Improving health for the world's poor: what can health professionals do?

May 2007

BMA

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Rt. Hon. Hilary Benn MP

Secretary of State for International Development

Improving health for the world's poor: what can health professionals do?

Hilary Benn

Today, health is much debated internationally and the promises of greater aid, debt relief and a focus on Africa offer the opportunity to make significant progress in the years ahead. But how can health professionals in the UK best contribute to improving global health and fighting world poverty?

Four years ago, the British Medical Association with support from the Department for International Development set out to increase awareness among its members of international development. It initiated a discussion about how individual members and the Association itself could effectively contribute to reducing poverty in the poorest countries.

This booklet represents the culmination of that work. It discusses a range of current and future health challenges. Some, such as climate change are relatively new and increasingly urgent; others such as clean water and sanitation, hunger and malnutrition are long standing but demand greater attention if we are to make progress. Underlying all is the importance of governance and the decisions countries make to ensure systems are in place to provide universal access to basic health services. It identifies opportunities for the BMA as well as individual health professionals to act as advocates for better health and development.

I am very pleased to be able to introduce this booklet, which I hope will inspire many people to bring their professional expertise to support international efforts to eradicate world poverty.

Hilary Benn

Improving health for the world's poor: what can health professionals do?

Introduction

Mr James Johnson

Mr James Johnson

Chairman of Council, British Medical Association

Achieving change for the world's poor

I am delighted to introduce this new publication which I hope will inspire health professionals and their organisations to realise the powerful role they can play in improving health for the poorest people.

Global health is currently enjoying a high profile in the UK. In February, Lord Crisp's report on global health partnerships highlighted the contribution which UK expertise can make to the improvement of health in poor countries. More recently, the Chief Medical Officer of England, Sir Liam Donaldson, called for a new UK global health strategy which made the protection and promotion of health one of our responsibilities as citizens of the world.

The BMA welcomes this strong commitment from the UK government, and we hope other nations will be encouraged to follow suit. In particular, we share Lord Crisp's view that there is a pool of untapped expertise and insight amongst UK health professionals which, if harnessed, could make a huge difference to health in the developing world. In fact, that difference is already being made. Increasing numbers of UK health workers voluntarily undertake humanitarian work in the developing world every year. Hospitals and clinics are also playing their part. With the NHS Links initiative, the Tropical Health Education Trust has pioneered the development of international exchanges between UK hospitals and their counterparts in poor countries, promoting the sharing of skills for the benefit of both partners. All of this work continues to be invaluable in helping to regenerate health systems and improve the standard of care where it is so badly needed.

There is, however, scope for the health sector to do even more. Change for the world's poor will only occur when informed voices are raised and cages are rattled. Health professionals, their Colleges, trade unions and governing bodies – a powerful and respected coalition – now have the potential to emerge as leading advocates for the improvement of health in the South. This new publication by the BMA recognises the possibilities which lie ahead and, building on the work of Crisp and Donaldson, provides an agenda for change.

Barriers to health

In the pages which follow, you will find discussion and analysis by leading experts of eight barriers to the improvement of health for the world's poor. The health impacts of each issue are laid bare and make for sober reading. Millions go without the medicines they need. 42% of the population of sub-Saharan Africa lacks access to an improved water source and, at this rate, the region will not meet the Millennium Development Goal target on water until 2040. While global food production has doubled in the last 40 years, 820 million people in developing countries remain undernourished. On their own, such statements still have the power to shock. Taken as a whole, this publication is a powerful indictment of the state of world health and the inability – or even unwillingness – of those in power to take remedial action.

We also explain how health professionals and their organisations can lead efforts to achieve change for the better. Each issue is followed by recommendations for action by health

professionals and their organisations. In reading through them, I am struck by the sheer range of possibilities which exist for health professionals to become involved and add value. There are opportunities to lobby governments, raise awareness, and to work with governments, civil society and the development sector in formulating policies which will restore health to its rightful place at the heart of development.

A new phase

This publication brings new hope for those who care about the world's health. At the same time, it also brings to an end the first phase of work in this area by the British Medical Association. We could not have produced this publication without funding from our partnership with the Department for International Development (DfID) which began in 2003 and ended in March of this year. I am deeply grateful to DfID for enabling us to explore the possibilities which exist for the BMA and other medical associations across the world to channel their experience and insight into the global health arena. Over the coming months, we will be exploring and shaping our own role in taking forward the issues covered in the following pages. I hope that you will feel encouraged to do the same, and that together we will help to bring about change for those who need it most.

James Johnson
Chairman of Council, British Medical Association

Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
BBC	British Broadcasting Corporation
BMA	British Medical Association
DfID	Department for International Development
EU	European Union
GDP	Gross Domestic Product
GP	General Practitioner
HIV	Human immunodeficiency virus
IPCC	Intergovernmental Panel on Climate Change
MDG	Millennium Development Goal
MP	Member of UK Parliament
NGO	Non-governmental organisation
NHS	National Health Service
PCT	Primary Care Trust
R&D	Research and Development
TB	Tuberculosis
TRIPS	Agreement on the Trade-Related aspects of Intellectual Property Rights
UK	United Kingdom
UN	United Nations
UNICEF	The United Nations Children's Fund
US	United States
USTR	United States Trade Representative
WHO	World Health Organisation
WTO	World Trade Organisation

Improving health for the world's poor: what can health professionals do?

Chapter 1

Health systems – why they need to be at the heart of all our societies

Mike Rowson

We all feel anxious and vulnerable when a serious illness strikes ourselves or our loved ones. Here in the UK we know that when that event happens, we can find advice, treatment and support from our health services fairly easily. But for many of the world's people this is not the case (box 1.1).

Imagine living where there are no health services. The nearest health centre is a day's hard journey away and you will have to walk. Even if there is a clinic nearby there is no guarantee it will be stocked with medicines, or staffed by someone who can prescribe them. You don't know that you will be able to afford your treatment if one can be prescribed. And there could be the prospect of a referral somewhere else for further tests.

You might not go. You might instead rely on a healer and their natural remedy or on pills sold in a local market. You might cope with the illness as best you can. But in all likelihood, you or your loved ones will suffer needless pain, and may even die. The risks associated with illness, and our fear of those risks, are why health systems have a special place at the heart of our societies.

Box 1.1   Quick facts on health system inequities
- 1.3 billion people lack access to basic health care services
- Worldwide, 100 million people are pushed into poverty every year by health care costs
- Developing countries bear 90% of the world's disease burden but possess just 12% of the world's health care resources
- In the poorest developing countries average spending on health is just US$30 per person. In the developed world it is US$3,000 per person/per year.

Sources: Gottret and Schieber (2006); WHO (2005)

Health services are only one part of the whole health system jigsaw (box 1.2), but we focus on them and the workers who staff them in this chapter. In doing so, we look at three key issues: health care financing, strengthening the public sector and supporting health workers.

Box 1.2   What is a health system?
- Public health: prevention, cross-sectoral action, emergency preparedness
- Health services: what most regard as the heart of the health system – ideally provided according to need and financed equitably
- Human resources and knowledge: training and education of health workers; surveillance systems
- Ethics, accountability and policy: mechanisms to ensure accountability, citizen rights and involvement of users; ethical integrity and professional behaviour; policy development and planning.

Source: Mackintosh and Koivusalo (2005)

Health care financing

The world as a whole spends US$3.2 trillion every year on health care. However, 88% (US$2.8 trillion) of this is spent in rich nations, where 16% of the world's population live. Developing countries, with 84% of the world's population and 90% of its disease burden, possess just 12% of its health care resources (figure 1.1).

Figure 1.1 The gross mismatch between resources and need

Global Health Spending

Low and middle income countries

High income countries

Global Disease Burden

Low and middle income countries

High income countries

Source: Gottret P, Schieber G (2006).
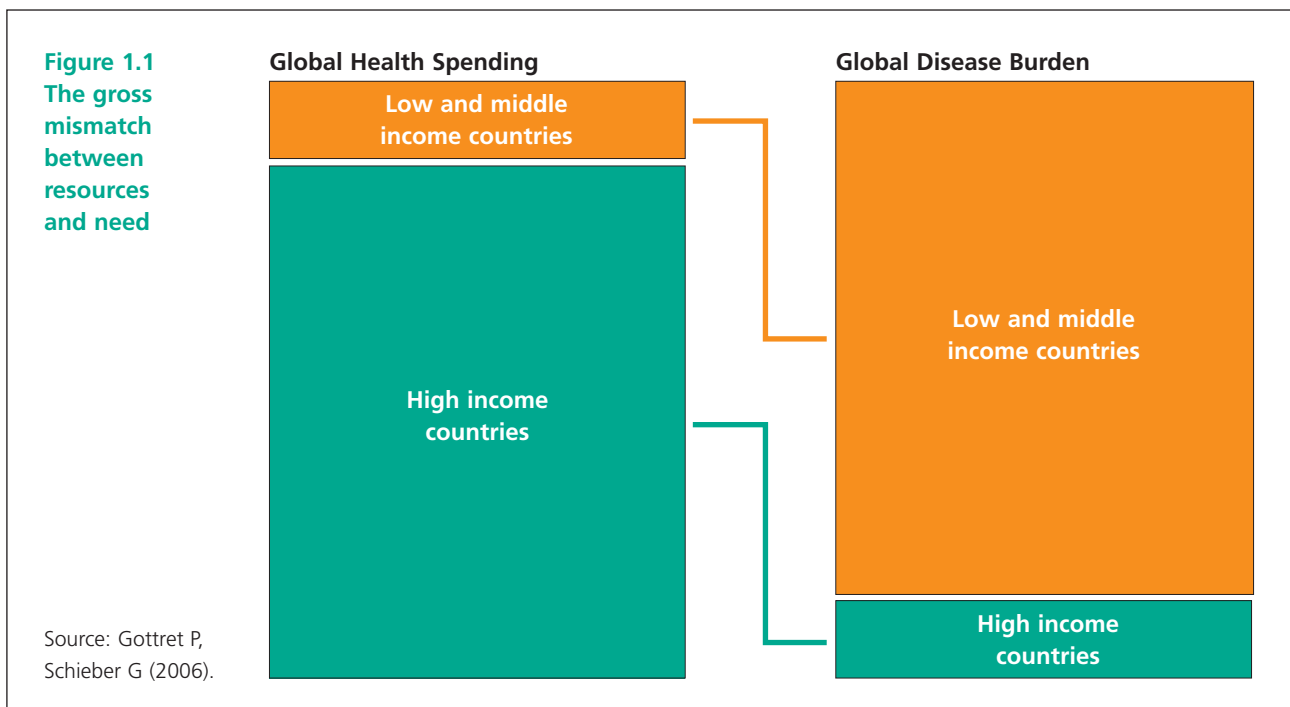
This inequality in spending reflects the deep wealth divide between rich and poor countries (table 1.1). In low income countries, average health expenditure is only US$30 per person a year. This figure is half of what the World Health Organisation reckons is needed to run a minimally-functioning health system and roughly 100 times less than what is spent in rich countries with a much lower burden of disease.

Table1.1: Composition of health expenditures in high-, middle-, and low-income countries, population-weighted averages, 2002

Countries by income group	Gross Domestic Product /capita	Total health expenditure/capita	Government expenditure on health as % of total health spending
Low-income countries	US$424	US$30	29%
Lower-middle-income countries	US$1,333	US$82	42%
Upper-middle-income countries	US$5,267	US$310	56%
High-income countries	US$27,464	US$3,039	65%
Source: Gottret and Schieber (2006). Figures are for 2002 and have been rounded.			

On top of this, in most low income countries, health expenditure mainly comes directly out of people's pockets when they need care. This is the worst form of health financing: it can easily throw people into destitution because health care costs can be very large. When people have no cash to pay, they and their families start to sell their assets as the story in box 1.3 shows. Worldwide it is estimated that 100 million people every year are pushed into poverty by health care costs.

Box 1.3   The cost of a long illness

K was working in Dar es Salaam in Tanzania when she fell sick. She used all the money she had saved in order to pay for treatment. When she didn't get better, her belongings had to be sold to pay health charges. Then, when she still failed to recover, her father mortgaged his coconut plantation to pay for treatment, but to no avail. "Finally, we just took her home and waited for her days to finish, as there was nothing left to sell to help her," K's sister recounts. "In the end, she died and my father lost his plantation as he couldn't afford to reclaim it within the agreed time."

Source: Save the Children (2006)

Although international aid helps to increase public spending on health, it can also cause problems. Different donors may have different funding priorities and can pull governments in different directions. In addition, much money has been directed at a few major killers such as HIV/AIDS, tuberculosis and malaria. This can lead to the neglect of other illnesses and distort the priorities of front-line workers. When aid programmes are channelled through vertical, stand alone projects, it can also cause the health system to become fragmented and disorganised.

An adequate budget that is reliable and funded by donors over a five to ten year period, and which can be managed in a rational and coordinated manner is an essential feature of health systems development. Achieving this goal will require greater efforts at mobilising domestic and international resources, as well as improving coordination and management of donor and government plans.

Strengthening the public sector

Many developing countries have experienced a long-period of under-funding of public services, leading to deterioration of facilities and demoralisation of workers. Table 1.1 shows how little government spending makes up of total health spending. In low-income countries the public sector spends on average an abysmal $8.6 per person annually to meet health needs. Economic recession, poor governance, and fiscal austerity imposed by the International Monetary Fund have all constrained government spending and, as a result, an unregulated private sector has emerged to fill the gaps.

As table 1.1 also shows, richer countries choose to spend a greater proportion of their health budgets through governments – and they do so for good reason. Governments have the necessary oversight and authority to rationally plan health care according to population needs, keep costs down and promote social protection for the poor and vulnerable. There is also evidence which suggests that, when the majority of health care financing comes through government, health outcomes are better – even when other health promoting factors such as rising incomes are taken into account.

Yet it is a huge challenge for governments in poor countries to live up to their duties, which include achieving the Millennium Development Goals for health (box 1.4). Chronic public sector failures must be corrected. Ministries of Health must rebuild their dilapidated infrastructure, inspire their workforce and develop the information systems required for effective management. At the same time, given the extensive privatisation of health care, ways must be found to shape the private sector in the public interest and to block the worst forms of health care commercialisation, particularly the development of separate private insurance schemes for the rich and the growth of profit-driven clinical practice.

Box 1.4   Tough challenges: the Millennium Development Goals for health
Eight Millennium Development Goals were agreed by world leaders at the UN's Millennium Summit in the year 2000. There are three goals directly related to health – all represent highly ambitious targets.

- Goal 4: Child mortality rate to be cut by 66% over the period from 1990 to 2015.
- Goal 5: Maternal mortality ratio to be reduced by 75% over the same period.
- Goal 6: Spread of HIV/AIDS, TB and malaria to be have been halted and begun to be reversed by 2015.

Whilst some countries are on track to meet the targets, most are not, particularly in sub-Saharan Africa. There are also a number of other targets that indirectly impact on health, most notably Goal 1 on reducing poverty. However, there are no goals which directly relate to strengthening whole health systems.

Supporting health workers

The World Health Organisation now estimates that there are critical shortages of health workers in 57 countries, especially in South and South-East Asia and sub-Saharan Africa (see figure 1.2).

Figure 1.2
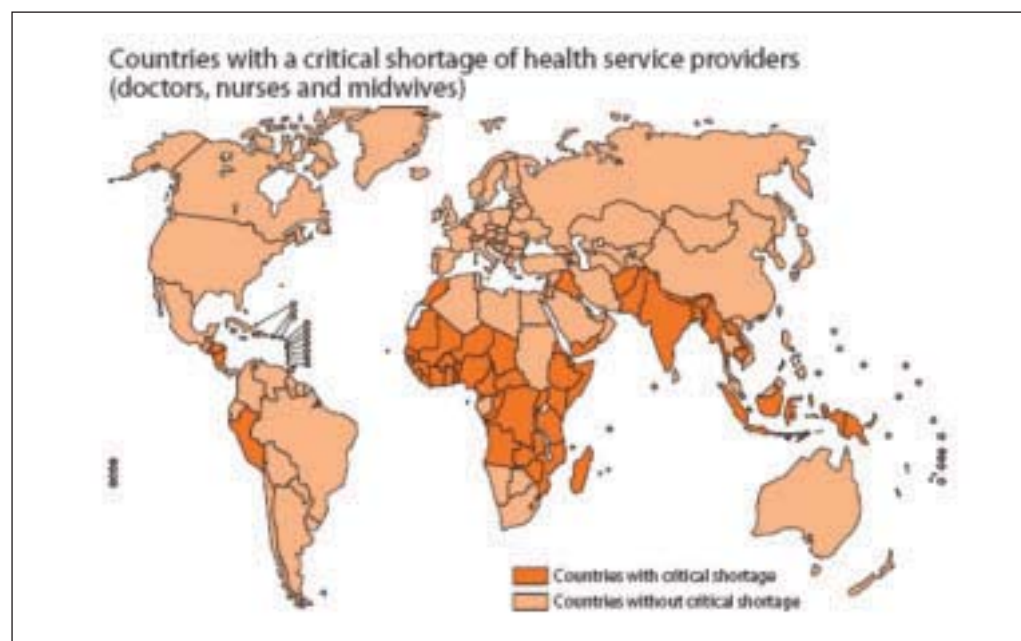
Source: WHO (2006).

The need to deal with the problems facing health workers in poor nations has hit the headlines in the UK in recent years because of large-scale professional migration from developing to developed nations. Migration is symptomatic of the problems we have been describing in poor country health systems. Health workers who face low wages, poor working and living conditions, and limited prospects for further training and career advancement, will be attracted to work abroad.

International migration is not the only symptom of a human resource crisis – health worker migration from public to private (including non-profit) health services within countries also illustrates the pull of better pay and conditions and a crisis in the public sector. As pressures grow on those workers who remain in the public sector, patients report problems of abuse and bullying, as well as under-the-counter charging (box 1.5). For poor people, such behaviour increases their sense of vulnerability and powerlessness and makes it less likely that they will seek health care.

Box 1.5   Bad experiences of health care

A young man, from La Calera, Ecuador says: "In the hospital they don't provide good care to the indigenous people like they ought to. Because of their illiteracy they treat them badly… they give us other medicines that are not for the health problem we have".

A man from Tanzania says: "We would rather treat ourselves than go to the hospital where an angry nurse might inject us with the wrong drug". Elsewhere in Tanzania, men, women and young people say over and over again that they are treated "worse than dogs". Before they have a chance to describe their symptoms, they "are yelled at, told they smell bad, and [that they are] lazy and good-for-nothing…"

Source: World Bank and WHO (2002).

Priorities for action on health systems

More funding needed for government health systems in developing nations

Absolute lack of finance underlies so many of the problems in health services in poor countries that it has to be the top priority for campaigners. Developing country governments should strive to meet the target of collecting at least 20% of GDP in public revenue and then allocating at least 15% of this to health. Additional targets might be needed to ensure that investments are made at the district level and in primary health care services for the most needy.

International donors should step up their funding for health care and provide this in a predictable manner in the long-term in line with recipient government priorities. Large amounts of funding for specific diseases should be avoided.

Abolish user charges, move towards tax- or insurance-based funding

User charges are the worst way of financing health care. More and more countries are reducing or getting rid of fees all together – increasing utilisation by vulnerable groups as a result. Donor support can help countries realise this goal, and take incremental steps towards the goal of being able to finance more health care from tax or population-wide insurance schemes.

Health workers need better pay, working conditions and prospects

Reversing the brain drain will not be easy. But well-judged investments in improving terms and conditions for health workers can make a difference. The UK government has made an important contribution to this goal by providing increased funding for health professionals in Malawi. Workers have been coming back to the public sector as a result. But the initiative faces failure without the support of other donors, as the labour market continues to exert a strong pull towards private and non-profit providers who can afford to pay even more.

However, low-pay cannot excuse bad behaviour. Governments and national medical associations can play a key role in monitoring standards, help to develop ethical norms for provider behaviour and support the ability of civil society groups to campaign on behalf of poor and vulnerable groups.

Repay our debts

The UK, which receives a massive subsidy by employing health workers from poor nations without incurring training costs, has a special duty to financially assist poor countries to rebuild health systems. Beyond providing money, policy-makers in the UK should also recognise the value of providing other forms of support such as encouraging UK health workers and management staff to spend time abroad as a part of their careers. All parts of the UK health system should acknowledge both our debt and our moral responsibility to help our colleagues in less fortunate situations. This includes the BMA, Royal Colleges, and research institutions as well as NHS Trusts and individual health professionals – all can play their part. Given the threat of the spread of infectious disease across borders, this effort should also be seen as in the UK's own self-interest.

What can the BMA and other health professional organisations do?

• Add their voice to existing campaigns on the need for more funding for government-provided health care in developing countries and against user charges.

• Expand their collaboration with counterparts in developing countries and enable them to lobby their own governments and donors more vigorously for better pay and conditions for health workers.

• Talk to their counterparts in poor countries about their important role in monitoring the behaviour of health workers and in making sure that health care promotes equity.

• Actively engage with the recent report by Lord Crisp on global health partnerships and help the UK government and the NHS to move forward with strategies for how they can help UK health professionals work in developing countries.

• Call for more international health teaching for medical students in order both to encourage them to work abroad and to equip them to face the global health challenges which already affect us in the UK.

What can individual health workers do?

• Ask your Primary Care Trust or hospital trust to allocate a portion of its budget towards an international health programme.

• Volunteer your own services and work abroad for a period of time.

• Join organisations which are campaigning for better health systems in poor countries.

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Useful websites and further reading

World Health Organisation http://www.who.int/
Global Health Watch http://www.ghwatch.org
Medact http://www.medact.org
Eldis Health Systems Resource Guide http://www.eldis.org/healthsystems/index.htm

Chapter 2

Water power – the contribution of clean water and sanitation to health

Belinda Calaguas and Brandon Cheevers

Contribution to health

Safe water and adequate sanitation are fundamental to maintaining and improving human health. A recent poll organised by the *British Medical Journal* concluded that the provision of sanitation was the most important medical milestone of the last 150 years. This was in recognition of the huge impact it had on improving life expectancy rates from the nineteenth century onwards in the now developed world (box 2.1). A study by the World Health Organisation suggests that today effective water, sanitation and hygiene interventions could eliminate around 24% of the global disease burden.

Box 2.1 Water and sanitation in historical perspective
The role played by water and sanitation in the development of thriving economies is well known and highlights the links between clean water and sanitation and public health outcomes and human development. The improvement of water and sanitation services in nineteenth century London, Paris and New York – where dysentery, typhoid and diarrhoea severely undermined population health – led to vast improvements in life expectancy from 1850 onwards. Political and social reforms, together with the required finance, put in place the economic, regulatory and technological infrastructure needed to break the link between water and sanitation and infectious disease. Life expectancy rose by 15 years in Britain in the four decades after 1880, while water reforms in the US led to life expectancy at birth rising by 16 years in the first four decades after 1900; while child deaths plummeted, and typhoid was virtually eliminated.

Water-related disease continues to be a leading cause of mortality and morbidity, mostly in the developing world, as recent cholera outbreaks in Uganda, South Africa, and Sudan indicate (box 2.2). Children account for the majority of deaths and ill health linked to water and sanitation, with about 1.3 million deaths annually from diarrhoeal diseases, including cholera, among children under five years of age. Lack of access to safe drinking water is also an underlying cause of malnutrition in children.

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Box 2.2 Water, sanitation and disease

The most important disease groups linked to water and sanitation include:

- diarrhoeal diseases, which account for 1.5 million deaths annually (including 1.3 million amongst children)
- malaria, responsible for a million deaths annually
- intestinal nematode infections, which affect one third of the world's population
- lymphatic filariasis, which affects 25 million people
- trachoma, which affects 5 million people
- schistosomiasis, which affects 200 million people.

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Water, sanitation and hygiene interventions, and better health education, represent the most sustainable and resilient solutions for combating diseases including trachoma, schistosomiasis and malaria. The health-related benefits of safe drinking water and adequate sanitation are also vital in the fight against HIV/AIDS, helping to lessen sufferers' susceptibility to opportunistic infections.

Clean water and sanitation lessen the burden on the overstretched health services of the developing world and free up money which can then be spent on tackling other health problems. Interventions yield benefits valued at many times the cost of investment: the WHO estimates that every US$1 spent on improving water supply generates a return of between US$5 and US$28 from increased productivity as well as the savings on costs of medication and treatment that result from a healthier population.

Children and adults around a communal well in Cameroon. Stagnant water around such sites can provide breeding areas for Culex mosquitos which carry malaria

Source: WHO/TDR/ Mark Edwards

Access to a sustainable, clean and affordable water source and adequate sanitation is also fundamental to human development and to the reduction of poverty. Yet across the developing world 1.1 billion people still do not have access to improved water sources and 2.6 billion people live without basic sanitation. This is a crisis that locks the poorest into poverty, with women and children suffering disproportionately. Target 10 of Millennium Development Goal (MDG) 7 aims to halve the amount of people without access to water and sanitation by 2015, and success in the water and sanitation sector is crucial to achieving progress in other MDGs, including health, education and economic productivity (box 2.3).

Box 2.3 The power of water and sanitation

The ability of people, especially women and children, to attain an education, access social justice and fulfil their ability to increase economic productivity is directly affected by water and sanitation coverage.

- Girls are prevented from attending schools through time lost fetching water, while the availability of a separate, private latrine at school is an important factor in encouraging girls and female teachers to attend school. The WHO says 443 million school days will be gained with universal access to safe water and sanitation. Preventing water- and sanitation-related illness can increase the cognitive potential of all children and increase their school attendance.

- The time lost to long-distance water collection, an activity mostly undertaken by women and female children, underpins the gender inequalities linked to water and sanitation. Women are disempowered when they lose the opportunity for socially and economically productive activities to time spent fetching water and looking after children who are sick as a result of water- and sanitation-related illness. Women are empowered when they have more time for child care and rest, while income-generating activities increase their independence. A safe, private place to go to the toilet improves their security and maintains their dignity.

- The economic security of households increases when women have more time for economic activities, and when all adult members of the household are healthy and available for work. Preventing disease alleviates poverty, and saves money at the household level that would otherwise be spent on medical treatment.

Yet despite the evidence base and the historical lessons about the importance of water and sanitation to public health outcomes and human development, the sector is still marginalised in the priorities of aid recipient governments and the donor community, and there remain many obstacles to meeting the MDG target, including a lack of political will, weak institutional frameworks and a lack of financial resources.

The amount of money the sector receives has remained static over the last decade, and has fallen relative to other sectors such as health and education. Under-funding at both the international and national levels has produced inadequate investments in much-needed physical and institutional infrastructure, and there are still disparities in coverage between urban and rural areas, and within urban areas.

At the country level, public spending on water and sanitation is frequently less than 0.5% of its Gross Domestic Product (GDP) and is often dwarfed by military spending, while global spending will have to increase by a minimum of US$10 billion extra annually to meet the MDG target.

Though the world is on track to meet the MDG target for safe drinking water, largely due to significant progress in China and India, in sub-Saharan Africa, where safe water coverage levels are at their lowest, progress is slow. Forty-two per cent of the population of sub-Saharan Africa lacks access to an improved water source and, at this rate the region will not meet the MDG target on water until 2040. While all other regions around the world are moving forward in relative and absolute terms in respect of access to an improved water source, Africa is going backwards, with access deteriorating due to decaying infrastructure and failures to invest in rehabilitation and expansion, all resulting in increasing water stress. Water related health expenditure, lost productivity and labour diversion cost the region 5% of its GDP. These are losses that are sustained by the poorest households.

The sanitation situation is even worse, with current coverage rates suggesting that by 2026 one in four people will still be without a safe place to go to the toilet. Sub-Saharan Africa is not expected to meet the sanitation target until 2076 at current rates. The cost of not meeting the MDG target for sanitation, based on current global trends, is that an additional 10 million children will die from diarrhoeal diseases by 2026, with Africa's children bearing the brunt of this preventable illness.

An open sewer along a roadside market in Ghana

Source: WHO/TDR

Sanitation, even more than water, as a sector suffers from institutional fragmentation, low political status, and ineffective national planning. The stigma attached to sanitation within many countries makes it harder to move it up the political agenda. Closing the gap between water and sanitation coverage is crucial not just because of the intrinsic value of adequate sanitation but because of the mutually reinforcing benefits of a combined approach to water and sanitation provision.

The water and sanitation sector is in crisis because there is a lack of political will to implement changes that will help the poorest and most marginalised. Policies and practices must change to encompass principles of equity, poverty reduction, sustainability and accountability.

Policy changes needed

Both WaterAid and the United Nations Development Programme's *Human Development Report 2006*, which was dedicated to water issues, have identified the critical actions at international, national and local levels that must be undertaken if the MDG target is to be attained. The following is taken from the Programme of Action for the End Water Poverty campaign.

At the *international* level, donor and recipient governments must prioritise water and sanitation and increase spending. An internationally-recognised framework of policy actions must be established, to include:

- a global task force of senior policymakers acting as the focal point within the international aid system to monitor country level and global progress in reaching the water and sanitation targets, or universal coverage. It should hold to account donor and recipient governments and other institutions that impede progress.

- the creation of a Global Action Plan, recognised by the international development community. It should oblige donors and recipients to ensure that the required finance is in place to achieve the MDG target, committing recipient countries to spending up to 1% of GDP on water and sanitation. Donor governments must make up any financial shortfalls. Governments must produce coordinated sector plans.

At the *national* level within recipient countries, governments should own the policy design, implementation and monitoring processes, with the donor community in a supporting role.

- Recipient governments should develop a framework for the sector that allocates responsibilities for financing, coordination and monitoring and evaluation. It should include one country plan that establishes targets, costs and financing gaps, one coordinating mechanism, and one monitoring and evaluation framework. Progress should be monitored and results made public.

Governments must address weak sector governance at the *local* level, and seriously address the weaknesses of systems designed to deliver water and sanitation services.

- Ensuring that services are targeted and reach the poor and marginalised must be an aim at the heart of the policy-making process and investment decisions.

- Serving the urban poor must be at the top of the urban water and sanitation services priority list. Legal barriers to serving the poor should be removed, service providers held accountable, and regulations established and enforced. Non-state providers must be included within the public service system. Donors should support local stakeholders in directing reform.

- It should be a priority to deal with the weak capacity of local government agencies to plan, monitor and deliver services. National governments and donors should address this weakness and reverse the skills shortages at local levels. Local governments should open up to civil society participation in their planning and budgeting processes and be receptive to community-led initiatives.

What can the BMA and other health professional organisations do?

The global health community has much to offer in ensuring that water and sanitation targets are met around the world and especially in sub-Saharan Africa. Water and sanitation campaigners could benefit greatly from health professional advocacy, particularly where this support focuses on drawing the links between health and well-being and sustainable access to water and sanitation services. Research into this link is still needed, not just globally, but especially in developing countries.

Health professional organisations like the BMA could support the End Water Poverty campaign by joining the campaign coalition, and contacting their sister associations in Europe and elsewhere to do the same. As a start, the BMA and other health associations could in 2008, the International Year of Sanitation, join global and national efforts to draw attention to the health and other social risks associated with the absence of toilets and systems for managing excreta and waste-water. They could do this on their own or in coalition with other organisations already working on this issue. Individual health professionals could join the End Water Poverty campaign as advocates and become involved in the various actions that the campaign is planning over the coming months and years.

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Further reading and useful websites

End Water Poverty http://www.endwaterpoverty.org/

IRC International Water and Sanitation Centre http://www.irc.nl/

Tearfund International Learning Zone/Water and Sanitation
http://tilz.tearfund.org/Research/Water+and+Sanitation/

UNDP Human Development Reports http://hdr.undp.org/reports/global/2003/

WaterAid Learn Zone http://www.wateraid.org.uk/uk/learn_zone/

World Bank www.worldbank.org/watsan

World Health Organisation Water, Sanitation and Health http://www.who.int/water_sanitation_health/en/

Chapter 3

Climate change – the need for health leadership

Charlotte May

Introduction

There is now overwhelming evidence and scientific consensus that human activity is changing the earth's climate. Increasing concentrations of carbon dioxide (largely due to the burning of fossil fuels and forests), methane (arising from agricultural and oil extraction activities as well as the thawing of permafrost), nitrous oxide gases and halocarbons are trapping heat within the Earth's atmosphere and warming it (the greenhouse effect). Global warming is already evident in increases in air and ocean temperatures, the widespread melting of ice and snow, and rising sea levels. Graph curves for temperature rise closely mirror those for global CO_2 emissions (figure 3.1)

In 1988, governments, the World Meteorological Organisation and the United Nations Environment Programme set up the Intergovernmental Panel on Climate Change (IPCC) to assess, synthesise and discuss the scientific evidence on climate change, its likely impacts and the options for prevention, mitigation and adaptation.

Since 1988, incorporating input from thousands of scientists across the world, the IPCC has issued several reports which have become progressively clearer in their conclusion that global warming is real. Although a degree of 'denialism' still exists, there is general consensus that climate change represents one of humankind's greatest challenges.

Despite the evidence and the threat of potentially catastrophic consequences, climate changing emissions are rising faster than ever. Linking climate models with estimates of future human population, economic activity and technological change, the IPCC predicts that global average temperatures will rise by several degrees (between 1.1°C and 6.4°C) by 2100.

Figure 3.1 **Rising carbon dioxide...**
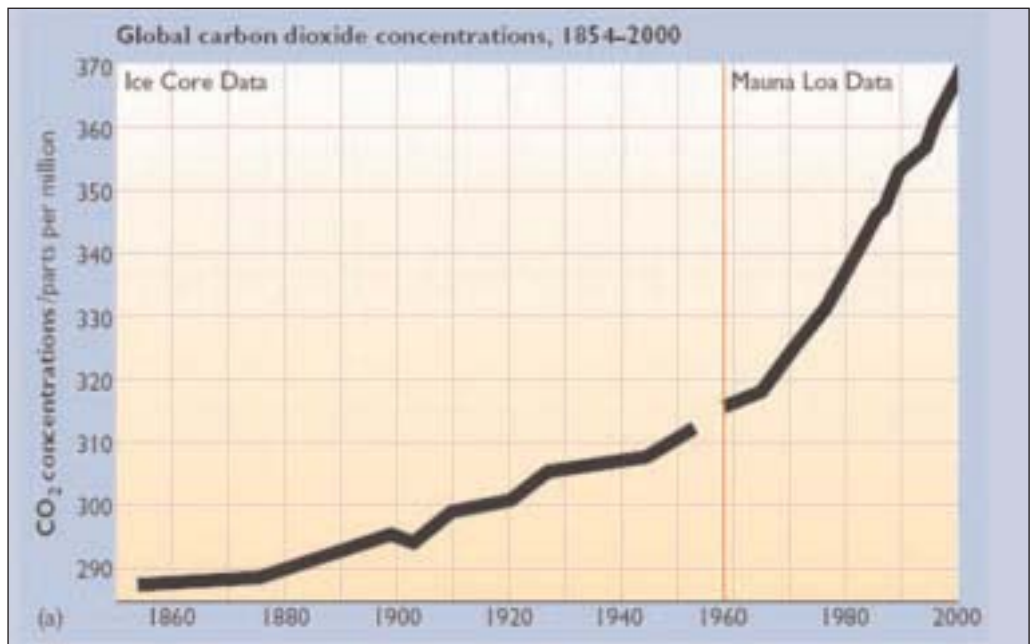
Source: Open University

Atmospheric concentrations of carbon dioxide 1854–2000. (Carbon dioxide data from 1958 were measured at Mauna Loa, Hawaii; pre-1958 data are estimated from ice cores.) Atmospheric CO_2 concentrations are now 37% higher than pre-industrial levels.

...rising temperatures

Source: Open University

Improving health for the world's poor: what can health professionals do?
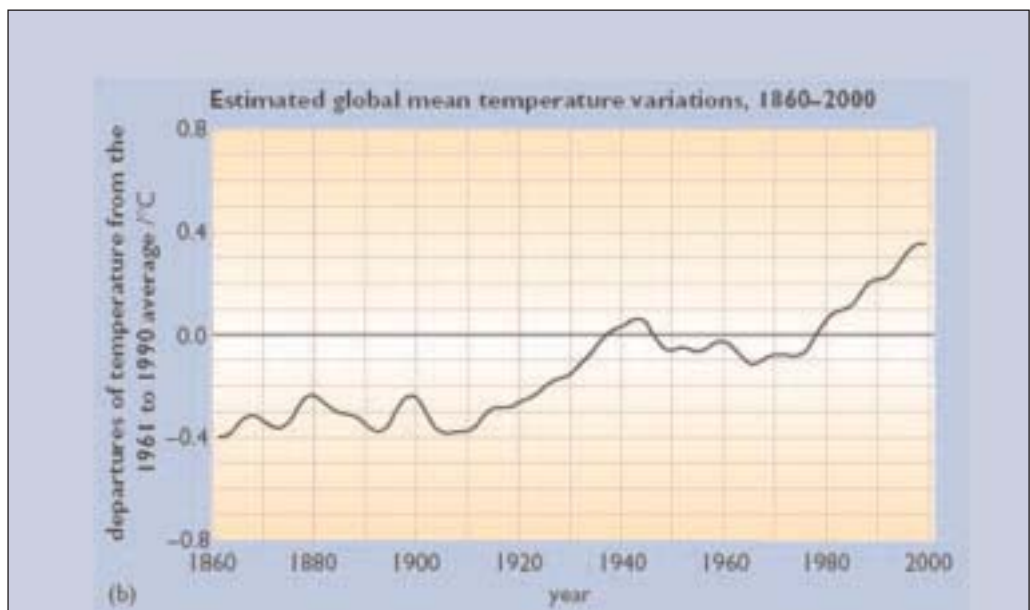
Impacts on health and development

As climate change accelerates, it will manifest differently across the planet. In some parts of the world, much of Africa, it will mean even higher temperatures and lower or less predictable rainfall. In some regions, climate change may initially be beneficial to human populations (less cold related illness, increased crop yields), but for the vast majority of the world's population the impacts on health and livelihoods are set to be overwhelmingly negative. In the next twenty years, it is predicted that the high temperatures which caused an excess of 50,000 deaths during the heat wave in Europe in 2003 will be the new norm. Other parts of the world may experience prolonged periods of drought, a higher frequency of extreme weather events (such as cyclones and hurricanes), or more frequent and serious bouts of flooding.

The WHO, the IPCC and others have stressed that there will also be an increase in vector-, water-, food- and rodent-borne diseases. For example, it has already been established that there has been an increase in the spread of malaria in parts of sub-Saharan Africa as a result of climate change. It is estimated that before the end of this century, 182 million people will die in sub-Saharan Africa from climate change-related disease alone.

However, the most devastating impacts on health will arise indirectly from crop failure, water shortages, sea level rise and associated economic and social disruption. The IPCC's most recent report has projected that by the end of the century southern Europe will face severe water shortages, poor crop yields and economic decline due to high temperatures. Conflicts over increasingly scarce natural resources (already seen in disputes over land and water in Sudan and the Middle East) are also likely to become more frequent – the UN Security Council now has on its agenda the implications of climate change for international security. Millions of people could become environmental refugees, forced to migrate in search of their basic needs for survival. In preparation for the risk of migrants fleeing from the threats of flooding, India has just completed a 4,500km fence along the whole Bangladeshi border. The UK Department for International Development sees climate change as the most serious threat to development and the achievement of the Millennium Development Goals.

A man does his washing in a deep hole he has dug in a dried up river bed in Cameroon – the only way he can find water.

Source: WHO/TDR/ Mark Edwards

Recent research by NGOs, including Christian Aid and Oxfam, shows that millions of poor people are already facing the effects of climate change. For example, parts of Kenya are facing longer and more frequent periods of drought, with desertification and dwindling fresh water supplies. It is difficult to attribute single weather events unequivocally to climate change, but development organisations in Bangladesh have noted an increase in the frequency of severe flooding. The WHO estimates that hundreds of thousands of deaths have been caused in recent years by climate-related disasters in Bangladesh, Mozambique, China and Venezuela.

Global responsibilities and vulnerabilities

Historically, the majority of climate changing emissions have emanated from rich industrialised countries such as the US, Germany, France, Italy, Japan and the UK (box 3.1). Today, they remain the biggest polluters on a per capita basis, although industrialising countries such as China and India are also rapidly increasing their emissions.

Box 3.1   The UK's emissions

Effective action on climate change has to be global, but the UK, as one of the richest countries and biggest polluters, has to take a lead. While it is claimed that the UK is responsible for only 2% of worldwide carbon emissions, recent research suggests that UK businesses have been under-reporting their emissions totals. In addition, emissions that take place in other countries to produce goods that are consumed in the UK are not attributed to the UK. Furthermore, government figures released in March 2007 show that UK emissions are rising.

The unequal shares of responsibility for global warming across countries and different population groups, both in the present and in the past, together with the disparities in levels of socio-economic development, pose some of the most difficult political barriers to addressing this global emergency. On the one hand we need to reduce global warming emissions; on the other, we need to provide the opportunities for development that billions of the world's poorest people currently are denied.

Perversely, although poor populations and low-income countries have contributed relatively little to global warming emissions, they will experience a disproportionate amount of the negative consequences, and be least able to cope with the effects. Much of the developing world already is hotter and experiencing unpredictable patterns of rainfall. Populations in poor countries tend to be more dependent on climate-sensitive natural resources, and have less financial and institutional capacity to adapt. The IPCC's April 2007 report predicts that 75-250 million Africans could face water shortages by 2020, with devastating impacts on food security.

Most authorities/policy-makers acknowledge that global warming and climate change will never be addressed in a just and fair way without the rich and the powerful nations agreeing to accept some degree of redistribution (of resources and economic opportunity) to the poor and weak. For those living high-income lifestyles, this will mean decreasing consumption and travel, and changing certain behaviours.

Recommendations

Scientists are clear on the need for rapid and significant decreases in the volume of greenhouse gas emissions as well as for plans to mitigate the effects of irreversible climate change. But there is a yawning gap between the science and the politics of climate change which urgently needs to be bridged.

Existing international agreements and national plans of action are insufficient to head off the changes that have been predicted. Action has been delayed by apathy, denial, resistance from those with vested interests, and a disproportionate faith in technological "fixes". Action has also been delayed by disagreement about what is considered fair and just, and by the huge disparities in economic and political power which can undermine the adoption of multilateral solutions.

However, the costs of not acting are far greater than the costs of taking drastic action now. In 2006, the Stern report called climate change "the greatest market failure ever seen", estimating that a "business as usual" policy in the face of climate change could cut global consumption per head by 20% now and into the future, whereas taking action now would cost around 1% of GDP, and would stimulate growth in sustainable, low carbon technologies.

A number of proposals have been made for reducing global warming emissions. These range from technological innovations to mechanisms aimed at capping and rationing carbon emissions. One framework for reducing emissions has been labelled 'contraction and convergence'. This relies on the establishment of a time-bound target for reducing global emissions ('contraction'). Carbon emission quotas would then be allocated equally to all the Earth's citizens. However, people would be allowed to trade their quotas, with the likely result that financial resources would flow from the rich to the poor. Over time, it is predicted that disparities in global warming emissions between different population groups would reduce ('convergence').

Although there are logistical barriers to the practical implementation of 'contraction and convergence', it describes a mechanism and approach for reducing global warming emissions which will help tackle poverty and reduce socio-economic inequalities at the same time.

Much of the inertia in taking action on climate change is because it is perceived to lead to deterioration in the quality of life. However, while there are difficult changes to make, change could also be positive and beneficial. It has been argued that a low-carbon lifestyle could be healthier than our current high-carbon lifestyles.

For example, changing the way we travel and organise our work could lead to improvements in physical and mental health. Presently, road transport (which accounts for 26% of the UK's climate changing emissions) contributes to damage to health and communities, and traffic levels are still increasing. By contrast, policies which reduce road traffic could simultaneously encourage people to do more exercise, by building more cycling and walking into their daily lives. Recent research in the UK has shown that lack of physical activity costs the NHS more than £1 billion a year. Almost 290,000 people died from diseases associated with lack of exercise in 2003-4, with more than 35,000 of those deaths directly attributable to inactivity.

In developing countries too, the short term health and economic gains of leapfrogging to cleaner policies and technologies are potentially huge. Industrialised countries which historically have made profligate use of fossil fuels should now assist poor countries to access and adopt clean technology.

BMA International Department

What can the BMA and other health professional organisations do?

The BMA, and health professional organisations generally, enjoy substantial influence nationally and internationally. They are well placed to:

- Highlight the public health dangers of climate change as well as the many health benefits associated with greener economic activity and lifestyles. The BMA can educate, inform and mobilise the health community, helping to create the critical mass of opinion and energy required to make change politically and socially feasible.

- Take action to reduce their own emissions by reducing energy consumption, promoting the use of renewable energy, reducing travel (for example, by increasing video or telephone conferencing) and improving waste management.

- Catalyse change in the rest of the NHS, as well as among individual BMA members, by advocating the use of energy experts (for example, organisations like the Carbon Trust and Envirowise) to help GP surgeries and NHS facilities work towards becoming 'carbon neutral'.

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poverty and the global water crisis. New York, UNDP WHO (2003). *Climate change and human health – risks and responses*. Geneva, WHO.

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BBC climate change portal
http://news.bbc.co.uk/1/hi/sci/tech/portal/climate_change/default.stm
Carbon Trust – the climate change challenge
http://www.carbontrust.co.uk/climatechange/climatechange/default.htm
New Scientist climate change portal
http://environment.newscientist.com/channel/earth/climate-change

Improving health for the world's poor: what can health professionals do?

Chapter 4

Practising fair and ethical trade – within the health system

Mahmood Bhutta

Introduction

Trade is one of the key engines of social and economic development. Britain's development was to a significant extent founded on its imperial control of global trade. In many instances, trade results in net benefits to all involved. Yet trade can also create or reinforce unequal, exploitative and damaging relationships between countries and communities.

Over the past few decades, the world has seen a huge expansion of trading activity catalysed in part by a global push to liberalise economies and remove trade barriers. Nevertheless, in spite of this additional trading activity, billions of people still lack basic foods and goods, and there has been a widening in inequalities between the countries of the world.

This has led to the development of the concept of 'fair and ethical trade' which makes the point that trade needs to be conducted in ways that are ethical and do not harm. As a consequence, we can now walk down the aisles of a supermarket and choose to purchase coffee and tea which is grown, processed and traded in ways that are ethical and allow for a greater sharing of the benefits of trade. Put another way, we have discovered that we can use our consumer or purchasing power to discourage the continuation of agricultural, manufacturing and mining practices that are unfair, exploitative and oppressive.

The same concept can be applied to trade in a range of medical commodities.

Fair and ethical trade of medical commodities

The NHS purchases millions of pounds worth of medical equipment and commodities every month from a variety of suppliers. What proportion of this equipment is produced in ways that adhere to basic labour and occupational health standards?

Surprisingly, there is little information on the origins of the equipment and commodities we buy. We rarely ask where equipment and commodities are manufactured and under what conditions. The suppliers certainly don't provide such information readily. However, there are examples of unethical manufacturing practices that should raise some concerns. Take for example the following case about the manufacture of surgical instruments in Pakistan.

The manufacture of surgical instruments in Pakistan

Sialkot is known as the export capital of Pakistan. With a population of about 600,000 people, it is dominated by three export industries: surgical instruments, sports goods and leather goods. Sialkot supplies two-thirds of the world's basic surgical instruments, with more than 300 manufacturing firms producing over ten thousand different types of instrument.

Production in Sialkot is labour-intensive. Over 100,000 workers are employed in the surgical instruments industry. While this provides some income for many families, there are several concerns about the way the industry is organised and run.

Health and safety standards in Sialkot. Workers are regularly exposed to metal dust, noise and toxic chemicals.

(Source: Martin Kunz, Fair Deal Trading Partnership)

Many children work in
the surgical instrument
industry in Sialkot.

To reduce overheads, most of the local firms subcontract the early processes of manufacturing to workers employed in small workshops or their own homes, before production is finalised in local factories. These sub-contracted manual labourers – who forge, file, grind, electroplate and heat during the early processes of converting raw materials into surgical instruments – are poorly remunerated, earning on average US$2 per day. None of them are salaried; they are only paid if and when they work. They are also forced to work in unsafe conditions, suffering from a high incidence of machine-related injuries, as well as exposure to toxic metal dust, noise, repetitive strain injuries and corrosive chemicals such as sulphuric acid, nitric acid and trichloroethylene.

There is also significant use of child labour. In a financially deprived situation, and without the availability of education, it can make sense for children to be in gainful employment; but, when this is cycled through generations, it prevents any upward economic migration and traps people in poverty. With the help of the International Labour Organisation, there has been a large reduction in the number of children employed in Sialkot's surgical instrument industry. However, it is estimated that up to 2,400 children are still employed in this way.

One survey of the health of children in the industry reported that 95% suffered from poor sleep and 80% from pain in the lower back, neck and shoulders. Half the children had been injured at work, for which there is neither any compensation nor financial assistance for the costs of health care.

Once the surgical instruments have been manufactured in Sialkot, most are then sold to 'middle-companies', mainly based in Tuttlingen, Germany. These companies then sell on the instruments to end-users at much higher prices. For example, a pair of surgical scissors may be sold to a German middle-company for US$1 who may then sell this on to an end-user for US$80. Often, these instruments may even be labelled as having been 'Made in Germany'.

Responding to unethical and unfair trade

Although more research is required to describe and assess the full extent and manner in which which surgical instruments used in Britain are manufactured unethically, the medical community can already begin to take some action towards the establishment of ethical purchasing policies within the health sector. In the same way that there are mechanisms for labelling the fair trade credentials of various agricultural products, the health community should lobby for similar mechanisms to be applied to surgical and medical equipment.

Efforts to establish fair trade practices for surgical and medical instruments could establish a helpful precedent. Other materials consumed in the health system could also become the focus for fair purchasing policies. For example, health services could insist on the purchase of bed linen that is derived from fair trade cotton; or the purchase of surgical gloves and urethral catheters that are manufactured from fair trade rubber.

At present, although the UK government has declared itself a key proponent of the EU framework for corporate and social responsibility and the National Health Service Purchasing and Supply Agency has stated its wish to support a sustainable development policy, concrete steps towards establishing ethical trading and purchasing policies have not been taken.

What can the BMA and other health professional organisations do?

- Commission research to further investigate whether and to what extent medical and surgical instruments used in Britain are manufactured under unethical and unsafe conditions.
- Declare support for fair and ethical trade as a concept, with particular emphasis on the purchase of surgical and medical equipment.
- Liaise with groups (such as the Fairtrade Foundation and the Ethical Trade Initiative) specialised and experienced in developing, promoting and regulating fair and ethical trade initiatives in other sectors.
- Encourage the World Health Organisation and other national medical associations to adopt ethical purchasing policies.
- Ask the NHS Purchasing and Supply Agency and individual hospital trusts to develop ethical purchasing guidelines.

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Ethical Trade Initiative http://www.ethicaltrade.org/

Fairtrade Foundation http://www.fairtrade.org.uk/

Chapter 5

Hunger and obesity side by side – malnutrition in Africa today

Mickey Chopra and Corinna Hawkes

Hunger in the midst of plenty

There is now more than enough food to feed everybody on the planet. Food production has doubled in the last 40 years and global food prices have fallen by 50 per cent and are at an all-time low. But 820 million people in developing countries remain undernourished. The number of undernourished people has declined by just three million people since the beginning of the 1990s.

By far the largest number of undernourished people live in South Asia, but it is only in Africa (and particularly Central Africa) where the number of undernourished people has actually increased. In contrast to global trends, the number of stunted children in Africa has risen since 1980, as has the proportion and number of underweight. According to UNICEF, in nearly all African countries more than 50 per cent of pre-school children have iron deficiency and more than 30 per cent suffer from Vitamin A deficiency.

Obesity amongst hunger

While hunger and micronutrient deficiency persist, the number of people who are consuming too many calories as part of an unhealthy diet (excessive sweeteners, fats, energy-dense processed foods) is also rising. In 2005 approximately 1.6 billion adults worldwide were overweight, at least 400 million of whom were obese. This is not just a developed country phenomenon. The number of people who are overweight or obese is growing rapidly in developing countries. Rates are particularly high in Latin America, but are also rising throughout Africa. In South Africa, for example, overweight and obesity is 57 per cent for women and 29 per cent for men; in urban Cameroon, rates of over 25 per cent among men and almost 50 per cent among women have been reported.

A public health crisis

This 'double burden of malnutrition' represents a public health crisis. Whereas in the United Kingdom the phenomenon of widespread hunger was gradually replaced by the current epidemic of obesity, Africa is bearing the burden of both at the same time, with severe consequences for the health of the continent.

Under-nutrition is the leading cause of premature mortality in sub-Saharan Africa. Under-nutrition and micronutrient deficiencies are linked with poor immunity and high rates of infections, including diarrhoea, pneumonia, measles and malaria. It is estimated that under-nutrition is an underlying cause of more than 55 per cent of infant deaths in Africa. Children who have been provided with nutrition supplements are more than 30 per cent less likely to have episodes of diarrhoea or pneumonia.

At the other extreme, obesity is a leading risk factor for chronic conditions, such as heart disease, diabetes and cancers. These diseases require long-term care and are extremely expensive to treat.

Poor people with chronic diseases often lack treatment: research in South Africa has shown that among people with high blood pressure, the wealthiest 30 per cent of the population were more than twice as likely to have received treatment as the poorest 40 per cent.

And just because people consume sufficient energy does not mean they have sufficient micronutrient intake: food-related anaemia is still a problem in overweight/obese women. There are in fact further links between under- and over-nutrition: low birth-weight and stunting followed by rapid growth increases the risk of obesity in adulthood; inadequate micronutrient consumption is associated with several chronic diseases; and obese adults and stunted children can be found in the same households.

What is causing this double burden?

Poverty and other underlying causes
Poverty is a widely recognised cause of under-nutrition. The poor are more likely to be born with low birth-weight to mothers who are undernourished, and are less likely to receive energy-rich complementary food or iodised salt. Poorer children also live in environments that predispose them to illness and death. They are less likely to live in households with safe water or sanitation and more likely to be exposed to indoor air pollution – a result of the greater reliance on burning coal and biomass fuel (such as wood and animal dung) for cooking and heating, coupled with inadequate ventilation.

But tackling under-nutrition is not solely a function of poverty reduction: under-nutrition has declined in countries with varying declines in poverty levels. Countries in Asia with similar levels of poverty in the 1970s and similar economic growth rates over subsequent decades have experienced different declines in under-nutrition: Sri Lanka and Thailand showed rapid improvement, Indonesia showed slower but consistent improvement, and the Philippines little progress. In Latin America, under-nutrition affected an estimated 21 per cent of the region's population in 1970, declining to 7.2 per cent by 1997, while the rate of poverty (measured by income level) decreased only slightly from 45 per cent to 44 per cent. Differences in childcaring practices, access to basic health services and women's status relative to men have been cited as reasons for these improvements (box 5.1).

Box 5.1 Breastfeeding to beat malnutrition
An example of a childcare practice that promotes nutrition is exclusive breastfeeding (i.e. where the infant is given nothing but breastmilk and any prescribed medication). This is a crucial 'vaccine' for babies, especially those born in Africa. Young infants who are not fed this way have a seven-fold and five-fold increased risk of death from diarrhoea and pneumonia respectively. The benefits of breastfeeding and the negative effects of artificial feeding in poverty-stricken environments led to the development of the International Code of Marketing of Breastmilk Substitutes. The Code prohibits the marketing of infant foods, teats and bottles in ways that could interfere with breastfeeding. Rates of exclusive breastfeeding are low (less than 10 per cent) in many African countries. However, in countries such as Ghana, where there has been investment in enforcing the Code and promoting exclusive breastfeeding, rates have been rising.

Access to functioning primary health care systems is particularly important for preventing and treating infections like measles that cause poor nutritional status. Access to health care also strengthens nutritional practices as it enables children's growth to be monitored. Unfortunately many children do not have access to even these most basic of services. Immunisation coverage, a good proxy for access to primary care services, has been stagnating at sub-optimal levels in most African countries and actually falling in others over the last 15 years. There is concern that new resources for conditions such as HIV and TB (where a lot of the interventions are hospital-based or in separate facilities) will take even more staff away from primary care activities.

In the village of Affe in northern Senegal, community health worker Ndeye Sock discusses feeding habits with a mother, Atta Diaw Niang, to agree on ways to increase the weight of her child

Source:
B. Niang/BASICS/USAID

Women's status in society is associated with child nutritional outcomes in sub-Saharan Africa. It has been estimated by the International Food Policy Research Institute that, if women and men enjoyed equal status, child under-nutrition in the region would decrease by nearly 3 per cent – a reduction of 1.7 million malnourished children under three. This is because higher status leads to improved nutrition among women, better prenatal and birthing care for women, healthier complementary feeding practices, and higher quality of substitute child caretakers.

Other, broader determinants of nutrition such as warfare, political instability and HIV/AIDS are especially important in Africa. Countries with experience of war and political instability like Burundi, Eritrea and Ethiopia have tended to suffer disproportionately high rates of hunger. In these countries, warfare has affected macroeconomic performance and basic livelihoods, and hunger is even used as a weapon: combatants have cut off food supplies and hijacked food aid. High HIV/AIDS infection rates are also associated with high rates of hunger in Africa. Women and girls are hit hardest by HIV/AIDS due to greater social and biological vulnerability to infection, with negative consequences for childcaring practices, and thus nutrition.

The role of food systems

Understanding the role of the food system (i.e. the interdependent processes of producing, distributing and consuming food) is critical if we are to make sense of the current situation in Africa and elsewhere. In sub-Saharan Africa, more than three-quarters of hungry people live in rural communities. One-third live in rural, non-farm households such as those dependent on herding, fishing or forestry. One in every two suffering from hunger are in farm households on marginal lands, where environmental degradation threatens agricultural production.

Lack of agricultural development

Communities with high levels of under-nutrition are characterised by inadequate agricultural development: according to the Food and Agriculture Organisation of the United Nations (FAO), there is a strong correlation between increased agricultural productivity and reductions in the number of undernourished. Agriculture not only provides food, but is a livelihood for many rural people. More resources devoted to agricultural development, directed at small farmers and landless people, mean more opportunities for improved nutrition.

Yet agricultural growth rates have been low in Africa compared to other regions, and the situation for many in rural Africa is worsening: poor fishing communities are seeing their catches reduced by commercial fishing; foresters are losing their rights as logging companies move in under government concessions. Average land per capita among rural farmers in developing countries declined from 3.6 hectares in 1972 to 0.26 hectares in 1992 – and is likely to fall further by 2020. The situation for female headed households is even worse. And landlessness is rising in most rural regions of Africa because of higher farming densities and unequal land distribution.

Impact of globalisation

Whilst national policies to shore up rural development are important, it is also clear that agriculture in sub-Saharan Africa has suffered in the face of global competition and international trade policies. World market prices for traditional exports, such as cotton and coffee, have fallen in recent years, and subsidy programmes for farmers in the developed world have flooded Africa with cheap imports, pushing African producers out of business.

As a solution, African countries are now being advised to enter the global agricultural marketplace in so-called 'non-traditional' exports, such as fruits, flowers and vegetables. The market for horticultural exports from Africa is growing rapidly, many of them destined for the United Kingdom. For example, exports of horticultural products from Kenya have grown at over six per cent per year for the past 30 years. And British consumers now spend over £1 million every day on fruits and vegetables exported from sub-Saharan Africa, providing income that supports the livelihoods of over a million people and injects an estimated £200 million into rural economies in Africa. But conditions of work can be very poor, especially for women. And even if these exports generate greater income, it is not necessarily accompanied by better nutrition, given the importance of complementary measures such as caring practices as well as access to health systems. Governments need to ensure that increasing incomes in these communities are converted into better nutrition.

Deterioration of African agriculture is also leading to rapid urbanisation, which creates conditions in which people are exposed to new products, technologies, and unhealthy goods spread by globalisation and the transnational companies that help drive it (box 5.2). People are also adopting less physically active types of employment, and unplanned urban sprawl can further reduce physical activity levels by discouraging walking or cycling. For example, in the Gambia, rural livelihoods have become virtually unsustainable following the collapse of groundnuts as a cash

crop owing to foreign competition. This has encouraged population drift to urban centres. Sedentary occupations and high-fat diets are causing burgeoning obesity in the cities. Even in remote rural areas remittance payments from those in the city or abroad have increased purchasing power, and cheap imported vegetable oils are an important commodity in local shops. Obesity is now rapidly spreading throughout the Gambian countryside, bringing with it a new burden of debilitating and costly chronic diseases. Throughout sub-Saharan Africa, case-specific mortality rates from diabetes are higher than in the United Kingdom.

Box 5.2 Transnational companies and obesity
Transnational companies dominate world food production. While these companies often bring much needed investment to sub-Saharan Africa, they are also introducing new foods and new ways of eating. Coca-Cola, for example, is the largest consumer goods provider in Africa. Annual per capita consumption of Coca-Cola drinks in Africa doubled between 1986 and 2006, with particularly strong growth in countries such as South Africa and Nigeria. Under the premise that 'great marketing works' the company utilises a wide variety of advertising techniques to encourage consumption, just as it does in the United Kingdom and elsewhere. But, the market for carbonated soft drinks is declining in the developed world owing to health concerns, just as these companies are looking more and more to Africa as a source of revenue growth. The aim is to entrench new dietary habits that will last for generations.

Addressing the double burden of malnutrition in Africa is going to take concerted action. Interventions are needed that tackle the immediate and broader causes of malnutrition. Dietary behaviours, health systems and food systems all need to be oriented towards reducing the double burden of malnutrition in Africa.

What can the BMA and other health professional organisations do?

Lobby the British government and international organisations like WHO to:
• invest in the monitoring and improvement of nutritional status in developing countries
• ensure that companies adhere to the International Code of Marketing of Breastmilk Substitutes.

Work with donor agencies (such as DfID) to:
• improve nutrition in rural Africa though agricultural development; there should be a particular incentive to improve nutrition in communities which export food to the UK
• support health systems development in sub-Saharan Africa.

Work with governments and civil society in Africa and the UK to:
• apply the lessons learned in addressing obesity and chronic diseases in the UK to prevention and control efforts in developing countries
• discourage British food business from promoting unhealthy diets abroad.

Promote wider understanding in Britain about the nature of nutritional problems in developing countries by providing information to their members about:
• micronutrient deficiencies as a cause of ill-health (acute famine is not the only problem)
• overweight and obesity as an emerging health problem.

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Chapter 6

Tobacco control in developing and developed countries

George Roycroft

The adverse health consequences of tobacco

Tobacco consumption is a significant cause of morbidity and is the leading preventable cause of premature death worldwide. Smoking causes a wide range of fatal illnesses including cancers, cardiovascular diseases and respiratory diseases, and is now known to contribute to numerous other adverse health effects such as cataracts, abdominal aortic aneurysm, low bone density, peptic ulcer disease, low birth weight, foetal death and still birth. A 2002 report by the World Health Organisation (WHO) showed that exposure to secondhand smoke – which is the smoke exhaled by smokers and smoke that is emitted from the burning end of a cigarette, pipe or cigar – causes premature death and disease in children and adults who do not smoke. The US National Cancer Institute has also shown that the use of smokeless tobacco products (including snuff and chewing tobacco) is associated with numerous serious health problems including cancers (eg oral); tooth decay and gum disease; stillbirth, low birth weight and pre-eclampsia; cardiovascular risks and diabetic complications.

The global tobacco epidemic

There are approximately 1.3 billion smokers worldwide of which 84 per cent live in low- and middle-income countries. As a result of the increasing global adult population, the number of smokers is expected to reach 1.6 billion by 2025. Since the 1970s there has been an overall decline in per capita cigarette consumption in high-income countries and a concurrent increase in low- and middle-income countries. However, while the prevalence of smoking among men in high-income countries has declined over this period, the proportion of young women and teenagers who smoke has increased in these countries. The prevalence of smoking among men in low- and middle-income countries has increased significantly since the 1970s. The WHO and the World Bank estimate that if current global trends in tobacco consumption continue, the number of deaths attributable to tobacco each year will exceed 10 million by 2020, and 70 per cent of these will occur in developing countries. This will pose significant challenges to economic and public health progress in the developing world.

Tobacco control – an international perspective

The increased consumption in developing countries is the result of a lack of effective tobacco control polices. This has been exacerbated by the liberalisation of the tobacco control regulatory framework following the introduction of international trade agreements. The removal of trade barriers has significantly increased tobacco use as a result of greater competition caused by lower pricing, greater advertising and promotion, and other activities that stimulate demand. The shift of the global tobacco epidemic to developing countries has also been fundamentally shaped by the activities of the tobacco industry (Yach and Bettcher). The introduction of more stringent tobacco control policies in developed countries has increased the focus of the tobacco industry on emerging markets in developing countries where regulation is less strict and where sales are continuing to rise. As the WHO noted in the World Health Report 2002, this has resulted in

increased activity by the tobacco companies in Eastern Europe, Asia-Pacific, Latin America, Arab nations and Africa. Researchers have shown how the tobacco industry has continued to use strategies to protect its interests that include denial of the health impact of active and passive smoking (Francey and Chapman, Glantz et al.), manipulation of tobacco products including the use of additives that increase the addictiveness of cigarettes (Kessler), non-disclosure of the content of their products (Bates et al.), and resistance to regulation (Yach and Bettcher).

A boy in Senegal examines a cigarette packet.

Source: GLOBALink

The implementation of comprehensive tobacco control polices is a vital public health measure. Successful tobacco control programmes are backed up by strong legislation and strictly enforced. They employ a mix of approaches that regulate the demand and supply of tobacco products including taxation, health promotion, bans on advertising and promotion, smoking restrictions, the provision of smoking cessation services, restrictions on access, and taking action on smuggling. These approaches have been shown to be effective at reducing tobacco-related morbidity and mortality when used in combination. The implementation of tobacco control polices are a cost-effective way to save lives and benefit the economy. The World Bank has consistently shown that tobacco control policies do not affect government revenues in the short- or medium-term. By contrast, the global health-care costs resulting from tobacco use have been estimated to exceed US$200 billion per year, of which one-third fall on developing countries (Barnum). To avoid the high economic cost of increased tobacco consumption, it is essential that governments in developing countries take action to implement comprehensive tobacco control policies that offset efforts by the tobacco industry to promote future tobacco use.

In 2005, World No
Tobacco day emphasised
the importance of health
professionals in providing
information and
guidance on questions
about tobacco use

Source: WHO

National and regional stakeholder organisations such as health professional organisations (HPOs), health groups, dedicated anti-smoking groups and other non-governmental organisations (NGOs) have a key role in lobbying for, promoting and supporting national tobacco control programmes. HPOs, in partnership with other stakeholder organisations, can support the introduction of effective tobacco control policies by disseminating relevant information, implementing media campaigns, responding to consultations, supporting national and international initiatives (such as World No Tobacco Day), and lobbying government departments. The lack of adequate funding, expertise and resources for tobacco control in the developing world means that it is essential that HPOs and other groups in developed countries support the efforts of their counterparts. Health professionals are uniquely placed to complement national tobacco control policies by informing their patients about the adverse health impacts of tobacco use, providing opportunistic interventions to support them in stopping smoking, and acting as champions for smoking cessation and smoke-free places in the community. It is important that HPOs support their members in doing this by recognising the importance of individual action by health professionals, and disseminating evidence-based research and reference materials.

Effective regulation at an international level is equally important to ensure the success of national tobacco control policies and to address cross-border factors (eg smuggling and trans-national tobacco company advertising) that influence tobacco use internationally. The introduction of the Framework Convention on Tobacco Control (FCTC) by the WHO in February 2005 has provided renewed impetus in this area. The FCTC is a legally binding treaty which was negotiated by the 192 member states of the WHO. It commits governments to reducing the burden of tobacco-related morbidity and mortality. The treaty incorporates a range of measures designed to reduce the devastating health and economic impacts of tobacco and provides the basic tools for countries to enact comprehensive tobacco control legislation. The key provisions set out by the treaty are aimed at encouraging countries to:
- enact comprehensive bans on tobacco advertising, promotion and sponsorship
- obligate the placement of rotating health warnings on tobacco packaging that cover at least 30 per cent (but ideally 50 percent or more) of the principal display areas and can include pictures or pictograms
- ban the use of misleading and deceptive terms such as "light" and "mild"
- protect citizens from exposure to tobacco smoke in workplaces, public transport and indoor public places
- combat smuggling, including the placing of final destination markings on packs
- increase tobacco taxes.

The FCTC encompasses additional measures such as mandating the disclosure of ingredients in tobacco products, providing smoking cessation services, encouraging legal action against the tobacco industry, and promoting research and the exchange of information among countries. The treaty is an important first step to effective international tobacco control as it co-ordinates international, national and regional efforts; facilitates the sharing of research and expertise; prioritises tobacco control within governments; and raises public awareness. While the FCTC is legally binding on countries that ratify the treaty, the onus is on national governments to implement the framework conventions and protocols. The UK government signed up to the FCTC in 2003 and box 6.1 shows the main focus of its tobacco control policies to date.

Box 6.1   Tobacco control in the United Kingdom

Smoking prevalence and tobacco consumption has declined steadily in the UK over the last two decades with the proportion of adults aged over 16 who smoke cigarettes falling from 45 per cent in 1974 to 24 per cent in 2005. Following adoption of the FCTC in June 2003, tobacco control policies in the UK have focused on:

- Reducing exposure to second hand smoke through smoke-free legislation. Comprehensive smoke-free legislation prohibiting smoking in enclosed public places and workplaces is due to be implemented in England on 1 July 2007, and was introduced in Wales, Northern Ireland and Scotland on 2 April 2007, 30 April 2007 and 26 March 2006 respectively.

- Regulating tobacco products. The Tobacco Products (Manufacture, Presentation and Sale) (Safety) Regulations 2002 introduced the requirement for larger, hard-hitting health warnings on tobacco packs in the UK, and prohibited misleading terms such as "low-tar", "mild" and "light" from tobacco packs. The regulations also set new requirements for the maximum yields of tar, carbon monoxide and nicotine in cigarettes. Further changes will see the introduction of pictorial warnings on tobacco products and the minimum age of sale for tobacco will be raised from 16 to 18 from 1 October 2007.

- Reducing availability of tobacco products and regulating supply. HM Revenues and Customs department introduced several measures to tackle trade in smuggled cigarettes in its 2000 Tackling Tobacco Smuggling strategy including prominent fiscal marks on packs, increased punishment for those caught smuggling products and increased numbers of enforcement agents.

- Tobacco media/education campaigns. Several campaigns involving advertising, PR and direct marketing have been run in the UK (for example, the 'get unhooked' campaign) aimed at motivating smokers to quit and educating the public about the dangers of smoking and second hand smoke.

- The provision of smoking cessation services. In response to the 1998 White Paper Smoking Kills, comprehensive smoking cessation services are now provided on the UK National Health Service (NHS). Stop smoking aids such as Nicotine Replacement Therapy (NRT) and bupropion have also been made available on prescription on the NHS.

- Reducing tobacco advertising and promotion. The introduction of the Tobacco Advertising and Promotion Act 2002 prohibits the advertising and promotion of tobacco products in the UK, including sponsorship. Separate regulations also prohibit brand-sharing (i.e. the promotion of a tobacco product by another product or vice versa).

It is important that national and regional stakeholder organisations, including national medical associations, lobby and support governments in implementing the FCTC. To assist implementation of the FCTC, HPOs and other relevant organisations in developed countries should share information, resources and expertise on tobacco control policies and health promotion practices with their counterparts in the developing world.

The BMA and tobacco control

The BMA has long been involved in tobacco control and has published a number of reports in this area. The harmful effects of active and passive smoking on children and on the reproductive system are examined in *Breaking the cycle of children's exposure to tobacco smoke* and *Smoking and reproductive life*. The BMA called for the introduction of smoke free legislation in the UK in *Towards smoke free public places* which examines the health risks associated with smoking in public places and makes evidence-based recommendations for measures to protect public health. This was followed by *The human cost of tobacco* which sets out doctors' individual stories of the devastating effects of second-hand smoke; and *Behind the smokescreen: the myths and the facts* which challenges the arguments of those opposed to smoke free legislation.

Leading by example, smoking has been prohibited at all BMA meetings since 1984 and has been banned on all BMA premises. Between 1997 and 2006, the BMA ran the Tobacco Control Resource Centre (TCRC) which worked in partnership with national medical associations across Europe to promote tobacco control, supporting them in their efforts to help patients, educate their members and inform public policy with respect to tobacco. The BMA Science and Education Department maintains a lead role in the work of the BMA on tobacco control by responding to external consultations and working closely with the BMA press and parliamentary units in lobbying the UK government.

Recommendations

What can the BMA and other health professional organisations do?

Health professional organisations in developed countries can support smoking cessation in countries in the developing world by:

- forming links with HPOs in developing countries to share knowledge, resources and expertise on tobacco control

- supporting HPOs in developing countries in lobbying their respective governments, and international bodies, to promote the introduction of comprehensive tobacco control policies that are regularly monitored and strictly enforced. These policies should be in line with the Framework Convention on Tobacco Control (FCTC) and include:
    - comprehensive bans on smoking in work places and public places
    - increased taxation on tobacco and tobacco products
    - bans on the advertising and promotion of tobacco and tobacco products
    - health warnings on all tobacco products
    - increasing the minimum age of purchase for tobacco and tobacco products
    - action on smuggling of tobacco and tobacco products
    - comprehensive provision of smoking cessation services.

HPOs in all countries should promote a nationwide tobacco-free culture by:

• Setting a public example by making their own organisations, or the organisations in which they work, tobacco-free.

• Supporting and publicly endorsing national and international anti-tobacco campaigns (such as World No Tobacco Day).

• Supporting the introduction of effective tobacco control policies. Adopting and publicising relevant evidence-based policies on tobacco use and regulation through statements and declarations. Working in partnership with other stakeholder organisations, responding to relevant consultations, implementing media campaigns, and providing information to counter the arguments presented by organisations against the introduction of tobacco control policies.

• Supporting and encouraging their members to promote tobacco control initiatives and smoking cessation. Providing up to date information on smoking cessation and the adverse health impacts of the use of tobacco through the production and dissemination of appropriate reference materials and resources.

What can individual health professionals do?
Health professionals should support national tobacco control initiatives and act as community champions for smoking cessation by promoting smoke-free workplaces and public places in their community. They should stop smoking themselves and ensure their premises are smoke-free.

Health professionals also have a responsibility to:
• Inform their patients of the adverse health impacts of tobacco use. Advise on the health risks associated with smoking and exposure to second-hand smoke as well as the risks associated with the use of other forms of tobacco product (eg smokeless tobacco).

• Help their patients to stop smoking. Providing opportunistic interventions as well as support and advice on how to quit, prescribing appropriate treatment such as nicotine replacement therapy (NRT), and referring them to specialist smoking cessation services where necessary and available.

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Useful websites

Framework Convention on Tobacco Control: http://www.fctc.org

Tobacco Control Resource Centre publications are available at http://www.doctorsandtobacco.org

Chapter 7

Patents, poverty and PPPs – fairer ways of solving the medicines crisis

Martin Carroll

Introduction

Millions of people throughout the world have no access to the essential medicines they need. Several factors contribute to this unacceptable situation including poor healthcare systems, shortages of healthcare workers, and weak transport infrastructure. This chapter is concerned with two further reasons:

- the inadequate financing of research and development (R&D) into a variety of "neglected diseases"
- the impact of patents, and the World Trade Organisation's (WTO) Agreement on Trade Related Aspects of Intellectual Property Rights (TRIPS) on the price of medicines.

Research and development for neglected diseases: new hope to halt the neglect?

In a globalised world, it may come as something of a shock to learn that, until the onset of the Millennium, effective treatments for 90% of the world's global disease burden were generally unavailable. This situation persisted for so long that the WHO drew up a list of ten "neglected diseases": malaria, tuberculosis, leishmaniasis, schistosomiasis, onchocerciasis, lymphatic filariasis, Chagas disease, leprosy, African trypanosomiasis and dengue. Many of these diseases are only found in low-income, tropical countries. Often, medicines, if they were available, were priced beyond the means of the people who needed them most, or were highly toxic.

The reasons lie in a combination of market forces and a lack of funding. Drug companies are unwilling to invest in 'uncommercial' markets where it is hard to make profits. On top of this, a lack of government commitment, and in the poorest countries that are most afflicted by these diseases, an absolute shortage of public funds has made it almost impossible to sustain sufficient levels of funding for more effective therapies. Box 7.1 shows how this has affected the availability of treatment for two of the diseases from the WHO list.

A 19-year-old recent mother lies dying from late-stage African trypanosomiasis and adverse reactions to melarsoprol. She is being attended to by her mother who waits constantly by her bedside.

Source WHO/TDR

Acute Chagas disease in a child.

Source: WHO/TDR

> **Box 7.1   Neglected diseases: Chagas disease and sleeping sickness**
>
> Chagas disease is endemic to Latin America. It is caused by the parasite *Trypanosoma cruzi*, and kills about 50,000 people every year from the chronic complications of the illness. The acute phase, which is treatable, largely goes unnoticed leaving many to go on to develop fatal chronic complications such as congestive cardiac failure. Currently, there is not a good diagnostic test for the acute phase of the illness, nor any effective treatment once the acute phase has passed.
>
> African sleeping sickness (African trypanosomiasis) is transmitted by the tsetse fly in many countries in sub-Saharan Africa. It kills up to 60,000 people every year. Current treatment with melarsoprol is so toxic that it kills one in 20 people. Another drug, eflornithine, is less toxic but costly and has to be administered intravenously every six hours over 14 days. Production of this drug was actually halted a few years ago because it was unaffordable to African countries and hence unprofitable to manufacture. However, production restarted when eflornithine was found to remove women's facial hair – a more profitable market. Ensuing publicity led pharmaceutical companies in 2001 to make a large scale donation of the drug as part of an agreement with the WHO.

This situation was common for many of the diseases on the WHO list. The implications for neglected diseases were devastating: of the 1,393 new chemical entities marketed between 1975 and 1999, only 16 were for tropical diseases and tuberculosis. In many cases, the only drugs available for the treatment of these diseases had been in use for decades, their efficacy gradually declining in the face of new strains of the diseases they were designed to cure.

Since 2000, however, there have been changes in the way R&D for these diseases has been approached and managed. Public health-driven, not-for-profit organisations have begun to work with industry groups to drive drug development and reverse decades of neglect. Research funded by the Wellcome Trust in 2005 demonstrated that these public-private partnerships (PPPs) were emerging as key players at almost every stage of the drug development process, from clinical trials to drug implementation. Evaluating the performance of PPPs alongside that of public groups and the pharmaceutical industry working alone, the research also found that PPPs could be efficient and develop new medicines – often the result of breakthrough innovation – which were more affordable to poor countries. PPPs manage and enable drug development but do not actually develop the drugs. Instead, PPPs secure public and private sector funding and determine their portfolio of work on the basis of public health impact. This enables them to manage several projects at one time.

Several of the small number of PPPs have gone from strength to strength. The Medicines for Malaria Venture (MMV) currently has five combination drugs already in human clinical trials, a significant improvement from six years ago, when antimalarial drug development was virtually at a standstill. Similarly, the Drugs for Neglected Diseases initiative (DNDi), a collaboration of seven research laboratories from around the world, financed by many different organisations, including Médecins sans Frontières, has developed a new low-cost combination treatment for malaria which it is now manufacturing and distributing with the help of the drug company, Sanofi.

Yet, despite the successes of MMV and DNDi, sponsorship for PPPs has been slow in coming. It has been estimated that there is a £1 billion funding shortfall in the R&D pipeline for neglected diseases.

Other possible innovations are being proposed. For example, prize funds would provide financial rewards to companies who develop new treatments or vaccines for diseases that affect millions. Patent pooling is another potential approach. This occurs when a number of patent rights held by different owners are brought together and collectively managed. A patent pool for essential medicines would provide a 'one stop shop' to manage patents and grant licenses. Originator drug companies would submit their patents to 'the pool' in return for a capped royalty. The pool would then provide licences to manufacturers to produce generic versions of their products. In 2006, the World Health Assembly established an Intergovernmental Working Group to devise a global strategy and action plan for needs-driven health research, which is discussing these types of ideas.

Patents, trade agreements and TRIPS

The new round of discussions within the WHO could also be seen as an attempt to reconcile opposing interests in access to medicines for the poor: the call for drug development to be driven by health needs (which lies at the heart of the PPP approach), and the limitations imposed on access by market forces and intellectual property legislation.

Patents traditionally have been used to reward inventors by giving them control of the manufacture and sale of their inventions. In recent years, the scope of patents has however been expanded. They increasingly cover various aspects and elements of the natural world (e.g. DNA and plant material) as well as ideas (intellectual property). The period of time allocated to patent protection has also been progressively lengthened. These developments represent a profound transformation of patterns of ownership and scientific endeavour within society, with major implications for medical research into the treatment of disease.

In 1995, the WTO began the process of standardising intellectual property legislation across all countries. TRIPS (the Agreement on Trade-Related aspects of Intellectual Property Rights) extended the period of patent protection to 20 years. Medicines were incorporated into this new intellectual property regime. This means that originator drug companies – those that develop a new medicine – have the exclusive right to produce a new drug for 20 years. A staggered timetable was adopted for the implementation of TRIPS: rich countries had to comply immediately, most other countries in 2006, and the Least Developed Countries in 2016.

Prior to TRIPS, individual countries could formulate their own patent laws. Countries without strict patent laws gave drug manufacturers some freedom to make generic versions of medicines that were under patent elsewhere. This allowed India, for example, to produce generic versions of first line antiretroviral drugs, which were under patent in the UK and US. This enabled patients with HIV/AIDS to be treated at a fraction of the cost.

The enforcement of TRIPS in countries such as India and Thailand has made it much more difficult for them to continue with more cost-effective approaches to treating patients. There remains considerable disagreement over whether or not the current globalised intellectual property regime provides an effective framework for balancing commercial interests against public health needs, or a fair playing field for governments, corporations, and citizens to interact with each other. These tensions are currently being played out in a number of disputes across the world, including two high-profile disputes in India and Thailand (box 7.2).

Box 7.2   The struggle for accessible medicines in India and Thailand

India: As India was not required to implement TRIPS until 2005, those drugs that were patented between 1995 and 2005 were held in a 'mailbox' for the Indian patent office to review once TRIPS was officially implemented. When India introduced its new patent law it included a clause stating that patents would only be granted to drugs which were new compounds, including those in the mailbox. The drug company Novartis is taking the Indian Patent Office to court because the office would not issue a patent for the Novartis anti-cancer drug Gleevec (imatinib mesylate) as it did not judge this drug to be a new compound. Almost a quarter of a million people have signed a petition asking Novartis to drop the case.

Last year, GlaxoSmithKline (GSK) found itself in a similar position when the Indian Patent Office refused to grant a patent for the drug Combivir – a fixed dose combination of two existing drugs: zidovudine and lamivudine. Large protests by patient and treatment advocacy groups outside the GSK offices in Bangkok and in Bangalore, India, urged the company to withdraw the Combid/Combivir patent applications and forced GSK to back down.

Thailand: The Thai Government is working very hard to provide universal access to ARVs to all those who need it. Many people now need to switch to second line treatment, as first line treatment is no longer working. In order to provide second line treatment at affordable prices, Thailand recently issued a compulsory licence for the second line drug Kaletra (lopinavir/ritonavir), produced by Abbott. Abbott has responded by declining to register any new drugs in Thailand.

The TRIPS agreement does contain a number of 'flexibilities' that provide low and middle income countries with mechanisms to continue to produce or import cheaper, generic versions of patented medicines that are considered essential. These flexibilities include giving governments the right to issue compulsory licenses to drug companies to manufacture patented medicines, but only for domestic use. If a country does not have a local drug manufacturing industry, there are mechanisms within the flexibilities to allow it to import generic medicines from other countries.

However, these flexibilities have been rendered less flexible by the protracted procedures needed to implement them. In recent years, drug companies have successfully lobbied the US and European governments to insert additional intellectual property rights into bilateral and regional free trade agreements or into European 'partnership agreements'. These have come to be known as TRIPS-plus agreements. The Central American Free Trade Agreement (CAFTA) is one example of TRIPS-plus in action. The CAFTA prolongs patent periods for up to 5 years, and also grants 'data exclusivity' to drug companies for a certain number of years. This means that even after a patent has ended, generic manufacturers are prevented from accessing clinical safety data from the originator drug company (which they are allowed to do within TRIPS) and have to produce their own safety data before being allowed to market their own generic brands. This not only delays the introduction of the generic drugs into the market, but also causes inefficiency (by forcing generic manufacturers to repeat clinical safety trials) and threatens the economic viability of generic drug companies.

Access to medicines: what does the future hold?

In 2003, the BMA lobbied the UK delegation to the 5th WTO Ministerial Conference in Cancún, highlighting concerns expressed by its members about the restrictions imposed by TRIPS on access to medicines in poor countries. It also called for a full review of TRIPS provisions. This did not happen for, as is well known, the Cancún talks broke down in acrimony due to disagreements between rich and poor countries. Attempts by successive Ministerial Conferences to end the deadlock have largely met with failure and the situation looks unlikely to change in the near future. Without the prospect of a full resumption of the trade talks, the difficulties surrounding the agreement on intellectual property rights look set to remain for some time yet. In the meantime, there are encouraging signs. PPPs are playing a small but valuable role in developing drugs for a range of diseases affecting the world's poor. With more funding support, they will be able to reach more people. At the same time, the ongoing discussions within WHO on a global strategy for needs-driven research and development promises to expand the possibilities even further and put the health needs of developing countries at the centre of policy debate.

What can the BMA and other health professional organisations do?

- Educate and inform the medical profession about patents, TRIPS and trade agreements and their impacts upon the efficiency of pharmaceutical R&D, and the price of medicines.
- Renew calls for a review of TRIPS when WTO trade talks are resumed.
- Lobby the UK Government to strongly support the ongoing work within WHO to establish a global strategy for needs-driven health research and development.
- Highlight the health value of PPPs and urge governments to increase their funding of PPPs for the research, development, production and sustainable financing of new medicines for the poor.
- Call on the UK Government to withdraw its support for any TRIPS-plus clauses within European Partnership Agreements.
- Monitor the disputes between drug companies, governments and citizens in India and Thailand with a view to establishing an impartial and independent position.

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Chapter 8

A crisis of leadership – does the WHO run global health?

David McCoy

Today's global health challenges

The task of governing global health has never been so important. The threat of lethal global pandemics, the movement of health workers between countries, the proliferation of new global health initiatives and partnerships, the impact of international trade agreements on health care, climate change, and the continued impoverishment of countries and billions of people within an integrated global economy are all issues that highlight the need for effective public health leadership at the global level.

This is particularly true for the poorest countries which not only suffer from high burdens of disease and low levels of financial, technical and human resources, but also from their weak position within an often hostile international political and economic environment.

The world is shrinking and societies have become ever more interdependent. But, as socio-economic disparities deepen and become more visible, aggravating cultural, racial and religious tensions, global public health leadership offers a mechanism to foster peace, stability, justice and well-being for all, in rich and poor countries alike.

Indeed, one of the most consistent messages from campaigning groups is that the negative effects of globalisation need to be counter-balanced by a stronger social and developmental framework within which access to essential health care is realised for all.

UK health professionals and global health governance

Doctors, nurses and other health professionals have historically played important roles not just as healers of individual bodies and minds, but also as agents of social change, helping with the evolution of more civilised, healthy and just societies. This tradition of progressive 'medical-social activism' now needs to be applied at the level of global governance.

In 2004, the UN-sponsored World Commission on the Social Dimension of Globalisation highlighted the need for civil society to shape globalisation by raising public awareness, undertaking research, mobilising public opinion, strengthening democratic accountability and mobilising national support for global reform measures. The Commission suggested that scientists and physicians should play their part in these tasks. Organisations such as the BMA were thereby challenged to become a constituent part of global civil society.

Lord Crisp's recent report on global health partnerships argued that the NHS should play a pro-active role in supporting health improvements in poor countries. This chapter argues that the health community should also help improve the effectiveness of global health governance.

The World Health Assembly is the supreme decision-making body for the WHO. It meets once a year and is attended by delegations from all of the WHO's 192 Member States.

Source: WHO

Who leads global health?

Established in 1948, the World Health Organisation (WHO) is one of the specialised agencies of the United Nations. Its Constitution provides it with a broad and important set of international functions – from disease surveillance and strengthening health systems to the promotion of public health and international standards for food, pharmaceuticals and biological agents.

The WHO has been regarded by many as one of the more trusted and effective of the UN institutions. For many health workers it is an unrivalled source of objective, evidence-based health information. It helped devise the concept of the essential drugs list and promoted breastfeeding in the face of the powerful marketing of infant formula. Its leadership role in the eradication of smallpox and the development of the Alma Ata Declaration on Primary Health Care is frequently lauded (box 8.1). More recently the WHO steered the development of a Framework Convention for Tobacco Control and pushed countries to update regulations aimed at ensuring effective international cooperation on the surveillance and control of infectious disease epidemics.

> **Box 8.1 Articles from the Alma Ata Declaration on Primary Health Care (1978)**
>
> **II:** The existing gross inequality in the health status of the people particularly between developed and developing countries as well as within countries is politically, socially and economically unacceptable and is, therefore, of common concern to all countries.
>
> **III:** Economic and social development, based on a New International Economic Order, is of basic importance to the fullest attainment of health for all and to the reduction of the gap between the health status of the developing and developed countries. The promotion and protection of the health of the people is essential to sustained economic and social development and contributes to a better quality of life and to world peace.
>
> **VI:** Primary health care is essential health care based on practical, scientifically sound and socially-acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community.
>
> **IX:** All countries should cooperate in a spirit of partnership and service to ensure primary health care for all people since the attainment of health by people in any one country directly concerns and benefits every other country.
>
> **X:** An acceptable level of health for all the people of the world by the year 2000 can be attained through a fuller and better use of the world's resources, a considerable part of which is now spent on armaments and military conflicts. A genuine policy of independence, peace, détente and disarmament could and should release additional resources that could well be devoted to peaceful aims and in particular to the acceleration of social and economic development of which primary health care, as an essential part, should be allotted its proper share.

However, while it continues to be an institution of enormous importance, all is not well with the WHO. Over the past 20 years, the Organisation has suffered a number of blows to its confidence, capacity and credibility.

The entry of the World Bank into the health sector and its ability to make large amounts of finance available to poor countries soon resulted in the WHO becoming a junior partner when it came to supporting health improvement in developing countries. Donors lost interest in the WHO's broad vision of public health, and started to put funding into immunisation and other disease control programmes whose success could be measured more easily.

Since the beginning of the century, the global health landscape has been transformed again. A bewildering array of new initiatives and partnerships, including President Bush's Emergency Fund for AIDS Relief, the Global Fund to Fight AIDS, TB and Malaria and the Global Alliance for Vaccines and Immunisation have been added to the patchwork of international health aid. The wealthy Bill and Melinda Gates Foundation has also focussed on global health and has funded many of the new programmes. This has caused the roles and responsibilities of global health institutions to become blurred and confused and has further diluted the authority of the WHO.

This loss of influence has been aggravated by poor funding of the WHO, whose budget is too small to match its responsibilities and mandate. Furthermore, much of the funding it does receive, is often tied to the conditionalities of the major donor countries. Rather than having a clear and

rational plan and budget, the WHO's programme of work is largely cobbled together according to what its divisions and departments can raise funds for. The inadequate funding base of the WHO also leaves it susceptible to inappropriate and unaccountable private influence. As 'public-private partnerships' increasingly become one of the building blocks of global health governance, UN institutions run the risk of being influenced by companies with commercial interests.

The nature of globalisation has also rendered health care and health systems susceptible to determinants that lie beyond the direct influence of the WHO. The World Trade Organisation (WTO) for instance, has an increasing effect on health services. Its well-known agreement on intellectual property rights with its extension of patent terms is influencing the price and availability of medicines. But it was developed without considered medical and public health input and only recently has a civil society-led campaign on access to essential drugs highlighted its deficiencies.

The WHO also finds itself unduly influenced by governments seeking to promote their own particular agendas. Although governed on the basis of equal voting rights amongst all countries, the richer and more powerful governments have a greater degree of influence. The United States, which in recent years has been hostile to the very concept of multilateralism, has sometimes acted as a barrier to the WHO's ability to act as an effective agency of global health. For example, the US has in the past backed corporate interests in the face of the WHO's attempts to draw attention to their heath-harming activities, and also demanded the WHO pay less attention to the impacts of trade on health.

Dr Margaret Chan,
Director-General, World
Health Organisation

Source: WHO

While changes to its external environment have conspired to undermine performance, the WHO also suffers from internal weaknesses. Its bureaucracy does not have the best reputation for efficiency; its management has allowed professional morale and motivation to decline; and its arcane procedures for the appointment of senior staff retain little credibility.

For all these reasons there is a growing awareness of the need for health advocates to pay attention not just to the threats and unmet needs of disease and illness, but also deal with the weaknesses and deficiencies of key global health institutions. Addressing the latter is ultimately essential for addressing the former.

What needs to happen?

Funding for the WHO must be substantially increased, with a greater proportion devoted to its core budget and with fewer strings attached.

The WHO's record of acting as the world's health conscience should be revitalised. This could take the form of WHO adopting a more courageous and robust position with respect to the unfair health and wealth divides that scar today's world, as well as the intellectual property rules which are undermining the fight for better health.

The WHO needs to evolve into an organisation of the people, not just of governments. Initiatives are required to improve civil society's engagement with the WHO, particularly civil society organisations from low- and middle-income countries.

The WHO must adopt standards that are consistent with the concept of good governance. The election procedures for the Director-General of the WHO and the appointment procedures for senior managers must be reformed to ensure greater transparency and public accountability. All potential conflicts of interest must be declared by senior staff and the full terms and conditions of any 'public-private partnership' put in the public domain.

Change the staffing mix of the organisation. More social scientists, economists, pharmacists, lawyers, and public policy specialists are required to reflect the cross-disciplinary needs of effective global health action, as well as more representation from developing countries.

Strengthen the regional offices of the WHO, particularly the African Regional Office.

Improve the monitoring of the WHO. Non-government organisations, the health press and the general media need to improve their capacity to monitor and evaluate not just the performance of the WHO, but also the manner in which it is being governed and influenced.

What can the BMA and other health professional organisations do?

For the WHO to reach its full potential as an effective and just instrument of global health improvement, many actors will need to take different actions on different aspects of the WHO. What actions could organisations like the BMA realistically and legitimately perform?

Inform and educate the community of UK health workers:

In a globalised world, the BMA and other health professional organisations can play a pro-active role in educating and informing their members about global health governance. (As an organisation representing a well-educated and influential sub-section of British society, the BMA could remind its members and the wider public that they are global citizens by stimulating debate and discussion about global governance and the role of Britain in improving global health.)

Lobby the British government:

• to adequately and appropriately fund the WHO
• to support a motion at the World Health Assembly which calls for future elections of the Director-General, as well as the appointment of all senior staff, to be conducted in a way that is consistent with accepted standards of transparency and good governance.

Lobby parliamentarians:

- to adopt a more critical view of the challenges of global health and good global health governance.

Lobby the US government alongside US-based health associations:

- to adequately and appropriately fund the WHO.

Lobby and support the World Medical Association:

- to establish a programme of work aimed at strengthening the WHO.

Lobby the WHO:

- to ensure the complete transparency of all its public-private partnerships with particular attention being paid to publicising all forms of joint working between the WHO and the pharmaceutical, food and beverage and tobacco industries
- to demonstrate improved financial and human resource management
- to strengthen its departments dealing with poverty, development and globalisation, in recognition of the fact that these factors represent fundamentally important influences on health and health systems.

Provide support and funding to developing country medical associations:

- to establish their own programme of work aimed at strengthening the WHO and improving global health governance.

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