



United Nations
Educational, Scientific and
Cultural Organization



Report of
the International Bioethics
Committee of UNESCO (IBC)
ON SOCIAL
RESPONSIBILITY
AND HEALTH





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INTRODUCTORY REMARKS

Article 14 of the UNESCO Universal Declaration on Bioethics and Human Rights (2005), perhaps the most innovative article of the Declaration, introduces the principle of social responsibility and health in the field of bioethics, thus opening up perspectives for action that go beyond just medical ethics and affirming the need to place bioethics and scientific progress within the context of reflection open to the political and social world.

Health is definitely everyone's responsibility: from individuals to groups of people organized within societies, educational institutions, public and private sectors, and obviously governments.

Article 14 is complex and it is why the UNESCO's International Bioethics Committee – advisory body of 36 independent experts - decided to focus on the principle set forth therein. After almost 4 years of reflection and debates, at its sixteenth (ordinary) session (Mexico City, 26-28 November 2009), the UNESCO's International Bioethics Committee finalized its **Report on Social Responsibility and Health**, published now in this second volume of the series of publications devoted to the reports of IBC on principles of the Declaration.

When we consider the complexities of the issues surrounding social responsibility and health, and the need to address related public health questions from a bioethical standpoint, this timeframe is hardly surprising and reflects the quite new approach given to public health issue and bioethics by article 14 of the Declaration.

IBC does not pretend to have drawn up an exhaustive nor prescriptive document. The report is built upon the large amount of work and debates on public health policy issues already carried out in other international bodies, in particular the World Health Organization (WHO), and attempts to find a proper balance between the empirical data, the theoretical discourse and the practical implications arising when applying the principle of social responsibility and health.

After a descriptive part on the social determinants of health and constraints on health access, and a specific section devoted to the elaboration of the ethical and legal dimensions of the principle of social responsibility and health, the Report presents a sample of possible concrete strategies and courses of action in order to translate the principle of social responsibility and health into specific policy applications, with a view to promote the highest attainable standard of health for all.

We hope that the reflection and debates within IBC, as embodied in this publication, will inspire and stimulate stakeholders - individuals, sectors of society and States - to meet the goals of social responsibility and health, with a view of fostering the highest attainable standard of health for all.

Donald Evans

Chairperson

UNESCO's International Bioethics Committee

Report of the International Bioethics Committee of UNESCO (IBC) ON SOCIAL RESPONSIBILITY AND HEALTH

This Report is the result of a long reflection within the UNESCO's International Bioethics Committee (IBC) which began at its twelfth session (Tokyo, Japan, December 2005) immediately after the adoption of the Universal Declaration on Bioethics and Human Rights.

It does not pretend to be exhaustive nor prescriptive and does not necessarily represent the views of the Member States of UNESCO. It also does not aim at duplicating the work or debates on public health policy issues already addressed in other international bodies, in particular the World Health Organization (WHO), and it has indeed built upon such work and debates.

It attempts to address public health policy questions from a bioethical standpoint by developing the ethical and legal dimensions of the principle of responsibility and its relations to health, thus enriching the reflection on the principle of social responsibility and health as stated in the Declaration and its practical application.

I. INTRODUCTION

1. The **Universal Declaration on Bioethics and Human Rights** (hereafter 'the Declaration') was adopted by acclamation on 19 October 2005 by the 33rd session of the General Conference of UNESCO (the full text of the Declaration is given in Annex III). In its Preamble, the Declaration expresses the desirability of "developing new approaches to social responsibility to ensure, whenever possible, that progress in science and technology contributes to justice, equity and to the interest of humanity" and devotes an entire article – Article 14 – to the issue of social responsibility and health. By including Article 14, the Declaration opens up perspectives for action that go beyond just medical ethics and reiterates the need to place bioethics and scientific progress within the context of reflection open to the political and social world.

2. Article 14 significantly broadens the agenda of bioethics, so that the social and basic issues related to the provision of health care are taken into account. It is designed to draw the attention of policy makers in the field of medicine and life sciences to the practical concerns of bioethics, contributing to re-orienting bioethical decision-making towards issues that are urgent for many countries. Even though the list is not exhaustive, five specific elements are singled out as priority and universal areas of decision to be taken into account:

- a) access to quality health care and essential medicines, especially health of women and children;
- b) access to adequate nutrition and water;
- c) improvement of living conditions and the environment;
- d) elimination of the marginalization and exclusion of persons on the basis of whatever grounds;
- e) reduction of poverty and illiteracy.

The stakeholders are numerous and include governments, and groups of people organized within societies, such as communities identified, for example, by religious beliefs or ethnic characteristics, commercial companies, political organizations, educational institutions, law enforcement agencies and others.

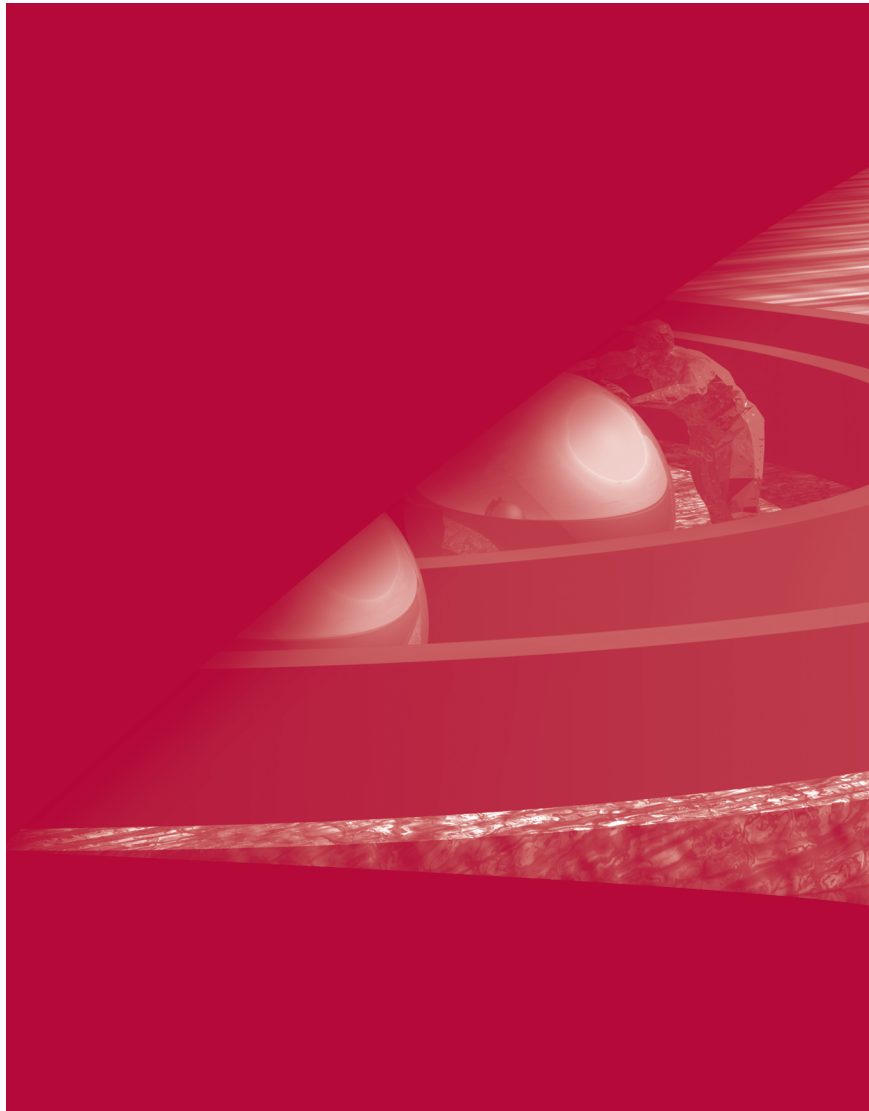
3. Bioethical analysis of Article 14 should take into account the global perspective of health care problems that are confronted by all people similarly, though in different conditions, and its implications within different cultures and traditions. Article 14 does not make it possible to regard the geographical boundaries of a society as the point at which social responsibilities end. If so, governments would be encouraged to look no further than to the needs and interests of their own citizens in discharging these obligations, and commercial companies, no further than to their shareholders, clients and employees. However, although it is clear that States have national responsibility for their citizens, health can no longer be isolated to national pockets of interests and responsibilities. International trade and research activities, for example, involve social relationships beyond State boundaries.

4. Article 14 is complex, and it is essential that its possible interpretations and applications be elaborated. This is why the UNESCO International Bioethics Committee (IBC) decided to focus on the principle of social responsibility and health, as set forth in Article 14 of the Declaration.

5. This report is the result of a long reflection within IBC which began at its twelfth session (Tokyo, Japan, December 2005) immediately after the adoption of the Declaration. It does not pretend to be exhaustive nor prescriptive and does not necessarily represent the views of the Member States of UNESCO. It also does not aim at duplicating the work or debates on public health-policy issues

already addressed in other international bodies, in particular the World Health Organization (WHO), and it has indeed built upon such work and debates. It attempts to address those questions from a bioethical standpoint by developing the ethical and legal dimensions of the principle of responsibility and its relations to health, thus enriching the reflection on the principle of social responsibility and health and its real application.

SOCIAL DETERMINANTS OF HEALTH AND CONSTRAINTS TO HEALTH CARE ACCESS



II. SOCIAL DETERMINANTS OF HEALTH AND CONSTRAINTS TO HEALTH CARE ACCESS

6. At the beginning of the 21st century we have to consider the effects of two different and conflicting processes. On one side, scientific progress has made available new and more effective therapies, surgical techniques, drugs and technical instruments for diagnosis and treatment of diseases that were once considered incurable. There is increasing awareness of the importance of health care as a fundamental right. As a result, in many countries life expectancy is much higher than it was for the previous generations, and other improvements are likely to materialize. On the other side, global health conditions are marked by inequities due mostly to poverty and lack of access to health care services.

7. Recently, it has become a common view that the social and economic conditions that make people ill and raise the need for their medical care serve as a foundation for the health of the population as a whole. Consequently, health policy has been increasingly viewed as more than the provision and funding of medical care. Instead, it includes, among other concepts, the lifelong importance of health determinants in early childhood, as well as the effects of poverty, unemployment, malnutrition, working conditions, drugs, social support, life style issues such as adequate food, and position in the social ladder (an overview of the global health conditions is given in Annex II).

8. According to WHO (WHO Commission on Social Determinants of Health, 2008) the determinants of health include the social, physical and economic environments, as well as individual characteristics and behaviours. The context of people's lives determines their health, not less than their genetic inheritance and their personal choices and way of life. Thus, blaming individuals for having poor health is inappropriate. In many circumstances, individuals are unable to directly control many of the determinants of health. These determinants include factors such as:

- income and social status – higher income and social status are linked to better health. The greater the gap between the richest and poorest people, the greater the differences in health;
- education – low education levels are linked with poor health, more stress and lower self-confidence;
- physical environment – safe water and clean air, healthy workplaces, safe houses, communities and roads all contribute to good health;
- employment and working conditions – people in employment are healthier, particularly those who have more control over their working conditions;
- social support networks – greater support from families, friends and communities is linked to better health;
- culture – customs and traditions, and the beliefs of the family and community all affect health;
- genetics – inheritance plays a part in determining lifespan, healthiness and the likelihood of developing certain illnesses;
- personal behaviour and coping skills – balanced eating, keeping active, smoking, drinking, and how we deal with life's stresses and challenges all affect health;
- health services – access and use of services that prevent and treat disease influence health;
- gender – men and women suffer from different types of diseases at different ages.

9. Throughout the world, vulnerable and disadvantaged peoples have less access to health resources, get sicker and die earlier than those in more privileged social positions. The greatest share of health problems is attributable to the social conditions in which people live and work. Good

medical care is vital to the well being of populations, but it is not enough to meet major health challenges and to overcome health inequities. Action to reduce health inequalities aims to improve everyone's level of health through fully addressing the needs of the most disadvantaged, and assisting countries in need to improve the health conditions of their populations.

10. Tackling major health determinants is of great importance for reducing the burden of disease and for promoting the health of the general population. Without action on social determinants, those countries in greatest need will neither meet the health-related United Nations Millennium Development Goals (MDG), nor achieve global targets for reducing chronic diseases such as cardiovascular diseases, cancer and diabetes. Problems are especially urgent in developing countries where the burden of chronic illnesses is growing rapidly on top of the burden of infectious diseases.

11. WHO's Commission on Social Determinants of Health (2008) established the following overarching recommendations:

- a) improve the conditions of daily life – the circumstances in which people are born, grow, live, work and age;
- b) tackle the inequitable distribution of power, money and resources – the structural drivers of those conditions of daily life – globally, nationally and locally;
- c) measure the problem, evaluate action, expand the knowledge base, develop a workforce that is trained in the social determinants of health, and raise public awareness about the social determinants of health.

12. More recently, in May 2009 the Sixty-second World Health Assembly, after having considered the report of the WHO Commission, recommended to all Member States:

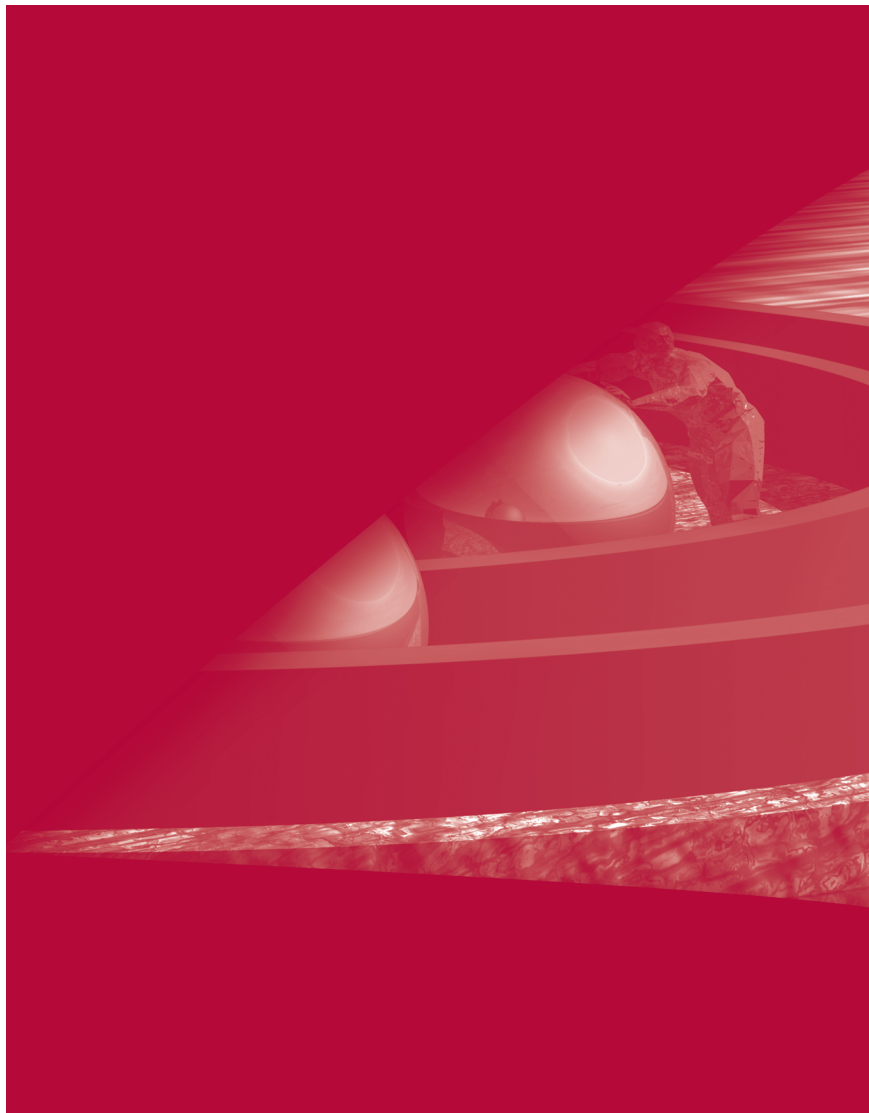
- to tackle the health inequities within and across countries through political commitment on the main principles of 'closing the gap in a generation' as a national concern, as is appropriate, and to coordinate and manage intersectoral action for health in order to mainstream health equity in all policies, where appropriate, by using health and health equity impact assessment tools;
- to develop and implement goals and strategies to improve public health with a focus on health inequities;
- to take into account health equity in all national policies that address social determinants of health, and to consider developing and strengthening universal comprehensive social protection policies, including health promotion, disease prevention and health care, and promoting availability of and access to goods and services essential to health and well-being;
- to ensure dialogue and cooperation among relevant sectors with the aim of integrating a consideration of health into relevant public policies and enhancing intersectoral action;
- to increase awareness among public and private health providers on how to take account of social determinants when delivering care to their patients;
- to contribute to the improvement of the daily living conditions contributing to health and social well-being across the lifespan by involving all relevant partners, including civil society and the private sector;
- to contribute to the empowerment of individuals and groups, especially those who are marginalized, and take steps to improve the societal conditions that affect their health;
- to generate new, or make use of existing, methods and evidence, tailored to national contexts in order to address the social determinants and social gradients of health and health inequities;
- to develop, make use of, and if necessary, improve health information systems and research capacity in order to monitor and measure the health of national populations, with

disaggregated data such as age, gender, ethnicity, race, caste, occupation, education, income and employment where national law and context permits so that health inequities can be detected and the impact of policies on health equity measured.

13. The initiatives undertaken around the world to combat health inequalities are wide-ranging. One approach, such as the one adopted by Brazil, is the creation of a national commission on social determinants of health centred on three basic commitments to equity, evidence and action. Another approach, based on regional studies among 22 European countries, focuses on improving educational opportunities, income distribution, health-related behaviour and health care access in order to reduce health inequalities. Yet another initiative to study knowledge networks to find opportunities for improved action in key areas emphasized (not surprisingly) the pivotal role that national governments and civil society have in achieving greater health equity.

14. It is to be expected that the future will witness more positive developments in the urgent task of improving health conditions by concerted actions involving the social determinants of health. As stated in a Lancet editorial (November, 2008): "All societies must strive to close their gaps in health equity in a generation. Too much is at stake not to do so".

THE ETHICAL AND LEGAL DIMENSIONS OF SOCIAL RESPONSIBILITY AND HEALTH



III. THE ETHICAL AND LEGAL DIMENSIONS OF SOCIAL RESPONSIBILITY AND HEALTH

a. The emergence of the notion of social responsibility

15. Moral obligations are deeply rooted in social relationships and as such are integral to societies. They find their home in the context of societal institutions, such as the family, as well as in social practices such as promise keeping. They are independent of the law insofar as they are not usually justiciable. Indeed, where obligations become justiciable it is evident that the laws in question find their origins in social commitments and responsibilities, the neglect of which leads to totally unacceptable social consequences which society seeks to remedy. Moreover, over the centuries the world's major religions have encouraged the extension of the notion of responsibility for others beyond the confines of the family to communities, countries and across national boundaries.

16. However, the expression 'social responsibility' has come into use only recently. The term appeared in the context of the ethics of private companies and institutions, as the way of defining the moral duties these companies have with the societies in which they are rooted, beyond the constraints and obligations determined by law. This relatively new expression implies that the notion of responsibility is extended from individuals to groups and communities, but also from private to public institutions and corporations, inasmuch as the latter share the same scope of activities and produce effects that are potentially beneficial or harmful for workers, suppliers, customers, other concerned persons or the environment. Institutions and corporations do not only have a legal personality, but also a 'moral' one.

17. Social responsibility should be understood as being part of what has traditionally been called moral obligations. These obligations cannot be imposed by others or by the State. The difference between legal and moral obligations does not imply that the latter are less important. It simply implies that there is no legal coercion to fulfil them. Nonetheless, the more significant the consequences for failure to conform to these norms, the greater is the moral obligation to do so. This is especially so when we consider the duties deriving from a fundamental right. Thus, the concept of social responsibility is widened, both within and between States: it is not just about beneficence.

18. This is the context of the ethical analysis of Article 14 of the Declaration. What is at stake is a fundamental right, together with the awareness of a limit of attainability. The novelty and the importance of this article is that it explicitly widens the concept of social responsibility, applying it not only to the private sector but also to the public domain. That's why the task of social responsibility is to be shared by the private sector and States and governments, which are called to meet specific obligations to the maximum of the available resources in order to implement and progressively achieve the full realization of this right. Article 1.2 of the Declaration emphasizes that the Declaration "is addressed to States". Articles 21, 22, 23, and 24 reaffirm their irrevocable responsibilities.

b. Wide scope of article 14

19. Article 14.1 is of crucial importance to a proper understanding of the wide ranging scope of the Article as a whole. It clearly states that the promotion of health and social development is not only a purpose, but "a central purpose of governments". This purpose is not to be pursued just by the means of moral persuasion, but it should be the subject of deliberate governmental policy. The centrality of this goal is easy to justify in the democratic tradition, but also moving from the mere,

very basic obligation of the sovereign to protect citizens from the threat of war or violence. In our time we also include the risk of death due to (untreated) disease as one of the main threats facing citizens. The legitimation of sovereignty must therefore be the ability to protect citizens from current threats, and this gives a reason to make the promotion of health, and the protection against health threats a central purpose of government. Similarly, States have obligations to protect citizens from social threats like poverty or severe environmental degradation.

20. Article 14 also makes it clear that “all sectors of society” should participate in the promotion of health and social development. Health is a basic good because it contributes significantly to welfare and satisfaction. Individual well-being and welfare are connected with social development. This is a normative and not a descriptive statement, and is perhaps the most important statement of the Article. The implication is that health and social development are not merely the concern of the health care sector, but of all sectors of society, for example the educational services and private enterprises. It is possible for a sector in society not to feel any responsibility for health and social development and not to act in a way that promotes health and social development. Article 14 denies the legitimacy of such attitudes. No sector in society or single citizen can isolate themselves from responsibility for the promotion of health and social development.

21. A corollary to this is that it is a valid criticism of a sector in society if it does not take this responsibility seriously, whether this criticism is made by the government, civil society organizations or individuals. The exact addressee of such criticism can be difficult to identify because even with an intuitive grasp of what ‘a sector of society’ is, there is rarely any natural or elected representative of such a sector whom we can address. We may, for instance, believe that the globalized food industry does not take responsibility for obesity prevention seriously enough, but there may not be one easily identifiable representative of that industry to whom we can address our criticism or who would be able to act on it.

c. Article 14 and the notions of health and social development

22. The two leading contenders for a philosophical conception of health are:

- the bio-statistical conception: health as a state of species typical functioning;
- the action-theoretic conception: health as an ability to pursue autonomously chosen goals.

23. The bio-statistical conception of health sees health as an objective biological state that can be defined in terms of species typical functioning, in relation to an age and gender- matched reference class. A healthy organ is thus an organ with species typical functioning, and a healthy organism is an organism where all parts are functioning at their species typical level. The attraction of this conception of health is that it is apparently objective, value free and linked to biology only. This conception has been criticized for obscuring the value elements in the identification of health needs, health interventions and health outcomes.

24. The action-theoretic conception of health sees it as the set of biological and mental properties that enables an agent to pursue goals. The healthy agent is thus the agent not restricted by biology in pursuing his or her reasonable goals. This conception is avowedly value-laden in the sense that what counts as health for you may not count as health for me if we have different reasonable life goals. Values are also involved in determining what counts as ‘reasonable goals’. The attraction of this conception of health is that it inherently links health with the main reasons why we value health. It has been criticized, on the one hand, for allowing too many states to be classed as healthy (for persons who have limited life goals) and, on the other hand, for allowing too many states to be classed as unhealthy (for persons who have expansive and ambitious life goals).

25. It is plausible that the action-theoretic conception is closer to the conception of health and the value of health embodied in the Declaration in Article 14.2a: “health is essential to life itself and must be considered to be a social and human good”. Indeed, this is clearly not a purely biological conception. However, in many policy decisions (e.g. in relation to public health interventions) it will not matter what conception of health the policy maker adopts. There is a large overlap between the states as healthy (or unhealthy) by the two conceptions, and most people who are affected by the policy decision will be unhealthy and in need of health promotion in each sense.

26. Determining the content of the concept of ‘social development’ is more complicated partly because the reference of ‘social’ is vague and partly because the concept of ‘development’ is itself contested. Positive social changes can occur across the whole range of societal sectors and activities, but they are not all equally important and it would, for instance, be strange to define an improved ability of teenagers to sing in tune and keep rhythm as a social development that government should promote as a central purpose even though it would undoubtedly be a beneficial social change.

27. We therefore need to ask what kind of social developments are covered by the obligations outlined in Article 14. A help in this task is the partial explication provided by article 14.2a-e. Any social change that improves one of the areas mentioned here (access to quality health care and essential medicines; access to adequate nutrition and water; improvement of living conditions and the environment; elimination of the marginalization and the exclusion of persons on the basis of any grounds; reduction of poverty and illiteracy) is in itself a social development that should be promoted by governments and all sectors in society.

28. It is important to note that the social developments that should be promoted refer to developments in material conditions (e.g. access to water and environmental protection), formal and cultural structures (e.g. elimination of marginalization and exclusion), and education (e.g. reduction in illiteracy). The scope of promotion of social development is wide and is inherently linked to that of health, since the areas of social development are at the same time the social determinants of health.

d. The status of health as ‘a good’

29. Article 14.2a – as mentioned above – states that “health is essential to life itself and must be considered to be a social and human good”. But exactly what kind of good is health?

30. Many philosophical and ethical theories acknowledge health as a basic good, either on its own or because of the strong links between health, welfare and social participation. These arguments are not challenged by the fact that some individuals do not value their health or consider the health of others to be important. There is no doubt that having healthy citizens is a benefit to society and that health is a social or public good. The health of individuals contributes positively to general social conditions.

31. Some ethical theories advance the argument that talking about health as a public good treats it as a commodity, and not as a basic need. Even if one agrees with this approach, it is still difficult to escape the duty to contribute to the access to health care for everybody in the world.

32. The emergence and re-emergence of communicable diseases and pandemics emphasize the importance of thinking globally about health, from an economic and an ethical point of view. This perspective, moving away from individually-centred bioethics, should take into consideration contextual and cultural differences. Cure and care do not have the same priority and are not reflected in the same policies in each country. However, political leadership in all States should endeavour to allocate resources to the prevention of disease and to the protection and promotion of health. Considering health as a universal common good can also commit countries to work towards a more equitable distribution of health resources.

e. Health as a human right

33. December 2008 marked the 60th anniversary of the Universal Declaration of Human Rights, which provides the foundation for the international code of human rights. This code gives an internationally agreed set of standards to guide and assess the conduct of governments across a wide range of sectors and has a direct bearing on medicine, public health, and health systems. The lack of health care and commitment to promoting health directly infringes upon the right which is simply the keystone of all the others: the right to life.

34. Access to health care and the right to health, however, are not synonymous. Of course, it is impossible to ensure something like a right to be perpetually healthy. In turn, the simple right to health care may appear too narrow to include important factors like safe environmental conditions or adequate sanitation. Therefore, the international community has clarified the concept of the right to health both in its meaning and in its scope. The International Covenant on Economic, Social, and Cultural Rights (1966) includes as a central provision the right to health in international human rights law with a decisive specification: “the States Parties to the covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health” (Art. 12). The content of the right is what is actually attainable and not whatever possibility one could ever think of.

35. Accepting attainability as the standard implies that what we ought to do cannot be realized overnight; it is expressly subject to both progressive realization and resource availability. At the same time, this ‘fundamental’ human right encompasses many duties and goals: medical care, access to safe drinking water, adequate sanitation, education, health-related information, and other underlying determinants of health. It includes freedoms, such as the right to be free from discrimination and involuntary medical treatment, and entitlements such as the right to essential primary health care. The right to health requires an effective, responsive, integrated health system of good quality that is accessible to all.

36. Progressive realization also means that a country has to improve its human rights performance steadily; if there is no progress, the government of that country has to provide a rational and objective explanation. Because of their greater resources, more is expected of high-income than of low-income countries. However, the right to health also imposes some immediate obligations, such as non-discrimination and the requirement for States to have a national plan for health care and protection. Furthermore, the right to health requires that there are indicators and benchmarks to monitor progressive realization and that individuals and communities have opportunities for active and informed participation in health decision making that affects them. Under international human rights law, high-income countries have some responsibilities towards the realization of the right to health in low-income countries. Because the right to health generates legal entitlements and obligations, effective mechanisms of monitoring and accountability are needed.

37. According to the United Nations Special Rapporteur on the right to the enjoyment of the highest attainable standard of physical and mental health (2007), this right consists of global standards generating legal obligations which demand effective mechanisms of accountability. The combined effect of these three dimensions – standards, obligations and accountability – may result in the empowerment of disadvantaged individuals and communities.

f. Social responsibility, justice, solidarity and equality

38. Whatever contents the concept of human dignity may include in different cultures and traditions, a fundamental right ought to be conceived in terms of equality. That means, following the Universal Declaration of Human Rights of 1948, that neither distinctions stemming from “race, colour, sex,

language, religion, political or other opinion, national or social origin, property, birth or other status”, nor those made on the grounds “of the political, jurisdictional or international status of the country or territory to which a person belongs” (Art. 2), should operate as factors of restriction and constraint. In the case of health care, however, it is not the pursuit of the highest but rather of the highest attainable standard that can be claimed as such a right. The idea of attainability already emphasized implies the acknowledgement of some limits. Does it imply, by the same token, the acceptability of inequalities? Huge, growing inequalities are indeed what we see both at the domestic and especially at the international level.

39. In the United Nations Millennium Declaration of 2000, Heads of State recognized that they have both “separate responsibilities” to their individual societies and a “collective responsibility to uphold the principles of human dignity, equality and equity at the global level”. In the *Discussion Papers* released in 2008 by WHO (*Addressing Ethical Issues in Pandemic Influenza Planning*), two different levels of responsibility are consequently pointed out. Governments have a first and primary obligation to the people for whom they are directly responsible. Beyond this duty, there is an obligation to help other countries, which is increased in so far as more resources are available and the governments abroad lack the means to protect the health of their people. This obligation can also entail some legislative measures.

40. Current discussions about justice, solidarity and equality are relevant for a proper understanding of the justification for and scope of the obligations imposed by Article 14, especially because these concepts are mentioned in other preceding articles of the Declaration. The maximum of equality remains the ultimate goal when everyone’s right to life is at stake. The standard of equity and fairness must ensure in any case that the minimum to support human dignity be guaranteed to every individual. At the domestic level, the enjoyment of the highest attainable standard of health and access to quality health care without distinction – among others – of economic conditions, are obligatory goals for governments. In the transnational context, the States retain their freedom to choose what to do, even within some innovative frame of political integration. The European Union, for example, has reaffirmed in the Commission White Paper of 23 October 2007 (*Together for Health: A Strategic Approach for the EU 2008-2013*) that “the area of health is essentially the responsibility of the Member States”. Therefore, the role of other umbrella organizations becomes more important, and a call for solidarity unavoidable.

41. According to the group conception of social solidarity, it is the case that without existence of a definable group of which one can feel a member, solidarity has no meaning. In most groups there will be some tendency to prefer or to be benevolent towards other members of the group. But solidarity requires more than that, thus involving an issue of justice. It requires an idea of shared life or destiny. It also requires a sense of belonging, integration or rootedness of each individual member within the group. This sense of belonging is the underlying motivation which changes the passive acceptance of a common destiny to active work for common goals. If solidarity can be harnessed to goals such as the promotion of health and social development it can be a powerful motivating force.

42. Besides that, solidarity can play a relevant role as an effective complement for the lack of legally binding rules. Seeing health as a universal common good motivates countries to work towards a more equitable distribution of health resources: vaccines, drugs, innovation, and research. We all know that scientific progress will not stop but its applications should benefit every region of the world and not only help rich countries to increase the quality of life of their citizens, while poor countries are still lacking what is needed to survive decently. From this perspective, health becomes a shared ‘social’ responsibility, in order to enable every human being to enjoy the highest attainable standard of dignity and quality of life.

g. Relationship of Article 14 with other articles of the Declaration

43. Article 14 of the Declaration cannot be interpreted as an isolated fragment of text. In accordance with Article 26 of the Declaration, any interpretation must take account of the whole of the Declaration, in particular the other principles. These provide both constraints on the possible interpretations and guidance concerning the fundamental values underlying the Declaration.

44. First of all, Article 14 should be read in the light of Article 13 on solidarity and co-operation ("Solidarity among human beings and international cooperation towards that end are to be encouraged."). This Article reflects the commitment that the Declaration is based not only on the individualist concept of rights but that it also recognizes the importance of solidarity between individuals and across communities, with special regard to those rendered vulnerable (Art. 8). Cooperation between and among individuals, families, groups and communities should be of special concern in the relevant decision-making and the establishment of appropriate practices within the scope of the Declaration. The international dimensions of health care today are more significant than ever before. Rare diseases that are sometimes neglected by health care systems at the national level may be very dangerous in other parts of the world, and addressing these requires international cooperation. In other cases such as HIV/AIDS-prevention and flu pandemics, for example, the ethical dimensions of health care inevitably go beyond national frontiers.

45. As progress in science and technology is viewed as crucial for health and social development, it becomes clear that Articles 15, 23 and 24 are also highly relevant for the promotion of such development. Furthermore, these articles state that high income, industrialized countries, have a special responsibility with regard to the promotion of benefit sharing, solidarity and international cooperation in the field of science and technology, by assisting developing countries in building up their capacity, thus enabling them to make use of the fruits of scientific and technological progress and to develop their own research policies and scientific and technological know-how.

46. Article 15, in dealing with the benefits resulting from scientific research and its applications and the need to share them with society and the international community, echoes Article 14. It identifies as concrete areas of implementation of such sharing the access to quality health care, provision of new diagnostic facilities, new treatments, or medical products stemming from research.

47. The relevance of Article 21 (Transnational practices) to Article 14 relates to the crucial role attributed to 'progress in science and technology' to promote health and social development. Article 21.3 states that transnational health research "should be responsive to the needs of host countries". This implies that the promotion of health and social development is not the sole responsibility of the government of a country hosting transnational research; States sponsoring transnational research also have a responsibility in safeguarding that the transnational research undertaken in a host country contributes to the research needs of that particular country. Moreover, Article 21 not only addresses States and governments involved in transnational practices but also public and private institutions associated with such practices. This implies that promotion of health and social development in a country hosting transnational research is also a shared responsibility of such involved institutions.

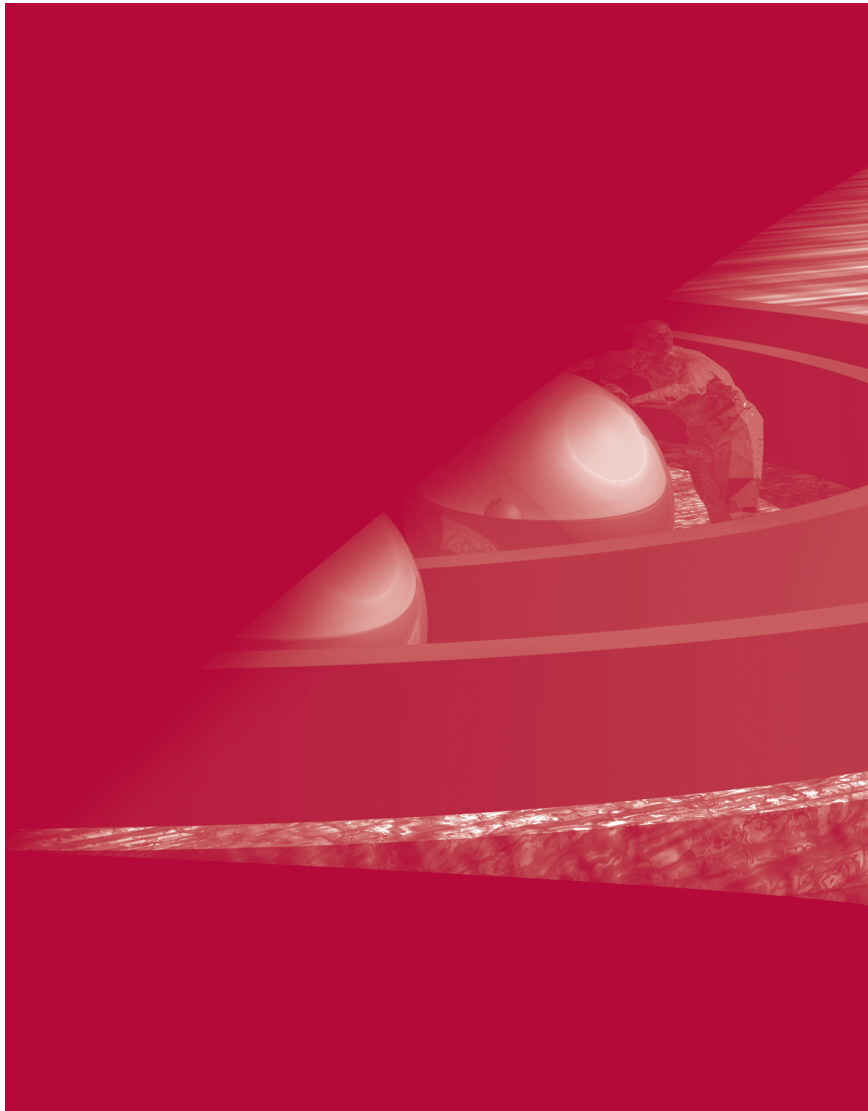
48. Article 22 is also particularly relevant to the application of Article 14. By stating that "States should take all appropriate measures, whether of a legislative, administrative or other character, to give effect to the principles of the Declaration", Article 22.1 emphasizes the commitment of States to the implementation of appropriate actions to facilitate the concrete application of the principle of social responsibility and health. Article 22.2 emphasizes the role of States in establishing independent, multidisciplinary and pluralistic ethics committees. The relevance of such institutions

in relation to Article 14 relates to the role they could play in developing sustainable research priority policies within the domain of health and social development in the countries concerned.

49. The relevance of Article 23 (Bioethics education, training, and information) to Article 14 also relates to the crucial role attributed to 'progress in science and technology' to promote health and social development, in so far such development is dependent on:

- the production, implementation and application of context sensitive scientific and technological products, and
- raising awareness of and sensitizing researchers, policymakers and the public to the ethical implications and possibilities of scientific and technological progress.

SPECIAL AREAS OF FOCUS



IV. SPECIAL AREAS OF FOCUS

a. Health care

50. Improving health is not only an outcome of development but also a prerequisite for development. Consequently, investment in health yields one of the highest rates of return that a country can achieve. Despite important biomedical and biotechnological advances with positive results in reducing morbidity and mortality, access to health care is far from satisfactory. There is a growing gap between medical knowledge and medical practice, sometimes referred to as 'know-do gap'. Millions of people have no access to proper health care. Even in developed countries, many well established preventive treatments are not used, resulting in complications and sometimes, the need to use more expensive treatments when the preventable illness actually occurs. Many effective treatments are frequently underused or misused.

51. Some examples illustrate the magnitude of this problem. According to the Joint United Nations Program on HIV/AIDS (UNAIDS) 2008 Report, by the end of 2007, an estimated 33.2 million people were living with HIV, of whom 2.1 million were children, and 2.1 million died from AIDS. As many as 6,800 people are infected with HIV every day because of poor access to affordable, proven interventions to prevent HIV transmission. Only about 2,700 additional people receive antiretroviral therapy per day. Despite progress, antiretroviral therapy coverage remains low: only 31% of people in need were receiving antiretroviral therapy in 2007. That same year, an estimated 2.5 million people were newly infected with HIV. Although mother-to-child transmission has been almost entirely preventable for years, only a third of infected pregnant women receive antiretroviral drugs to prevent transmission, and even fewer receive medications for their own health. According to WHO, 27 million children have not been vaccinated to prevent different illnesses; many patients do not receive treatments based on evidence; about 30% of patients with myocardial infarction do not receive aspirin to prevent new events; 50% of patients with coronary disease do not receive beta blockers, only 37% receive statins and less than 40% have LDL cholesterol less than 100, all factors which prevent new coronary events. Undetected and untreated hypertension, depression and failures in prenatal care are examples of underused medical services.

52. In contrast, some technological interventions are overused thus denying the application of scarce resources to patients who need them. For example, some patients undergo medical interventions in circumstances where there is an unacceptable harm/benefit ratio; others are exposed to expensive treatments simply because the technology exists without there being any reasonable expectation of receiving an affordable benefit. On the other hand, a variety of new treatments, with scientifically known benefits compete with traditional treatments for which there is no reliable evidence of effectiveness, often with negative results. Additionally, bona fide treatments for a specific clinical application are also used for other clinical indications without good evidence of safety or effectiveness. Antibiotics are frequently overused, which increases adverse reactions and antibiotic resistance. Coronary angiographies, carotid endarterectomies, gastrointestinal endoscopies, and pacemakers have also been reported in the literature as examples of overuse.

53. The most significant worldwide barrier to improving the levels of attainment of health through health care interventions is the scarcity of resources. The costs of medical care have driven up potential health expenses far beyond the limits of all countries' realistic budgets, even in the richest countries. The increase in health care costs reduces the opportunities of many patients to receive the treatment they might need.

54. Even if it is accepted that full equality of the access to the best possible care will not be achievable, each member of society, irrespective of his or her economic position, should have equitable access to an adequate level of health care. In order for a health care system to be just and equitable, it needs first to be efficient so that resources are not wasted and thus denied to patients. However the call for efficiency might appear to demand that the investment of health resources must aim for the maximum amount of benefit. Such a view would entail, for example, that some groups of needy patients such as the chronic sick, the elderly and the disabled will be denied care because more can be achieved for other patients than for them. This would be inequitable. Thus in reaching treatment decisions the difficult tension between efficiency and equity has to be managed. This will involve that important ethical questions be addressed such as: Should all new technologies be available to every patient? Should all patients be treated? Should the capacity to benefit from a treatment be a threshold concept identifying a patient's need for a treatment or should the degree of benefit determine who should receive a treatment?

55. Today, it is accepted that allocation of resources is an important element of respecting social responsibility in health care. What criteria should be followed? Solutions are not easy to find and coping with these issues will require, first of all, an intense educational and consultative programme which should include all members of society, followed by a wide deliberation process which should be addressed to:

- defining the concepts of health and illness, understanding the limits of application of technology;
- setting forth strategies for defining the health necessities in health care, as well as the criteria for establishing a decent minimum in health care;
- discussing acceptable criteria for rationing, and clarifying the limits of the patients' rights regarding the use of new technologies;
- noting and evaluating the tension between the efficiency of health care and equity of access to health care.

b. Research

56. Improving health requires the effective application of research aimed at creating new knowledge and new technologies. This includes the whole spectrum of research such as biomedical sciences (creating affordable and accessible new drugs, vaccines, diagnostics and appliances), health systems and policy research, social sciences, political sciences, health economics, behavioural and operational research, epidemiological research into the relationship between health and the cultural, physical, political and social environments, as well as the development of best practice guidelines.

57. Health research can make a major contribution both to health and to more general social development. At the 2008 Bamako Global Ministerial Forum, Ministers of Health, Ministers of Science and Technology, Ministers of Education and ministerial representatives from 62 countries recognized that in a world facing significant environmental, demographical, social and economic challenges, research is essential to clarify the nature and scope of health problems, to develop and implement effective life-saving interventions and accelerate achievement of the Millennium Development Goals. The so-called 'Bamako Call for Action' urges national governments to give priority to development of policies for research and innovation for health as part of their broader national strategies.

58. Many countries need international aid to ensure that research for health is part of its total package and is fitted in a manner that enhances national health research systems.

59. Moreover, few of the world's resources for health research are directed to solving the specific health problems of developing countries. In 1990, the Commission on Health Research for Development estimated that less than 10% of the global health research resources (totalling US\$30 billion/year in 1986) were being applied to the health problems of developing countries, which accounted for over 90% of the world's health problems – an imbalance subsequently captured in the term the '10/90 gap'. The world now spends considerably more on health research: the latest estimate puts the figure at US\$105.9 billion for 2001, of which 44% by the public sector, 48% by the private for-profit sector and 8% by the private not-for-profit sector. Despite these positive increases, there is still a massive under-investment in health research relevant to the needs of low- and middle-income countries.

60. In particular, more research is needed to address the lack of appropriate drugs and technologies to treat the multiple burdens of communicable and chronic diseases that many developing countries now face, and to provide knowledge and evidence about what policies, systems and services work in different places and settings, about what is failing, and about what is needed to improve the situations in the most cost-effective ways.

61. A specific recommendation on research funding was made at the end of Forum 8 in 2004 in Mexico City, stating:

To provide the resources necessary for essential research within developing countries, we urge governments of these countries to spend at least 2% of their national health budgets on health research, as recommended by the 1990 Commission on Health Research for Development. These funds should be used locally for health research and research capacity strengthening. Also in line with the Commission's recommendation, donors are urged to allocate 5% of their funding for the health sector to health research and research capacity strengthening in developing countries. Monitoring the use of funds for capacity development is a vital complementary activity.

62. There is a problem regarding how governments perceive research. If they see research as an expenditure and not as an investment, the amount of funds will be scarce. This is most likely in poor countries where more limited funds have to be distributed among greater needs thus making health research a low priority. This creates a vicious circle making it impossible to achieve vital improvements to the determinants of health in the form of relevant new knowledge and expertise.

63. Setting of research agendas for developing countries is important. But who should set these agendas in developing countries? What methods should be used? It is important to empower countries to set their own agendas and priorities. Countries need to involve all national stakeholders in formulating them. There is a need to focus scarce resources on health research in poor countries in order to optimize health benefits and achieve equity. There is a need to budget for research and to see research as an investment. It is difficult to ask a government with a budget of only a few dollars per person per year to spend on health, to contribute to the research agenda, but there is a need for them to make a start. The Declaration places an obligation on Member States to consider carefully their proportionate expenditure on health, education and defence.

c. Industry

64. Every industry activity implies social responsibility. Work conditions can be harmful for people. Pollution can damage the environment and jeopardize the well-being of the population. Marketing strategies are often used to boost unhealthy behaviour related to food and lifestyles. Research itself may serve profit-oriented activities more than interests and needs of individuals and society, exposing experts to conflicts of interest that are always very dangerous because of their influence in decision-

making processes. Globalization has made these risks more evident and has made the traditional institutional means of control less effective.

65. The pharmaceutical industry is particularly addressed by this responsibility, which includes different aspects. Development agencies have challenged the pharmaceutical industry (but some remarks could apply to public research as well) to improve its efforts to tackle the health crisis affecting developing countries. They consider that a socially responsible company should have policies on access to treatment for developing countries which include the five priorities of pricing, patent, joint public private initiatives, research and development and the appropriate use of drugs. They observe that industry currently defines its policy on access largely in terms of philanthropic ventures. Some important initiatives have been taken. Nonetheless, critical challenges remain, particularly the issue of pricing.

66. The generalized lack of interest on the part of industry in research geared to the development of new vaccines and drugs to treat tropical diseases and ailments typical of the poor could be explained by the high cost of research and the small or negative profit margins to be expected. Since the establishment of the World Trade Organization (WTO) and the signing of the Agreements on Trade-Related Aspects of Intellectual Property Rights (TRIPS), developing countries have faced increases in the cost of basic medicines, whose protective patents enable the pharmaceutical industry to impose their price. Consequently, some basic medicines cannot be made available to poor population groups at affordable prices. The industrial and commercial rationale of the pharmaceutical industry often runs counter, however, to the public health objectives of developing countries that are confronted by epidemics of diseases such as AIDS, malaria, and tuberculosis. The excessively high price of medicines puts them virtually beyond the reach of the world's poorest communities.

67. One solution to prohibitive prices, which are indeed a huge stumbling block, would be to reach agreements with the pharmaceutical industry on a voluntary price differentiation between rich and poor countries, allowing the latter to pay only production costs and not research and development costs. WHO and UNAIDS have had some success in this regard. This system presupposes, however, that poor countries agree not to re-export the medicines to rich countries and that they are careful to ensure that the products are properly used to reduce any possibility of resistance. The TRIPS Agreement has also been revised in favour of the poorest countries. Those that do not have the capacity to produce medicines may now request an extension of compulsory licenses for generic products protected by patent, so that they may be imported from other countries. Although the number of generic medicines is large it is likely to rise in the future because of the expiration of patents.

68. Some valuable recent projects have a charitable aspect and will not generate profits. Examples include the new Institute for Tropical Diseases in Singapore for the discovery of drugs for tuberculosis and dengue, and a considerable number of privately funded projects aimed at new treatments for malaria, elephantiasis, river blindness, HIV/AIDS, leprosy, dengue and sleeping sickness.

d. Education

69. It has been demonstrated that illiteracy and poverty are two major factors that produce poor health and poor social development. It is also known that low literacy impacts on mortality and quality of life. This is why Article 14 starts by advocating the promotion of health and social development and concludes by calling for the reduction of poverty and illiteracy. Current data, according to the UNESCO Institute for Statistics, indicate that around 774 million adults are unable to read and write. In sub-Saharan Africa, there are now more illiterate adults than in 1990, and 150 million primary school-age children are out of school according to a joint UNESCO/UNICEF

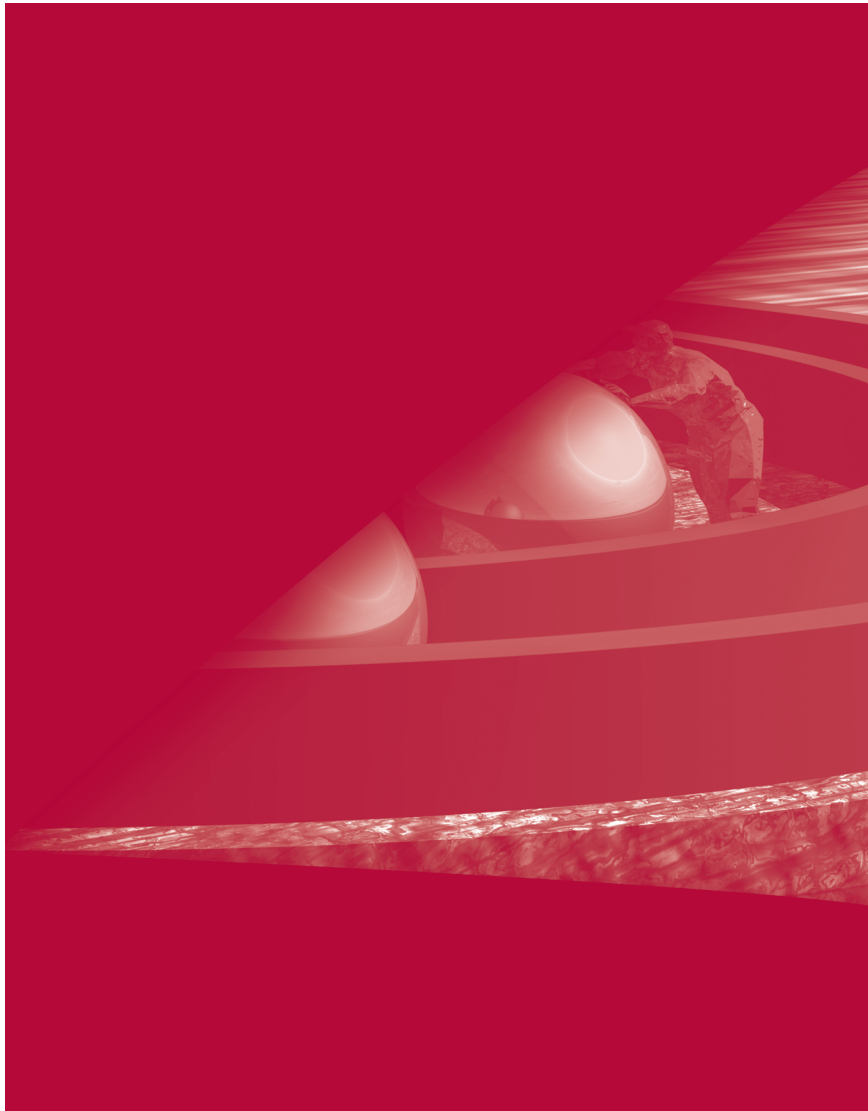
global estimate. This number equals almost one in five of children worldwide and so millions of people are unable to achieve health literacy, which has been defined as “the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions”.

70. The term illiteracy can also be related to science education. In the so-called knowledge societies it is almost impossible for a country to have the capacity to cope with scientific progress without a strong cohort of researchers. This means that children must become literate in science early in their life, in order to develop a basic understanding of the world around them and the capacity to support science development.

71. It is the responsibility of governments to ensure that the development of human resources of the health sector (e.g. in dentistry, nursing, midwifery education, etc.) in developing countries is integrated with the health care systems and funding allocation systems of those countries, appropriate with the needs and demands of disadvantaged groups within the population.

72. Governments should also provide opportunities for education in bioethics as called for in Article 18 of the Declaration. It is through education in bioethics that citizens will be enabled to engage in debates about moral issues pertinent for their country and other countries.

COURSES OF ACTION



V. COURSES OF ACTION

73. The social responsibility of promoting the highest attainable standard of health can only be realized through concrete action. Courses of such action, as revealed by decades of experience in pursuing the health agenda, are multitude. Those identified in this report represent a sample of strategies that are neither exhaustive nor readily applicable to many countries. Therefore, acknowledging a plethora of other alternative ways forward, and with due respect to the sovereign choice of a national strategy by each Member State, this section attempts to provide a general overview of what can be done in order to translate the principle of social responsibility and health, as set forth in Article 14 of the Declaration, into specific policy applications.

a. Decision-making procedures

74. It is evident that pursuing the goals of promoting health and social development is not without cost and that few societies, if any, have the resources to actively pursue all the goals mentioned in Article 14 to an ideal standard. Societies will have to prioritize between and within goals. Recent work on priority setting in health care and on societal priority setting more generally shows that there is no algorithm that can provide uncontestable answers to how such priorities should be set. However this fact should not be used as a justification for not achieving as much as possible within these limits.

75. Article 14 of the Declaration must be considered a blueprint for more explicit and detailed formulations of the concepts related to solidarity, reciprocity, justice and dignity as they relate to the formulation, justification and application of health-related policies by Member States. Its wide scope and vagueness of formulation should not deter legislators and policy makers from considering it as a step forward in the consolidation of a widespread agreement on rights and duties surrounding one of the most essential societal functions, which is to enhance, preserve and promote social well-being at the individual and group levels, respecting cultural diversity, caring for the worst-off, ensuring value for money spent and striving at equity and quality in the creation and delivery of health-related services.

76. Procedures for priority setting emphasize the application of a fair process allowing agreement on what is legitimate and fair. Key elements involve transparency, relevant and acceptable rationales, and procedures for revising decisions. The basic notion behind the process is to increase the likelihood of priority decisions based on a commitment to fairness.

77. It may be said that four principles have been identified as essential to the process of priority setting in health: treating people equitably, favouring the worst-off peoples, maximizing total benefits for society, and promoting or rewarding social usefulness. The application of these general principles should follow agreed-upon rules of procedures in order to become legitimized. It should be noted, however, that the first two of these principles can come into tension with the second two in a number of ways. For example, whilst it is right to promote efficiency in order to avoid wasting scarce resources it is unjust to deny needy citizens health care simply because greater total benefit could be delivered to others by an alternative use of resources. In such cases some of the most needy people, such as the chronic sick and people with disabilities, would be denied care on the grounds that there are limits to the degree of benefit which they can hope for. Section d) in Article 14 can be read as referring to such groups.

78. It is important therefore to note that any societal priority setting within and between goals outlined in Article 14 would have to follow a legitimate decision-making procedure. More generally a decision maker who is contemplating a decision with implications for the promotion of health and/or social development ought to ensure that the effect of the contemplated activity on all the goals mentioned in Article 14 are considered. Otherwise there is a significant possibility that important considerations will be overlooked in the decision-making process. Article 14 can thus be the basis for a rough checklist for the reasonableness of arguments given by policy makers to justify decisions in the areas covered by the Article.

b. Transnational scope

79. Article 14 may appear not to have implications in an international context and its wording may suggest an explicit restriction to national States as all the actions Article 14 describes are within the scope of normal governmental activities. In this context, it is important to remember that all articles in the Declaration must be taken together as a whole. This means that Article 21, which covers transnational activities, must inform the reading of Article 14. This implies that as all governments are involved more or less in activities with other States, the indications of Article 14 should be considered in relation to all those activities with nations with which a given State is engaged. For example a company engaged in activities in a country other than the country in which it is incorporated cannot, by invoking that it only has obligations in 'its own country', exclude itself from extended obligations to citizens of the other country who are affected by its interests. Thus, for example, a company outsourcing the manufacture of its products to another country should take a serious interest in the health and safety conditions of those who make their products.

80. Another possible transnational aspect of Article 14 relates to intellectual property. Establishing rules for the legal recognition and exploitation of intellectual property is one of the ways in which a state can ensure that "...progress in science and technology ..." (Art. 14.2) advances health and social development. But modern intellectual property regimes reach far beyond the borders of individual States. In so far as the intellectual property regime of one State has implications elsewhere, or in relation to negotiations concerning international intellectual property rules, State and societal actors have an obligation to consider the effects of the rules on other States. There are provisions in international patent law which provide for the consideration of ethical issues in the application of patents.

81. The occurrence of natural disasters often imposes demands on health care systems of countries which are beyond the capacity of those countries to meet. International agreements between governments on collaboration in providing assistance in such cases would greatly improve the efficiency of the delivery of care undertaken by non-governmental organizations. The involvement of these valuable organizations could be included in these agreements in order to empower the affected communities.

c. National bioethics committees

82. According to Article 19c of the Declaration, national bioethics committees should be established in order to "assess scientific and technological developments, formulate recommendations, and contribute to the preparation of guidelines on issues within the scope of this Declaration".

83. In accordance with the Declaration, national bioethics committees should be independent, multidisciplinary and pluralistic bodies with an ethics mandate that does not only cover medical research. They should be established in order to assess scientific and technological developments

in all the bio-, life- and health sciences. Besides, they should also be established to formulate recommendations and foster debate, education and public awareness in bioethics. These national bodies should therefore be encouraged to take responsibility of:

- identifying the most pertinent research for health and social development needs in the country concerned and formulating recommendations about sustainable research priority policies within the domain of health and social development;
- being kept continuously informed about current and potentially relevant questions of research ethics within the field of medicine and international convention related to human research, and ensuring that medical research involving humans are evaluated by an accredited committee;
- fostering debate and public awareness about the ethical dimensions of the link between health and social development;
- promoting a deeper insight into the conditions of a 'fair' rationing about priority setting and allocation of resources in public and private health care systems;
- supporting the concrete experiences of solidarity, such as the willingness to donate organs, but also to volunteer in civil society to help suffering and marginalized people;
- suggesting solutions for the crucial issues concerning equity in access to health care and equitable access to medical treatment.

84. This would represent a way of linking Article 14 on social responsibility and health to the need for developing sustainable research priority policies within the domain of health and social development in the countries concerned, as well as protecting vulnerable individuals within the health system.

d. Quality assurance in health care

85. Article 14 promotes "access to quality health care". Considering the variety of developments in medical care the concept of quality is of major importance. Scientific progress has made it possible to prevent and treat many diseases once considered incurable. Yet we have the problem of ensuring adequate control and application of these treatments in order to protect patients. Lack of national, international and professional controls facilitates unsound practice. For example, we have many drugs and techniques of uncertain efficacy and unclear adverse event profiles which are strenuously promoted. International cooperation is called for in order to provide adequate information and training to clinicians, agreed best practice guidelines and protections of patient rights and dignities.

86. Quality assurance in health care requires that:

- 1) adequate preventions and/or treatments, based on sound evidence, are applied at the right time;
- 2) primary or secondary harm are avoided or reduced;
- 3) patient dignity and rights are respected.

87. To satisfy these requirements of quality care it will be necessary to:

- promote research aimed to produce clear guidelines of the effectiveness of the different treatments available;
- develop strategies to reduce the gap between knowledge and medical practice;
- develop strategies to reduce errors;
- define the concepts of health and illness, understand the limits of technology;
- set forth strategies for defining the health necessities in health care, as well as the criteria for establishing a decent minimum in health care;
- discuss acceptable criteria for rationing, and clarify the limits of patient rights regarding the use of new technologies.

88. Moral responsibility increases in proportion to knowledge. When a person gets sick or dies due to an illness with unknown preventive or effective treatment, there is a responsibility to investigate possible explanations or treatments. However, when people get sick with preventable or treatable illnesses, a more focussed responsibility exists which has to be recognised by societies. Members of society in general and patients in particular bear a great burden of harm because of the lack of adequate quality health care systems. This is a burden which costs lives, reduces functioning and wastes resources thus hindering social development. Improving the quality of health care systems requires therefore the cooperation of all institutions and members of society, each needing to know and accept their own responsibilities for its achievement.

e. Global health risks

Climate change and health

89. There is widespread scientific consensus that the world's climate is changing. Climate change refers to any significant change in measures of climate that lasts for decades or longer. The world's climate is showing signs of a shift, becoming warmer, with more precipitation and weather extremes. These climatic changes could potentially create more variable weather, stronger and longer heat waves, more frequent and severe droughts, extreme weather events such as flooding and tropical cyclones, rises in sea level, and increased air pollution. Other effects may result from the shifting and disruption of the ecosystem. Each of these changes has the potential to negatively affect health. While climate change is recognized as a global issue, the effects of climate change will vary across geographic regions and populations.

90. Climate change has the potential to impact health in many ways, and will have its greatest effect on those who have the least access to the world's resources and who have contributed least to its cause. Without mitigation and adaptation, it will increase health inequity especially through negative effects on the social determinants of health in the poorest communities. Failure to provide mitigation and adaptation would be to disrespect the principle of social responsibility.

91. The threat to health is especially evident in the poorest countries, particularly in sub-Saharan Africa. Their poverty and lack of resources, infrastructure, and often governance, make them far more vulnerable to the effects of climate change. Warmer climate can lead to drought, pressure on resources (particularly water), migration, and conflict. The implications for the health of local populations are acute - on the spread and changing patterns of disease, notably water-borne diseases from inadequate and unclean supplies, on maternal and child mortality as basic health services collapse, and on malnutrition where food is scarce. Changes in infectious disease transmission patterns, for example, are a likely major consequence of climate change. Especially in poor countries, the impacts of major vector-borne diseases and disasters can limit or even reverse improvements in social development. Another important effect of climate change is skin cancer; many epidemiological studies have implicated solar radiation as a cause of melanoma and other types of cancer, in fair-skinned humans. Recent assessments project increases in skin cancer incidence and sunburn severity due to stratospheric ozone depletion, for at least the first half of the twenty-first century.

Pandemics

92. Recent events in world health have called attention to the vulnerability of populations in a globalized environment. The outbreak of H1N1 pandemics confronted governments and industry with unprecedented challenges and ethical dilemmas. The general considerations outlined as a result

of the pandemic may well apply to all circumstances where scarcity represents a problem for implementing health-related priority setting. There is a strong emphasis on efficiency on the part of health care systems and equity in access and distribution of resources. In addition, as stressed in most documents on the relation between scarcity and ethics, accountability, public consultation about the measures to be taken, and trust in policy makers and decision makers are essential aspects of any action at the world level.

93. In the face of a pandemic, making decisions in relation to national and international action that will help to mitigate the effects of the pandemic, diminish its long-term economic and social consequences, and save life in an equitable manner. They should take account of the need to balance the political and technical dimensions of decision-making; the need for sound and objective scientific and ethical criteria, and the need to sustain public confidence in the fairness and effectiveness of public policies. Planning should give full consideration to issues of equity and fairness. This is difficult because it is already clear that no government will be in a position to provide full or adequate protection to everyone. Vaccines will be insufficient or will not be available, and in many circumstances a shortage of health care workers and resources will make it impossible to provide proper care. The commitment to equity and fairness does not imply giving everyone the same treatment, however. It implies taking decisions about the allocation of scarce resources transparently according to criteria that are rational, and applying these criteria consistently.

94. It is vital to establish in advance decision-making procedures that will permit governments and international institutions to make rapid assessments about the level of risk and priorities of need during the peak phase, and sound decisions during each phase of the pandemic. These decision-making procedures should aim to provide governments with sound foundations for principles of equity, non-discrimination, solidarity and reciprocity which have been recognized in numerous legally-binding international and human rights standards. The power of ethical values and notions of human solidarity should not be underestimated, even in a severe crisis, especially if these values can be focused through the media. This underlines the importance of developing a sound communications policy. Arguments based on human rights obligations and ethical principles will be more effective before the onset of a pandemic and after it ends.

Food shortages

95. According to the United Nations Food and Agriculture Organization (FAO), it is now estimated that almost one billion of the world's population of 6.5 billion people is suffering from hunger. Almost all of the world's undernourished population lives in developing countries, mostly composed of vulnerable groups: children, women and indigenous populations. Water shortages, soil losses and rising temperatures from global warming are placing severe limits on food production. The global cereal production in 2008 reached a new record, which should in theory be enough to cover the projected needs for 2008/09, and to allow a modest replenishment of world stocks. But, the cereal stocks-to-utilization ratio is at its lowest level in 30 years. The increase in cereal production in 2008 was accomplished by developed countries. In response to more attractive prices, and because of a greater elasticity of their supply relative to demand, they increased their cereal output by 11%. Developing countries, by contrast, only recorded an increase of 1.1%. That is a compelling evidence of the degree of underinvestment in agriculture in these countries over the last 20 years. This particularly serious international food insecurity situation is however the chronicle of a disaster foretold, because resources to finance agricultural programmes in developing countries have been falling, instead of rising, and that the target of halving world hunger by 2015 risks not to be reached. Indeed, under prevailing trends, that target would only be met in 2150 instead of 2015. Transgenic foods present both hopes and risks in this regard and are associated with social

needs and expectations. Governments and industry should enter into public-private partnerships to cope with the increased demand for information and proceed to establish labeling and other measures that may help people arrive at autonomous decisions regarding the use of genetically modified food products, animal or vegetable.

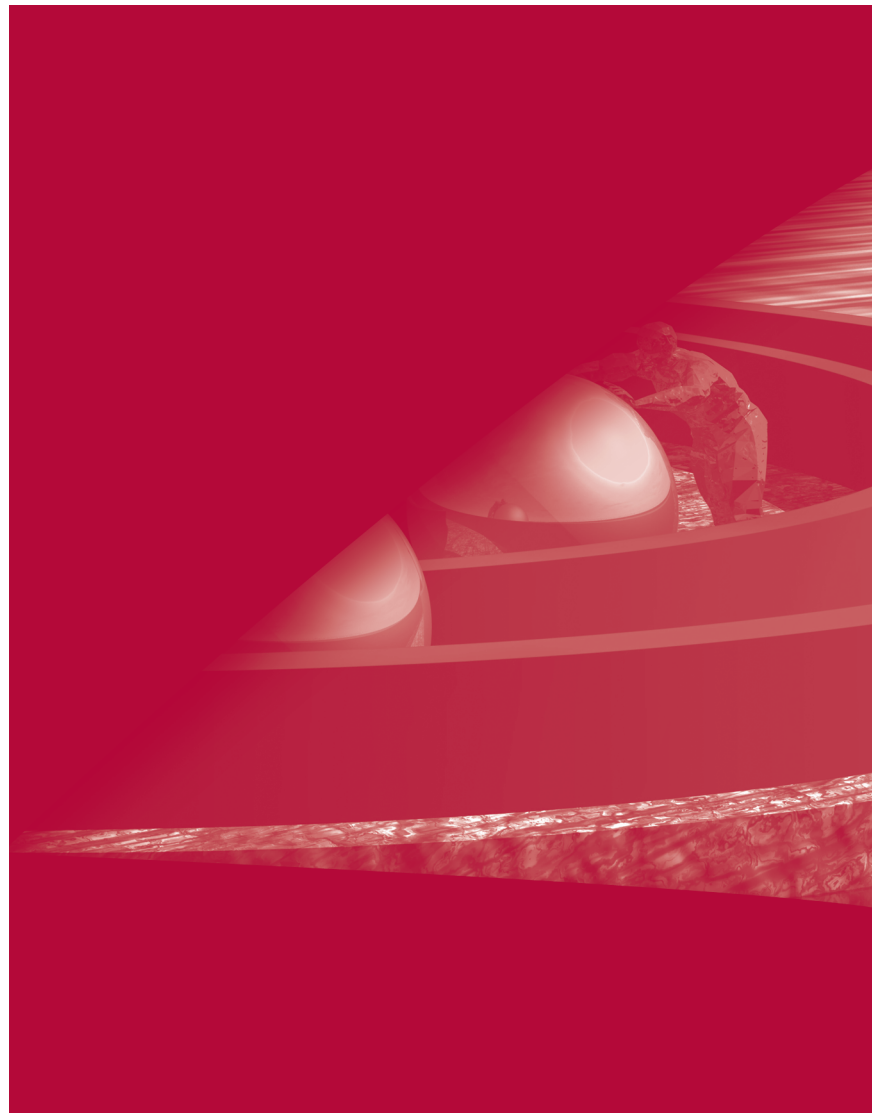
f. Media

96. The emphasis on the importance of knowledge on the part of citizens in achieving the highest attainable standard of health draws attention to the social responsibility of those who provide information to the public. The media have a very important role to play in knowledge dissemination.

97. In today's society, the media (written and spoken press and television) play a major role in the life of citizens. They are in a position to be very helpful in sensitizing the population to health challenges and in explaining widely current questions and their societal dimensions. For that purpose, the concerned public authority and scientific organizations and institutions need to provide scientifically valid and understandable information to the media.

98. In fulfilling their mission, it is of utmost importance that media avoid sensationalism or alarmism which may cause uncertainties and confusions, or even panic, with possibly serious collateral damage. It is then essential that fundamental issues be highlighted and accurately reported.

CONCLUSIONS



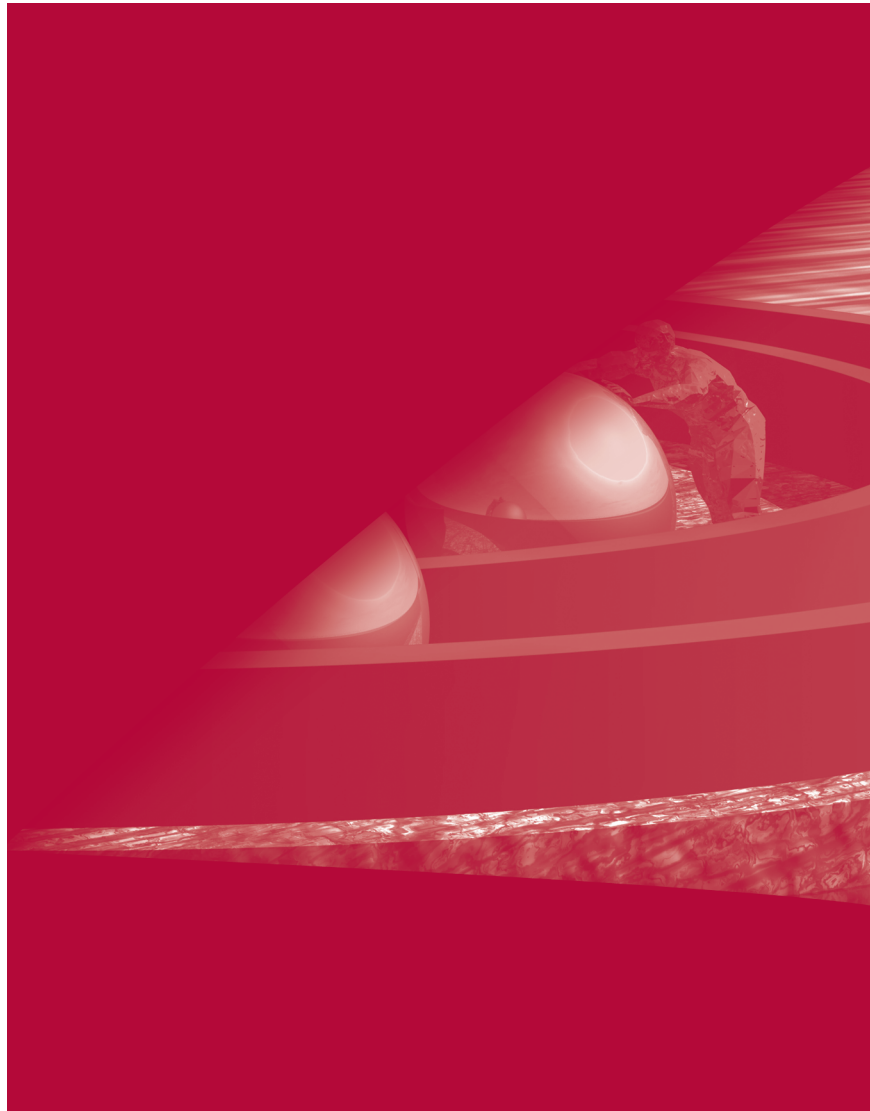
VI. CONCLUSIONS

99. In this Report, the International Bioethics Committee (IBC) has discussed a number of specific as well as general issues that pose a threat to the ability to meet the goals of social responsibility and health, and has endeavoured to address the responsibility of individuals, sectors of society and States to continue to support and enhance the legitimate interests of all people to have access to health care of good quality and to the highest attainable standard of health.

100. In recognition of the importance of our responsibilities to each other, it is important to acknowledge that the achievement of these goals requires not only a serious effort to improve health and health care delivery but also acceptance of the responsibility to minimize or eradicate avoidable risk of threats to health and well-being. Injustice, discrimination, intolerance, violence, accidents and conflicts equally represent risks to the values endorsed in this Report as would failure to pursue those goals that are concerned with health care and its delivery.

101. Meeting the aspirations highlighted in this Report requires profound and active acceptance of our inter-connectedness. Social responsibility is a principle that defines and celebrates our common humanity and our mutual commitment to improving the health of individuals and communities.

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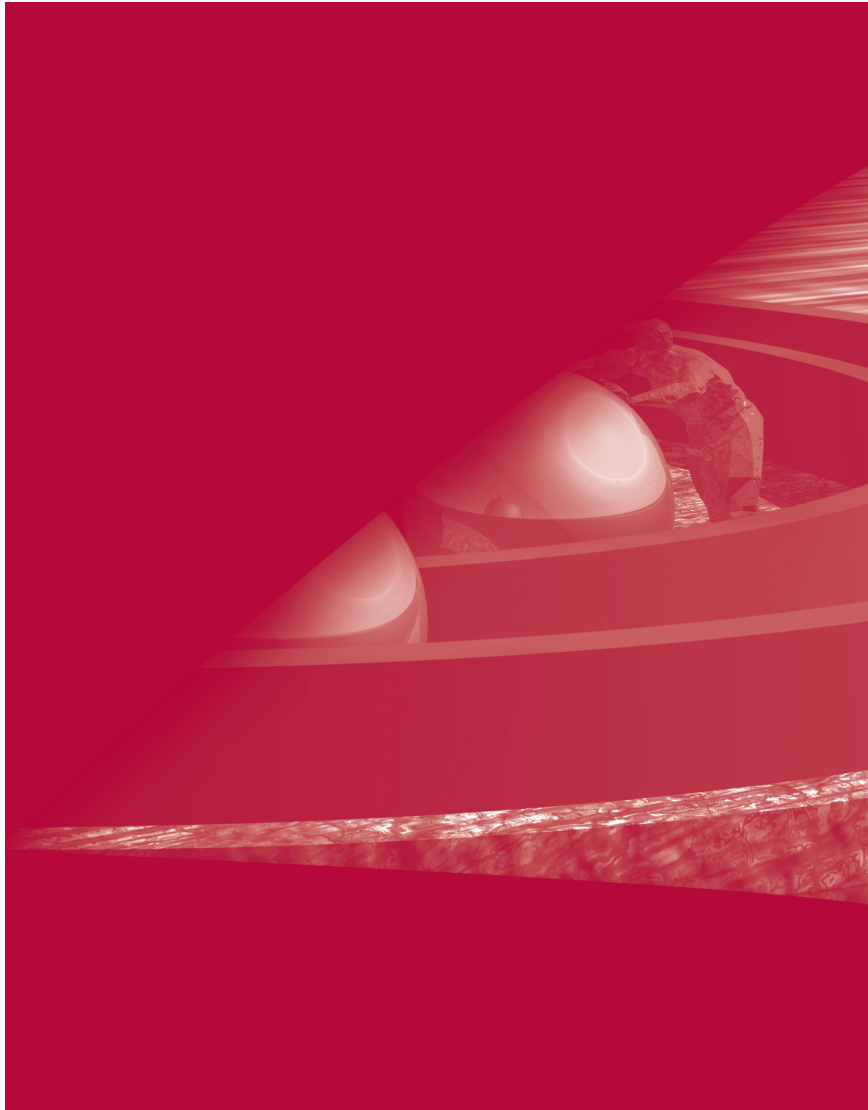


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ANNEXES



HISTORICAL OVERVIEW OF INTERNATIONAL INITIATIVES IN PROMOTING THE PRINCIPLE OF SOCIAL RESPONSIBILITY AND HEALTH

INITIATIVES UNDERTAKEN WITHIN THE UN SYSTEM

The international context regarding health and social responsibility can be traced back to many existing international instruments, declarations, international covenants or statements, as well as initiatives, which explicitly refer to health and welfare of human beings.

Constitution of the World Health Organization (WHO)

The well-known Constitution of WHO defines health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” and affirms that “the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition”.

Universal Declaration of Human Rights

The Universal Declaration of Human Rights (1948) refers to health and welfare of human beings in Article 25, which States that: “Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services...”, and follows:

- (2) Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection.

International Covenant on Economic, Social and Cultural Rights

Article 15 of the International Covenant on Economic, Social and Cultural Rights (1966) states that “everyone has the right to enjoy the benefits of scientific progress and its applications”.

Article 12 states:

1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.
2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:
 - a) the provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;
 - b) the improvement of all aspects of environmental and industrial hygiene;
 - c) the prevention, treatment and control of epidemic, endemic, occupational and other diseases;
 - d) the creation of conditions which would assure to all medical service and medical attention in the event of sickness.

In the year 2000, substantive issues arising in the implementation of the International Covenant on Economic, Social and Cultural Rights were added in General Comment no.14.

Health-for-All by the Year 2000

In 1977 the Thirtieth World Health Assembly decided that the main social goal of governments and WHO in the coming decades should be the attainment by all people of the world by the year 2000 of a level of health that would permit them to lead a socially and economically productive life. This goal is commonly known as Health-for-All by the Year 2000 (Resolution WHA30.43).

The commitment to global improvements in health, especially for the most disadvantaged populations, was reviewed in 1998 by the World Health Assembly. This led to the development of 'Health-for-All for the Twenty-First Century' policy and programme, within which the commitment to primary health care is restated.

In the report of the 51st World Health Assembly, it is indicated:

Over the past two decades primary health care acted as a cornerstone of Health-for-All. Despite gains, however, progress has been hampered for several reasons, including insufficient political commitment to the implementation of Health-for-All, slow socioeconomic development, difficulty in achieving intersectorial action for health, insufficient funding for health, rapid demographic and epidemiological changes, and natural and man-made disasters. Further, poverty has increased worldwide. Health has suffered most where countries have been unable to secure adequate income levels for all.

The report also indicates that primary health care policy approaches should reinforce the following points:

- make health central to development and enhance prospects for intersectorial action;
- combat poverty as a reflection of primary health care's concern for social justice;
- promote equity in access to health care;
- build partnerships to include families, communities and organizations;
- reorient health systems towards promotion of health and prevention of disease.

The WHO "Health-for-All" commitment and programme were marked by a series of Global Conferences on Health Promotion which began in Ottawa in 1986 and produced the Ottawa Charter on Health Promotion. This benchmark conference was followed by conferences in Adelaide (1988), Sundsvall (1991), Jakarta (1997), Mexico City (2000), and Bangkok (2005).

Alma Ata Declaration

The International Conference on Primary Health Care (PHC), held in Alma-Ata, Kazakhstan, in 1978, realized that improving health called for a comprehensive approach whereby primary health care was seen as "the key to achieving an acceptable level of health throughout the world in the foreseeable future as a part of social development and in the spirit of social justice". The Conference adopted The Alma-Ata Declaration which reaffirmed that "health... is a fundamental human right and that the attainment of the highest possible level of health is a most important worldwide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector". The Conference called for a transformation of conventional health care systems and for broad intersectorial collaboration and community organization.

Ljubljana Charter

The Ljubljana Charter, adopted by the Ministers of Health or their representatives from the European Member States of WHO at the WHO Conference on European Health Care Reforms in Ljubljana, Slovenia in June 1996, addressed health care reforms in the specific context of Europe. The purpose of this Charter was to articulate a set of principles which are an integral part of current health care systems or which could improve health care in all the Member States of WHO in the European Region. These principles emerged from the experience of countries implementing health care reforms

and from the European health-for-all targets, especially those related to health care systems. Recently, Member States of the same WHO region established the Tallinn Charter (June, 2008), which commits them to improve people's health by strengthening health systems, while acknowledging social, cultural, and economic diversity.

Jakarta Declaration

The promotion of social responsibility for health was first established as a priority at the WHO Fourth International Conference on Health Promotion: New Players for a New Era – Leading Health Promotion into the 21st Century, held in Jakarta, Indonesia in July 1997.

In the final Declaration, the Conference, the first to be held in a developing country, and the first to involve the private sector in supporting health promotion, recommended that decision makers must be “firmly committed to social responsibility” and both public and private sectors “should promote health by pursuing policies and practices that:

- avoid harming the health of individuals;
- protect the environment and ensure sustainable use of resources;
- restrict production of, and trade in, inherently harmful goods and substances such as tobacco and armaments, as well as discourage unhealthy marketing prices;
- safeguard both the citizen in the marketplace and the individual in the workplace;
- include equity-focused health impact assessments as an integral part of policy development”.

Bangkok Charter

More recently, the Bangkok Charter, adopted at the WHO Sixth Conference on Global Health Promotion held in Thailand in August 2005, identified actions, commitments and pledges required to address the determinants of health in a globalized world through health promotion. Thus, it was recommended that “governments at all levels must tackle poor health and inequalities as a matter of urgency because health is a major determinant of socioeconomic and political development”. Its four key commitments were to make promotion of health:

- central to the global development agenda: strong intergovernmental agreements that improve health and collective health security and effective mechanisms for global governance for health are needed;
- a core responsibility for government as a whole: the determinants of health need to be addressed by all ministries at all levels of government;
- a key focus of communities and civil society: well-organized and empowered communities are highly effective in determining their own health, and are capable of encouraging governments and the private sector to be accountable for the health consequences of their policies and practices;
- a requirement for good corporate practice: the private sector has a responsibility to ensure health and safety in the workplace and to promote the health and well-being of employees, their families and communities, and to contribute to lessening wider impacts on global health.

UN Millennium Development Goals

Further international efforts to meet the needs of the poorest, including better health, have been included in the eight UN Millennium Development Goals (MDG) (United Nations Millennium Declaration adopted by the General Assembly in September 2000). The MDG address health in a global and social perspective. Indeed, among the development goals, reduction of child mortality (Goal 4), improvement of maternal health (Goal 5) and combat HIV/AIDS, malaria and other

diseases (Goal 7) can be found. Moreover, one of the seven modalities set out to achieve Goal 8 'Develop a global partnership for development' is to provide access to affordable essential drugs in developing countries in cooperation with pharmaceutical companies.

Commission on Social Determinants of Health

The Commission on Social Determinants of Health (CSDH) was established by WHO in 2005 to support countries and global health partners to address the social factors leading to ill health and inequities. It was tasked to collect, collate, and synthesize global evidence on the social determinants of health and their impact on health inequity, and to make recommendations for action to address that inequity. The Commission functioned as a global network bringing together hundreds of researchers and practitioners from universities and research institutions, government ministries, and international and civil society organizations.

The Final Report published by the Commission in 2008 (*Closing the gap in a generation*) sets out key areas – of daily living conditions and of the underlying structural drivers that influence them – in which action is needed. It provides analysis of social determinants of health and concrete examples of types of action that have proven effective in improving health and health equity in countries at all levels of socioeconomic development.

INITIATIVES UNDERTAKEN BY OTHER ORGANIZATIONS

Outside the United Nations systems, a number of alliances between public, private, nongovernmental, and international organizations and civil society have been organized with the aim to address the determinants of health in a globalized world through health promotion. Recent initiatives are described below as examples.

Global Forum for Health Research. At recent parallel meetings of the Forum 8, organized by the Global Forum for Health Research and the Ministerial Summit on Health Research in Mexico City in November, 2004, over 1,400 policy makers, health ministers, researchers and representatives of governments, development agencies, and research institutions examined the issue on how research could improve strategies and help to attain the MDG. One of the conclusions of both the Forum and the Summit was that achieving the MDG will require addressing health and its determinants in a comprehensive way and will necessitate further health research of high quality, focused on the needs of developing countries and vulnerable populations. It must give systematic attention to cross-cutting issues of poverty and equity, taking account of inequities based on gender, ability, ethnicity and social class, among others; the needs of both the aged and the largest generation ever of young people 0-19 years, and the needs of other specifically disadvantaged groups such as migrants, refugees and those exposed to violent conflict. It was concluded that all the participants must commit themselves to the shared responsibility of advancing the volume and pace of health research that is focused on improving the lifespan and health of people everywhere. Special consideration was given to increase funding for health systems research, as this activity of research is the one that may have the largest impact on improving health.

At a 2008 meeting in Bamako, Ministers and representatives of Ministries of health, science and technology, education, foreign affairs, and international cooperation from 53 countries recognized that research and innovation have been and will be increasingly essential to find solutions to health problems, address predictable and unpredictable threats to human security, alleviate poverty, and accelerate development, and called national governments for action.

Grand Challenges in Global Health. This initiative is a partnership dedicated to supporting scientific and technical research to solve critical health problems in the developing world. The initiative's partners are the Bill & Melinda Gates Foundation, the Canadian Institutes of Health Research, the Foundation for the National Institutes of Health, and the Wellcome Trust. A grand challenge is meant to direct investigators to a specific scientific or technical breakthrough that would be expected to overcome one or more bottlenecks in an imagined path towards a solution to one or preferably several significant health problems. Therefore a grand challenge is envisioned as distinct from a simple statement of one of the major problems in global health, such as malnutrition or the lack of access to medical care. The initiative has identified and supported seven long-term goals to improve health in the developing world:

- to improve childhood vaccines;
- to create new vaccines;
- to control insects that transmit agents of disease;
- to improve nutrition to promote health;
- to improve drug treatment of infectious diseases;
- to cure latent and chronic infection;
- to measure health status accurately and economically.

Reaching the Poor Programme (RPP). This is an effort to begin finding better ways of ensuring that the benefits of health, nutrition, and population (HNP) programmes flow to disadvantaged population groups. It has been undertaken by the World Bank, in cooperation with the Gates Foundation, and the Dutch and Swedish Governments. In order to help improve how well HNP programmes reach poor people, the RPP seeks to:

- determine which HNP programmes do or do not reach disadvantaged groups effectively. The resulting information, produced through application of recently-developed quantitative techniques for assessing programmes' distributional performance, is intended to provide guidance to policy makers about which approaches to adopt or to avoid in developing pro-poor initiatives;
- encourage others to undertake similar determinations of HNP programme effectiveness in reaching the poor. More widespread application of the techniques just mentioned, derived from the 'benefit incidence' approach used to determine who benefits most from government expenditures, would allow policy makers to assess and then improve their performance in reaching the poor on an ongoing basis.

The programme considers that health policies do not have to be inequitable: "While most health, nutrition, and population services exacerbate poor-rich inequalities by achieving much lower coverage among the disadvantaged than among the better-off, many significant and instructive exceptions exist. This demonstrates the feasibility of reaching the poor much more effectively than at present, and point to promising strategies for doing so."

GLOBAL HEALTH CONDITIONS - AN OVERVIEW

(This Annex includes mostly findings of the World Health Organization, for illustrative purposes. The pertinent references are mentioned in the Bibliography section)

Global health conditions at present have been summarized in 2006 by WHO: "In this first decade of the 21st century, immense advances in human well-being coexist with extreme deprivation. In global health we are witnessing the benefits of new medicines and technologies. But there are unprecedented reversals. Life expectancies have collapsed in some of the poorest countries to half the level of the richest – attributable to the ravages of HIV/AIDS in parts of sub-Saharan Africa and to more than a dozen 'failed States'. These setbacks have been accompanied by growing fears, in rich and poor countries alike, of new infectious threats such as SARS and avian influenza and 'hidden' behavioural conditions such as mental disorders and domestic violence. The world community has sufficient financial resources and technologies to tackle most of these health challenges; yet today many national health systems are weak, unresponsive, inequitable – even unsafe. What is needed now is the political will to implement national plans, together with international cooperation to align resources, harness knowledge and build robust health systems for treating and preventing disease and promoting population health." More recently, at the midpoint between 2000 and 2015, a WHO analysis shows encouraging signs of progress, particularly in child health. For some diseases, current gains need to be sustained, particularly AIDS, tuberculosis, and malaria. Areas where there have been little or no improvements include maternal and newborn health. In addition, the challenges presented by weak health systems, the health transition, and emerging health threats will become increasingly prominent in the near future.

MAJOR PUBLIC HEALTH PROBLEMS

Despite progress in the medical and health fields, major public health problems and inequalities of health care between North and South still remain. Today 800 million individuals suffer from hunger and malnutrition, and more than a billion people do not have access to safe drinking water, basic education, and health care. In this information age where future development is supposed to be based on knowledge, two billion are not connected to an electricity supply and more than 4.5 billion or 80% of the world's population is deprived of basic telecommunication technology.

Maternal mortality

Every year some 536 000 women die of complications during pregnancy or childbirth, 99% of them in developing countries. The global maternal mortality ratio of 400 maternal deaths per 100 000 live births in 2005 has barely changed since 1990. Most maternal deaths occur in the African region, where the maternal mortality ratio is 900 per 100 000 live births, with no measureable improvement between 1990 and 2005. Progress in reducing maternal mortality and morbidity depends on better access to, and use of, good maternal and reproductive health services. The proportion of pregnant women in the developing world who had at least one antenatal care visit increased from slightly more than half at the beginning of the 1990s to almost three quarters a decade later. Over the period 2000–2008, 65% of births globally were attended by skilled health personnel, 4% more than in 1990–1999.

Child mortality

Undernutrition is an underlying cause in more than one third of child deaths. In 2007, there were an estimated 9 million child deaths, significantly fewer than the 12.5 million estimated in 1990, with a 27% decline in the under-5 mortality rate over that period to 67 per 1000 live births in 2007. Reducing child mortality increasingly depends on tackling neonatal mortality; globally, an estimated 37% of deaths among children under five occur in the first month of life, most in the first week. Countries making the least progress are generally those affected by high levels of HIV/AIDS, economic hardship or conflict. Much of the progress in reducing child mortality can be attributed to increased immunization coverage, use of oral rehydration therapies during episodes of diarrhoea, use of insecticide-treated mosquito nets, access to artemisinin-based combination therapies, efforts to eliminate disease due to *Haemophilus influenzae* type b infection and reduced disease incidence due to improved water and sanitation. However, because the availability and use of proven interventions at community level remain low, pneumonia and diarrhoea still kill 3.8 million children under five each year.

Infectious diseases

Infectious diseases continue to be a serious burden around the world, in developing as well as industrialized countries. Infections can cause illness, disability and death in individuals while disrupting whole populations, economies and governments. Transmissible diseases constitute the main cause of death in the poorest countries: 59% of deaths reported in the 20 poorest countries are caused by such diseases, compared with 8% in the 20 richest countries. WHO estimates that in 2002 some 11 million people died from infectious and parasitic diseases, 52% of them in Africa, 26% in South-East Asia, and 3% in Latin America. The main causes of annual deaths from transmissible diseases were respiratory infections (4 million), HIV/AIDS (2.8 million), tuberculosis (1.5 million), diarrhoea (1.8 million), and malaria (1.3 million).

As people, products, food and capital travel the world in unprecedented numbers and at historic speed, so, too, do the myriad of disease-causing microorganisms. Because national borders offer only a trivial impediment to such threats, especially in the highly interconnected and readily traversed 'global village' of our time, one nation's problem soon becomes every nation's problem. The worldwide resurgence of dengue fever, the introduction of West Nile virus into New York City in 1999, the rapid spread of HIV infection in Russia, and the global spread of multidrug-resistant tuberculosis are but a few examples of the profound effects of globalizing forces on the emergence, distribution and spread of infectious diseases. No nation is immune to the growing global threat that can be posed by an isolated outbreak of infectious disease in a seemingly remote part of the world. In addition to the known diseases, there are new epidemics such as SARS, which infected some 8,000 people in 30 countries in 2003, and avian influenza, which led to the slaughter of millions of animals in three continents; experts fear that the virus could mutate and unleash a human influenza pandemic. WHO released in 2005 the second edition of the International Health Regulations, specifying the measures States should get into line with and devoting special attention to the issue of travellers and of baggage, cargo, and goods inspection.

HIV/AIDS is one of the most urgent threats to global public health. Most of the infections with HIV and deaths due to the disease could be prevented if people everywhere had access to good services for preventing and treating HIV infection. New estimates indicate that 2.7 million people were newly infected with HIV during 2007 and that there were two million deaths related to AIDS, bringing the total number of people living with HIV to 33 million. The percentage of adults living with HIV globally has remained stable since 2000. Use of antiretroviral therapy has increased; in the course

of 2007, about one million more people living with HIV received antiretroviral therapy. However, despite this, of the estimated 9.7 million people in developing countries that need treatment, only 3 million were receiving the medicines. Progress has been made in prevention, but at the end of 2007 only 33% of HIV-infected women had received antiretroviral drugs to reduce the risk of mother to child transmission.

In 2006, an estimated 3,300 million people were at risk of malaria. Of these, some 1200 million were in the high-risk category (living in areas with more than one reported case of malaria per 1,000 population per year). Although it is still too early to register global changes in impact, 27 countries (including five in Africa) have reduced reported cases of the disease and/or deaths resulting from it by up to 50% between 1990 and 2006. Coverage of interventions for the prevention and treatment of malaria has increased. There has been a significant growth in the production and use of insecticide-treated mosquito nets, although global targets are still not being met. By June 2008, all but four countries and territories with a high burden of the disease had adopted artemisinin-based combination therapy as the first-line treatment for falciparum malaria, and use of combination therapies is being scaled up.

The MGD target in respect of halting and reversing the incidence of tuberculosis was met globally in 2004. Since then the rate has been falling slowly. Tuberculosis prevalence and death rates per 100 000 population declined from 296 in 1990 to 206 in 2007 for the former, and from 28 in 1990 to 25 in 2006 for the latter. Globally, the tuberculosis case-detection rate under the DOTS approach (Directly Observed Therapy, Short-course) increased from an estimated 11% in 1995 to 63% in 2007. The rate of improvement in case detection slowed after 2004, largely as a result of earlier successes in the countries with the largest number of cases. Data on treatment success rates under the DOTS approach indicate consistent improvement, with rates rising from 79% in 1990 to 85% in 2006. Multidrug-resistant tuberculosis and HIV associated tuberculosis pose particular challenges in some regions.

An estimated 1200 million people are affected by neglected tropical diseases, chronic disabling infections that thrive in conditions of impoverishment and weak health systems. In 2007, 546 million people were treated to prevent transmission of lymphatic filariasis. Only 9585 cases of dracunculiasis (guinea-worm disease) were reported in the five countries in which the disease is endemic, compared with an estimated 3.5 million reported in 20 such countries in 1985. The global prevalence of leprosy at the beginning of 2008 stood at 212 802 reported cases, down from 5.2 million cases in 1985.

Chronic diseases

Heart disease, stroke, cancer, chronic respiratory diseases and diabetes are by far the leading cause of mortality in the world, representing 60% of all deaths. Out of the 35 million people who died from chronic disease in 2005, half were under 70 and half were women. Visual impairment and blindness, hearing impairment and deafness, oral diseases and genetic disorders are other chronic conditions that account for a substantial portion of the global burden of disease.

According to WHO, half a century ago, a child born in Europe could expect to live for about 66 years, a life expectancy at birth that was the highest of any region in the world except North America. By contrast, average life expectancy at birth 50 years ago was 38 years in sub-Saharan Africa, 41 years in Asia, 45 years in the Middle East, 51 years in Latin America and the Caribbean, and 60 years in Oceania. Over the following 50 years, average life expectancy at birth improved all over the world, increasing by almost 27 years in Asia, 23 years in the Middle East, 21 years in Latin America, 14 years in Oceania, and 11 years in sub-Saharan Africa. The smallest increase

was in Europe, where life expectancy increased by only 8 years, probably due to the very slow pace of change in some parts of the continent of Europe.

As populations age in middle- and low-income countries over the next 25 years, the proportion of deaths due to non-communicable diseases will rise significantly. Globally, deaths from cancer will increase from 7.4 million in 2004 to 11.8 million in 2030, and deaths from cardiovascular diseases will rise from 17.1 million to 23.4 million in the same period. Deaths due to road traffic accidents will increase from 1.3 million in 2004 to 2.4 million in 2030, primarily owing to increased motor vehicle ownership and use associated with economic growth in low- and middle-income countries. By 2030, deaths due to cancer, cardiovascular diseases, and traffic accidents will collectively account for 56% of the projected 67 million deaths due to all causes. This increase in deaths from non-communicable diseases will be accompanied by large declines in mortality for the main communicable, maternal, perinatal, and nutritional causes, including HIV infection, tuberculosis, and malaria. However, deaths worldwide from HIV/ AIDS are expected to rise from 2.2 million in 2008 to a maximum of 2.4 million in 2012 before declining to 1.2 million in 2030.

It is predicted that the four leading causes of death in the world in 2030 will be ischaemic heart disease, cerebrovascular disease (stroke), chronic obstructive pulmonary disease (COPD), and lower respiratory infections (mainly pneumonia). Much of the increase in COPD is associated with projected increases in tobacco use. On the other hand, road traffic accidents will emerge as the fifth leading cause of death in 2030, rising from its position as the ninth leading cause in 2004. Although deaths due to HIV/AIDS are projected to fall by 2030, it will remain the tenth leading cause of death worldwide. Deaths due to other communicable diseases are projected to decline at a faster rate: tuberculosis will fall to no. 20 and diarrhoeal diseases to no. 23 in the list of leading causes.

Tobacco is the single largest cause of preventable death in the world today, being a risk factor for six of the eight leading causes of death. Tobacco kills a third to a half of all those who use it. On average, every user of tobacco loses 15 years of life. Total tobacco-attributable deaths from ischaemic heart disease, cerebrovascular disease (stroke), chronic obstructive pulmonary disease and other diseases are projected to rise from 5.4 million in 2004 to 8.3 million in 2030, almost 10% of all deaths worldwide. More than 80% of these deaths will occur in developing countries.

Deaths from infectious diseases, maternal and perinatal conditions, and nutritional deficiencies combined are projected to decline by 3% over the next 10 years. In the same period, deaths due to chronic diseases are projected to increase by 17%. This means that of the projected 64 million people who will die in 2015, 41 million will die of a chronic disease – unless urgent action is taken. Contrary to common perception, 80% of chronic disease deaths occur in low and middle-income countries. From a projected total of 58 million deaths from all causes in 2005, it is estimated that chronic diseases will account for 35 million, which is double the number of deaths from all infectious diseases (including HIV/AIDS, tuberculosis and malaria), maternal, and perinatal conditions, and nutritional deficiencies combined. The total deaths from chronic diseases are projected to increase by a further 17% over the next 10 years, while deaths from infectious diseases, maternal, and perinatal and nutritional deficiencies combined are expected to decline.

The threat is growing – the number of people, families and communities afflicted is increasing. This growing threat is an under-appreciated cause of poverty and hinders the economic development of many countries. Common, modifiable risk factors underlie the major chronic diseases. These risk factors explain the vast majority of chronic disease deaths at all ages, in men and women, and in all parts of the world. They include: unhealthy diet, physical inactivity, and tobacco use. The burden of chronic disease has major adverse effects on the quality of life of affected individuals, causes premature death and creates large adverse – and underappreciated – economic effects on families, communities and societies in general.

Despite global successes, chronic diseases have generally been neglected in international health and development work. Furthermore, these diseases have not been included within the global Millennium Development Goal targets. Chronic diseases hinder economic growth and reduce the development potential of countries, and this is especially true for countries experiencing rapid economic growth, such as China and India. However, it is important that prevention is addressed within the context of international health and development work even in least developed countries, which are already undergoing an upsurge in chronic disease risks and deaths.

Malnutrition

Malnutrition is still one of the major public-health problems in the world, as shown by the low nutrition indices in many countries of the South, but above all in East and West Africa (0.46 and 0.50 respectively). Furthermore, it is estimated that over 800 million people do not have access to good-quality food in sufficient quantity and that over 2 billion suffer from deficiencies of micronutrients such as vitamin A, iodine, and iron. Every year, nearly 11 million children under-five die and almost all of these deaths occur in developing countries, three quarters of them in sub-Saharan Africa and South Asia, two regions that also record the highest incidence of problems relating to hunger and malnutrition. Generally, although these children do not die from famine but from neonatal ailments and a variety of curable infectious diseases, particularly diarrhoea, pneumonia, malaria and measles, most of these children would not die if their immune systems were not weakened by malnutrition. Finally, hunger and malnutrition are the main causes of destitution and extreme poverty, giving rise to criminal and violent behaviour.

Hungry children start attending school late (if at all); they finish their studies earlier and learn less, which impedes progress towards primary and secondary education for all. Under-nutrition of women is one of the most destructive results of gender inequality: it reduces their education and employment opportunities and impedes progress towards gender equality and women's autonomy. Hunger and malnutrition increase the incidence and lethality rate of the health problems that cause most deaths during pregnancy and parturition. Hunger and poverty destroy the immune systems of population groups, force them to adopt risky survival strategies and substantially increase the risk of infection and death from HIV/AIDS, malaria, tuberculosis, and other infectious diseases.

SOCIAL DETERMINANTS OF HEALTH

Throughout the world, people who are vulnerable and socially disadvantaged have less access to health resources, get sicker and die earlier than people in more privileged social positions. The greatest share of health problems is attributable to the social conditions in which people live and work, referred to as the social determinants of health. Good medical care is vital to the well being of populations, but improved clinical care is not enough to meet today's major health challenges and overcome health inequities.

Without action on social determinants, those countries in greatest need will neither meet the health-related MDG nor achieve global targets for reducing chronic diseases such as cardiovascular diseases, cancer and diabetes. Problems are especially urgent in developing countries where the burden of chronic illnesses is growing rapidly on top of the burden of unresolved infectious epidemics.

Health status, therefore, should be of concern to policy makers in every sector, not solely those involved in health policy. To reduce inequalities in health across the world there is a need for a major thrust that is complementary to development of health systems and relief of poverty: to take action on the social determinants of health. Such action will include relief of poverty but it will have the broader

aim of improving the circumstances in which people live and work. It will, therefore, address not only the major infectious diseases linked with poverty but also non-communicable diseases – both physical and mental – and violent deaths that form the major burden of disease and death in every region of the world outside Africa and add substantially to the burden of communicable disease in sub-Saharan Africa. If the major determinants of health are social, so must be the remedies. Treating existing disease is urgent and will always receive high priority but should not be to the exclusion of taking action on the underlying social determinants of health. Disease control, properly planned and directed, has a good history, but so too does social and economic development in combating major diseases and improving population health. Wider social policy will be crucial to the reduction of inequalities in health.

Poverty. Links between poverty, increasing population, environmental degradation, poor health, human migration and strife are well known. One could be the cause and the effect of the other. A vast amount of data is now available to establish that the health problems of the poor differ significantly from those of the rich, within a country and between countries. The current trade and economic policies (the free flow of trade and money) around the world has brought economic growth for the fortunate in the largest and strongest economies but has also created widening gaps in wealth and health between and within the countries. To realize an environmentally sound, economically productive, socially responsible and behaviourally possible development requires a developmental strategy which ensures economic growth translated into human development: only then can it be sustainable. 150 million people suffer catastrophic health care costs each year. From 89 countries included in a WHO study, each year an average of 2.3% of households experience financial catastrophe due to health care costs, corresponding to over 150 million people worldwide. More than 100 million people are impoverished because they must pay for health care. Catastrophic health care spending occurs in countries at all levels of development. Nevertheless, the problem is more frequent and more severe in middle-income and in low-income countries.

Overpopulation. High fertility rates have historically been strongly correlated with poverty, high childhood mortality rates, low status and educational levels of women, deficiencies in reproductive health services and inadequate availability and acceptance of contraceptives. Poverty and population are linked so closely that their solution must go hand in hand. At the moment poor countries are unable to provide for the total resources required for this purpose. With the exception of sub-Saharan Africa much of the developing world is now well into a transition from high fertility and mortality rates to low ones. The world is thus both younger and older than ever before. Globally, the contraceptive prevalence rate increased from 59% in 1990–1995 to 63% in 2000–2006. Nonetheless, in some regions it remains very difficult to reduce the considerable unmet need for family planning and the high rates of adolescent fertility. Globally, there were 48 births for every 1000 women aged 15–19 years in 2006, only a small decline from 51 per 1000 in 2000. Today half the population in developing countries is under 23 years old, an estimated 800 million people – 15% of the world's population is thus in their teens. This results in a 'demographic momentum' implying that even after the fertility rate falls below replacement levels, the population would continue to increase for several decades hereafter. A doubling of the number of older people in developing countries in the next 25 years will mount to 'an unprecedented demographic revolution'. Ageing populations add to the national pool of chronic debilitating diseases like cardiac and cerebrovascular disorders, degenerative arthritis, osteoporosis, dementia, Parkinson's disease, cancer etc., which add to the already rising cost of health care.

Malnutrition. Altogether it looks as if the global race between population and food is at best going to be rather too close, for the poorest communities it is already being lost (because the prices are rising). Everyone agrees that the world's population will exceed 8 billion by 2025, an increase of

30% in 25 years. Future increases in food supplies, required to feed these extra numbers, must come primarily from rising biological yields, rather than from area expansion and large-scale irrigation expansion. The challenge is world wide, and both technological and political in nature. The technological challenge is enormous, requiring the development of new, highly productive, more nutritious, environmentally sustainable production systems. Some of the already available new technologies, such as genetically modified organisms (GMOs), post-harvest technologies, pest control and food storage, can help meet some of these challenges. Under-nutrition triggers an array of health problems like stunted growth, proneness to infections and worst of all mental retardation and cognitive impairment. Adverse socioeconomic circumstances during foetal life and in early childhood also have a specific influence on mortality from stroke and stomach cancer in adulthood, which is not due to the continuity of social disadvantage throughout life. Deprivation in childhood influences risk of mortality from coronary heart disease in adulthood, although an additive influence of adulthood circumstances is seen in these cases.

Life styles. Evidence suggests that modern inactive life styles, affluence related over consumption of food-stress associated with 'get rich quick' or 'extremely competitive world', over-indulgence in unhealthy food and beverages, smoking and recreational drugs, promiscuous sex, and breaking down of conventional joint family systems are responsible for the emerging morbidity and mortality profile already prevalent in many developed countries. Obesity, diabetes, hypertension, cardio- and cerebrovascular and mental disorders are already responsible for increasing cost of health care globally. The number of people suffering from diabetes worldwide is projected to more than double from 135 million now to almost 300 million by 2025. Globally, the prevalence of chronic, non-communicable diseases is increasing at an alarming rate. About 18 million people die every year from cardiovascular disease, for which diabetes and hypertension are major predisposing factors. Propelling the upsurge in cases of diabetes and hypertension is the growing prevalence of overweight and obesity – which have, during the past decade, joined underweight, malnutrition and infectious diseases as major health problems threatening the developing world. The main culprit is an environment which promotes behaviour that causes obesity.

Lack of access to health care. Health care has a limited but not negligible role as a determinant of health. It has been estimated that 5 years of the 30-year increase in life expectancy achieved is due to improved health services. Of these 5 years, it has been estimated that curative services contributed about 3.5 and clinical preventive services about 1.5 years. The greatest share of this gain from health care can be attributed to diagnosis and treatment of coronary heart disease, which contributes 1 to 2 of these additional years of life. It is important, inasmuch as possible, to assume the needs of the population rather than its level of wealth as the benchmark of quality. It is not only the developed countries that have a right to access to health care, as testified for example, by the Salam Cardiosurgery Centre of Khartoum, which provides free medical care to patients coming from many African countries. Although nearly all developing countries publish an essential medicines list, the availability of medicines at public health facilities is often poor. Surveys in about 30 developing countries indicate that availability of selected medicines at health facilities was only 35% in the public sector and 63% in the private sector. Lack of medicines in the public sector forces patients to purchase them privately. In the private sector, however, generic medicines are often sold at several times the international reference price, while originator brands are generally even more expensive.

Physical environment. The physical environment affects health and disease in different ways. Safe water and clean air, healthy workplaces, safe houses, communities, and roads all contribute to good health. Examples include exposure to toxic substances that produce lung disease or cancers; safety at work, which influences injury rates; poor housing conditions and overcrowding, which can increase the likelihood of violence; transmission of infectious diseases and mental health problems,

and urban-rural differences in cancer rates. The presence of natural or man-made hazards is a source of environmental diseases, which might be seen as the visible and clinical indication of inadequate environmental conditions. Key areas of action could be outdoor and indoor air pollutants, noise, indoor environment and housing conditions, water quality contamination, radiation and chemical exposures. The impact of these factors is felt in association with hearing problems, sleeping disorders, stress leading to hypertension and other circulatory diseases, skin and other cancers, asthma, or birth defects.

Genetic endowment. Genetic factors are recognized as having a significant influence on health, and it will be important to gain a better understanding of these influences. Genetic determinants are important constitutive factors for individual health; however, they presently fall beyond the scope of public health interventions. The field of genetics will become more and more important in future years as nearly every disease has constitutive and/or acquired genetic components. The identification of disease-susceptibility genes as well as the identification of acquired somatic mutations underlying a specific disease, e.g., cancer, can provide a wealth of new information vital to a more thorough understanding of many common illnesses. Such information can be used to determine both how diseases are diagnosed and how new treatments or more specific drug targets can be identified. For the most part, genetic factors are currently understood as contributing to a greater or lesser risk for health outcomes, rather than determining them with certainty. Genetic factors also interact with social and environmental factors to influence health and disease. It will be important to understand these interactions to learn why certain individuals with similar environmental exposure develop diseases whereas others do not.

Travel/Migration. The present world is characterized by increasing mobility of populations and individuals. Modern means of transportation facilitate greatly the speed and diversity of this mobility. International travellers now number nearly one billion persons per year. The vast majority travel for short periods of time for recreational or professional reasons. But there are some international migrants – approximately 150 million in the world – who travel primarily on a one way ticket, usually from poor to rich countries. Their circumstances of travel and living conditions in their new country may be difficult with restricted access to medical services. Some (refugees) are forced to leave their country for reasons of insecurity and war. Those travellers and migrants will facilitate transmitting the epidemic of emergency and re-emergency diseases such as SARS, avian flu, HIV/AIDS, and tuberculosis.

Lack of access to safe water leads to 8 million deaths every year, as a result of water-borne diseases (cholera, typhoid, diarrhoea), half of them children. Currently, 1.4 billion people do not have access to safe drinking water and 2.6 billion, that is, 42% of the world's population, are not served by basic sanitation systems (sewage collection and treatment). The United Nations estimates that some 1.6 million lives could be saved each year if access to clean drinking water and to sanitation and hygiene services could be improved. Moreover, natural disasters are increasingly common and 90% of them are water-related. They are the result of improper land use. The case of Lake Chad in Africa is a striking example since it has lost nearly 90% of its surface area since the 1960s, mainly because of overgrazing, deforestation, and large unsustainable irrigation projects. Lack of safe water and poor sanitation are important risk factors for mortality and morbidity, including diarrhoeal diseases, cholera, worm infestations and hepatitis. Globally, the proportion of the population with access to improved drinking-water sources increased from 76% to 86% between 1990 and 2006. Since 1990, the number of people in developing regions using improved sanitation facilities has increased by 1,100 million. Nevertheless, in 2006, there were 54 countries in which information was available where less than half the population used an improved sanitation facility.

Environmental consequences of development. Development under the best of circumstances has some adverse effects on health by affecting the environment on one hand and life style on the other.

These are further exacerbated when socio-political compulsions demand rapid economic development – ‘development at all cost’ – unmindful of their socio-cultural, administrative milieu – as happens in many developing countries. The inescapable, though commonly recognized fact is that the introduction of new technologies, necessary for development brings with it irreversible social, ecological and health consequences, which under certain circumstances can be harmful. A proliferation of water bodies for irrigation purposes increases the number of breeding sites for disease vectors such as mosquitoes resulting in resurgent malaria, dengue, and Japanese encephalitis. Deforestation and soil erosion expand the habitat of sand flies, which transmit leishmaniasis. Increasing use of pesticides for purposes of agricultural production is estimated to be responsible for more than 2 million cases of human poisoning every year resulting in 20,000 deaths. Some signals of the threat to the sustainability of our ecosystem are: global warming, enlarging ozone hole, acid rain, increasing loss of forests and biodiversity, diminishing availability of cultivable land, environmental pollution of air, water and land, threatened water resources, perceptible reduction in global food reserves, progressive depletion of non-renewable sources of energy, large scale population migrations – within a country (rural-urban) and across national boundaries – in search of sustenance, growing menace of urban slums, unacceptable levels of unemployment in most countries, increasing inequities of wealth distribution between the ‘haves’ and the ‘have nots’ nationally and internationally, resulting in social strife, criminality and wars.

UNIVERSAL DECLARATION ON BIOETHICS AND HUMAN RIGHTS⁽¹⁾

The General Conference,

Conscious of the unique capacity of human beings to reflect upon their own existence and on their environment, to perceive injustice, to avoid danger, to assume responsibility, to seek cooperation and to exhibit the moral sense that gives expression to ethical principles,

Reflecting on the rapid developments in science and technology, which increasingly affect our understanding of life and life itself, resulting in a strong demand for a global response to the ethical implications of such developments,

Recognizing that ethical issues raised by the rapid advances in science and their technological applications should be examined with due respect to the dignity of the human person and universal respect for, and observance of, human rights and fundamental freedoms,

Resolving that it is necessary and timely for the international community to state universal principles that will provide a foundation for humanity's response to the ever-increasing dilemmas and controversies that science and technology present for humankind and for the environment,

Recalling the Universal Declaration of Human Rights of 10 December 1948, the Universal Declaration on the Human Genome and Human Rights adopted by the General Conference of UNESCO on 11 November 1997 and the International Declaration on Human Genetic Data adopted by the General Conference of UNESCO on 16 October 2003,

Noting the United Nations International Covenant on Economic, Social and Cultural Rights and the International Covenant on Civil and Political Rights of 16 December 1966, the United Nations International Convention on the Elimination of All Forms of Racial Discrimination of 21 December 1965, the United Nations Convention on the Elimination of All Forms of Discrimination against Women of 18 December 1979, the United Nations Convention on the Rights of the Child of 20 November 1989, the United Nations Convention on Biological Diversity of 5 June 1992, the Standard Rules on the Equalization of Opportunities for Persons with Disabilities adopted by the General Assembly of the United Nations in 1993, the UNESCO Recommendation on the Status of Scientific Researchers of 20 November 1974, the UNESCO Declaration on Race and Racial Prejudice of 27 November 1978, the UNESCO Declaration on the Responsibilities of the Present Generations Towards Future Generations of 12 November 1997, the UNESCO Universal Declaration on Cultural Diversity of 2 November 2001, the ILO Convention 169 concerning Indigenous and Tribal Peoples in Independent Countries of 27 June 1989, the International Treaty on Plant Genetic Resources for Food and Agriculture which was adopted by the FAO Conference on 3 November 2001 and entered into force on 29 June 2004, the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) annexed to the Marrakech Agreement establishing the World Trade Organization, which entered into force on 1 January 1995, the Doha Declaration on the TRIPS Agreement and Public Health of 14 November 2001 and other relevant international instruments adopted by the United Nations and the specialized agencies of the United Nations system, in particular the Food and Agriculture Organization of the United Nations (FAO) and the World Health Organization (WHO),

(1) Adopted by acclamation on 19 October 2005 by the 33rd session of the General Conference of UNESCO.

Also noting international and regional instruments in the field of bioethics, including the Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine of the Council of Europe, which was adopted in 1997 and entered into force in 1999, together with its Additional Protocols, as well as national legislation and regulations in the field of bioethics and the international and regional codes of conduct and guidelines and other texts in the field of bioethics, such as the Declaration of Helsinki of the World Medical Association on Ethical Principles for Medical Research Involving Human Subjects, adopted in 1964 and amended in 1975, 1983, 1989, 1996 and 2000 and the International Ethical Guidelines for Biomedical Research Involving Human Subjects of the Council for International Organizations of Medical Sciences, adopted in 1982 and amended in 1993 and 2002,

Recognizing that this Declaration is to be understood in a manner consistent with domestic and international law in conformity with human rights law,

Recalling the Constitution of UNESCO adopted on 16 November 1945,

Considering UNESCO's role in identifying universal principles based on shared ethical values to guide scientific and technological development and social transformation in order to identify emerging challenges in science and technology taking into account the responsibility of the present generations towards future generations, and that questions of bioethics, which necessarily have an international dimension, should be treated as a whole, drawing on the principles already stated in the Universal Declaration on the Human Genome and Human Rights and the International Declaration on Human Genetic Data and taking account not only of the current scientific context but also of future developments,

Aware that human beings are an integral part of the biosphere, with an important role in protecting one another and other forms of life, in particular animals,

Recognizing that, based on the freedom of science and research, scientific and technological developments have been, and can be, of great benefit to humankind in increasing, inter alia, life expectancy and improving the quality of life, and emphasizing that such developments should always seek to promote the welfare of individuals, families, groups or communities and humankind as a whole in the recognition of the dignity of the human person and universal respect for, and observance of, human rights and fundamental freedoms,

Recognizing that health does not depend solely on scientific and technological research developments but also on psychosocial and cultural factors,

Also recognizing that decisions regarding ethical issues in medicine, life sciences and associated technologies may have an impact on individuals, families, groups or communities and humankind as a whole,

Bearing in mind that cultural diversity, as a source of exchange, innovation and creativity, is necessary to humankind and, in this sense, is the common heritage of humanity, but emphasizing that it may not be invoked at the expense of human rights and fundamental freedoms,

Also bearing in mind that a person's identity includes biological, psychological, social, cultural and spiritual dimensions,

Recognizing that unethical scientific and technological conduct has had a particular impact on indigenous and local communities,

Convinced that moral sensitivity and ethical reflection should be an integral part of the process of scientific and technological developments and that bioethics should play a predominant role in the choices that need to be made concerning issues arising from such developments,

Considering the desirability of developing new approaches to social responsibility to ensure that progress in science and technology contributes to justice, equity and to the interest of humanity, Recognizing that an important way to evaluate social realities and achieve equity is to pay attention to the position of women,

Stressing the need to reinforce international cooperation in the field of bioethics, taking into account, in particular, the special needs of developing countries, indigenous communities and vulnerable populations,

Considering that all human beings, without distinction, should benefit from the same high ethical standards in medicine and life science research,

Proclaims the principles that follow and adopts the present Declaration.

GENERAL PROVISIONS

Article 1 – Scope

1. This Declaration addresses ethical issues related to medicine, life sciences and associated technologies as applied to human beings, taking into account their social, legal and environmental dimensions.
2. This Declaration is addressed to States. As appropriate and relevant, it also provides guidance to decisions or practices of individuals, groups, communities, institutions and corporations, public and private.

Article 2 – Aims

The aims of this Declaration are:

- (a) to provide a universal framework of principles and procedures to guide States in the formulation of their legislation, policies or other instruments in the field of bioethics;
- (b) to guide the actions of individuals, groups, communities, institutions and corporations, public and private;
- (c) to promote respect for human dignity and protect human rights, by ensuring respect for the life of human beings, and fundamental freedoms, consistent with international human rights law;
- (d) to recognize the importance of freedom of scientific research and the benefits derived from scientific and technological developments, while stressing the need for such research and developments to occur within the framework of ethical principles set out in this Declaration and to respect human dignity, human rights and fundamental freedoms;
- (e) to foster multidisciplinary and pluralistic dialogue about bioethical issues between all stakeholders and within society as a whole;
- (f) to promote equitable access to medical, scientific and technological developments as well as the greatest possible flow and the rapid sharing of knowledge concerning those developments and the sharing of benefits, with particular attention to the needs of developing countries;
- (g) to safeguard and promote the interests of the present and future generations;
- (h) to underline the importance of biodiversity and its conservation as a common concern of humankind.

PRINCIPLES

Within the scope of this Declaration, in decisions or practices taken or carried out by those to whom it is addressed, the following principles are to be respected.

Article 3 – Human dignity and human rights

1. Human dignity, human rights and fundamental freedoms are to be fully respected.
2. The interests and welfare of the individual should have priority over the sole interest of science or society.

Article 4 – Benefit and harm

In applying and advancing scientific knowledge, medical practice and associated technologies, direct and indirect benefits to patients, research participants and other affected individuals should be maximized and any possible harm to such individuals should be minimized.

Article 5 – Autonomy and individual responsibility

The autonomy of persons to make decisions, while taking responsibility for those decisions and respecting the autonomy of others, is to be respected. For persons who are not capable of exercising autonomy, special measures are to be taken to protect their rights and interests.

Article 6 – Consent

1. Any preventive, diagnostic and therapeutic medical intervention is only to be carried out with the prior, free and informed consent of the person concerned, based on adequate information. The consent should, where appropriate, be express and may be withdrawn by the person concerned at any time and for any reason without disadvantage or prejudice.
2. Scientific research should only be carried out with the prior, free, express and informed consent of the person concerned. The information should be adequate, provided in a comprehensible form and should include modalities for withdrawal of consent. Consent may be withdrawn by the person concerned at any time and for any reason without any disadvantage or prejudice. Exceptions to this principle should be made only in accordance with ethical and legal standards adopted by States, consistent with the principles and provisions set out in this Declaration, in particular in Article 27, and international human rights law.
3. In appropriate cases of research carried out on a group of persons or a community, additional agreement of the legal representatives of the group or community concerned may be sought. In no case should a collective community agreement or the consent of a community leader or other authority substitute for an individual's informed consent.

Article 7 – Persons without the capacity to consent

In accordance with domestic law, special protection is to be given to persons who do not have the capacity to consent:

- (a) authorization for research and medical practice should be obtained in accordance with the best interest of the person concerned and in accordance with domestic law. However, the person concerned should be involved to the greatest extent possible in the decision-making process of consent, as well as that of withdrawing consent;
- (b) research should only be carried out for his or her direct health benefit, subject to the authorization and the protective conditions prescribed by law, and if there is no research alternative of comparable effectiveness with research participants able to consent. Research which does not have potential direct health benefit should only be undertaken by way of exception, with the utmost restraint, exposing the person only to a minimal risk and minimal burden and if the research is expected to contribute to the health benefit of other persons in the same

category, subject to the conditions prescribed by law and compatible with the protection of the individual's human rights. Refusal of such persons to take part in research should be respected.

Article 8 – Respect for human vulnerability and personal integrity

In applying and advancing scientific knowledge, medical practice and associated technologies, human vulnerability should be taken into account. Individuals and groups of special vulnerability should be protected and the personal integrity of such individuals respected.

Article 9 – Privacy and confidentiality

The privacy of the persons concerned and the confidentiality of their personal information should be respected. To the greatest extent possible, such information should not be used or disclosed for purposes other than those for which it was collected or consented to, consistent with international law, in particular international human rights law.

Article 10 – Equality, justice and equity

The fundamental equality of all human beings in dignity and rights is to be respected so that they are treated justly and equitably.

Article 11 – Non-discrimination and non-stigmatization

No individual or group should be discriminated against or stigmatized on any grounds, in violation of human dignity, human rights and fundamental freedoms.

Article 12 – Respect for cultural diversity and pluralism

The importance of cultural diversity and pluralism should be given due regard. However, such considerations are not to be invoked to infringe upon human dignity, human rights and fundamental freedoms, nor upon the principles set out in this Declaration, nor to limit their scope.

Article 13 – Solidarity and cooperation

Solidarity among human beings and international cooperation towards that end are to be encouraged.

Article 14 – Social responsibility and health

1. The promotion of health and social development for their people is a central purpose of governments that all sectors of society share.

2. Taking into account that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition, progress in science and technology should advance:

- (a) access to quality health care and essential medicines, especially for the health of women and children, because health is essential to life itself and must be considered to be a social and human good;
- (b) access to adequate nutrition and water;
- (c) improvement of living conditions and the environment;
- (d) elimination of the marginalization and the exclusion of persons on the basis of any grounds;
- (e) reduction of poverty and illiteracy.

Article 15 – Sharing of benefits

1. Benefits resulting from any scientific research and its applications should be shared with society as a whole and within the international community, in particular with developing countries. In giving effect to this principle, benefits may take any of the following forms:

- (a) special and sustainable assistance to, and acknowledgement of, the persons and groups that have taken part in the research;
- (b) access to quality health care;
- (c) provision of new diagnostic and therapeutic modalities or products stemming from research;
- (d) support for health services;
- (e) access to scientific and technological knowledge;
- (f) capacity-building facilities for research purposes;
- (g) other forms of benefit consistent with the principles set out in this Declaration.

2. Benefits should not constitute improper inducements to participate in research.

Article 16 – Protecting future generations

The impact of life sciences on future generations, including on their genetic constitution, should be given due regard.

Article 17 – Protection of the environment, the biosphere and biodiversity

Due regard is to be given to the interconnection between human beings and other forms of life, to the importance of appropriate access and utilization of biological and genetic resources, to respect for traditional knowledge and to the role of human beings in the protection of the environment, the biosphere and biodiversity.

APPLICATION OF THE PRINCIPLES

Article 18 – Decision-making and addressing bioethical issues

1. Professionalism, honesty, integrity and transparency in decision-making should be promoted, in particular declarations of all conflicts of interest and appropriate sharing of knowledge. Every endeavour should be made to use the best available scientific knowledge and methodology in addressing and periodically reviewing bioethical issues.

2. Persons and professionals concerned and society as a whole should be engaged in dialogue on a regular basis.

3. Opportunities for informed pluralistic public debate, seeking the expression of all relevant opinions, should be promoted.

Article 19 – Ethics committees

Independent, multidisciplinary and pluralist ethics committees should be established, promoted and supported at the appropriate level in order to:

- (a) assess the relevant ethical, legal, scientific and social issues related to research projects involving human beings;
- (b) provide advice on ethical problems in clinical settings;
- (c) assess scientific and technological developments, formulate recommendations and contribute to the preparation of guidelines on issues within the scope of this Declaration;
- (d) foster debate, education and public awareness of, and engagement in, bioethics.

Article 20 – Risk assessment and management

Appropriate assessment and adequate management of risk related to medicine, life sciences and associated technologies should be promoted.

Article 21 – Transnational practices

1. States, public and private institutions, and professionals associated with transnational activities should endeavour to ensure that any activity within the scope of this Declaration, undertaken, funded or otherwise pursued in whole or in part in different States, is consistent with the principles set out in this Declaration.
2. When research is undertaken or otherwise pursued in one or more States (the host State(s)) and funded by a source in another State, such research should be the object of an appropriate level of ethical review in the host State(s) and the State in which the funder is located. This review should be based on ethical and legal standards that are consistent with the principles set out in this Declaration.
3. Transnational health research should be responsive to the needs of host countries, and the importance of research contributing to the alleviation of urgent global health problems should be recognized.
4. When negotiating a research agreement, terms for collaboration and agreement on the benefits of research should be established with equal participation by those party to the negotiation.
5. States should take appropriate measures, both at the national and international levels, to combat bioterrorism and illicit traffic in organs, tissues, samples, genetic resources and genetic-related materials.

PROMOTION OF THE DECLARATION

Article 22 – Role of States

1. States should take all appropriate measures, whether of a legislative, administrative or other character, to give effect to the principles set out in this Declaration in accordance with international human rights law. Such measures should be supported by action in the spheres of education, training and public information.
2. States should encourage the establishment of independent, multidisciplinary and pluralist ethics committees, as set out in Article 19.

Article 23 – Bioethics education, training and information

1. In order to promote the principles set out in this Declaration and to achieve a better understanding of the ethical implications of scientific and technological developments, in particular for young people, States should endeavour to foster bioethics education and training at all levels as well as to encourage information and knowledge dissemination programmes about bioethics.
2. States should encourage the participation of international and regional intergovernmental organizations and international, regional and national non governmental organizations in this endeavour.

Article 24 – International cooperation

1. States should foster international dissemination of scientific information and encourage the free flow and sharing of scientific and technological knowledge.
2. Within the framework of international cooperation, States should promote cultural and scientific cooperation and enter into bilateral and multilateral agreements enabling developing countries to

build up their capacity to participate in generating and sharing scientific knowledge, the related know-how and the benefits thereof.

3. States should respect and promote solidarity between and among States, as well as individuals, families, groups and communities, with special regard for those rendered vulnerable by disease or disability or other personal, societal or environmental conditions and those with the most limited resources.

Article 25 – Follow-up action by UNESCO

1. UNESCO shall promote and disseminate the principles set out in this Declaration. In doing so, UNESCO should seek the help and assistance of the Intergovernmental Bioethics Committee (IGBC) and the International Bioethics Committee (IBC).

2. UNESCO shall reaffirm its commitment to dealing with bioethics and to promoting collaboration between IGBC and IBC.

FINAL PROVISIONS

Article 26 – Interrelation and complementarity of the principles

This Declaration is to be understood as a whole and the principles are to be understood as complementary and interrelated. Each principle is to be considered in the context of the other principles, as appropriate and relevant in the circumstances.

Article 27 – Limitations on the application of the principles

If the application of the principles of this Declaration is to be limited, it should be by law, including laws in the interests of public safety, for the investigation, detection and prosecution of criminal offences, for the protection of public health or for the protection of the rights and freedoms of others. Any such law needs to be consistent with international human rights law.

Article 28 – Denial of acts contrary to human rights, fundamental freedoms and human dignity

Nothing in this Declaration may be interpreted as implying for any State, group or person any claim to engage in any activity or to perform any act contrary to human rights, fundamental freedoms and human dignity.

COMPOSITION OF THE INTERNATIONAL BIOETHICS COMMITTEE (IBC) (2008-2009)

NAME	TERM OF OFFICE
<p>AMIRASLANOV Prof. (Mr) Ahliman (Azerbaijan)</p> <p>Rector of the Azerbaijan Medical University Head of the the University Oncology Clinic at the City Cancer Center Member of the Azerbaijan Academy of Sciences</p>	2006-2009
<p>BOUSTANY Prof. (Mr) Fouad (Lebanon)</p> <p>Professor at the Medical School of Beirut Secretary-General, Lebanese Ethics Advisory Committee for Health and Life Sciences Member of the National Council for Scientific Research Former President of the Lebanese Order of Physicians</p>	2008-2011
<p>CHANDRA Prof. (Mr) Sharat H. (India)</p> <p>Emeritus Professor, Department of Microbiology and Cell Biology, Indian Institute of Science, Bangalore Honorary Professor, Jawaharlal Nehru Centre for Advanced Scientific Research, Bangalore Director of the Centre for Human Genetics, Bangalore Member of the National Bioethics Committee</p>	2008-2011
<p>DAAR Prof. (Mr) Abdallah (Oman)</p> <p>Professor of Public Health Sciences and Professor of Surgery, University of Toronto, Canada Co-Director, Programme in Life Sciences, Ethics and Policy, McLaughlin-Rotman Centre for Global Health, University Health Network and University of Toronto Senior Scientist and Director of Ethics and Policy, McLaughlin Centre for Molecular Medicine, University of Toronto Fellow of the Third World Academy of Science (TWAS) UNESCO Avicenna Prize for Ethics in science, 2005</p>	2008-2011
<p>DRUML Dr (Mrs) Christiane (Austria)</p> <p>Doctor of Law Managing Director of the Ethics Committee, Medical University of Vienna and the Vienna General Hospital Chair of the Commission for Bioethics, Federal Austrian Chancellery</p>	2008-2011

- D'EMPAIRE Prof. (Mr) Gabriel** (Venezuela) 2004-2011
 Professor of Bioethics, Central University of Venezuela
 Director of Coronary and Intensive Care Unit, Clínicas Caracas Hospital
 President of the Bioethics Clinical Association of Venezuela
 Guest Member of the National Academy of Medicine of Venezuela
-
- EVANS Prof. (Mr) Donald** (New Zealand) 2004-2011
 Professor of Philosophy
 Director of the Bioethics Centre, University of Otago
 Former member of the National Ethics Advisory Committee of New Zealand
-
- GEFENAS Prof. (Mr) Eugenijus** (Lithuania) 2002-2009
 Associate Professor and Director of the Department of Medical History and Ethics, University of Vilnius
 Adjunct Professor at the Centre for Bioethics and Clinical Leadership, Graduate College, Union University (United States of America)
 Chairperson of the National Bioethics Committee of Lithuania
-
- GRACIA Prof. (Mr) Diego** (Spain) 2008-2011
 Professor of History of Medicine and Bioethics, Medical Faculty, Complutense University of Madrid
 Director, Institute of Bioethics of the Foundation for the Health Sciences, Madrid
 Honorary Professor at the University of Chile, University of Lima, Peru, and University of Cordoba, Argentina
 Member of the Royal National Academy of Medicine of Spain
-
- HU Prof. (Mr) Ching-li** (China) 2006-2009
 Emeritus Professor of Medicine and Senior Advisor, Shanghai Jiaotong University School of Medicine
 Deputy Director, Biomedical Ethics Research Centre, Shanghai Jiaotong University School of Medicine
 Former Deputy Director-General (1988-1997) and former Assistant Director-General (1995-1997) of the World Health Organization (WHO)
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- HURIET Prof. (MR) Claude** (France) 2004-2011
 Emeritus Professor of Medicine, Faculty of Medicine, Nancy
 President of the Institut Curie
 Honorary Senator
 Former Member of the National Consultative Ethics Committee for Health and Life Science
-
- IJALAYE Prof. (Mr) David Adedayo** (Nigeria) 2002-2009
 Emeritus Professor of International Law, Obafemi Awolowo University
 Senior Advocate at the Supreme Court of Nigeria
 Fellow of the Nigerian Society of International Law
 Fellow of the Nigerian Institute of Advanced Legal Studies

- KOLLEK Prof. (Mrs) Regine** (Germany) 2002-2009
 Professor of Health Technology Assessment, University of Hamburg
 Member and former Vice-Chairperson of the German National Ethics Council
 Former Chairperson of the Advisory Board on Ethics, Federal Ministry of Health
-
- KUBAR Prof. (Mrs) Olga** (Russian Federation) 2008-2011
 Head of the Clinical Department, Saint-Petersburg Pasteur Institute
 Former Chair, Forum for Ethics Committees in the Commonwealth of Independent States
-
- LA ROSA RODRIGUEZ Dr (Mr) Emilio** (Peru) 2006-2009
 Surgeon
 Doctor in Anthropology and Human Ecology
 Member of the Peruvian Society of Bioethics
 Former Director of the Health and Society Study and Research Centre (CRESS), France
 Former Vice-Chairperson of the Intergovernmental Bioethics Committee of UNESCO (IGBC)
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- LEVY-LAHAD Prof. (Mrs) Ephrat** (Israel) 2006-2009
 Associate Professor in Internal Medicine and Medical Genetics and Director of the Medical Genetics Unit, Hebrew University
 Member of the Bioethics Advisory Committee, Israel Academy of Sciences and Humanities
 Member of the National Helsinki Committee for Genetic Research in Humans
-
- LOLAS Prof. (Mr) Fernando Stepke** (Chile) 2008-2011
 Psychiatrist
 Professor at the Faculty of Medicine and Director of the Interdisciplinary Centre on Bioethical Studies, University of Chile
 Director of the Bioethics Programme, Pan American Health Organization (PAHO)
 Member of the Royal Spanish Academy
 Former Director of the Psychiatric Clinic and Former Vice-Rector of the University of Chile
-
- LUNA OROSCO Dr (Mr) Javier** (Bolivia) 2006-2009
 Medical Doctor
 Head of the Surgeon Unit of the University Hospital, La Paz
 Coordinator of the National Bioethics Committee
-
- MAIMETS Prof. (Mr) Toivo** (Estonia) 2004-2011
 Professor at the Institute of Molecular and Cell Biology, University of Tartu
 Director of the National Centre of Excellence for Gene and Environmental Technologies
 Former Minister of Education and Research
 Former Vice-Rector of the University of Tartu

MARTIN Dr (Mr) Jean (Switzerland) 2006-2009

Physician

Member of the National Commission of Ethics for Human Medicine

Former Chief Medical Officer for the Canton of Vaud

Former Consultant of the World Health Organization (WHO) and the United Nations Population Funds (UNFPA)

MARTÍNEZ PALOMO Prof. (Mr) Adolfo (Mexico) 2002-2009

Chairperson of IBC

Emeritus Professor Centre for Research and Advanced Studies (CINVESTAV)

Coordinator of the Council of Science and Technology of the Presidency of Mexico

Member of the National Bioethics Council

Member of the Third World Academy of Science

Former Director-General of CINVESTAV

Former Chairperson of the Mexican Academy of Science

MASSOUGBODJI Prof. (M.) Achille (Benin) 2008-2011

Senior Physician, Laboratory of Microbiology, National Hospital and University Centre of Cotonou (CNHU)

Founding member of the Ethics Committee, Faculty of Health Sciences, Cotonou

Founding member of the Pan African Bioethics Initiative (PABIN)

President of the Beninese Association of Fight against AIDS

MC LEAN Prof. (Mrs) Sheila (United Kingdom) 2006-2009

International Bar Association Professor of Law and Ethics of Medicine

Director of the Institute of Law and Ethics in Medicine, University of Glasgow

Member of the Wellcome Trust Biomedical Ethics Panel

MENG Prof. (Mr) Kwang-ho (Republic of Korea) 2006-2009

Professor of Preventive Medicine

Former Dean of the School of Public Health, Catholic University of Korea

President of the Korean Society for Medical Education

Former Vice-President of the Korean Society for Biomedical Ethics

MORISAKI Prof. (Mr) Takayuki (Japan) 2004-2011

Professor of Molecular Pathophysiology, Osaka University

Director of the Department of Bioscience, National Cardiovascular Centre Research Institute

Member of the Bioethics and Biosafety Commission, Council of Science and Technology of Japan

ÖZGÜC Prof. (Mrs) Meral (Turkey) 2004-2011

Professor and Director of the Department of Medical Biology, Hacettepe University
Director, Scientific and Technical Research Council of Turkey (TUBITAK) DNA/Cell Bank
Chairperson of the Bioethics Committee of the Turkish National Commission for UNESCO
Member of the European Society for Human Genetics

PERALTA-CORNEILLE Prof. (Mr) Andrés (Dominican Republic) 2006-2009

Medical Doctor
Professor of Bioethics, Santiago Technological University
Member of the Executive Board of the UNESCO-REDBIOETICA for Latin America and the Caribbean
Member of the International Bioethics Association
Founding member and former Chairperson of the National Bioethics Committee

ROGNE Prof. (Mrs) Sissel (Norway) 2006-2009

Professor of Biotechnology, Faculty of Medicine, University of Bergen
Director-General of the Norwegian Biotechnology Advisory Board
Chairman of the ad hoc group on bioethics of the Norwegian National Commission for UNESCO
Member of the ethics committee in the NORFUND Biotech Investment Fund, India

SALEH Prof. (M.) Fawaz (Syrian Arab Republic) 2004-2011

Professor of Law, University of Damascus
Professor and Secretary-General of the Higher Institute of Business Administration
Head of Legal Affairs, University of Damascus
Member and Secretary-General of the Syrian Bioethics Committee

SASTROWIJOTO Prof. (Mr) Soenarto (Indonesia) 2008-2011

Doctor of Medicine
Emeritus Professor, Department of Ear-nose-Throat and Head & Neck Surgery, School of Medicine, Gadjah Mada University, Yogyakarta
Director of the Center for Bioethics and Medical Humanities School of Medicine Gadjah Mada University, Yogyakarta
Member of National Bioethics Committee
Member of National Committee on Research Ethics in Health Sciences
Former Vice-Chairperson of the Intergovernmental Bioethics Committee of UNESCO (IGBC)

SEMPlici Prof. (Mr) Stefano (Italy) 2008-2011

Professor of Social Ethics, Faculty of Philosophy, University of Rome Tor Vergata
Editor of the international journal Archives of Philosophy
Scientific Director, Lamaro Pozzani College, Rome
Member of the Scientific Board, Institute for General and Applied Ethics, Borromeo College, Pavia

- SEROUR Prof. (Mr) Gamal Ibrahim Abou** (Egypt) 2006-2009
 Professor of Obstetrics and Gynaecology
 Director of the International Islamic Center for Population Studies and Research
 Member of the Egyptian National Bioethics Committee
 Secretary-General of the International Federation of Fertility Societies
 Former Dean of the Faculty of Medicine, Alazhar University
 Former President of FIGO Committee for Ethical Aspects of Human Reproduction and Women's Health
-
- SNEAD Prof. (Mr) Carter IV** (United States of America) 2008-2011
 Associate Professor, Notre Dame Law School, Indiana
 US Permanent Observer on the Council of Europe Steering Committee on Bioethics
 Former General Counsel of the President's Council on Bioethics
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- STIENNON Prof. (Mrs) Jeanine-Anne** (Belgium) 2006-2009
 Emeritus Professor at the Faculty of Medicine, University of Mons-Hainaut
 Vice-President and former President of the National Bioethics Committee
 Honorary Dean of the Faculty of Medicine, University of Mons-Hainaut
 Member of the Belgian Royal Academy of Medicine
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- TOURE Dr (Mrs) Aïssatou** (Senegal) 2006-2009
 Immunologist and Researcher, Pasteur Institute, Dakar
 Member of the National Health Research Council
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- WASUNNA Dr (Mrs) Monique K. Ajilong** (Kenya) 2008-2011
 Consultant Physician and Specialist in Tropical Medicine and Infectious Disease
 Acting Director of the Kenya Medical Research Institute (KEMRI)
 Chief Research Officer in Tropical Medicine and Infectious Disease (KEMRI)
 Scientific Advisory Committee member for the World Health Organization on Accessible Quality-Assured Diagnostics
 Member of the University of Nairobi and Kenyatta Hospital Scientific and Ethics Committee
 Board member of the University of Nairobi, Institute of Tropical Medicine and Infectious Diseases



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- **Social and Human Sciences Sector**
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The Division of Ethics of Science and Technology embodies the priority UNESCO gives to the promotion of ethics of science and technology, with emphasis on bioethics.

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The Division also functions as the executive secretariat for three international ethics bodies, namely the World Commission on the Ethics of Scientific Knowledge and Technology (COMEST), the International Bioethics Committee (IBC) and the Intergovernmental Bioethics Committee (IGBC).

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