WMA OFFICERS

OF NATIONAL MEMBER MEDICAL ASSOCIATIONS AND OFFICERS

President-Elect
Dr N. Arumagam
Malaysian Medical Association
4th Floor MMA House
124 Jalan Pahang
53000 Kuala Lumpur
Malaysia

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The South African Medical Association
P.O Box 74789 Lynnwood Ridge
0040 Pretoria
South Africa

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USA

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10623 Berlin
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P.O. Box 3566
Israel

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

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1. and 2. Main building, 3. Entrance main building

Website: http://www.wma.net

WMA Directory of National Member Medical Associations Officers and Council

Association and address/Officers

Verge del Pilar 5,
4art. Despatx 11, Andorra La Vella
Tel: (376) 823 525/Fax: (376) 860 793
E-mail: coma@andorra.ad
Website: www.col-legidemetges.ad

ARGENTINA S
Confederación Médica Argentina
Av. Belgrano 1235
Buenos Aires 1093
Tel/Fax: (54-114) 383-8414/5511
E-mail: comra@sinectis.com.ar
Website: www.comra.health.org.ar

AUSTRALIA E
Australian Medical Association
P.O. Box 6090
Kingston, ACT 2604
Tel: (61-2) 6270-5460/Fax: -5499
Website: www.ama.com.au
E-mail: ama@ama.com.au

AUSTRIA E
Österreichische Ärztekammer
(Austrian Medical Chamber)
Weihburggasse 10-12 - P.O. Box 213
1010 Wien
Tel: (43-1) 51406-931
Fax: (43-1) 51406-933
E-mail: international@aek.or.at

REPUBLIC OF ARMENIA E
Armenian Medical Association
P.O. Box 143, Yerevan 375 010
Tel: (3741) 53 58-63
Fax: (3741) 53 48 79
E-mail:info@armeda.am
Website: www.armeda.am

AZERBAIJAN E
Azerbaijan Medical Association
5 Sona Velikham Str.
AZE370001, Baku
Tel: (994 50) 328 1888
Fax: (994 12) 315 136
E-mail: Mahirs@lycos.com /
azerma@hotmail.com

BAHAMAS E
Medical Association of the Bahamas
Javon Medical Center
P.O. Box N999
Nassau
Tel: (1-242) 328 6802
Fax: (1-242) 323 2980
E-mail: mabnassau@yahoo.com

BANGLADESH E
Bangladesh Medical Association
B.M.A House
15/2 Topkhana Road,
Dhaka 1000
Tel: (880) 2-9568714/9562527
Fax: (880) 2-9566060/9568714
E-mail: bma@aitlbd.net

BELGIUM F
Association Belge des Syndicats Médicaux
Chaussée de Boondael 6, bte 4
1050 Bruxelles
Tel: (32-2) 644-12 88/Fax: -1527
E-mail: absym.bras@euronet.be
Website: www.absym-bras.be

BOLIVIA S
Colegio Médico de Bolivia
Casilla 1088
Cochabamba
Tel/Fax: (591-04) 523658
E-mail: colmedbo_oru@hotmail.com
Website: www.colmedbo.org

BRAZIL E
Associaçao Médica Brasileira
R. Sao Carlos do Pinhal 324 – Bela Vista
Sao Paulo SP – CEP 01333-903
Tel: (55-11) 317868 00
Fax: (55-11) 317868 31
E-mail: presidente@amb.org.br
Website: www.amb.org.br

BULGARIA E
Bulgarian Medical Association
15, Acad. Ivan Geshov Blvd.
1431 Sofia
Tel: (359-2) 954 -11 26/Fax:-1186
E-mail: usbls@inagency.com
Website: www.blsbg.com

CANADA E
Canadian Medical Association
P.O. Box 8650
1867 Alta Vista Drive
Ottawa, Ontario K1G 3Y6
Tel: (1-613) 731 9331/Fax: -1779
E-mail: monique.laframboise@cma.ca
Website: www.cma.ca

CHILE S
Colegio Médico de Chile
Esmeralda 678 - Casilla 639
Santiago
Tel: (56-2) 4277800
Fax: (56-2) 6330940 / 6336732
E-mail: sectecni@colegiomedico.c
Website: www.colegiomedico.cl

see page ii

CHINA **E**
Chinese Medical Association
42 Dongsi Xidajie
Beijing 100710
Tel: (86-10) 6524 9989
Fax: (86-10) 6512 3754
E-mail: suyumu@cma.org.cn
Website: www.chinamed.com.cn

COLOMBIA **S**
Federación Médica Colombiana
Calle 72 - N° 6-44, Piso 11
Santafé de Bogotá, D.E.
Tel: (57-1) 211 0208
Tel/Fax: (57-1) 212 6082
E-mail: federacionmedicacol@
hotmail.com

DEMOCRATIC REP. OF CONGO F
Ordre des Médecins du Zaire
B.P. 4922
Kinshasa – Gombe
Tel: (242-12) 24589/
Fax (Présidente): (242) 8846574

COSTA RICA **S**
Unión Médica Nacional
Apartado 5920-1000
San José
Tel: (506) 290-5490
Fax: (506) 231 7373
E-mail: unmedica@sol.racsa.co.cr

CROATIA **E**
Croatian Medical Association
Subiceva 9
10000 Zagreb
Tel: (385-1) 46 93 300
Fax: (385-1) 46 55 066
E-mail: orlic@mamef.mef.hr

CZECH REPUBLIC **E**
Czech Medical Association .
J.E. Purkyne
Sokolská 31 - P.O. Box 88
120 26 Prague 2
Tel: (420-2) 242 66 201/202/203/204
Fax: (420-2) 242 66 212 / 96 18 18 69
E-mail: czma@cls.cz
Website: www.cls.cz

CUBA **S**
Colegio Médico Cubano Libre
P.O. Box 141016
717 Ponce de Leon Boulevard
Coral Gables, FL 33114-1016
United States
Tel: (1-305) 446 9902/445 1429
Fax: (1-305) 4459310

DENMARK **E**
Danish Medical Association
9 Trondhjemsgade
2100 Copenhagen 0
Tel: (45) 35 44 -82 29/Fax:-8505
E-mail: er@dadl.dk
Website: www.laegeforeningen.dk

DOMINICAN REPUBLIC **S**
Asociación Médica Dominicana
Calle Paseo de los Medicos
Esquina Modesto Diaz Zona
Universitaria
Santo Domingo
Tel: (1809) 533-4602/533-4686/
533-8700
Fax: (1809) 535 7337
E-mail: asoc.medica@codetel.net.do

ECUADOR **S**
Federación Médica Ecuatoriana
V.M. Rendón 923 – 2 do.Piso Of. 201
P.O. Box 09-01-9848
Guayaquil
Tel/Fax: (593) 4 562569
E-mail: fdmedec@andinanet.net

EGYPT E
Egyptian Medical Association
„Dar El Hekmah“

MACEDONIA **E**
Macedonian Medical Association
Dame Gruev St. 3
P.O. Box 174
91000 Skopje
Tel/Fax: (389-91) 232577

MALAYSIA **E**
Malaysian Medical Association
4th Floor, MMA House

OFFICIAL JOURNAL OF THE WORLD MEDICAL ASSOCIATION

Hon. Editor in Chief
Dr. Alan J. Rowe
Haughley Grange, Stowmarket
Suffolk IP14 3QT
UK

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

Dr. Ivan M. Gillibrand
19 Wimblehurst Court
Ashleigh Road
Horsham
West Sussex RH12 2AQ
UK

Business Managers
J. Führer, D. Weber
50859 Köln
Dieselstraße 2
Germany

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THE WORLD MEDICAL ASSOCIATION, INC.
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01212 Ferney-Voltaire Cedex, France

Publishing House
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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.
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The General Assembly of the World Medical Association takes place in South Africa in October. At a time when the continuing burden of disease, AIDS/HIV, Malaria, Tuberculosis etc., inadequate resources and under-funding of need is so great (despite the international response so far), it is thus appropriate that the Assembly is meeting in the African continent.

Although the agenda of the General Assembly will be much occupied with the necessary updating of WMA policy statements, including the International Code of Medical Ethics *(see Council meeting report in WMJ 52(2))* and possibly adopting statements on other issues such as Obesity, Pandemic Influenza etc., no doubt other matters relating to major health issues including those of the African continent will be raised during the meeting.

The Scientific session will be devoted to "Health as an Investment" and "Advocacy", providing an opportunity to examine aspects of these topics as diverse as Investment in Human Resources, Medical Research, Public-funded healthcare planning – not to mention the economic aspects of the topic. The presentation will consider the obligations of governments in the provision of basic health care, move on to aspects of Advocacy and finally address the Role of National Medical Associations in the topics addressed.

Looking round the world today, it is clear that health care is a major topic of discussion not only in developing countries. Developed countries, with health care – often long established and well developed – are also experiencing major problems although not to the same degree. It is not without significance that in considering the economics of health, both its promotion and care, governments are now trying to assess the value of investment in health and how the best value for this type of investment can achieved. This situation is not without its effect on physicians, as can be seen in the notes on news from the regions and national medical associations (p. 82). Disquiet is with lack of resources both financial and human, due not only to problems associated with the economy or productivity in both developing and developed countries. In developing countries it can be due to emergence of new diseases or inadequate control of old ones, or by armed conflict or social unrest.

In developed countries as well, governmental and healthcare system's suggested or imposed changes, or dissatisfaction with the working conditions of health professionals,

Medical Ethics and Human Rights

in global health research. In Dr. Vichai Chokevivat (Thailand), its Chairman's words " the network of regional forums cre-

Medical Ethics and Human Rights

na's planning, the WHO's project, and different scenarios for distributing scarce resources such as Tamiflu. Dan Wikler made an interesting observation that during the 1918-19 influenza pandemic, the annual number of deaths from TB in the U.S.A. decreased by almost the same amount as the increase in deaths from the 'flu.

- "Ethical Lessons from Unit 731's Human Experiments" – Takashi Tsuchiya from Osaka gave a detailed account of the Japanese biological weapons programme in Manchuria and elsewhere. He noted that following W.W. II the U.S. did not investigate medical crimes of the Japanese but sought the data to use against the U.S.S.R. The Soviets did conduct some trials but both the Japanese and the Americans covered up the atrocities. The first Japanese exposé was in 1981 but only in the 1990s did the crimes become known outside Japan. The Japanese medical profession considers the subject taboo.
- Another session on "Professionalism in Medicine" was chaired by David Rothman of Columbia University. He dealt with the current challenges to professionalism, including conflicts of interest, weak self-regulation, medical errors, lack of civic engagement, patient use of the Internet and overwork. There were two presentations of surveys of American physicians' attitudes towards professional and ethical issues and one on professionalism among Chinese physicians.
- "From SARS to Avian Flu in China" – a presentation by Guang Zeng, Chief Epidemiologist, Center for Disease Prevention and Control. SARS caused Chinese politicians to become concerned with public health for the first time and to begin to overcome the tradition of secrecy and cover-up with regard to health-related problems. There is a better surveillance and reporting system now, although decentralization poses obstacles.
- "Bioethics Without Borders" – this consisted of presentations on the ethics activities of the WMA, WHO, UNESCO and the European Commission.

143,000 copies of a handbook on 180 common ailments and how to care for them, plus a telephone nurse advice helpline. Three years after the programme launch, an estimated $7.5 to 21.5 million was saved in unnecessary health care costs. More recently a similar initiative reported a reduction in unnecessary visits to the doctor of 23% and of 15% in unnecessary visits to emergency room services, and 16% of employees saving a sick day from work (see http://www.healthwise.org/a_communities.aspx).

- A workplace health education programme aimed at reducing unnecessary outpatient visits was designed by Lorig et al. A total of 5,200 employees attended a presentation, received self-help books, and completed self-administered questionnaires. The study found that a minimal cost, self-care workplace intervention can reduce outpatient visits by important magnitudes – up to 17% or 2.0 visits per household per year (Lorig et al 1985).

Based on these and other studies the potential benefits may be summarised as:

- Reducing time spent in seeing a general practice physician for minor or trivial ailments, giving physicians more time for more important cases.
- Reduction in the number of unnecessary visits to accident and emergency departments, again saving the time of these hard-pressed services.
- Increased motivation for patients and for healthy people in maintaining or improving their well being.

It is important to emphasise that none of these examples excludes healthcare professionals; indeed their full involvement helps ensure the success of self care schemes. An important point must, however, be made. In many poor countries the reality is of obligatory self care due to the absence of basic healthcare facilities. Obligatory self care is prevalent in the least developed countries and can be most unfortunate when it is a forced substitute for essential medical interventions. On the other hand, in many developed countries, the reverse is true – insufficient self care and over-dependency on the health care system gives a major opportunity to encourage self care in these countries. In both situations there are significant questions about the appropriate levels of self care for a country, given the particular circumstances, and around approaches for integrating self care into the mainstream health care systems.

Section 2 – Implications for physicians

Every person has the right to health education that will assist him/her in making informed choices about personal health and about the available health services. The education should include information about healthy lifestyles and about methods of prevention and early detection of illnesses. The personal responsibility of everybody for his/her own health should be stressed. Physicians have an obligation to participate actively in educational efforts (WMA Declaration of Lisbon on the Rights of the Patient).

As described above, self care is already widely practised in many parts of the world and this is likely to increase.

Physicians and medical associations may be sceptical of some of the claims of self care advocates, especially regarding the financial savings that can result from the expansion of self care (e.g., the reduction in hos-

Coulter, Angela and Magee, Helen (eds.): The European Patient of the Future, Maidenhead, UK: Open University Press, 2003

Dean, K. Self-care responses to illness: a selected review. Soc. Sci. Med 15a 1981 673-87.

Dean K. Conceptual, theoretical and methodological issues in self-care research. Soc Sci Med 29 1989 117-23.

Elo J, Myllykangas M. Perceived symptoms and action taking. J. Soc Med 23 1986 28-38.

Fu, D, Fu, H, European D, Fuc5angas Imc02818oropean 12

Verbrugge LM, Ascione FJ. Exploring the iceberg. Common symptoms and how people care for them. Med Care 25 1987 539-63.

Vita, AJ, Terry, RB, Hubert HB, Fries, JF. Aging, Health Risks, and Cumulative Disability. New England Journal of Medicine 338 1998 1035-1041.

Vulcovic N, Nichter, M. Changing patterns of pharmaceutical practice in the United States. Soc Sci Med 44 1997 1285-1302.

WHO. The role of the pharmacist in self-care and self-medication. Report of the 4th WHO Consultative Group on the role of the pharmacist. The Hague, The Netherlands, 26-28 August 1998. WHO/DAP/98.13, World Health Organization, Geneva 1998.

WHO. Guidelines for the regulatory assessment of medicinal products for use in self-medication. WHO/EDM/QSM/00.1, World Health Organization, Geneva 2000.

WHO. The World Health Report 2002. Reducing Risks, Promoting Healthy Life. World Health Organization, Geneva 2002.

World Medical Association. Statement on Self-Medication (www.wma.net/e/policy/ s7.htm)

for more than traditional international development assistance."

Dr Nordström praised recent initiatives aimed at providing sustainable financing mechanisms, such as the UNITAID initiative of France, Brazil, Chile, Norway and the United Kingdom, which uses a levy on airline taxes to channel new money to HIV work. He also noted that new potential mechanisms – such as advance market commitments – could provide incentives for research and development into new medicines and vaccines. He stressed that developed countries, including the G8, must live up to their financial and political HIV/AIDS commitments, and that national governments must also spend more on health domestically, and make HIV/AIDS a funding priority.

Medicines – access to drugs remains critical

Dr Nordström noted that "3 by 5" – the WHO and UNAIDS initiative to expand access to antiretroviral treatment to 3 million people in low- and middle-income countries by the end of 2005 – had influenced the HIV/AIDS landscape. He paid tribute to Dr Lee Jong-Wook, WHO's former Director-General, and his role in forcing a shift in approach and attitude to access to treatment. "This is demonstrated through a ten-fold increase in people on treatment in sub-Saharan Africa," he said. "But the challenges in that region also illustrate what still needs to be done. Seventy per cent of the global unmet need for treatment is in Africa."

He stressed that drug pricing was still an issue – to ensure that both first-line and second-line treatments were affordable. "There is growing momentum for innovation, research and addressing intellectual property issues to ensure maximum access to new products that save lives.

"We need ideas to turn into new drugs and diagnostics that strengthen our ability to safely treat infants and children as well as adults. We also need a vaccine and a microbicide."

"Universal access must include access to a skilled and motivated health worker," said Dr Nordström. "No improvement in financing or medical products can make a lasting difference in people's lives until the crisis in the health workforce is solved."

WHO

G8 commitments to infectious disease can improve global health security

ST PETERSBURG – At their July meeting Group of Eight vowed to improve the ways in which the world cooperates on surveillance for infectious diseases, including improving transparency by all countries in sharing information. The G8 also committed to continued support to fight HIV/AIDS, tuberculosis, malaria, and to eradication of polio. Dr. Anders Nordström, acting Director-General of the WHO said „Today the G8 spoke together on the essential need to tackle infectious diseases, because of their health, social, security and economic impacts", „The commitments are detailed and specific, and represent another step forward in G8 leadership on public health."

Dr. Nordström led a senior WHO team at the Summit to contribute to discussions on infectious disease and he addressed G8 leaders, in the presence of the Heads of State or Governments of Brazil, China, Congo, Finland, India, Kazakhstan, Mexico South Africa and invited UN leaders. He underscored priorities for infectious disease, including the need to:

- Sustain the political and financial momentum for scaling up against the major infectious diseases and basic health services: HIV, tuberculosis, malaria, polio and immunization.
- Manage new disease outbreaks and threats – including a potential pandemic influenza outbreak.
- Improve access to existing and new drugs and vaccines though expanded markets and increased affordability.
- Ensure there are enough motivated health workers in health centres and hospitals and address the current four-million health worker shortage. The biggest shortages are in the poorest countries where the need is greatest.
- Invest in innovative financing. The United Kingdom's support for the Immunization Financing Facility, and the France/Chile/Brazil/Norway plan to fund HIV/TB and malaria drugs through airline ticket taxes are very promising.

The 12-page health outcome document includes G8 country's commitments to: strengthen the global network for surveillance and monitoring; increase global preparedness for a human influenza pandemic; combat HIV/AIDS, tuberculosis and malaria; eradicate polio; make progress on measles and other vaccine-preventable diseases; ensure access to prevention, treatment and care including through research, the use of Trade-Related Aspects of Intellectual Property Rights (TRIPS) flexibilities and also strengthened health systems; and to address the health consequences of natural and man-made disasters.

The Russian Federation carried on the G8 tradition of supporting polio eradication and made a specific funding pledge for polio eradication, committing US$18 million to the programme, as did the United Kingdom in Gleneagles in 2005.

Geneva – A new global partnership that will strive to address the worldwide shortage of nurses, doctors, midwives and other health workers has been launched. The Global Health Workforce Alliance will draw together and mobilize key stakeholders engaged in global health to help countries improve the way they plan for, educate and employ health workers. Its secretariat will be hosted by the World Health Organization.

Responding to the call by African Heads of State, the G-8 and the World Health Assembly for urgent solutions to the health workforce crisis, the Alliance will seek practical approaches to urgent problems such as improving working conditions for health professionals and reaching more effective agreements to manage their migration. It will also serve as an international

er shortages, drawing on the top leadership of the major schools, whose task will be to develop a comprehensive national health workforce strategy.

Fifty-seven countries, 36 of which are in sub-Saharan Africa, have severe shortages of health workers. More than four million additional doctors, nurses, midwives, managers and public health workers are urgently needed to fill this gap. An adequate health workforce is defined by WHO as at least 2.3 well-trained health care providers available per 1000 people and balanced in such a way as to reach 80% of the population or more with skilled birth attendance and childhood immunization.

“The inadequacy of the health workforce in many developing countries is a major obstacle to providing essential life-saving health sery706.0016 7.f1 TD0.0.elo0.0.oogeof rs, u.eloping cforce i 71

dle-income countries today are African, compared with 25 percent in late 2003. Although sub-Saharan Africa has the greatest number of people on treatment, and the second-highest rate of treatment coverage among those who need it, the region still accounts for 70 percent of the global unmet treatment need.

In addition to expenditures by countries themselves, treatment scale-up has been funded through the U.S. President's Emergency Plan for AIDS Relief; the Global Fund to Fight AIDS, Tuberculosis, and Malaria; the World Bank; other bilateral donors, and pharmaceutical companies through contributions such as the Accelerating Access Initiative. In general, progress has been greatest in countries receiving specific assistance from these initiatives.

Increasing Equitable Access

Speaking on efforts to ensure equitable access to treatment among all people who need it, Dr De Cock reported that current data do not indicate any systematic bias against women in treatment access, with the proportion of female ART recipients corresponding closely to, and in some cases exceeding, the proportion of people infected.

However, other inequities are clear. While an estimated 800,000 children below the age of 15 require antiretroviral therapy, only about 60,000 to 100,000 are estimated to be receiving it. One in 7 people dying of HIV-related illness worldwide is a child under 15 years of age, a fact that is largely due to the failure to scale up programmes for the prevention of mother-to-child transmission of HIV and to prevent HIV infection in young women, noted Dr De Cock.

Despite the successes of such countries as Brazil, Thailand, and Botswana, only about six percent of HIV-positive pregnant women globally are currently benefiting from antiretroviral prophylaxis to help prevent HIV transmission in childbirth. In contrast, pediatric HIV disease has been virtually eliminated in the industrialized world.

People who contracted HIV through injecting drug use are also not receiving equitable access to treatment. In Eastern Europe and Central Asia, injecting drug users, a majority of them men, account for over 70 per cent of HIV-infected persons, but only about a quarter of treatment recipients.

Dr De Cock encouraged delegates at the meeting to evaluate treatment efforts not only based on the number of patients receiving care, but on the quality of treatment outcomes as well. Noting that most patients in developing country treatment programmes present with late-stage disease, he emphasized that improving treatment outcomes will require both diagnosing HIV and starting treatment earlier.

“A three-and-a half times higher death rate after one year of therapy in HIV-infected citizens of resource-poor countries compared with Europeans and North Americans should not be viewed as acceptable, and we must commit to change it,” said Dr De Cock. “These priorities are not radical new insights but they do require altered commitment to saving human life.”

Moving Towards Universal Access

Looking forward, Dr De Cock outlined five strategic directions, each of which represents a critical area where the health sector must lead if countries are to make progress towards achieving universal access, and on which WHO will focus its technical assistance. These include:

- expanding HIV testing and counselling;
- maximizing prevention opportunities in health care settings;
- increasing access to treatment and care;
- strengthening health systems; and
- investing in strategic information.

While stressing that prevention, treatment and care are inextricably linked, Dr. De Cock called for an increased emphasis on prevention efforts where HIV transmission is most intense. He also emphasized the

GENEVA – Leaders of the World Health Organization (WHO) and UNFPA, the United Nations Population Fund, are coordinating action to reverse the global trend of deteriorating levels of sexual and reproductive health and reduce the adverse impact on mothers, babies and young people.

WHO

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WHO

According to Hanne Bak Pedersen, Senior Adviser Pharmaceutical Policy, UNICEF Supply Division, “UNICEF is concerned that children's access to medicines is very low in many resource limited settings. Furthermore, there is a lack of availability

Medical Science, Professional Practice and Education

idating findings reported in July 2005 from the Orange Farm Intervention Trial in South Africa, funded by the French Agence Nationale de Recherches sur le SIDA (ANRS), which showed a reduction of 60% or more in the risk of acquiring HIV infection among circumcised men.

The interim data from the ongoing Uganda and Kenya trials were reviewed in June 2006 by the Data and Safety Monitoring Board (DSMB), which recommended that the studies continue on the grounds that there were not yet enough data to draw firm conclusions. The DSMB further proposed that an additional interim analysis of data from the two studies take place within the next year. “The results of the two ongoing trials will help clarify the relationship between male circumcision and risk of HIV in differing contexts, which is key to determining the reproducibility and application of the Orange Farm findings,” noted Dr Kevin De Cock, Director, WHO HIV/AIDS Department. “While we await these important results, UN partners and others are working to provide coordinated guidance and support to countries to help improve the safety of current male circumcision practices.”

An additional trial assessing the impact of male circumcision on the risk of HIV transmission to female partners, led by researchers at Johns Hopkins University, is currently under way in Uganda with results expected in late 2007. The effect of male circumcision on reducing the risk of HIV transmission among men who have sex with men has been studied but has not been the subject of a trial.

GUIDANCE AND SUPPORT EFFORTS NOW UNDERWAY

WHO, UNFPA, UNICEF and the UNAIDS Secretariat emphasize that their current policy position has not changed and that they do not currently recommend the promotion

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hidsjpport

Mobile Phone: +41 79 472 7917
E-mail: bartonknotts@unaids.org

UNICEF
Gerrit Beger
Telephone: +1 212 326 7116
Mobile Phone: +1 646 764 0200
E-mail: gbeger@unicef.org

informed or a proxy told this should be respected. Other adopted policy includes that stating that the public soliciting of organs from living donors is ethically acceptable under certain conditions including the proviso that it does not unreasonably disadvantage others on the organ waiting list. The policy adopted is intended to help guide doctors through the issues study of which will continue. (see http:/ww.ama-assn.org/ama/pub/category/16450.html).

AMA news also reports the formation of a Council on Physician and Nurse supply. This is part of the Consortium for Workforce Research Policy, a joint programme of Pennsylvania's School of Medicine, School of Nursing and the Leonard Davis Institute of Health Economics and will monitor and address the problems of what many say is a growing shortage of physicians and nurses across the USA. Interestingly there is also a report that following a five year study by a workforce of the Massachusetts Medical Society there is a shortage of primary care physicians in Massachusetts .The report "2006 Physician Workforce Study" also refers to severe to critical shortages of specialists in our r332aim

Review