WORLD HEALTH EDITORS NETWORK

MAKING GLOBAL HEALTH NEWS

Geneva, 18-19 May 2008

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Contents:

BACKGROUND

The World Health Editors Network (WHEN) is an independent, **informal** health communication network, launched by World Health Communication Associates (WHCA), World Health Professionals Alliance (WHPA) and WHO in March 2006.

Membership is voluntary and free; editors are at liberty to engage when and where it is appropriate, but open to contribute, share and absorb ideas and information. The only requirement for membership is that members agree to work towards agreed ethical guidelines (see below).

World Health Editors Network (WHEN)
Ethical Guidelines

1. First, try to do no harm. Human rights and the public good are paramount.
2. Get it right. Check your facts and your sources, even if deadlines are put at risk.
3. Do not raise false hopes. Be especially careful when reporting on claims for 'miracle cures' or potential 'health scares'.
4. Beware of vested interests. Ask yourself, 'Who benefits most from this story?'
5. Reject personal inducements. Always make it clear if material is being published as a result of sponsorship.
6. Never disclose the source of information imparted in confidence.
7. Respect the privacy of the sick, the disabled and their families at all times.
8. Be mindful of the consequences of your story. Remember that individuals who may be sick or disabled—especially children—have lives to live long after the media have lost interest.
9. Never intrude on private grief. Respect the feelings of the bereaved, especially when dealing with disasters. Close-up photography or television images of victims or their families should be avoided wherever possible.
10. If in doubt, leave it out.

In effect, WHEN operates at a global level in the same way as informal associations of health writers operate at a national level; and by developing relationships with publications around the world, editors will facilitate opportunities for professional development as well as new markets for their work.

INTRODUCTION

WHEN provides practical opportunities for editors of specialist and generalist health journals to 'think globally and act locally'—meeting occasionally, sharing information, gaining specialist knowledge and contacts, networking among colleagues across disciplines and national boundaries, and developing new strategies for disseminating public health messages.

WHEN is about creating two-way exchange platforms for journalists and scientists/ policymakers. WHEN uses the "benevolent cuckoo" approach to meetings. This approach links all meetings/workshops to other major health gatherings so as to highlight the issues and enhance media coverage. By organizing briefings and discussions at such newsworthy international health-related events and conferences, WHEN aims to achieve a dual purpose. Journalists attending get early access to relevant newsmaker scientists/ policy-makers. International agencies and companies get a sounding board, feeding back information about the efficacy of their information and campaigns.

The Meeting

This meeting of the Network was held in parallel with the World Health Professions Conference on Regulation, Geneva 2008, and the 61st WHO World Health Assembly.

The aim of the meeting was to encourage dialogue between health communicators and health professionals around agenda issues being discussed at both the WHPA conference and the World Health Assembly that followed. In addition to bringing news stories to the editors and journalists who attended, this format was adopted so that both journalists and scientists/policymakers could be made more aware of the challenges faced by the other and explore together how to develop communication strategies that could strengthen health awareness, perceptions, behaviours and policies.

To this end, several key speakers from a variety of different health backgrounds and organisations were invited to give presentations on relevant topical issues. Each of the presenters who attended did so on the understanding that they engage in two-way discussion with the floor about their topic, recent events and the efficacy of their messages, campaign approaches and communication strategies.

Ground rules

The meeting was held in English and adopted Chatham House rules, a UK convention which states that everything discussed can be made public but nothing can be attributed without permission. The guest speakers were asked to respect the time constraints of each attributed section of the meeting and were advised that journalists would be able to speak freely once a short presentation had been delivered.

1. WHPA CONFERENCE ON REGULATION: OVERVIEW OF KEY TOPICS

a. Dr Otmar Kloiber, Chief Executive Officer, World Medical Association (WMA)
b. Dr John Hunt, Interim Executive Director, FDI World Dental Federation
c. Dr Ton Hoek, Chief Executive Officer, International Pharmaceutical Federation (FIP)
d. Brenda Myers, Secretary General, World Confederation for Physical Therapy

The Regulatory conference

The WHPA conference focus on regulation builds on the understanding that effective regulation provides a basic framework for health system quality of care and patient safety. The WHPA sees healthcare system regulation as a joint responsibility of government and the professionals: neither one has sole discretion when it comes to regulating the system.

International exchange of information between professions and professionals is essential so professionals can learn from each other and each regulatory system. This can help either build or improve on current situations. Previous conferences on regulations have been international and regional, but never inter-disciplinary.

The inter-disciplinary aspect of this conference is noteworthy, especially the opportunities to interact and exchange ideas between the professions informally—i.e. during breaks and dinners—which is just as important as time spent together formally.

It is important that young regulatory systems learn from established, successful ones. Although the professions may not be the same, they can still learn from each other. Once you have the chance to step into a different realm, one that contains a variety of systems, ideas and professions, it creates a good chance to look back and analyse your own industry.

In Africa there are member associations that are keen to engage with their government regarding the subject of regulation. However, they need help, particularly in developing countries where dialogue between the government, professionals and the public needs adequate representation and attention.

Within developed countries, regulatory systems may be mature; however, they are changing. Thus, discussion and consultation with the government is vital and the FDI encourages such actions from their member associations.

The conference is testing an important information sharing tool. Proceedings are being disseminated real-time in a two-way web cast that includes worldwide participation. For example, Ethiopian participants from the healthcare professions have been able to ask questions and exchange ideas with participants in Europe. Conference organisers will learn from this experience and hopefully it can be extended .

Key issues of interest

Task-shifting and the lack of health professionals in the world are two of WHPA's major concerns this year. WHPA believes all patients across the world have a right to high-quality health care and that the retention and education of health professionals should be fostered, increased and financed to ensure all patients have access to adequate health care.

The WHPA and partners have started a campaign—'positive practice environment campaign'—to show how practice environments can be improved so they are more attractive for health professionals in terms of safety and working environment. WHPA has also produced a policy paper on task shifting.

Other key issues identifed included education, counterfeit medicines, rational use of medicines, re-emerging diseases (TB), ethical recruiting and importance of oral health.

Discussion:

What is the role of media and journalists in terms of regulatory issues—what would you like them to write about to advance your agendas?

There is a need for exchange. There is an audience out there that is looking for answers when it comes to regulations—questions like what does it cost? Who is involved? What are the differences between the models? Within this field we don't have an evidence-based decision process. Thus, we would welcome such research and consequently evidence.

What are your opinions on international trade and services and regulations?

Provision of health care will need to be analysed due to professionals and patients moving across borders.

Crossing borders is healthy for medicine and a strong stimulus for systems, and is often the only way for patients to get treated and professionals to get a job. However, there is a danger in doing this—we are now depleting some parts of the world from having health professionals. This is a major crisis in sub-Saharan Africa. The WHO requires 'ethical recruiting standards' and means of enforcing such standards.

61st WORLD HEALTH ASSEMBLY: OVERVIEW OF KEY TOPICS AND RESOLUTIONS

To assist journalistic analysis of the WHO 61st World Health Assembly (WHA), WHEN/WHCA has produced an 'unofficial' guide to the WHO 61st WHA. The guide includes key background documents and texts of resolutions that are on the agenda of the WHA. The focus on resolutions is because these specify actions the WHA is being asked to take.

Building upon this resource, the WHEN has invited experts from a variety of different perspectives to reflect on these resolutions, share insights, clarify any questions and ultimately demonstrate why these resolutions are going to be helpful.

The resolution development process

In order to reach the resolution stage, members of the WHO propose issues that are eventually filtered to the Executive Board. The Executive Board is composed of 34 individual technical experts, each one designated by a Member State. The main avenue for introducing resolutions to the WHA is through the Executive Board, which meets at least twice a year and essentially sets the agenda for what will follow at the World Health Assembly.[1]

2: Oliver Rosenbauer, Communications Officer, Polio Eradication Initiative, WHO

- Polio in 1988: 350,000 cases and 125 polio-endemic countries
- Polio in 2008: 423 cases, 4 polio-endemic countries and 8 re-infected countries
- Total 99% reduction in disease

This initiative has involved a vast number of organisations and individuals, including Unicef, the US Centres for Disease Prevention and Control, Rotary International, national health ministers, UN agencies, NGOs, donors (including private sector) and 20 million volunteers.

The strategies used in this eradication[2] of polio initiative involve routine immunization, national immunization days, continuous surveillance (particularly used as a prevention method) and 'mop-ups'. The 'mop-ups' are carried out at district level, since polio is now being geographically restricted. This is an immunization campaign that intends to revisit those areas that it previously did not reach.

Financially, this is approximately a $6 billion initiative. It has received many generous contributions, yet still has a funding gap of $490 million needed for surveillance and immunization campaigns. Recent tools created, such as the *monovalent vaccine*, allow the protection of children against polio to be twice as fast with half the amount of vaccine being used.

An intensified eradication effort was launched in 2007, which gathered all the stakeholders concerned and concluded that *this effort must be intensified, as we are too close to eradication to give up.*

Polio is still endemic in four countries: Nigeria in Africa, and Afghanistan, Pakistan and India in Asia. The bulk of remaining polio cases occur in these countries, but as polio is a communicable disease, population movements across borders will mean that there will

[1] WHO Executive Board: http://www.who.int/governance/eb/en/ (Accessed 01/06/08).
[2] "Eradicated" is defined as "the virus no longer exists, got rid of for all perpetuity."

still be isolated cases in neighbouring countries until such time as the disease has been eradicated.

Nigeria accounts for 90% of all remaining type 1 polio cases and has had a 6-fold increase in 2008. The main obstacle to eradication appears to be political commitment. Recent vaccination days demonstrated that 20% of children were missed.

Future tactics to combat polio can now be specifically tailored, as it is known where polio exists within districts. If the infrastructure and capacity exist, the Global Polio Eradication Initiative (GPEI) attempts to link such eradication programs alongside other programmes, such as those combating malaria.

The GPEI is on track to achieve major landmarks in 2008-2009, particularly in Asia. However, the increase in cases in Africa needs to be reversed.

The resolution that the WHO is analysing with regard to polio eradication highlights two factors: continuation of intensified efforts by the international community and post-eradication issues.

Discussion:

How long does it take for an area to be declared polio-free? And what happens post-eradication?

The short answer to the first question is, 1 year for type 1 polio with strong surveillance.

The second question requires the WHA to encourage international consensus on:

- *Containment—Virus contained under specific bio-safety regulations*
- *Eventually stop the use of OPV (oral polio vaccine), because in approximately 1 in every 2.4 million vaccines that are administered, this vaccine causes a case of polio*
- *The need to maintain a regulated stockpile of OPV in case of an outbreak*

Can you comment on two concerns that the campaign is causing in India, particularly regarding:

1. More children falling ill due to the vaccines and campaign
2. The campaign's impact on the current health service

Respectively:

In India we have not seen an increase in the number of vaccine-related cases and we can predictably say that vaccine-related cases will occur—1 in 2.4 million while using OPV. However, we are now using the monovalent vaccine that has proven to cause fewer vaccine-related cases. Often the vaccine-related cases (e.g. of paralysis), once analysed, have proven to be caused by other diseases such as Guillain-Barre (a non poliomore transient viral disease).

From our experience, within the polio infected areas of India few health services exist. Thus, we have trained health staff within these areas, and results from a survey carried out demonstrated that 90% of these health staff spend ¾ of their time on other interventions than polio. Consequently, we have created an infrastructure that previously did not exist.

Political problems in Nigeria:

Within the isolated Local Government Areas (LGA)/districts, there is not enough ownership by the LGA Chairmen. At the federal, state and religious level strong support exists. So within the LGAs we need the political ownership to say, our government block officers (at the grass roots level) must take responsibility to see that every child in their district has their vaccination during immunisation campaigns. These LGA leaders need to ensure that their medical staff, who are carrying out the vaccinations, do not overlook areas or children in the area. WHO cannot produce enough staff to carry out such actions, thus the ownership at the district level must step up.

3. International Health Partnership (IHP), Anna Marriott, Oxfam UK

The proliferation of 'vertical', largely disease-based initiatives in recent years, with so many different actors involved, is putting increasing burdens (and high transaction costs) onto Ministers of Health, especially in countries in the developing world. Attention is being diverted away from delivering health care and being accountable to citizens; instead, the governments end up being largely accountable to donors. Governments and donors have noted this problem, but while there has been a lot of talk, there has been no action. There has been a lot of duplication of effort, with large burdens, but no support, placed on health systems. In some cases, priorities are veering towards donor interests and not nationally identified priorities.

The International Health Partnership (IHP) aims to address this dilemma. The UK government launched this initiative with the World Bank and the WHO in September 2007.

IHP is a global compact signed by all stakeholders (donor and recipient countries) that could help developing countries build functioning health services. The scheme intends to provide long-term and predictable financing, which can be used to fund the salaries of desperately needed doctors and nurses. It is designed to co-ordinate health financing and address the problem of disparate projects.

The initiative is intended to help countries reach the Millennium Development Goals on health—in particular, the goal to reduce maternal mortality by 2015.

So far, signs that donor countries are behind the initiative are encouraging—Norway, Canada, France, Germany, the Netherlands and the UK have all announced their commitment. Eight developing countries (Ethiopia, Burundi, Mozambique, Kenya, Zambia, Nepal, Cambodia and Mali) will be the first to implement the initiative.

Discussion:

How does this 'coming together' of donors affect the smaller NGOs or donors?

Negatively: Often the voice of smaller donors, despite being progressive and continuing to receive funds, gets lost.

Positively: In regards to reporting back to your own tax payers and showing how aid is working, collective (larger) donors can have a greater scale impact than individual donors/smaller donors.

Issue of internal migration:

As NGOs offer professionals better incentives, health professionals leaving the governmental health service has consequences on the country.

Oxfam recognises the problem and is looking to sign up to a recently developed NGO 'Code of Conduct' on health. This 'Code of Conduct' is to ensure NGOs are working in alliance with government services and supporting the public health systems, rather than further draining its resources.

A key element of initiative is communications. What are the communications strategies?

International civil society and numerous large agencies are working together to inform and educate, largely through loose/informal networks that currently exist. Formally, a monthly newsletter is produced alongside the IHP web site. Likewise, as a communications exercise, Oxfam is encouraging national level meetings with stakeholders to discuss and distribute ideas and strategies.

4. Climate Change and Health, Franklin Apfel, WHCA

With the recent findings of the Intergovernmental Panel on Climate Change (IPCC) that the effects of temperature increases are already being observed on some aspects of human health, the net global effect of projected climate change on human health is expected to be negative, especially in developing countries, small island developing States and vulnerable local communities which have the least capacity to prepare for and adapt to such change. Projected climate changes could affect the health status of millions of people. This is through increases in malnutrition, in death, disease and injury due to extreme weather events, in the burden of diarrhoeal disease, in the frequency of cardio-respiratory diseases, and through altered distribution of some infectious disease vectors. It was noted further that climate change could jeopardize achievement of the Millennium Development Goals, including the health-related Goals, and undermine the efforts of the WHO Secretariat and Member States to improve public health and reduce health inequalities globally.[3]

Consequently, the issue of 'setting an example' and assessing our own actions, particularly in the West, is paramount to the lives of those in developing countries who are feeling the effects of our use of the environment.

Peter Kälin, Swiss Doctors for the Environment, presented to participants some examples of how his organisation is tackling issues of climate change and health and trying to make 'awareness-raising' of such issues part of the everyday work of doctors with their patients.

Public awareness adverts and posters, teaching the teachers and working with politicians to guide them towards using our planet more wisely are all ways in which health professionals can promote the information flow about environmental impacts on health.

Discussion:

Regarding the impact of healthcare systems on the environment, how might we reduce the amount of disposable waste used, e.g. plastic hand gloves?

A large amount of diseases in Ghana, for example, are preventable, due to the fact that they are environmentally-related diseases.

[3] Resolution on Health and Climate Change: http://64.233.183.104/search?q=cache:zN6T4KVnJhgJ:www.euro.who.int/WHD08/20080214_2+resolution+health+climate+change+WHO&hl=en&ct=clnk&cd=1&gl=uk&client=firefox-a (Accessed 01/06/08).

There is an increase in our consciousness regarding the impact of climate change, and this needs to continue parallel to our actions. For example, Hong Kong promotes and offers tax rebates for cars and other products that are environmentally friendly. Likewise, shopping markets offer discount for customers reducing or not using plastic bags. Some actions require government support to develop and promote.

This is a problem that flows across all industries, thus it requires collective thinking and promoting in order to achieve best results.

The health system can, and arguably should, provide a leading role in this regard, hence the need to put pressure on Resolution 11.11: Protecting Health From Climate Change.

5. Female Genital Mutilation, Dr Elise Johansen and Jitendra Khanna, Reproductive Health, WHO

The background to Resolution 11.8 on Female Genital Mutilation (FGM) is that currently, 100–140 million women and young girls live with FGM. New estimates from Africa suggest that approximately 92 million girls and women over the age of 10 years live with FGM, although there are no figures for countries outside of Africa or girls under the age of 10 years. International input supporting the prevention and post-mutilation treatment of these females does not match the size and scale of the problem. A WHO report in 2006 demonstrated, alongside other short- and long-term problems, the impact of FGM on birth complications: 1-2 babies in a 100 die every year due to FGM. Hence, it is increasingly being seen as a human rights violation.

Notably, in high prevalence countries the difference in FGM between elite and poverty-stricken areas is minimal. The decline in FGM globally has been very slow, and in some countries health professionals carry out 90% of FGM operations.

The goal of the resolution is to gain renewed commitment from member states and an increased amount of investment to tackle these issues. In addition, focus must remain on females who require post-FGM treatment.

Discussion:

There have been two particular paragraphs within the resolution that have generated debate, thus restricted complete implementation in terms of funds and support. The content of the disputed paragraphs, however, does not concern FGM: rather, they are matters concerning abortion. Notably, the United States recalled the resolution on these grounds.

It was argued that it is now a matter of trying to push the resolution as it is; however, in the future pulling these problematic paragraphs may be necessary if it is the only solution for implementing the resolution.

If FGM is illegal, how can it continue not to decrease?

Convincing people of the health risks concerned with FGM has proven to be successful. Nevertheless, it appears that the social pressure surrounding FGM is so great that despite its illegality, it persists. It is on this basis that anti-FGM campaigns are now working at a local community-based level, which understandably may prove to be a long-term commitment to the community, but will produce greater results as it will generate a community-based consensus against FGM.

Likewise, cultural sensitivity and relativism is a key issue regarding FGM. In tackling this problematic area only community-based intervention and solutions can make a real difference.

6. Patient-Centred Health Care, Jo Harkness, International Alliance of Patients' Organisations (IAPO)

IAPO is a global alliance, representing patients from many countries across many disease areas, which promotes patient-centred health care around the world. The members are patients' organizations working at the international, regional, national and local levels to represent and support patients,[4] their families and carers.

IAPO's vision is that patients should be at the centre of health care systems, and it is IAPO's mission to help build patient-centred health care worldwide by:[5]

- Realising active partnerships with patients' organisations, and maximising their impact through capacity building/training.
- Advocating internationally with a strong patients' voice on relevant aspects of health care policy, with the aim of influencing international, regional and national health agendas and policies.
- Building cross-sector alliances and working collaboratively with like-minded medical and health professionals, policy makers, academics, researchers and industry representatives.

Based on reports from the WHO, chronic diseases are the leading cause of mortality worldwide, accounting for 60% of all deaths. IAPO welcomes the proposed NCD strategy, which calls for a broad, multi-sectoral approach which should have a beneficial effect on health systems. It is IAPO's belief that in order to successfully address chronic illness, the involvement of the patient is essential. An example from Canada was highlighted, where patients are now informing health systems about the training health professionals require, particularly within the area of communication between professionals and patients.

In regards to counterfeit medicines, patient-centred health care is of the utmost importance. Better communication between professionals and patients can not only decrease the illegal trade, but more importantly it can give patients the knowledge needed to make a more rational decision.

IAPO encourages health professionals, and those reporting on such issues, to look at strategies and resolutions from a patient-centred approach and how the education of health professionals can emerge from the patient's requirements.

Discussion:

Are the resolutions of the 61st WHA progressive to IAPO?

In terms of combating diseases and improving patients lives—yes. But in terms of emphasising the need for patient-centred health care—no. This factor has not been given adequate attention within the resolutions.

What is the validity of the representation you give to patients?

[4] A patient is defined here as a person with any chronic disease, illness, syndrome, impairment or disability.
[5] IAPO: http://www.patientsorganizations.org/showarticle.pl?id=7;n=101 (Accessed 01/06/08).

IAPO represents their members and are continuously seeking ways of improving communications between members and their patients. Ultimately, this will increase the validity of IAPO representing millions of patients worldwide.

Are actors that are involved with funding given priority, as opposed to those that are not?

IAPO is governed by its members, but also has legal frameworks that allow for funding. IAPO dictates who carries out the research, on what issues, and how it is executed.

7. Counterfit Medicines, Valerio Reggi, Coordinator, Medicines Regulatory Support, WHO

Key points raised included:

1. Definition: What differentiates counterfeits from other medicines is the "deliberate intention to cheat those that receive the medicine or the medical product."
2. Extent: The proportionality of counterfeits within the world is impossible to affirm as there are no mechanisms in place to measure this global illegal trade.
3. The problem: The increased sophistication of the counterfeiters has allowed them to produce cheaper, easier to make, easier to distribute and harder to recognise counterfeit medicines.
4. Solution: There needs to be a collective effort between governments, police, medical professionals, NGOs, the UN and other concerned organisations to address the issue. These efforts must also be backed by political will.

Discussion:

In Africa over half the drugs on the market are counterfeits. African countries that liberalise their economies, a decision that is influenced by many international organisations, now face an increased difficulty in combating counterfeits because of the liberal economy. Thus, what are the starting points for decreasing this phenomenon?

It can be said that there is no 'one solution' to this problem. Each area must be analysed within its own variable factors. With this in mind, a good starting point is to assess the situation and identify the weaknesses within that area. These weaknesses are those factors that make such trade possible. Nevertheless, the problem of pricing should not be overlooked. If patients cannot afford their professionally prescribed medicine, they are economically forced to buy from the illegal market. Thus, the issue of 'affordability' of medicines within the health profession must be addressed alongside counterfeits.

Ideally, the resolution 11.13 will produce a consensus on the basis that this is a public health issue, and therefore requires enforcement and political will.

It is somewhat of a losing battle unless we focus on alternatives for patients. It is impossible to regulate an informal economy, therefore attention must be paid to alternatives for patients who cannot afford their medicines.

Pharmaceutical, NGOs, inter-governmental and governmental organisations need to get their hands dirty. A collective effort needs to emerge in order to confront this issue. Criminal gangs are a public health threat, and consequently a strong taskforce is required to fight them. This resolution should place a responsibility on everyone and lay good foundations for healthy guidelines.

8. Emerging Infectious Diseases, Bernardus Ganter, Epidemic and Pandemic Alert and Response, WHO

Population movement, growth and ageing have all contributed to the spread of diseases. In addition, climate change, globalised trade, urbanisation, food processing and biotechnologies have equally increased the chances of new infectious diseases emerging. A new disease is being detected almost every year.

Notably, statistics demonstrated that in 2006 international travellers increased to over 2 billion, and world trade in agricultural products increased 5-fold since 1950. Consequently, regulation on emerging infectious diseases has become an increasing challenge.

The International Health Regulations (IHR) are essential when examining infectious diseases. The spread of diseases across national borders is inevitable and globalisation ensures that such issues are the concern of everyone. IHR already has an agreed code of conduct that aims to protect against the spread of serious risks to public health, and the unnecessary or excessive use of restrictions in traffic or trade for public health purposes.

The major challenge that needs to be addressed in order to decrease the spread of infectious diseases relates to reporting and response time. Late reporting causes delayed response. Early reporting can contain the disease and prevent an increase of potential cases. Such challenges are recognised by the IHR but work still needs to be improved. The IHR need a global partnership with intergovernmental organisations, development agencies, WHO collaborating centres and technical partners and industry associations. With the technical support of the WHO, countries need to assess their national resources (e.g. budget and human resources), therefore allowing rapid detection and response to any outbreaks. Likewise, transport needs to be regulated—for example, ill travellers and the control of vectors/reservoirs. In regards to responding to events, arrangement of isolation and the application of specific controlled measures must be carried out.

Unfortunately, not all health systems can meet the challenge, due to weaknesses in their governments or economies, or temporary weakness due to change of government.

Perhaps most importantly within the area of emerging infectious diseases is the ability and success of communication strategies. As a result of this, 192 countries have a National Focal Point for 24/7 communications with WHO.

9. Migrant Health, Daniel Lopez Acuna, Director, Department of Recovery and Transition, WHO

Why the WHA is examining this topic:

- Voluntary and forced population movements are increasing.
- Migration refers to ‘internal displacement or international movement’.
- UN estimates 175 million migrants exist worldwide—including migrant workers (document and undocumented) and their families, international students, returnees, asylum seekers, victims of human trafficking and internal displacement.
- Very heterogenous population.

Vulnerability of migrants:

- Stress and risks associated with the process of migration.
- Migrants can bring to a destination risks that were associated with their country of origin. Or on the other hand, migrants can transmit risks back to their country of origin.

Important part of report being put forward to the WHA:

- Increased risks associated with the process of migration.
- Right to adequate health care like citizens of the country of destination.

Part of the proposed framework of the report being submitted to the WHA is to address the issue from the perspective of four fundamental principles of public health. This can give us a more comprehensive approach:

1. Need to avoid disparities between migrant and host country.
2. Ensuring migrants' right to health care.
3. The need for life-saving interventions, particularly in areas of natural disasters.
4. Minimise the negative impact of the migration process on health environment.

This demonstrates the need for multi-dimensional approaches to dealing with migrants' health and their impact on the environment.

Health workers and personnel must not be overlooked when considering the well-being and rights of migrants. Adequate support from multi-disciplinary/multi-dimensional approaches must be considered and implemented.

On the whole, WHO are advancing and improving migrants' health care via the Resolution 11.9 which highlights:

- Advocacy and policy development
- Fostering the promotion of migrant-sensitive health policy
- Advocating for migrants' health rights
- Promoting international cooperation
- Increase in assessment research of migrant information
- Capacity building of a network of research able to obtain migrant information in a systematic manner
- Enforcing migrant-friendly public services (i.e. minimum standards)

Discussion:

Gender vulnerability of migrants? Any attention being paid to this?

The resolution does make reference to gender vulnerability, particularly because of the increased feminisation of the migrant process and the vulnerable factors that appear alongside. However, the lack of information obtained from migrant movements limits the degree of efforts. In addition, advocacy must be applied to both migrants and gender sensitive migrants, thus it is a dual effort..

What is the potential impact of this Resolution?

There is optimism in that finally the Assembly addresses the issue. The challenge is to sustain the Resolution.

To what extent do you want to engage migrants in this effort?

It is essential. All stakeholders, particularly those suffering, must be involved. If the Resolution is passed, we intend to hold a large global conference, where migrants and/or their representatives can be present and have their voice heard.

10. Millennium Development Goals (MDG), Carla AbouZahr, Department of Measurement and Health Information, WHO

Positives:

- In 2006, childhood deaths fell below 10 million.
- Measles immunisations increased since 1990.
- Underweight prevalence has declined, with 58 countries on track to achieve MDG1.
- 76 developing countries on track to reach MDG target on safe drinking water.

Mixed:

- Use of insecticide treatment bed nets has increased, but is far short of the Abuja Declaration target of 60%.
- Number of people living with HIV continues to increase, but is lower than previously estimated.

Negatives: Child Mortality:

- Few countries on track to achieve MDG4, on Child Mortality.
- Those developed countries that have progressed do not contain a single sub-Saharan African country.
- The countries with the least progress are all in sub-Saharan Africa.
- Infections and diarrhoea kill most under 5 years old.
- 1 in 3 deaths occurs within the first month.

MDG5: Risks in Pregnancy and Childbirth:

- Within the top ten progressive countries, not one is a sub-Saharan African country.
- 12 of the 13 countries with the highest maternal mortality rates are in sub-Saharan Africa. 8 out of 10 have high HIV prevalence, and 2 out of 10 are in armed conflict.
- Vaccinations are only reaching 80% coverage.
- Availability of interventions on a 24-hour basis needs to improve.
- The 'coverage gap'[6] between the rich and poor demonstrates that the poor are less likely to access health care. Within Chad, 95% of the poor who need intervention do not receive it.

What can countries do?

- Invest in health care systems
- Recognise and act upon the inequalities produced by health care systems
- Remove financial barriers
- Prioritise diseases of the poor
- Deploy/improve services where the poor live
- Employ appropriate delivery channels

What can the development community do?

- Embed health in social and economic planning; multi-sectoral response

[6] The 'Coverage Gap', which measures the difference between the healthcare coverage of the rich and the poor, is a relatively new research method. Consequently, it can highlight state statistics that have previously produced a false representation of their countries' health care systems.

- Ensure long-term predictable aid
- Hold all partners accountable for their performance against international agreements

What WHO will do:

- Strengthen health situation and trends monitoring: global health observatory
- Equity focus: poverty, gender, geography
- Monitor cause-specific mortality trends
- Monitor health initiatives and their impact
- Enhance understanding of data limitations and need for investment in health information systems.

Discussion:

Figures presented are not 'breaking news', so what would change if the Resolution 11.12 is passed by the WHA?

Should the resolution be passed, WHO will be asked to take not only a monitoring role, but also an analytical role. Although previously the global UN reporting framework has been quite powerful it has not been very diagnostic, and this should help change that for the better.

In addition, we are witnessing a divergence between some successful countries and the not so successful countries. Thus, it is important to learn from these countries and implement, where possible, successful strategies.

11. Health Insurance in Low-income Countries, Esme Berkhout, Health Policy Advisor, Oxfam Novib

This initiative is a join effort between the following NGOs: Oxfam International, Action for Global Health, Médécins du Monde, Save the Children UK, Plan, Global Health Advocates and Act Up Paris.

The Rights to health and social security for all are still not a reality. Figures show, for example, that 1.3 billion people still lack access to the most basic health care; and 100 million have been pushed back into poverty by the need to pay for health care. User fees are inequitable and an additional barrier to health care for poor people. Current thinking favours prepayment and risk-pooling (cross-subsidisation, where the rich subsidise the poor, and the healthy subsidise the ill). It should also free up resources which can be targeted towards access to health care for the poor, and is more predictable than tax revenues.

Some donors and governments propose that health insurance mechanisms can close health-financing gaps and benefit the poor. Although beneficial for the people able to join, this method of financing health care has so far been unable to sufficiently fill financing gaps in health systems and improve access to quality health care for the poor. Donors and governments need to consider the evidence and scale up public resources for the health sector. Without adequate public funding and government stewardship, health insurance mechanisms pose a threat rather than an opportunity to the objectives of equity and universal access to health care.

Main concerns:

- Waiting for realisation of rights
- Policies for achieving universal access?

- Public funding too low
- Insurance won't fill funding gap
- Potential threat to equity and universal access

Recommendations:
- Consider insurance in relation to universal access, equity and efficiency
- Set out a timeline towards universal access, and ensure financing
- Consultation with civil society, including the most vulnerable groups
- Pay particular attention to equity
- Increase public resources
- Support abolition of user fees

Discussion:

Where is the intended support for this initiative going to come from?

Governments and donors have to supply the support required to achieve this goal. Essentially, because of the scale of the task, we have to push for this kind of support. Consequently, we understand there is not a short-term solution.

12. THE HEALTH AGENDA, 2008-2009: THE HEALTH PROFESSIONAL ASSOCIATIONS' PERSPECTIVE

a. Dr Jon Snaedal, President, World Medical Association (WMA)

Key issues for 2008-9:

1.Human resources:
- *Those who are recruiting professionals must obey an ethical conduct, in order not to drain a society of its health workers.*
- *There is need for an increase in training and education.*
- *There is a need for strengthening retention efforts.*

The concept of 'Task shifting' is not and will not be a viable solution to the problem of human resources or lack of them. The WMA would like to see a collaborated effort, involving the WHO, to resolve this problem on the basis of adequate evidence that highlights the areas urgently requiring attention.

2.Alcohol:
- *Increase prices*
- *Decrease availability*

The problem concerning alcohol is increasing worldwide. The public must be made aware of the scale of the problem and the detrimental consequences of increased alcohol consumption.

b. Dr Hiroko Minami, President, International Council of Nurses (ICN)

Three items were highlighted. Firstly, the Progress Report on Nursing and Midwifery (relating to the resolution passed at the 2005 WHA) virtually ignored the serious global shortage of nurses and midwives, and its impact on the health of populations. Secondly, this shortage is also reflected within WHO itself, with the latest WHO Human Resource Report (2007) showing a continuing decline in dedicated nursing posts within WHO—less

than 1% of all professional staff are nurses. At a time of global health crisis, when nurses' knowledge and skills are so desperately needed, the lack of nursing voice in policy and technical support weakens all WHO programmes.

Thirdly, ICN is very concerned that the shortage of nurses compromises the achievement of the health-related MDGs. That is why ICN is working to support health workers, especially in Africa. Projects include a mobile library, TB-MDRTB training programme for nurses in high-burden countries, Wellness Centres for Health Care Workers, the Girl Child Education Fund for orphan daughters of nurses, and leadership projects.

At the WHA, interventions focused on FGM, migrant health, climate change and counterfeit medicines are planned.

Discussion:

Active advocacy of nurses? Is WHO more sensitive to your issues?

Task shifting should not be carried out at the expense of other professions.We need to regulate the demand put on each profession.

Dr Otmar Kloiber, on 'Task shifting':

Similar problems to those seen between rural and urban areas within a country are evident between rich and poor countries. Rich countries are providing task-shifting tools. Consequently, some solutions to current problems are emerging. However, it is not a sensible choice to have this as a permanent fix. Where there is a shortage of human resources, we need long-term training facilities to emerge.

Task-shifting is not the preference of a country to resolve long-term problems. Likewise, emphasis must be put on retaining professionals. Currently, we see money being spent on training professionals without adequate money and attention being paid to retaining professionals.

c. Dr Burton Conrod, President, FDI World Dental Federation

The FDI encourages the publicity of the link between general health and oral health. This link can be seen via a variety of connections, gum disease and diabetes, and low-birthweight, pre-terminal babies to young women with severe gum disease, as well as the impact on the economy from missed responsibilities, such as work, due to oral problems, physiological health of patients with oral problems and many more. It is through these varieties of problems that appeals can be made to governments and donors, to encourage the treatment of oral health worldwide. Last year's WHA resolution on oral health called for all MS to put oral health on the health agenda, with a budget.

The devastating tsunami has touched the hearts of millions of people worldwide, also colleagues in the dental family. The FDI World Dental Federation, through its World Dental Development Fund (WDDF), is offering aid to the South-east Asian countries affected by the disaster and its aftermath. Monetary support for the tsunami victims and member organisations can be channelled through the WDDF. Any programme applications related to the disaster will also receive full priority.

Oral Health in Africa:

The World Dental Development Fund supports capacity building activities in dental public health in five West-African countries (Benin, Burkina Faso, Ivory Coast, Mali, Niger and Togo). Training courses for oral health managers in dental public health will be developed in close co-operation with a network of stakeholders, including the WHO, National governments, dental associations, the French NGO Aide Odontologique Internationale (AOI), as well as with local and international universities. This initiative is a direct result of the Planning Conference for Oral Health in the African Region that was organised by the FDI and WHO in April 2004 in Nairobi, Kenya.

Oral health in rural India:

The project is based in the region of the town of Chitrakoot, a poor rural area in India. In collaboration with a UK-based NGO, a dental clinic was provided to an existing hospital belonging to the project. The background and achievements of the project are impressive, including social and community development, micro-finance of small enterprises, education and gender issues. The equipment provided allowed expansion of the local health care facilities to offer dental treatment and education in oral health to a community of about 150,000 people.[7]

d. Dr Kamal M Midha, President, International Pharmaceutical Federation (FIP)

Rational use of Medicine:

Utilisation is paramount. Within the developed world more than 50% of medicines are not used properly or rationally. This needs to be tackled in national organisations where pharmacists practice. There is also the issue of counterfeit medicines, which is much more prevalent where regulatory controls are not stringent.

Human Resources:

12 principles on ethical conduct should be encouraged and implemented.[8]

FIP advocates are working on capacity building due to the fact that in many areas there are not qualified health workers. FIP has set up a task force on education. The work of the task force is to study the problem in countries where we have shortages of professionals, and consequently FIP has developed a 2-year action plan to tackle this problem. Implementation will be made on a local level with local people while local concerns are being addressed.

Task shifting does not solve long-term problems of sustainability. Thus, training and educating professionals that are going to remain in that area is important.

Discussion:

What is the FIPs' view on irrational formulations?

Combating this problem needs support from the national level. Combination products are sound if rational. Thus, in areas where preferred dosage is not available, correct combinations can prove to be life saving.

[7] FDI http://www.fdiworldental.org/public_health/4_1fund.html#AOI (Accessed 01/06/08)
[8] Principles of ethical practice of public health http://www.apha.org/NR/rdonlyres/1CED3CEA-287E-4185-9CBD-BD405FC60856/0/ethicsbrochure.pdf (Accessed 01/06/08)

Safety and availability of medicines are of profound concern to all health professionals. However, it is often forgotten that 'affordability' is also equally important.. Medicines have no meaning if they are not affordable to those who need them. Thus, FIP appeals and educates on such issues in the hope that eventually the public will determine how the industry operates.

13. Rüdiger Krech, Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ) GmbH

As an international cooperation enterprise for sustainable development with worldwide operations, the federally owned Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ) GmbH supports the German Government in achieving its development policy objectives. It provides viable, forward-looking solutions for political, economic, ecological and social development in a globalised world. Working under difficult conditions, GTZ promotes complex reforms and change processes. Its corporate objective is to improve people's living conditions on a sustainable basis.

The company also operates on behalf of other German ministries, the governments of other countries and international clients, such as the European Commission, the United Nations and the World Bank, as well as on behalf of private enterprises. GTZ works on a public-benefit basis. All surpluses generated are channelled back into its own international cooperation projects for sustainable development.

GTZ employs some 10,000 staff in more than 120 countries of Africa, Asia, Latin America, the Eastern European countries in transition and the New Independent States (NIS). Around 9,000 of these staff are national personnel.

We are fully aware that the major preconditions for the success of our company are not only the price and quality of the services we provide, but also our good reputation and our integrity. Integrity is rooted in the company's philosophy and is of personal significance to all staff. Our Code of Conduct comprises rules on how to deal with conflicts of interest and to avoid corruption.

The message we send out is that rather than seeing corruption as a necessary evil or a by-product of work processes, we are strongly committed to fighting it. The best way to combat corruption has always been to bring it out into the public.

GTZ is currently working with partners in around 2,700 projects to find solutions for complex structural and reform processes. We advise governments, international organisations and companies and carry out their projects as partners or on a contract basis.[9]

Discussion:

It was highlighted that long-term goals/contracts need to be considered in the Minister's budget. This will allow for adequate planning of health care systems, including training and sustaining professionals.

[9] GTZ Cooperate Profile: http://www.gtz.de/en/leistungsangebote/692.htm (Accessed 01/06/08).

WHEN EXCHANGE FORUM: WHPA AND WHEN MEMBER SPONSORED PROJECTS

14. NOMA Project, Denise Baratti, FDI

Noma is a devastating necrosis that starts as a benign lesion in the mouth, often as gingivitis. However, left untreated, it quickly devours the soft and bone tissues of the face, atrociously disfiguring its victims who are almost always very young children. Those who do not die from it are never again able to eat, speak or breathe normally. Most often, they are outcast by their community who see the disease as a curse.

Sub-Saharan Africa, the poorest region of the continent, is the epicentre of this disease. While the exact etiology and scope of Noma is unknown, it appears to be caused by a deficiency of the immune system attributable to malnutrition. According to the WHO, thousands of children between the ages of two and six may be affected each year. Epidemiological estimations are currently being worked on, but there are many obstacles: isolated areas that are difficult to access, poor health services, disorganised recording of cases or handling of data by authorities, extremely high mortality rate, hidden victims,[10] etc.

This disease is even more unacceptable in the 21st century, given that ordinary and affordable antibiotic treatment can easily stop the evolution of the gangrene if administered once the first symptoms appear. This is a classic neglected disease that deserves our sympathy and support.

15. Susan Jupp, Global Forum for Health Research

The Global Forum for Health Research is an independent international foundation (founded in 1998) promoting more health research to combat the neglected diseases and conditions that are major sources of ill health in developing countries and to reduce other inequalities in health and health research.[11]

What we do:

- Arrange gatherings
- Build networks
- Policy organisation
- Provide information
- Promote capacity strengthening
- Track R&D investment
- Eliminate social biases
- Set research priorities

This year's 10th anniversary conference will be held in Bamako, in Mali.

This Global Forum is now turning health research into research for health.

Notably, we should address taking research into communications/the media, so that decision/policy makers no longer have full discretion, as the public can demand services on the same sound research information.

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[10] Nonoma press release: http://www.nonoma.org/index.php?option=com_content&task=view&id=29&Itemid=46 (Accessed 01/06/08).

[11] Global Forum for Health Reseach, Mission: http://www.globalforumhealth.org/Site/001__Who%20we%20are/002__Mission.php (Accessed 01/06/08).

16. Wellness of Health Workers, Linda Carrier-Walker, International Council of Nurses

The Human Resources crisis is a huge, ongoing issue. ICN is not only doing a lot of work on policy, advocacy and research, it has also undertaken several practical projects to help health care workers (and their families) deal with the threats to their own health and wellbeing.

The Swaziland Wellness Centre for Health Care Workers and their families officially opened in September 2006. The centre, run by the Swaziland Nurses Association (SNA), aims to address the severe health workers crisis in Swaziland through attention to the health, well-being and capacity of the health workforce. It delivers health and other professional services to all Swazi health workers and their immediate families. The first of its kind, this initiative has been held up as a model of good practice by many global organisations, including the WHO and Physicians for Human Rights.

The Ministry of Health and Social Welfare, on behalf of Swaziland Government, has pledged total support for this initiative in terms of adding human resources and sustainability. The Government understands its responsibilities and is grateful to SNA for taking on this major initiative in giving a hand to the government.

The Centre is a result of an innovative partnership between the SNA, ICN, the Danish Nurses Organisation, the Stephen Lewis Foundation and BD Corporation.[12]

17. Kaushik Desai, Editor, PharmaTimes, Indian Pharmaceutical Association (IPA)

The Indian Pharmaceutical Association,[13] with its HQ in Mumbai, represents some 10,000 professionals attached to the pharmacy profession in India. It has five divisions—Community Pharmacy, Educational, Industrial Pharmacy, Hospital Pharmacy and Regulatory Affairs—and two regular publications, Pharma Times and Indian Journal of Pharmaceutical Sciences, in addition to publishing guidelines on Good Pharmacy Practice, etc. The brief presentation also elaborated on the following objectives:

☐ To promote the sciences and arts of Pharmacy in all aspects.

☐ To impart suitable education and training to the members preparing for the profession of pharmacy or to those already engaged in the profession.

☐ To undertake, carry on or promote scientific and technical research, experiments and tests of all kinds in pharmaceutical and allied sciences.

☐ To edit and publish journals, books, magazines, documents and other publications for promoting the causes of the profession of Pharmacy.

☐ To hold seminars, symposia, conferences and exhibitions for promoting the causes of the profession of Pharmacy.

The IPA also carries out various projects, particularly the TB Fact Card Project in conjuction with the WHO and Commonwealth Pharmaceutical Association.

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[12] Health Care Workers Wellness Centre: http://64.233.183.104/search?q=cache:ZrehV6Zw1Y4J:207.58.190.251/hrh/doc.php%3Fdoc_id%3D68%26action%3Dinline+Wellness+swaziland+linda&hl=en&ct=clnk&cd=1&gl=uk&client=firefox-a (Accessed 01/06/08).

[13] Further details about IPA are available on their website at www.ipapharma.org.