principle of democratic representation, and in order to acknowledge the different levels of ability to contribute to the WMA, both the coupling of dues to the number of notified physicians and the freedom of the associations to determine the number of physicians being notified may have to remain. However, they should be supplemented by recognition of the financial power of the respective country, making access to the WMA and representation in the WMA fairer for associations with less money.

However, as explained earlier, data on the economic strength of the nations is of only relative value due to comparability problems and relevance for the profession in the respective country. Individual calculation of the economic power of each country would be possible, but impractical in the framework of an organisation with more than 80 members.

Therefore, and in order to enable associations from countries with less financial power to obtain a higher share of representation, the contribution rate per member should be stratified from € 2.00 (current amount) in four levels (Category A, €0.40; Category B, €0.90; Category C, €1.50; and Category D, € 2.00), depending on the gross national income of the respective country. Thus, the four Categories (A to D) would reflect the wealth or economic power of a country, assuming that the financial situation of the physicians is roughly proportional to that.



Most of the main contributors to the WMA (in financial terms) would be classed in Category D and therefore would not see any change in their contributions and voting rights. The constituent organisations from economically less powerful countries would not receive a reduction in their dues amount, but they would get more voting rights.

Only if a country that has already notified the real number of physicians were to be classified in Categories A to C, would the income of the WMA possibly be reduced in the future. This is currently not the case.

## **B. Fairness and sustainability**

As the financial situation of each medical association may vary over time, the principal option of determining the number of physicians notified to the WMA should not be given up. However, those associations seeking representation in the Council should commit themselves for the full period of Council activities (2 years). Thus, an artificial increase in the number of members notified in the year of Council constitution, and a reduction in the following year, should be avoided, as this procedure is unfair to the other payers and puts the finances of the WMA in jeopardy. There are several options for change:

### **1. Maintenance rule**

In addition to constitution/election every two years, there should be an eligibility rule saying that the representation demonstrated at the time of election - a minimum of 50,000 reported members -

must be maintained during the period of office. Otherwise, the office will be terminated or, alternatively, voting rights will be suspended. This would apply equally to Council members from constituent organisations notifying more than 50,000 members, and to those elected with the votes from several constituent organisations.

The maintenance rule would also apply to Council seats awarded for a fraction of 50,000 notified physicians.

### **2. Look-back option**

Council seats would be awarded for notified or cumulative representations of 50,000 physicians during the last two years before the election. (Alternatively: in the year of election and the year before the election.) This model would give stability. However, it may discourage members notifying 50,000 members or more for the first time, as they would have to wait for one or two years.

The look-back option would also apply to Council seats awarded for a fraction of 50,000 notified physicians. Thus, the average number of notified physicians for the last two years (alternatively: the year of election and the year before the election) would be counted for the election process.

\* Details concerning country classification are available from the WMA Secretariat. (wma@wma.net)

I have doubts as to whether or not these images are helpful, as they divide the World into the “Good-ones” showing or painting the images, and the “Bad-ones” making the mistakes. Secondly, the images suggest that those talking about the mistakes know how to avoid them. But do they?

“If aviation produced as many dead as health care does – nobody would fly anymore, the operations would be shut down immediately!” So, why don’t we shut down health care institutions and resume business only when we are sure that no more mistakes happen?

Indeed, who would travel with a plane when the pilot doesn’t know how much fuel he has on board, fly a passenger plane without knowing where the journey is heading for, or take a plane whose engines are badly maintained or even burning?

Who entrusts himself or herself to pilot a long distance flight without maps, without navigation system, or would fly with a pilot who had been on duty for more than 24 hrs? Which airline would take on board a significant number of passengers who cannot pay? Which pilot would start knowing that he never can make it, or take a woman in labour on board? And who would join a travelling party, where politicians and leaders sing the song: “Put the passenger in the driver’s seat”?

But this is exactly the situation which physicians encounter every day in the real world: Starting to work without having appropriate resources – saving peoples’ lives and health and being blamed and often even charged for spending “too much”. -caring for severely suffering patients and having not having a confirmed diagnosis available. Caring for patients with chronic diseases where physicians are far away from understanding the disease – not to mention healing it! Taking care of and comforting those with terminal illness. Treating high risk patients and taking insurmountable responsibility on their own shoulders. Doctors do this even after having worked 36 hours already, because of the need, for example, to deal with the patient with a ruptured aneurysm which can’t wait until tomorrow. All this, taking also into account individual differences, wishes, preferences, emotions and personalities. Ever tried this with a fully loaded Jumbo Jet?

## **WMA Secretary General**

# **From the desk of the Secretary General**

## **“Danger on the safe side!”**

The pictures are dreadful – pictures of patients who have died because of medical errors! Sir Liam Donaldson, chief Medical Officer of England and Chairman of the WHO World Patient Safety Alliance starts his

standard presentation with such images and also allegorical images of several crashed Jumbo Jets as equivalents for the calculated number of people who reportedly die every day because of medical errors.



But this comparison can even be topped by those who have the answer as to why aviation is so much safer – those who really know about medicine and aviation: “Doctors don’t get hurt when they make mistakes – pilots do.”

### Isn’t that simple?

But what about those who acquired infections while treating patients even though they were being careful; or those ending up in the ditch when returning to the hospital in a cold winter night on icy streets, or when seeing their patients when called for an emergency? What about those who are killed in combat zones of conflicts they had nothing to do with. What about those who are burnt out and depressive after virtually working to death? What about those suffering from the emotional stress they encounter every day? There are far more doctors getting hurt from their work than pilots. But these are statistics nobody is interested in.

### Perhaps flying a plane and treating a patient isn’t all that similar

First, of all we usually fly for fun or business. In times of trouble both of these can wait. However no-one sees a doctor for fun. And let’s not forget: The (health) problem exists in the first place. Health Care systems are crisis management systems.

Secondly, when flying a plane there is for each (critical) situation one (!) ideal way to handle it. As a pilot you should know it by heart and everybody can look it up in the flight manual. Unfortunately, patients don’t bring their manuals with them and “standard patients” only exist in theoretical examinations. In the end flying an aeroplane is operating a machine. Treating a patient is caring for a human being!

Thirdly, a flight is a planned procedure. Each flight can and should be planned for its normal performance from the beginning to the end. Deviation from that rule is the exception. In health care this only sometimes happens.

While it would be wrong to disregard statistics, but physicians’ first care is for the

patient. Those who work a lot, make mistakes. We would be negligent if we ignored this.

### What can we do apart from regretting the situation?

Flying is not the same as treating patients. But aviation has inherent dangers as has medicine and aviation has dealt with many of these dangers very efficiently. Most of these solutions cannot be applied to medicine but some key elements can. These include reporting mistakes, accidents and near misses and analysing them, making materials and structures safer, and processes clearer and simpler. Also setting or changing rules in order to avoid mistakes and making systems more error-tolerant.

We are far away from this in medicine. In a „blame and shame“ culture nobody wants to admit his or her mistakes. Instead of learning from mistakes we punish for mistakes. Instead of making procedures clearer and simpler, we are confusing many processes more and more. When we set rules, they still are of a disciplinary nature and not made for safety from the beginning. Instead of making life saving systems more error-tolerant, we make them more economic, which in most cases doesn’t serve the purpose of safety.

A non-punitive system for reporting is needed. The process of reporting must be protected by law so that attorneys don’t see it as a fishing ground. What has been reported must be analysed. While this is expensive, it is certainly also a good investment in health.

A reporting system ensuring a certain degree of protection for the reporting person will have to provide some kind of amnesty. The reporting system in aviation depends on this. If someone fears being punished for reporting a mistake, nobody will report mistakes. However a non-punitive system can be no waiver of responsibility. Negligence and unresponsiveness must be subject to sanction; there can be no “carte blanche” for recklessness and stupidity. This approach can be achieved and examples are already working.

Another problem may be more difficult: Patients claim the right to be informed about

safety. They want not only to know about the safety of the procedure they may undergo, but they also want to know about the quality and safety standards and results of an individual institution. They want to know whom to trust. If reporting is to become a shame and blame-free process, this may be difficult to reconcile with the patients’ request for information. Maybe the current misconception is a misunderstanding of “transparency”. Nora O’Neil in her 2002 Reith Lecture “A Question of Trust” gave some clues to this. “In fact, our clearest images of trust do not link it with openness or transparency at all. Family life is often based on high and reciprocal trust, but close relatives do not always burden one another with full disclosure of their financial or professional dealings, let alone with comprehensive information about their love lives or health problems; and they certainly do not disclose family information promiscuously to all the world. Similarly, in trusting doctor-patient relationships (that’s the sort we supposedly no longer enjoy), medically relevant information was disclosed under conditions of confidence. Mutual respect precludes rather than requires across-the-board openness between doctor and patient, and disclosure of confidential information beyond the relationship is wholly unacceptable. Perhaps it is not then surprising that public distrust has grown in the very years in which openness and transparency have been so avidly pursued. Transparency certainly destroys secrecy: but it may not limit the deception and deliberate misinformation that undermine relations of trust. If we want to restore trust we need to reduce deception and lies rather than secrecy. Some sorts of secrecy indeed support deception, others do not. Transparency and openness may not be the unconditional goods that they are fashionably supposed to be. By the same token, secrecy and lack of transparency may not be the enemies of trust.



### Medical Science, Professional Practice and Education

## Patient Safety highlighted at World Health Professions' Reception

"The World Health Professions Alliance hosted a reception in Geneva for Ministers attending the 58<sup>th</sup> World Health Assembly on 16<sup>th</sup> May 2005. The three presidents of the professions (Nurses, Pharmacists, Physicians) in welcoming the guests spoke briefly about their concerns and activities.

The guests were addressed by the keynote speaker, Sir Liam Donaldson, who spoke about the important subject of Patient Safety. He referred to the research by Professor Pittet analysing and reporting on Risk Prevention. As Chairman of the World Alliance for Patient Safety, Sir Liam stressed the importance of the five essential challenges which need to be met. The first of these to be tackled in the first two year programme was *Infection*. Under the network title „CLEAN CARE IS SAFE CARE“, the initiative would

be launched this year. He emphasised that basic actions such as adequate hand washing, cleanliness in hospitals, buildings and homes, clean instruments were all essential, and that both health professionals and individual citizens need to take this seriously.

This message about cleanliness was endorsed by Professor Didier Pittet, Director of Infection Control, University of Geneva Hospitals, who gave more details of the problems. Among the most telling facts presented was that one in ten patients entering hospital developed an infection! What was essential was safe sterilisation, education and training, safe blood, safe injections and safe surgery, together with improved resources to achieve these. WHO would be producing guidelines for better provision of this aspect of Patient Safety.

## The Swedish Patient Insurance System – A No-Fault System

**Dr. Bernhard Grewin (Past President) and Mr Gunnar Lonnquist (International Secretary), Swedish Medical Association.**

*Continuing our series on medical liability, this paper, presented at the Oslo EFMA/WHO meeting in March 2005, describes the system which has been in existence in Sweden since 1975, and is now obligatory for all health care providers*

### Voluntary Insurance

A patient insurance - no-fault compensation scheme - has been in existence in Sweden since 1975. It was developed jointly by some of the large insurance companies and the public health care providers. The insurance was based on a voluntary commitment on the part of the health care providers to financially compensate patients for injuries caused to them in connection with diagnostic and therapeutic interventions. The majority of private

health care providers also joined the insurance scheme.

### Insurance Regulated by Law

From 1 January 1997 the patient insurance scheme has been regulated by law. According to the law all health care providers in Sweden are obliged to have a patient insurance. The County Councils (regional political bodies entrusted with the responsibility for planning, financing and delivering health care services to their populations) are by far the biggest healthcare providers in Sweden. They pay 45 Swedish kronor (SEK) or approximately 4.90 € per county inhabitant per year to the insurance scheme. No other factors, such as speciality and kind of treatment have an impact on this fixed amount.

The administration of the insurance and the payment of compensation is handled by a company jointly owned by the Swedish pub-

lic health care providers i.e. the County Councils.

For private medical care, which is rendered without any formal cooperation agreements between the private provider and the Counties, the private provider has to take a patient insurance of his own. This is usually done as part of a group insurance.

Payment of compensation due to injuries within this genuinely private health care field is administered by the respective insurance companies from whom the doctor or the medical unit has purchased the insurance policy.

The right to financial compensation (damages) for injuries incurred is independent of the regulations laid down by tort law. This means e.g. that the patient, in order to get compensation, **need not** prove that the injury has been caused by fault or negligence on the part of any health care personnel.

For injuries caused by pharmaceutical products (side-effects) a voluntary scheme is still operating, regulating the financial compensation.

### Requirements for Compensation

1. Patient-injury compensation can be granted for **injuries** – both physical and mental – **that have occurred in connection with providing health care services in Sweden** – including injuries occurring during transport e.g. ambulance transport.
2. **Personal injuries:** physical as well as mental injuries can be compensated.
3. **Causal connection:** The injury must have arisen as a result of the health care procedure performed.
4. **Types of injuries compensated:**
  - a) *Treatment injuries;* provided that the injury could have been avoided either by using another medical method or by using the method applied in another manner.
  - b) *Material-related injuries:* this refers to situations where the medical devices,



apparatus etc. have been defective in some way or that they have been used/handled in the wrong manner.

- c) *Diagnostic injuries*; if a wrong diagnosis has resulted in injuries to the patient.
- d) *Infection injuries*: a clear condition is that the infection must have been acquired as a result of the medical care situation. If the patient already had this infection it cannot be compensated. Of importance is also whether the risk of an infection could be foreseeable or not. The patient's basic illness and general medical condition are taken into account here.
- e) *Accident injuries*: due to accidents in connection with diagnostics, care, treatment, transport or other accident specifically related to the medical care provided.
- f) *Medication injuries*: these refer to injuries resulting from wrongful handling of the medications – wrong dosage or other mistakes. As mentioned above side-effects of drugs are not part of this insurance. They are compensated by means of a specific drug insurance.
- g) *Compensation is not possible* for injuries resulting from medical procedures which had to be taken in emergency situations without the possibility of adhering to normal routines.

**5. Principles for Compensation Amounts**

The compensation follows the principles laid down in tort law pertaining to personal injuries.

Economic loss (e.g. loss of income) as well as non-economic loss (pain and suffering) can be compensated.

A limited self-risk payment is involved in all cases compensated.

**6. Patient Claims Panel**

This body can give its opinion on various insurance cases. Patients, insurers, health care providers or courts of law can ask for its opinion.

The Panel consists of seven members. The Chairperson should be or at least have been a judge. The other six persons

should represent the patients (3), be medically qualified (1), be specifically knowledgeable on health care issues (1) and have good experience of settlement of claims concerning personal injuries within the insurance field.

**7. Limitation Period for Claims**

Claims for compensation must have been filed at the latest 3 years after the patient was informed of the possibility of claiming compensation, and definitely within 10 years after the injury occurred. Claims for compensation are most often made by the injured patient him/herself, but can also be made by a relative, should the injury render the patient incapable of filing the claim.

**8. Number of Cases**

The number of claims have during the last years been around 9,000/year. Ten years ago the corresponding figure was around 5,000.

Approximately 45% of the claims will result in compensation.

**9. Compensation Levels**

The amount of the compensation is based on the rules laid down in the Swedish tort law.

The most common compensation will be up to 20,000 SEK (2,162 €) per injury.

The average figure though is around 110,000 SEK (11,892 €). This is due to the fact that there are also cases which will result in much higher compensation.

There is an absolute ceiling on how high the compensation might be in any individual [one singular] case. That limit is at present 7,500,000 SEK (810,811 €). Such an amount might be considered e.g. if a brain damage occurs in connection during a child's birth resulting in life-long invalidity and life-long loss of income.

**10. Total Cost**

The total cost for the insurance compensation might be expressed in two ways:

In 2003 the total sum of compensation was 290,000,000 SEK (31,351,350 €) and for 2004 this figure is estimated to be around 310,000,000 SEK (33,513,515 €).

The compensations paid out in a certain year do not usually (not) pertain to the injuries incurred that year, since it takes time to process the claim.

In conclusion one might state that the existence of a no-fault patient insurance has considerably enhanced the possibilities for patients who have been injured in connection with health care treatment to get a reasonable financial compensation, and to get this compensation without having to resort to court of law procedures with the difficulty of proving that someone has been at fault and also risking losing such a tort law case resulting in sometimes heavy fees for legal counselling.

**Liability Insurances for Doctors**

Doctors also have individual Liability Insurances. These insurances cover e.g. possible costs for a tort law process but a small part of the premium is also a premium to the Patient Insurance Scheme. A tort law process against an individual doctor would be very rare in Sweden. The general Patient Insurance is one reason for that. Another reason is that claims in a tort law process would be primarily directed against the doctor's employer – if employed – according to the principle of vicarious liability – or against his company if he/she performs his work in that organisational form.

Therefore the premiums for doctors' liability insurances are very limited in an international comparison. Today (April 2004) the annual premiums charged by the most used insurance company for these matters are as follows:

Not yet licensed doctors	500 SEK	(54 €)
Employed licensed doctors	550 SEK	(59 €)
Licensed doctors employed and with other practice part-time	2392 SEK	(259 €)
Licensed doctors full time private		
Practice	3572 SEK	(386 €)

Note: 1 € = 9.25 SEK



## AIDS

# New Online Tool Kit On HIV/AIDS Prevention For Sex Workers

**GTZ, WHO and sex workers networks share information and lessons learned.**

**Berlin/Geneva** – The German technical cooperation (GTZ) and the World Health Organization, in collaboration with sex work networks around the world, are launching the first ever online tool kit aimed at helping sex workers to protect themselves and their clients from infection with HIV and other sexually transmitted infections. The tool kit is intended for use by people working with female, male and transgender sex workers including programme managers, field workers and peer educators. This is the first time this expertise has been formally documented and made widely accessible.

“Thanks to this innovative project, people working on HIV/AIDS prevention for sex workers can now learn what does and does not work from Poland to Papua New Guinea. Targeted HIV/AIDS prevention and care programmes are urgently needed for sex workers, injecting drug users and other vulnerable groups and we welcome GTZ’s leadership and support in this often under funded area,” said Dr Jim Yong Kim, WHO’s Director of HIV/AIDS.

Included in the online sex work tool kit are practical “how to do it” documents like “*Hustling for Health*” and “*Making Sex Work Safe*”, written by experienced sex worker groups to support programme managers in setting up and maintaining projects. “*Of Veshyas, vamps, whores and women*” for example, is based on experiences from an Indian NGO and gives practical advice on how to build up a network of peer educators in brothels and deal with the brothel owners, how to set up condom distribution networks and how to structure payment incentives for peer educators.

Despite proof that prevention programmes are useful in sex work settings, currently only 16% of sex workers have access to

these services. Around the world, poor services generally mean higher HIV prevalence.

“Sex workers know better than anyone about the problems they face, the kind of language and programs that are effective. Only by involving them can both male and female sex workers and clients be motivated to make use of condoms and health clinics,” said Friederike Strack from Hydra — one of the sex worker organizations collaborating on the tool kit.

The tool kit also includes valuable data and analysis which can be shared across regions and used to design better HIV/AIDS prevention programmes for sex workers, for example “*Police and Sex Workers in Papua New Guinea*”. A report on “*Meeting the sexual health needs of men who have sex with men in Senegal*” gives valuable insight into dealing with the cultural sensitivity surrounding male homosexuals in West Africa, how their lives are characterized by violence and rejection and that many find it easier to get help and treatment from clinics than traditional healers.

WHO and GTZ worked closely with sex work networks and organizations to produce an online collection of more than 130 easily-accessible documents, manuals, reports, and research studies. The aim of the tool kit is to make vital information about sex work interventions more accessible to a wider audience and to share lessons learnt to contribute to global efforts which will develop and increase effective HIV prevention and care interventions among sex workers.

“Targeted programmes make a difference — in Germany we have shown over the last 15 years that these kinds of interventions can really work. It’s important to share knowledge across borders and within communities to help save lives within one of the oldest professions in the world. We are

pleased to support this initiative,” said Thomas Kirsch-Woik, Senior Consultant HIV/AIDS, GTZ.

In many countries, sex workers are frequently exposed to HIV and other sexually transmitted infections (STIs). Where sex workers have poor access to HIV prevention, HIV prevalence can be as high as 60-90%. Evidence shows that targeted prevention interventions in sex work settings can turn the epidemic around.

In Thailand and Cambodia for example, condom use rose to over 80% and HIV and STIs declined dramatically thanks to large scale programmes targeting sex workers and clients. In Nairobi, Kenya, strengthened interventions with sex workers — including peer support, condom promotion and STI services — led to falls in HIV incidence, from 25-50 % to 4 % in Nairobi sex workers.

“To really have an impact on the epidemic, it is important for services and policies to be made more user-friendly and to be adapted to the reality of the sex work as well as to regional differences. Injecting drug use and sex work are closely linked in Eastern Europe and it is essential to integrate the services”, said Monica Ciupagea from the Open Society Institute Hungary which also collaborated on the tool kit development.

The HIV/AIDS Sex work tool kit brings together over a decade’s worth of research and practical experience on what does and not work to change behaviour and protect sex work and clients from HIV/AIDS. Now online, it will also be available as CD-ROM and hard copy in early 2005. The kit is a living document and will continue to be updated as new resources are released.

The Sex Work tool kit is one of a series of online tool kits produced by WHO and GTZ and can be found at [www.who.int/hiv/toolkit/sw](http://www.who.int/hiv/toolkit/sw). The Antiretroviral (ARV) Tool kit: A public health approach for scaling up ARV treatment ([www.who.int/hiv/toolkit/arv](http://www.who.int/hiv/toolkit/arv)) and the Tool kit for scaling up HIV Testing and Counselling services ([www.who.int/hiv/toolkit/tc](http://www.who.int/hiv/toolkit/tc)) are also available online.



## Twin Studies

# Twin study reveals genetic role in female infidelity

A confidential survey of more than 1,600 pairs of female twins has revealed that genetic factors have a substantial impact on how likely women are to cheat on their partner and how many sexual partners they will have.

This is the first ever study to look at the genes underlying these influences in humans.

The results of the new research – led by Professor Tim Spector, Director of the Twin Research Unit at St Thomas' Hospital, London – were revealed by Professor Spector during a press briefing at the Science Media Centre.

Female twins from the Twin Research Unit database answered a range of questions in a confidential questionnaire relating to their sexual attitudes and behaviour. They reported previous episodes of infidelity, total lifetime number of sexual partners and also their attitudes towards infidelity.

The average age of respondents was 50, their average number of sexual partners was between four and five, just over 20% admitted to infidelity, 25% were divorced and 98% were heterosexual.

Professor Spector says: "Not surprisingly, the average number of sexual partners was significantly higher among respondents who had been unfaithful compared with those who had remained faithful – a mean of eight compared with four."

Headline findings of the research study include:

- Genes are an important influence in explaining variation between women in both infidelity and number of sexual partners – with a heritability of 41% and 38% respectively.
- Further analysis of these results failed to support the hypothesis that a gene impli-

cated in previous research into patterns of sexual behaviour among rodents (AVPR1A or vasopressin gene) could explain the observed variation in human sexual behaviour.

- However, the study did find some evidence that genes in three other chromosomal areas (chromosomes 3, 7, 20) could be implicated.
- In contrast, attitudes to infidelity are not influenced to any significant degree by genetic factors – environmental factors including society, education or religion prevail.

## MS

# A UK national Multiple Sclerosis tissue Bank, funded by the MS Society, co-ordinates the collection of donated tissue and distributes samples to scientists conducting research into the causes and treatment of MS.

While other techniques can be used to study MS – such as experimental animal models, MRI and cell culture, they are not an adequate substitute for studying samples of tissue that have actually been damaged by MS. The bank not only takes donations of tissue from people with MS, but also from people without MS, which are vital for comparison purposes.

"The UK MS Tissue Bank exists only because of the foresight and generosity of people who have pledged their tissue to research," says Professor Richard Reynolds, its Scientific Director. "It is an act of pure altruism that will be of no benefit to the individual, but helps future generations."

- Believing infidelity was wrong in principle prevailed even in a significant proportion of those women who admitted having been unfaithful, highlighting the distinction between attitudes and actual behaviour.

Professor Spector says: "By demonstrating the heritability of female infidelity and number of sexual partners in humans, this study justifies additional genetic and molecular research on human sexual behaviour."

"The fact that psychosocial traits such as number of sexual partners and infidelity appear to behave as other common complex genetic traits in humans, in that they have a heritable component, lends support to evolutionary psychologists' theories on the origins of human behaviour."

Professor Spector believes that the logical conclusion of his team's new research may be that infidelity and other sexual behaviours persist because they have been evolutionarily advantageous for women.

Located at Charing Cross Hospital in London, the tissue Bank has put in place procedures allowing collection of tissue as quickly as possible after death to minimise deterioration – within 24 hours wherever possible.

"For a donation to work efficiently a lot of people need to work together, such as the relatives, GPs, funeral directors, hospital pathologists and tissue bank staff who retrieve the samples," says Dr Abhi Vora, Manager of the Tissue Bank. "We all pull out all the stops, seeing it as something positive and lasting to come out of a sad event."



Since it was set up in 1998, 1700 people have so far registered as tissue donors. To date, 84 people with MS and 14 people without MS donated tissues, which are being used in a total of 27 different research projects around the world.

“Donations from a single brain and spinal cord can be dissected to yield 200 different samples that can be supplied to many different research projects,” says Dr Vora.

Projects benefiting from the tissue bank include those aiding better diagnosis. Scanning slices of brain containing MS lesions, which are then examined under a microscope will allow any changes on the MRI to be directly compared with what is going on in the brain. Ultimately such projects may help scientists to understand more from MRI scans about the type of MS a person has and make it possible to target treatments more effectively.

Brain tissue is being used to see whether viruses and bacteria can be detected. Research teams from the Royal Free Hospital and the Imperial College School of Medicine in London, have developed sensitive techniques to see if the virus human herpes virus 6 (HHV6) and the bacterium *Chlamydia pneumoniae* are present in MS lesions donated to the tissue bank. Identifying agents that may trigger the damage in MS could mean that treatments may be developed to neutralise them.

Researchers from Belfast believe that an early step in the formation of a lesion is a subtle change in microglial cells that are normally resident in the brain. The group are currently characterising these cells in brain tissue from MS patients containing lesions at different stages of development. The study hopes to find out whether changes in the microglia herald the formation of an MS lesion.

Chemical messengers, Cytokines, released by cells within a developing lesion are central to the cascade of events that leads to demyelination. Understanding the role of these molecules is the goal of a number of projects supported by the Tissue Bank. Such research could form the basis of developing ways of knocking out the critical messengers and stopping damage.

## **MS Society sponsored research projects**

### **Some of the many research projects supported financially by the MS Society**

- providing samples of brain tissue to MS researchers worldwide
- identifying targets of myelin damage
- identifying unique proteins in myelin
- how to switch off damaging activity in MS
- finding ways to encourage repair of myelin
- identifying genes that make people susceptible to MS
- the role of viruses in MS
- identifying cells that could be used for the repair of myelin
- investigating how nerve fibres can be protected against MS
- finding ways to monitor disease activity in MS
- protecting the brain from leakage through the blood-brain barrier in MS
- identifying novel drugs that can help nerves work better in MS
- supporting the world’s first MRI scanner dedicated solely to MS research
- the role of social support for carers of people with MS
- identification of the role of a herpes virus in MS
- understanding how myelin is made
- using new imaging methods to look at nerve fibre damage in MS
- how to improve nerve function in MS
- how growth factors promote repair in MS
- identifying cells for transplantation to repair myelin
- potential role of hepatitis B virus in MS
- clinical trial treatment of incontinence
- setting up a research centre in rehabilitation of people with MS
- setting up new centres for MS research in Glasgow and Aberdeen
- education programme for people to help manage their MS
- looking at bone mass in people with MS
- identifying how to encourage repair of myelin
- helping people to cope with wheelchairs
- supporting the trial of cannabis in treating spasticity in MS
- clinical trial of whether cannabis can help control on continence
- investigate health provision needs in Northern Ireland
- helping people cope with entering long term residential care

## **WHO**

### **Dr. Lee addressing the World Health Assembly: ends with concern with preparation before Avian influenza strikes**

In his address to the World Health Assembly (WHA) in Geneva 21st May 2005, the Director General of WHO drew analogies between the discussions 60 years ago on how to assure the wellbeing of humanity after the Second World War and the situation before the World Health

Assembly. Sixty years ago it was necessary to consider how to apply the knowledge acquired at the price of the devastating fight of the previous years. Amongst other conclusions this resulted in the UN system. In our turn the WHA was meeting to learn the lessons of the past and put them into prac-



tice. The condition of the world continued to change and our institutions continue to adapt themselves. The agenda of the 58th WHA reflected the changes and bore witness to the continuing importance of the fight against sickness and the improvement of health essential for a viable world.

While the Millennium Goals placed Health at their centre, the translation of them into reality was very far from completion and progress towards them was not reassuring. „Unless we succeed in bringing about the major changes we are working for in the near future, the targets for reducing child mortality will not be achieved by 2015“. In some areas death rates have actually risen as a result of extreme poverty and epidemics. While the necessary technical and practical know-how exists, we have not found ways of applying it on a large enough scale.“ While funding for health development had risen steeply, it remained a small fraction of that needed.

Aiming at reinforcing the positive trend of improving results in countries, the budget shows increases in the areas of epidemic alert and response, maternal and child health, non-communicable diseases, tobacco control, and response to emergencies.

Dr. Lee stressed the importance of creative dialogue and negotiation as exemplified by the Convention on Tobacco Control. With 64 parties engaged in the Convention-now in force -the goal was the greatest possible number of Member states becoming Contracting Parties to maximise the effect of the Convention and to save lives.

Referring to the International Health regulations, if the WHA reached agreement on them this would be a landmark event for public health. He said that their significance would only be realised when they are in place, observed and implemented.

The Strategic Health Operations Centre, set up last year, had provided a valuable asset to global coordination. It provided instant communication between Member States and technical partners, with 60 offices, including the Emergency Network. Following the Tsunami in Asia, our Health Action in Crises unit used it to maximum advantage to coordinate responses.

Currently it was enabling health workers to contain the Angolan Marburg haemorrhagic fever outbreak. At the Thailand Tsunami Conference he had made clear that the warnings on possible cholera, malnutrition and epidemics in Thailand had avoided the escalation of the disaster by taking rapid action to ensure water safety, adequate nutrition, and reliability of disease surveillance. This was an unprecedented effort of collaboration including the government, non-governmental and private sector efforts.

The Global Outbreak Alert and Response Network, now comprising 130 institutions, has responded to more than 50 major disease outbreaks. Major demands included Avian influenza, Ebola, Marburg, meningitis, myocarditis and plague, and the Network was also involved in establishing the early warning system following the Tsunami disaster.

The success of the global effort to maintain and increase security depends on reliable information being available and clear to those who need it. The Health Metrics Network, a new partnership with support from the Bill and Melinda Gates Foundation, hosted by WHO, will provide extremely valuable support for this effort. Progress on the core information function in all activities is also highlighted by a new publication „World Health Statistics“, which provides national, regional and global information on 50 health indicators.

The Director General urged the need for research and the urgent need for new diagnostics, vaccines and treatments stressed at the Ministerial Summit on Health Research, held in Mexico. After consensus building meetings “we are ready to move forward with the International Clinical Trial Registry“ which will strengthen the research process and its ability to win public trust.“

The Commission on Social Determinants of Health launched in March, with leading practitioners from all six regions contributing, has the task of devising initiatives to make health systems work effectively and fairly in the context of defining and confronting major underlying causes of ill-health in the 21st century.

He stated that this year the focus of the World Health Report and World Health Day on the health of Mothers, newborn and children also reflected the importance of partnership. In this case the key partnership was with UNICEF and he welcomed Mrs Veneman its new Executive Director (who addressed the Assembly).

Referring to creative solidarity in health as one of the millennium goals, he said that combining expertise and resources was currently the greatest need, as well the basis for hope. The WHO goal of universal access to effective health is attainable, working with partners in fighting major infectious diseases, polio eradication, preventing and treating chronic diseases. He illustrated this with the campaign for treatment of 3 million people living with HIV/AIDS by the end of this year. This was a first step towards universal access to treatment.

While treatment of TB success rate had reached 82% , detection still lagged at 45%. The “reach and cure more patients“ meant adopting WHO policies for HIV-linked TB ,drug-resistant disease and bolstering service quality“

He expressed concern that in two countries polio had recurred. The urgent need is to achieve Polio eradication.

The strategy to achieve adequate malaria control continues ,with the new artemisinin-based combination therapies and long lasting insecticide repellent nets which are effective.

He referred to the growing threat to health systems from shortage of adequately trained staff. In 2006 the World Health Report will be on Human Resources for Health , which will be the theme of World Health Day. The Report will launch the decade of Human Resources for Health.

Dr. Lee ended by highlighting the serious threat to the world today - Avian influenza . „The timing cannot be predicted, but rapid international spread is certain once the pandemic virus appears.“ The Spanish pandemic in 1918 gave some idea of its potential magnitude. He continued “By good fortune we have had time, and still have the time , to prepare for the next global pan-



demic, because the conditions for it have appeared before the outbreak itself. We must do everything is our power to max-

imize that preparedness. When this event occurs, our response has got to be immediate, comprehensive and effective.“

## Remarks of Mr Bill Gates, co-founder of the Bill and Melinda Gates Foundation, at the World Health Assembly

Mr. Gates said that in his view – and there was no diplomatic way to put this: “The world is failing billions of people. Rich governments are not fighting some of the world’s most deadly diseases because rich countries don’t have them. The private sector is not developing vaccines and medicines for these diseases, because developing countries can’t buy them. And many developing countries are not doing nearly enough to improve the health of their own people”.

To be frank. “If these epidemics were raging in the developed world, people with resources would see the suffering and insist that we stop it. But sometimes it seems that the rich world can’t even see the developing world. We rarely make eye contact with the people who are suffering – so we act sometimes as if the people don’t exist and the suffering isn’t happening.

All these factors together have created a tragic inequity between the health of the people in the developed world and the health of those in the rest of the world.”

He would speak about how the world, working together, could dramatically reduce this inequity.

I first learned about these tragic health inequities some years ago when I was reading an article about diseases in the developing world. It showed that more than half a million children die every year from “rotavirus”. I thought, ‘Rotavirus’? – I’ve never even heard of it. How could I never have heard of something that kills half a million children every year!?”

When reading an article about diseases in the developing world he learnt that millions of children were dying from diseases that had essentially been eliminated in the United States. “Melinda and I assumed that if there were vaccines and treatments that could save lives, governments would be doing everything they could to get them to the people who needed them. But they weren’t. We couldn’t escape the brutal conclusion that – in our world today – some lives are seen as worth saving and others are not. We said to ourselves: This can’t be true. But if it is true, it deserves to be the priority of our giving.”

Today, in malaria; AIDS; tuberculosis; nutrition; maternal, newborn, and child illness; and so many other health problems, the world was not doing enough to deliver the solutions we do have, and we’re not spending enough to find the solutions we don’t have. As a result, millions of people die every year. This didn’t tell a flattering story. But the story wasn’t over. In fact, the story is starting to change.

He believed we were on the verge of taking historic steps to reduce disease in the developing world. What will make it possible to do something in the 21st century that we’ve never done before?

### Science and technology

Never before have we had anything close to the tools we have today to both spread awareness of the problems and discover and deliver solutions.

Global communications technology today can show us the suffering of human beings a world away. As the world becomes smaller, this technology will make it harder to ignore our neighbors, and harder to ignore the call of conscience to act.

We are seeing the power of conscience in efforts such as the United States’ Emergency Plan for AIDS, the United Kingdom’s Commission on Africa, and the Global Fund for AIDS, TB and Malaria.

But the desire to help means nothing without the capacity to help – and our capacity to help is increasing through the miracles of science. Again and again, over and over, scientists make the impossible possible.

Recent advances in basic research, particularly the sequencing of the genome, give us a foundation for much better progress against all disease. If we match these accelerating capacities of science with the emerging moral awareness of global health inequities – we have an historic chance to build a world where all people, no matter where they’re born, can have the preventive care, vaccines, and treatments they need to live a healthy life.

To build this world, I see four priorities: First, governments in both developed and developing countries must dramatically increase their efforts to fight disease.

The wealthy world’s governments must not be content to merely increase their commitment every year. They need to match their commitment to the scale of the crisis. Yet this will not happen unless we see a dramatic increase in the efforts of developing countries to fight the diseases that affect their people.

Countries in sub-Saharan Africa spend a smaller percentage of their gross domestic product on health than other regions of the world. A stronger commitment from developing countries will inspire a stronger commitment from the rest of the world.

Priority number 2. The world needs to direct more scientific research to health issues that can save the greatest number of lives – which means diseases that disproportionately affect the developing world. In the early 1900s, Nobel Prizes were awarded

for discoveries about the causes of both tuberculosis and malaria. Yet, more than a hundred years later, we don't have effective vaccines for either one. It's not because the problem is unsolvable; it's because we haven't put our scientific intelligence to the task. The world can change this – for malaria, tuberculosis, and many other diseases.

In order to get the world's top scientific minds to take on the world's deadliest diseases, in 2003 our foundation launched "The Grand Challenges in Global Health." We asked top researchers to tell us which breakthroughs could help solve the most critical health problems in the developing world. Scientists from more than 80 countries sent in thousands of pages of ideas, which led to 14 specific Grand Challenges in Global Health. Once we published these challenges, more than 10,000 scientists submitted proposals for research. They included ideas such as vaccines that don't need refrigeration, handheld microdevices that health workers can use with minimal training to detect life-threatening fevers, and drugs that can attack diseases that hide from the immune system. The quality of the ideas and the volume of the response showed us that when scientists are given a chance to study questions that could save millions of lives – they flock to it. We were so taken with the response that today we are announcing an increase of our commitment to these Grand Challenges from 200 million dollars to 450 million dollars.

I am optimistic. I'm convinced that we will see more groundbreaking scientific advances for health in the developing world in the next ten years than we have seen in the last fifty.

We're already seeing exciting advances.

We're seeing today a new, safe, cheap drug for visceral leishmaniasis, a disease that kills more than a quarter of a million people per year.

We've seen a demonstration this past year that we can have a single vaccine for pneumonia that could reduce all deaths in Africa by 15 percent. seeing older malaria drugs make way for new, more effective drugs – including new drug combinations that are

extremely effective with only 3 days of treatment.

Malaria vaccine in trials last year showing promise of preventing severe malaria.

And also progress this year towards the first new drug for sleeping sickness in 50 years – a new oral drug that was 100 percent effective and showed no toxicity in phase two trials.

Of course, one of our most daunting challenges is to create an effective vaccine to prevent HIV/AIDS. Some of the world's top scientific minds are working on this challenge, but many of the researchers are isolated, under pressure for immediate results, and unaware of their colleagues' discoveries.

Referring to the challenge of creating an effective vaccine to prevent HIV/AIDS he commented that, over the past two years the global scientific community has come together under the HIV Vaccine Enterprise to coordinate AIDS research under one strategy – to help eliminate duplication, identify the gaps, and maximize the synergy from so many brilliant minds. There is new energy around this global HIV Vaccine Enterprise, and our foundation has recently announced 400 million dollars in funds to implement critical parts of this plan. It is time that the energy and commitment to find an HIV vaccine matches the magnitude of the pandemic.

Not everyone shared this enthusiasm. We have been criticized for emphasizing the health discoveries that will come in the near future. Research into big health breakthroughs. Some point to the better health in the developed world and say that we can only improve health when we eliminate poverty. And eliminating poverty is an important goal. But the world didn't have to eliminate poverty in order to eliminate smallpox – and we don't have to eliminate poverty before we reduce malaria. We do need to produce and deliver a vaccine – and the vaccine will save lives, improve health and reduce poverty. Improving health improves education; it expands productivity; it results in people having smaller families, so that resources go further. When health improves, life improves by every

measure. That's why we will continue to invest a significant percentage of our resources in searching for low-cost, life-saving breakthroughs, especially through vaccine research – and we encourage wealthy governments to do the same.

The foundation would continue to invest life saving breakthroughs and he urged government to do the same.

Priority number 3. The world has to devote more thinking and funding to delivering interventions – not just discovering them.

"Imagine that one day there is worldwide rejoicing over the discovery of an effective AIDS vaccine. But imagine this too: we discover the vaccine, but don't distribute it. And millions continue to die.

What a horrifying thought. Most people would say we'd never let that happen. But, in a sense, we already are! That's what the world has been doing for decades in the case of diseases like measles, diphtheria, tetanus, and hepatitis B. In the past 5 years, more than 30 million children every year went unvaccinated with the basic vaccines that are widely used in the industrialized world. As a result, more than a million children die from vaccine-preventable diseases each year.

Getting the intervention to the people who need it should never be an afterthought; it should be built into the design of the new discovery."

We need an emphasis on "breakthroughs you can use" or what we like to call "deliverable technology" – which means getting it to the people who need it. At the very outset, researchers should be seeking interventions that are not only effective, but also inexpensive to produce, easy to distribute, and simple to administer.

If we can go from 20 pills a day to three pills a day, why can't we go from three pills a day to a once-a-month treatment?

Today, we have tuberculosis drugs that you have to take for 9 months. Why can't we find one that works in 3 days?

His background was in information technology very different from global health. "But it does give us a useful lesson: early in



the computer age, computers were very large and costly, which limited the number of people who could use them. The continuous process of discovering new designs helped make the technology smaller and cheaper so that someone like me could declare the goal of a computer in every home and on every desk. Millions more people can get the benefits of new discoveries if you make delivery a priority, and if delivery shapes the design.”

“Priority number 4. To find new discoveries and deliver them, we need to make political and market forces work better for the world’s poorest people.”

Political systems in rich countries work well to fuel research and fund health care delivery, but only for their own citizens. The market works well in driving the private sector to conduct research and deliver interventions, but only for people who can pay.

Unfortunately, these political and market conditions that drive high quality health care in the developed world are almost entirely absent in the rest of the world. We have to make these forces work better for the world’s poorest people.

There is a model in the Global Alliance for Vaccines and Immunization – an effort we launched in 2000 to address the tragedy of millions of children dying every year from vaccine-preventable diseases. When the project began, vaccines were sitting on the shelf as kids were dying from those very diseases. Other necessary vaccines were not being manufactured at all. The market wasn’t working to bring people what they needed because there wasn’t enough money to create a demand and guarantee a supply.

Since 2000, eleven governments have provided hundreds of millions of dollars for vaccine purchase and distribution. This has given companies a market incentive to manufacture these vaccines. As a result, in five short years, four million additional children have been immunized with basic vaccines, 42 million with hepatitis B, five million with haemophilus influenzae type B, and over three million with yellow fever – saving more than 700,000 lives.

“We hope even more funding will be made available through the proposed International Financing Facility for Immunizations proposed by the United Kingdom; with support pledged by France, Germany, Sweden, and Italy, this initiative would provide developing countries with the reliable funding they need, year after year, to buy vaccines, which gives the private sector the market incentive to make them and deliver them.” He believes that if we act on these four priorities, we can build a world where all people, no matter where they’re born, can have the preventive care, vaccines, and treatments they need to live a healthy life.

Governments in developed countries should match their financial commitments to the scale of the crisis – and make sure their efforts get results.

Governments in developing countries should make health a priority by dramatically increasing the percentage of their budgets they commit to health – particularly in their efforts to build health systems that can adopt and deliver low-cost interventions.

Citizens around the world should petition their governments to put up money to make market forces work better for the world’s poorest people.

“It’s one thing to define the goals and design the tasks, it’s quite another to get them done. An important duty falls to the health ministers in this room.”

He appealed to Health Ministers present. They occupied a crucial position between the people who make funding decisions and the people suffering from disease. They can make an immense difference by urging the world to make eye contact with the people who are suffering and can also show the world that there are solutions that work. One key to this is the new Health Metrics Network, which will be announced tomorrow and which the foundation are proud to support. This network will work to strengthen health information systems in countries so that health efforts are based on evidence, not speculation.

“There is no bigger test for humanity than the crisis of global health. Solving it will require the full commitment of our hearts and minds. We need both. Without compassion, we won’t do anything. Without science, we can’t do anything. So far, we have not applied all we have of either. I was optimistic that in the next decade, people’s thinking will evolve on the question of health inequity and people would finally accept that the death of a child in the developing world is just as tragic as the death of a child in the developed world.”

## Strengthening Health Information Systems to better address health needs worldwide

A new global partnership that will work to improve public health decision-making through better health information was launched on 18 May 2005 at the World Health Assembly (WHA). The Health Metrics Network (HMN), a partnership comprised of countries, multilateral and bilateral development agencies, foundations, global health initiatives and technical experts will increase the availability and use of timely, reliable health information by catalyzing the funding and development of

core health information systems in developing countries.

Today, despite the efforts of many country, regional and global partners, there are significant gaps in the health information that is available to policy-makers and health practitioners. “In some areas of the world, even basic facts such as a person’s birth, their death and cause of death are not recorded,” said Dr. LEE Jong-wook, Director-General of the World Health Organization (WHO). The Health Metrics Network will work to close this gap by

helping countries improve their ability to gather this vital health information. Accurate data is critical to identifying problems and implementing effective solutions for people's health."

HMN brings together health and statistical constituencies to build capacity and expertise for strengthening health information systems so that local, regional and global decision-makers have quality data on which to base decisions to improve health.

"Health information is not simply an end in itself but provides the basis for better decision-making," said Dr. Richard Klausner, Executive Director, Global Health, the Bill & Melinda Gates Foundation. "Good data, quality reporting and tracking, thoughtful analysis and consistent health information systems will enable decision-makers to make informed and therefore better decisions on disease control and human development."

HMN responds to a need for evidence-based policy-making that can enable countries to make more efficient use of health budgets. In addition, other global initiatives including the Millennium Development Goals, the Global Fund to Fight AIDS, Tuberculosis and Malaria, Global Alliance for Vaccines & Immunization (GAVI) and the President's Emergency Plan for AIDS Relief (PEPFAR) have increased the demand for sound health information.

HMN partners have agreed to align their individual efforts around a common health information framework thereby reducing overlapping and duplicative demands that have burdened fragile information systems in developing countries in the past.

"We have agreed to better coordinate and align our investments in the development of health information systems in accordance with the broader development agenda including the Millennium Development Goals," according to a statement endorsed by the HMN partners.

The initial HMN partners include: African Population and Health Research Center; Bill & Melinda Gates Foundation, Centers for Disease Control and Prevention of the U.S. Department of Health and Human Services, Danish International

Development Agency, Department for International Development (U.K.), European Commission, Ghana Health Services, Global Fund to fight AIDS, Tuberculosis and Malaria, GAVI, Ministry of Health, Mexico, Ministry of Public Health, Thailand, Organisation for Economic Co-Operation and Development, Statistics South Africa, Swedish International Development Agency, Uganda Bureau of Statistics, UNICEF, United Nations Statistics Division, U.S. Agency for International Development, World Bank and World Health Organization.

HMN will meet its objectives through a range of activities. Low- and middle-income countries will be eligible to apply for grants of up to US\$ 500 000 for health information system strengthening and can

call upon HMN partners for technical assistance.

By 2011, HMN expects that at least 80 countries will be able to report on agreed, standardized global health goals and indicators in a timely and sound manner.

HMN has received an initial grant of US\$ 50 million over seven years from the Bill & Melinda Gates Foundation and additional contributions from other donors including the Department for International Development (U.K.), U.S. Agency for International Development and Danish International Development Agency.

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## The World Health Report 2005 – *„Make every mother and child count“*

This year's World Health Report focuses on Maternal and Child Health under the title *„Make every mother and child count.“* This highlights the fact that there is only a decade left to achieve the Millennium Development Goals which, in particular, highlights access to care and improvement in health, particularly in the context of reduction of poverty.

The extensive analysis which precedes the Appendix of global basic statistical information, this year focuses especially on maternal and child health, reflecting the needs and problems in implementing the progress that is still required to ensure full implementation of the technical knowledge which, if put in place, would reduce mortality and morbidity in mothers and children alike. The overview preceding the seven chapter commentary refers at an early stage to the 3.3 million or more stillbirths, the 4 million plus deaths within 28 days of birth, the 6.6 million children dying before their fifth birthday, and the 529 thousand maternal deaths in pregnancy and during or following childbirth.

While referring to the increase in countries who have improved maternal and child health recently, depressingly, it states that those countries who had the highest burden of mortality and ill-health made the least progress in the 90's. For some, progress has even slowed down.

In analysing why progress is patchy and listing the many factors contributing to this, including inability to invest adequately in health systems, stress is laid on the disparities between countries and also between rich and poor within countries.

The seven chapters analyse not only the history of maternal and childcare, the progress as well as failings, but also outlines ways forward for progress, and the financial and other resources required to achieve this. They make compelling reading and hopefully will meet with an adequate response from both the wealthy industrialised nations as well as those still at various stages of development, and other international agencies.



## Sustainable Health Systems

# An Innovative Approach To Health Systems Research

### Science Can Do More – Research To Bridge The “Know-Do” Gap

Geneva – Health Systems Research has the potential to produce dramatic improvements in health worldwide and to meet some of the major development challenges in the new millennium. Effective research could prevent half of the world’s deaths with simple and cost-effective interventions, the World Health Organization says in a new world report on global health research.

The WHO *World Report on Knowledge for Better Health: Strengthening Health Systems* highlights aspects of health research that, if managed more effectively, could produce even more benefits for public health in future. It sets out the strategies that are needed to reduce global disparities in health by strengthening health systems.

Inequities in health are among the major development challenges in the new millennium and malfunctioning health systems are at the heart of the problem. Moreover, the culture and practice of health research should reach beyond academic institutions and laboratories to involve health service providers, policy-makers, the public and civil society.

The report also argues that science must help to improve public health systems and should not be confined to producing drugs, diagnostics, vaccines and medical devices. Biomedical discoveries cannot improve people’s health without research to find out how to apply them with in different health systems and diverse political and social contexts, thus ensuring that they reach those who need them the most.

“There is a sense that science can do more, especially for public health,” said Dr LEE Jong-wook, WHO Director-General. “There is a gap between today’s scientific advances and their application – between what we know and what is actually being done. Health systems are under severe pressure and there is an urgent

need to generate knowledge for strengthening and improving them.”

A team of 12 internationally prominent health researchers in both developed and developing countries, coordinated by Dr Tikki Pang, WHO Director for Research Policy & Cooperation, developed the 143-page *World Report on Knowledge for Better Health* over 18 months. Based on a wide-ranging consultative process and on previous reviews of global health research, the report advocates that health equity can only be achieved through better management of health research and increased investment in health systems research.

Health systems research suffers from a poor image and has been under-funded compared to biomedical research despite widespread recognition of its importance. The field attracts less than one tenth of 1% of total health expenditure in low-income countries.

The lack of attention given to this field is also reflected in the fact that only 0.7% of scientific articles published globally in the year 2000 were in the area of health systems research.

“It is extremely important to get this report out now. The report demonstrates the enormity and complexity of the problem and outlines a way to go forward,” said Eva Harris, President of the Sustainable Science Institute based at the University of California, Berkeley, USA. “It anticipates how the global community can get a handle on the problem in a constructive manner instead of lamenting a lack of action.”

In Africa, for example, it is estimated that only between 2-15% of children slept under bed-nets in 2001 – a simple, effective and proven method to prevent malaria. “We need to put a stronger emphasis on translating knowledge into actions – health systems research will help us to bridge this “know-do” gap”. Also, that research is an investment, not a cost”, said Dr Pang.

The report also illustrates how health systems research can strengthen human resources for health, health financing, as well as information and delivery of health services, with some projects already yielding impressive results. Among the research projects mentioned in the report is the Tanzania Essential Health Interventions Project (TEHIP) which was set up to find new ways to plan, set priorities and allocate resources as part of a major reform of the country’s health-care system. The aim was to

evaluate the impact of health interventions in terms of burdens of disease and per capita cost.

Researchers found that in two Tanzanian districts, malaria alone accounted for 30% of all healthy years of life lost due to deaths in 1996-97. In response, government planners increased the budget for malaria prevention and treatment programmes from 10% to 26% by 2000-2001. Overall, the research has resulted in a better match between disease burden and health budget allocation, and the child mortality rate has been reduced by more than 40% since the late 1990s.

“Health systems should nurture a stronger culture of learning and problem-solving to tackle the major health challenges of our times,” said Tim Evans, Assistant Director-General, WHO. “This could be achieved by understanding how elements within a health system interact with each other and by finding innovative ways to solve complex problems.”

## What is a health system?

A health system includes all actors, organizations, institutions and resources whose primary purpose is to improve health. In most countries a health system has public, private, traditional and informal sectors. Although the defining goal of a health system is to improve health, other goals are to be responsive to the population it serves. This responsiveness is determined by the environment in which people are treated, and should ensure that the financial burden of paying for health is fairly distributed. Four key functions determine the way inputs are transformed into outcomes that people value: resource generation, financing, service provision and stewardship. The effectiveness, efficiency and equity of national health systems are critical determinants of population health status.

## Ministerial summit on health research

Ministers of Health from more than 30 nations as well as representatives of research institutions, academia, non-governmental organizations, pharmaceutical companies and various key stakeholders in health/medical research gathered in Mexico City, Mexico, from 16-20

November 2004, to address the vital role of research in strengthening health systems and how it can better serve the health needs of the global population. Hosted by the Government of Mexico and the World Health Organization, the *Ministerial Summit on Health Research* focussed on the “know-do gap” – how to translate knowledge into action to improve health. The Summit also discussed research needed to

achieve the health-related Millennium Development Goals (MDGs) by 2015.

By gathering a large number of players in health research, the Summit represents a unique opportunity to develop a platform of specific initiatives to strengthen health systems and to improve information access. The key recommendations of the Summit have been incorporated into the “Mexico Agenda on Health Research.”

## Vaccinating african children against pneumococcal disease saves lives

Geneva – The World Health Organization has welcomed the results of a pneumococcal conjugate vaccine trial conducted in the Gambia which are published in the *Lancet* commented as follows:

Dr LEE Jong-wook, Director-General, WHO, declared:

“The results of this vaccine trial hold great promise for improving health and saving lives in resource-poor populations. The international community’s task now is to continue to work together productively to make the pneumococcal conjugate vaccine widely available to children in Africa, as lives are lost every minute to pneumococcal disease. Immunizing children with pneumococcal conjugate vaccine in developing countries will be a critical intervention towards achieving a two-thirds reduction in the under-five mortality rate, a Millennium Development Goal.”

Dr Felicity Cutts, principal investigator of the trial who is currently based at WHO, said:

“The trial results are highly positive and promising, and provide us with a clearer picture of the pneumococcal disease burden in Africa. The trial confirms that pneumococcal pneumonia, meningitis, and sepsis are major causes of death and serious illness among African infants and young children. Most importantly, it demonstrates that pneumococcal vaccination can prevent many of these serious infections even in a rural African setting. This is great news for children and parents in rural areas everywhere.”

A similar vaccine has had a dramatic impact on reducing pneumococcal disease in the

United States. The Gambia vaccine trial has now clearly demonstrated that a significant proportion of illness, disability and death in African children can be averted through vaccination against this disease, a leading killer, especially of young children in developing countries.

Dr Thomas Cherian, Team Coordinator in the WHO Initiative for Vaccine Research stated:

“Experience has shown that in areas where health systems are unable to provide hard to reach, rural populations with round-the-clock access to high-quality curative care, immunization can be delivered through outreach services to great benefit. The pneumococcal vaccine will therefore be particularly important to save lives in the most disadvantaged populations.”

The trial was supported by a broad coalition of international partners including the WHO Initiative for Vaccine Research, the National Institute of Allergy and Infectious Diseases/National Institutes of Health; the British Medical Research Council/United Kingdom working with The Gambia Government; the London School of Hygiene and Tropical Medicine; the U.S. Agency for International Development; the Centers for Disease Control and Prevention of the United States Health and Human Services Department; Wyeth-Lederle Vaccines; the Program for Appropriate Technology in Health (PATH) Children's Vaccine Program, as well as WHO.

In the Gambia and other African countries, rates of invasive pneumococcal disease (severe forms of the disease, where bacteria

are isolated from blood, spinal fluid or another site in the body where bacteria are not usually found), are up to ten times higher than in industrialized countries and the disease is a major cause of hospital admissions and deaths. WHO estimates that between 700,000 and 1 million children under five die from pneumococcal diseases each year.

A randomized, controlled, double-blind trial of a pneumococcal conjugate (made from linking purified polysaccharides or complex sugars from the coat of a disease-causing bacterium to a protein carrier) vaccine took place in eastern Gambia starting in August 2000. 17,437 children aged 6-51 weeks were enrolled in the study. Those 8719 children in the control group received a diphtheria-tetanus-pertussis-Haemophilus influenzae serotype b vaccine. 8718 children received pneumococcal conjugate vaccine, mixed with the tetravalent vaccine received by the control group.

Results of the trial indicated that in the group of children who received pneumococcal conjugate vaccine, there were:

- 37% fewer cases of pneumonia (as confirmed by chest X-ray);
- 15% fewer hospital admissions
- 16% reduction in overall mortality; and
- half the rate of laboratory-confirmed pneumococcal pneumonia, meningitis and septicemia.

Moreover, the vaccine was 77% effective in preventing infections caused by nine serotypes (strains) of pneumococcal bacteria whose sugar capsules make up the vaccine.

To summarise, in this rural African setting, pneumococcal conjugate vaccine was shown in this trial to be highly effective against pneumonia and invasive pneumococcal disease. It can substantially reduce admissions and improve child survival.

Full details of the trial are available in a *Lancet* 26 March 2005 Dr Felicity T. Cutts et al. “Efficacy of nine-valent pneumococcal conjugate vaccine against pneumonia and invasive pneumococcal disease in the Gambia: randomised, double-blind, placebo-controlled trial.”



**Regional and NMA News**

**Figures and facts from Africa**

**(extracted from a paper given at the BMA “Call for Action“ Conference)**

In the course of a presentation on Migration of Health Workers at the BMA Conference reported above, Professor Agyeman Badu Akosa, Director General of Health Services Ghana and President of the Commonwealth Medical Association, described the organisation of healthcare in Ghana and identified three problems of Human Resources, These were

- a) Poor retention of staff
- b) Inadequate production of staff
- c) Maldistribution.

After elaborating on these, setting out the reason why there is a brain drain from this country and possible factors which might reverse this, he addressed more generally the situation concerning the migration of physicians in the Sub-Saharan countries, quoting figures from Hagopian et al 2004, and his analysis of migration to the USA.

Of the 771491 physicians (2002), 23% trained in low- income or lower middle-income countries, 5335 physicians were from Sub-Saharan Africa. This represented more than 6% of the physicians currently practicing in Sub-Saharan Africa now.

Of 87 medical schools in the Region, it appears that ten medical schools in four countries (South Africa, Ghana, Nigeria and Ethiopia) produce 79.4% of the émigré physicians to the USA (targeting these 10 medical schools could therefore be of greater value than addressing the problem in 47 countries).

The cost of training physicians who subsequently migrate was estimated to be 9 million \$US a year for Ghana and 20 million \$US for Nigeria. (Hagopian & Ofose et al, unpublished 2003)

(Medical students contribute 5% only of the costs of their medical education)

It is of interest to note that the U.N. Commission for Trade and Development estimates that each professional leaving Africa costs the continent 184000 \$US or 4 billion \$US a year. The loss of tax revenue from absent physicians also represents a significant economic loss.

Compared with affluent countries the distribution of physicians in the population is

Africa is dramatically demonstrated by the following:

Country	Physicians per 100,000 population
USA	279
Canada	229
Australia	240
UK	164
Uganda	4
Zambia	7
Ghana	6
South Africa	57

**The healthcare skills drain – a call to action**

On 14 April 2005, the British Medical Association organised an international conference on the global health workforce in association with the Commonwealth, and with participants from the American Medical Association, the American Nurses Association, the Canadian Medical Association, the Federation, Health Canada, the Medical Council of Canada, the Royal College of Nursing and the South African Medical Association. The conference agreed the following principles and recommendations.

The lack of healthcare workers in developing countries, particularly those in sub-Saharan Africa, is an emergency that demands urgent action. The impact of healthcare worker migration from developing to developed countries is a significant component in this crisis.

All citizens have a right to enjoy the highest attainable standard of health, and this, along with the prevention and treatment of ill health, is central to sustaining poor people's ability to escape poverty. Measures to realise these aims are essential to the Millennium Development Goal of poverty reduction.

Therefore, recognising that:

- all countries need an adequate healthcare workforce strategy and the means to manage this, and that the workforce represents the most important investment in healthcare systems;
- many countries have actual and projected shortages of health workers. Examples include a projected deficit by 2020 in the USA of 200000 doctors and 800000 nurses, and one million health workers in Sub-

Saharan Africa to meet the Millennium Development Goals (MDGs) by 2015.

- In countries which already have severe shortages of healthcare workers (fewer than one health worker per 1000 population) further loss of such workers through premature death or migration is very likely to result in loss of health services and loss of life in the countries' populations;
- Billion dollar funds amassed to address overwhelming global health problems (such as HIV/AIDS) are constrained primarily by the lack of healthcare professionals;

the conference agreed on the following **four key points:**

- 1) All countries must strive to attain self-sufficiency in their healthcare workforce without generating adverse consequences for other countries;
- 2) Developed countries must assist developing countries to expand their capacity to train and retain physicians and nurses, to enable them to become self-sufficient;
- 3) All countries must ensure that their healthcare workers are educated, funded and supported to meet the healthcare needs of their populations;
- 4) Action to combat the skills drain in this area must balance the right to health<sup>1</sup> of populations and other individual human rights.

<sup>1</sup> Universal Declaration of Human Rights (1948), Article 25.1; International Covenant on Economic, Social and Cultural Rights (1976), Article 12.1.