



# **WORLD HEALTH EDITORS NETWORK**

## **Development Meeting**

**World Meteorological Organization,  
Geneva, 20-21 May 2006**

## **REPORT**

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# World Health Editors Network (WHEN) Workshop Geneva, May 20-21, 2006 Report

## BACKGROUND

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

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

### World Health Editors Network (WHEN) Ethical Guidelines<sup>1</sup>

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

In effect, WHEN operates at a global level in the same way as informal associations of health writers operate at a national level; and by developing relationships with publications around

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<sup>1</sup> First drafted in 1998 by the media ethics charity MediaWise, these guidelines were developed in consultation with health communicators, health correspondents and the International Federation of Journalists over two years. The final version was adopted by the WHO European Health Communications Network as guidance for good practice.

the world, editors will facilitate opportunities for professional development as well as new markets for their talents.

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

**Possible WHEN Roles  
March 2006, ICN meeting Geneva**

- A sounding board feeding back to WHO and other IGOs, international agencies and companies information about the efficacy of their information and campaigns.
- A conduit for myth-busting materials and to assist in quashing false rumours about health issues.
- A forum through which to devise or co-ordinate and develop ethical codes for health communications, to share lessons learned from mistakes.
- A change agent to encourage professional development and ‘quality control’ (for example testing the efficacy of different approaches to ‘peer review’ and lobbying for common standards; considering the role of investigative reporting in health communications; etc, etc)
- A syndication service, sharing material across borders as a mean of broadening understanding of health issues.

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

### **The Meeting**

This meeting of the Network was held in parallel with the biennial conference of the World Health Professions Alliance<sup>2</sup> (WHPA) and in the run-up to the World Health Assembly.

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

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<sup>2</sup> The World Health Professions Alliance consists of the World Medical Association (WMA), International Council of Nurses (ICN), International Pharmaceutical Federation (FIP), and World Dental Federation (FDI).

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

The meeting was organised by the World Health Communications Associates (WHCA) and the World Health Professionals Alliance (WHPA) with support from Johnson and Johnson.

## INTRODUCTION

### Ground rules

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

### Tour de Table

The group was welcomed and the WHEN process and background explained. An introduction of all members present took place. National medical, nursing and pharmacy association journal editors and communication officers were represented, together with health website editors, patient groups, science editors and senior health professionals and officials. The group were all from European countries and the readerships from the different publications and outlets varied. Some had larger readerships than others and some were considered to be leaders in their field, with the power to influence government and general health practice.

## EXCHANGE SESSION—Meetings, websites, announcements

During the meeting, participants were given the opportunity to draw the attention of the participants to news, developments, information, and other topics of interest. Matters brought to the attention of the meeting included:

- The Global Health Forum has just opened a website health forum for discussion about health policies, health activists, etc. The focus is on the debate about whether there is a global framework for research in health: [www.HR4D.net](http://www.HR4D.net).
- A number of other helpful websites were mentioned, including: [www.globalink.org](http://www.globalink.org); [www.inasp.info/health/forum](http://www.inasp.info/health/forum); [www.alphagalileo.org](http://www.alphagalileo.org); [www.comminit.com](http://www.comminit.com); [www.comminit.com/drum\\_beat](http://www.comminit.com/drum_beat); [www.globalhealthforum.org](http://www.globalhealthforum.org).
- The World Congress for Communication on Development is taking place 25-27 October 2006.

- The pharmacists are looking at the pharmaceutical industry to see what is being done about legitimate medicines.
- The Global Forum for Health Research has a meeting on Combating Disease and Promoting Health in Cairo, 29 October-2 November 2006.
- The WMA was issuing two press releases that day—one calling for Taiwan to be given observer status at the World Health Assembly and the other demanding that China stop using prisoners for organ donations.
- The World Dental Federation is currently working on the launch of the Portuguese version of the *Tobacco or Oral Health* guide that will take place in Lisbon on World No Tobacco Day.
- The World Health Professionals Alliance have just signed an agreement to encourage FIFA to make the World Cup a smoke-free event and have just finished the press release on this.

## PRESENTATIONS and JOURNALIST FEEDBACK

Presentations were given on a number of “hot” topics, by speakers from key agencies with direct involvement in the topics presented:

- Anti-Microbial Resistance (AMR) : ECDC
  - Introduction to ECDC Ben Duncan, Communications, ECDC
  - Anti-Microbial Resistance Peet Tull, AMR Project Leader, ECDC
- Human Resources for Health—Migration : WHO/WHPA
  - Introduction & World Health Report Manuel Dayrit, HRH, WHO
  - Nursing Migration Mireille Kingma, WHPA
- Avian Flu’ : WHCA/UNICEF
  - Case Study, Turkey Line Jacobsen, UNICEF
  - Making preparations count Franklin Apfel, WHCA
- The Global Fund to Fight AIDS, TB & Malaria
  - An update on HIV/AIDS Oliver Sabot, Global Fund
- Counterfeit Drugs and Patient Safety : WHO/ICN
  - IMPACT Valerio Reggi, Dept of Medicines Policy and Standards, WHO
  - Malawi Dorothy Ngoma, ICN Executive Director of the Malawi Nurses Association

## Session Summaries

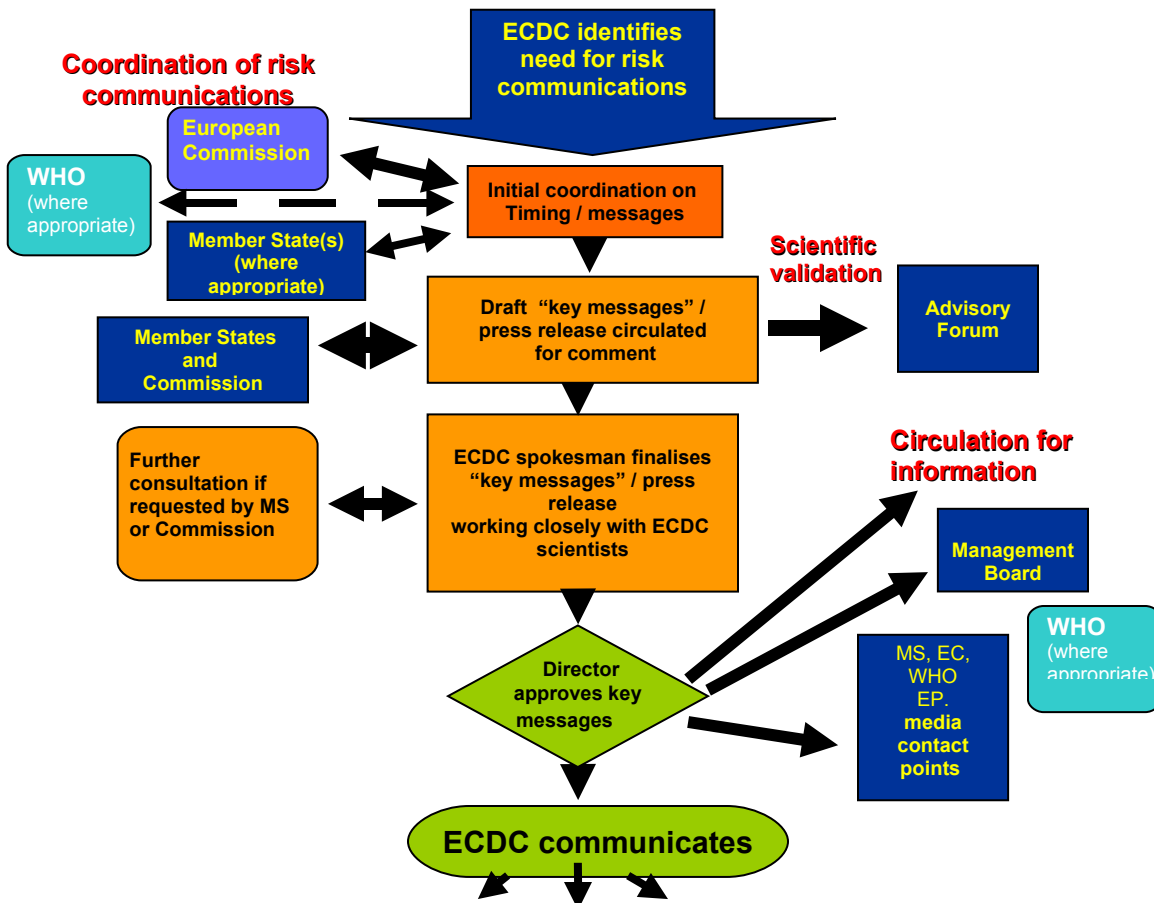
### 1. EUROPEAN CENTRE FOR DISEASE PREVENTION & CONTROL (ECDC)—A NEW AGENCY

ECDC is a relatively new European Union agency launched at the beginning of 2005. Based in Stockholm, its purpose is to work with and coordinate national health protection bodies across Europe to strengthen and develop continent-wide disease surveillance, early warning and response systems

Communication is defined as one of the Centre’s responsibilities, as stipulated within its Founding Regulations (Article 12):

*1. The Centre shall communicate on its own initiative in the fields within its mission, after having given prior information to the Member States and to the Commission. It shall ensure that the public and any interested parties are rapidly given objective, reliable and easily accessible information with regard to the results of its work. In order to achieve these objectives, the Centre shall make available information for the general public, including through a dedicated website. It shall also publish its opinions produced in accordance with Article 6.*

*2. The Centre shall act in close collaboration with the Member States and the Commission to promote the necessary coherence in the risk communication process on health threats.*



**Discussion:**

Clarification was requested regarding the geographical extent of ECDC’s activities. The definition of “Europe” used by ECDC includes countries outside the EU, such as Iceland, Norway and Lichtenstein, but they also have the capacity to respond on a global level—ECDC had already been involved in China and Iraq.

The need to consult the Member States and the Commission before engaging in any risk communications meant that the coordination of risk communications within ECDC is quite a complex process (see Chart). Journalists expressed concern that the complex process involved in issuing press releases might mean that they would not be able to get a response from ECDC when they needed one. However, it was explained that, as with most communications, the speed of response “depended on the question” and sometimes it would be possible to issue a response without consulting anyone.

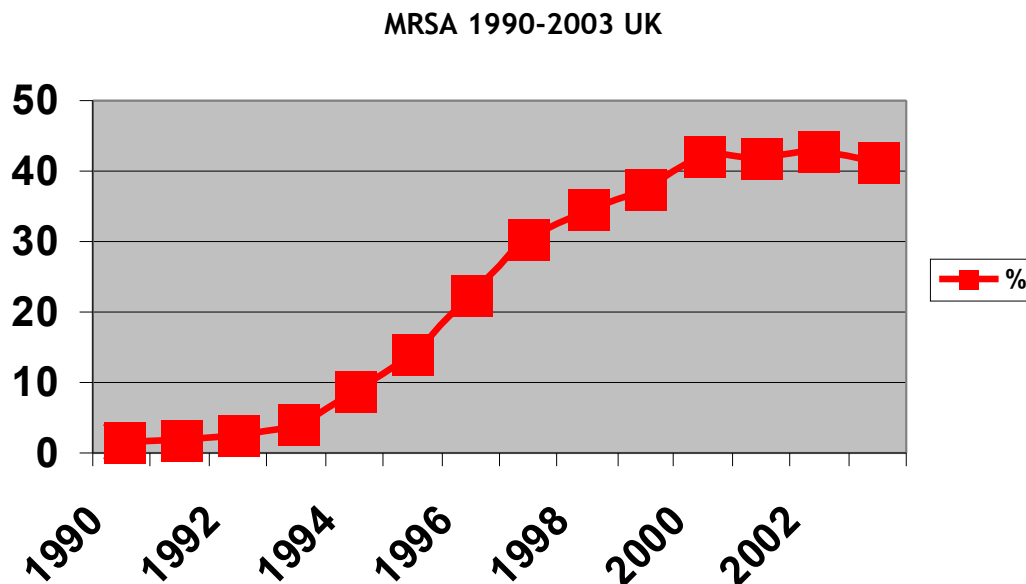
In response to queries about who would be in a position to respond to the media’s requests for information in the event of outbreaks, it was explained that ECDC would most likely take the lead on outbreaks within the European Region, and WHO beyond the European Region.

It was also hoped that ECDC would be able to produce a list of European experts to whom the media could turn in times of crisis, although the staffing situation at the moment did not allow time to create such a list.

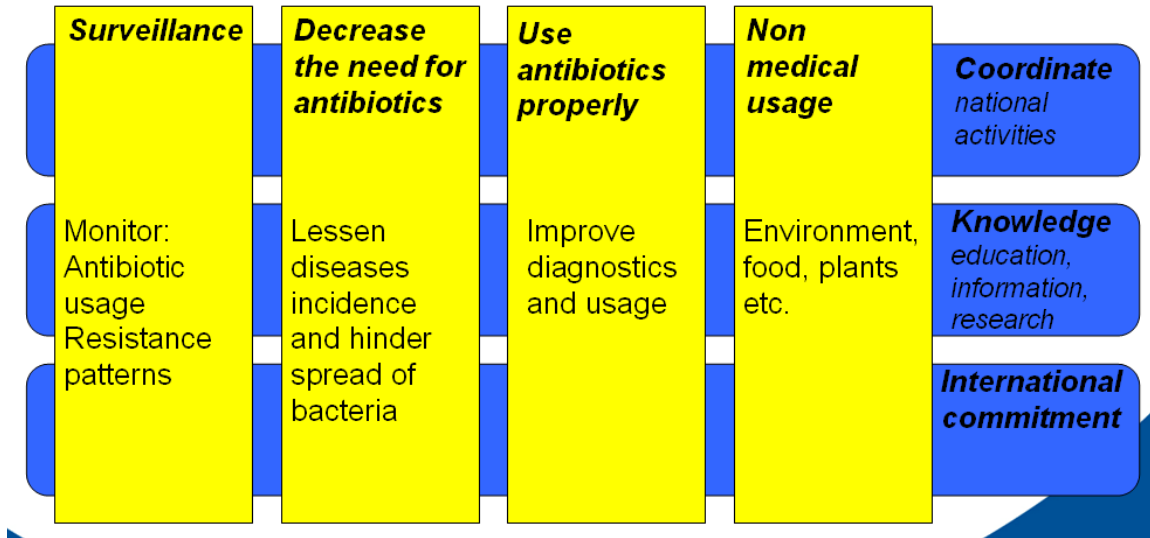
ECDC action during the outbreak of pandemic flu’ in Turkey in January 2006 was summarised as well and is included in the pandemic flu’ topic below.

**Antimicrobial Resistance**

Peet Tull gave a presentation on the issues surrounding antimicrobial resistance in Europe and the consequences of populations developing immunity to antibiotics. For example, in the case of methicillin—the drug used to treat staphylococcus aureus—as much as 40 per cent of the population where it is in wide use had developed immunity.



The presentation looked at the public health effects of increasing AMR, and suggested that increased resistance could cost more than could be afforded. The problem had to be tackled on many different levels:



The presentation then went on to look at how the problem involved many interrelated areas, and many different stakeholders (“the public” was identified as “a forgotten stakeholder”), and ended by asking the question, “How do we reach out to our major stakeholders?”

**Discussion:**

The problem faced by both public health experts and the communication field was well illustrated in the following discussion:

*“Can we stop this? Do we have a way of handling this? Well, we are publishing a background paper on it this month [May 2006] which shows the difficulties. But how do you reach out to health care staff and the general public? This is going on everywhere but it is not a perceived as a health risk—even though it’s already there.”*

*“This is one of the biggest problems you face over these issues. How do you start to work on advocacy/communication ideas/training issues/capacity development? How do you reach out to health professionals and patient groups? Because we rely on people like you, experts in your field, to provide us with information that will make headlines. However, people are not interested in the fact that a few people a day [sic] die, as the media generally wants to focus on the bigger numbers rather than incremental growth.”*

Those in attendance in this session were able to provide feedback in the form of advice and guidance to what the media and the health community needs from a new agency of this kind.

### Being a “good” source of information

Scientist and policy-makers are good sources when they provide ...

- New “dramatic” facts and data, presented in an understandable way
- Human interest stories
- “Off the fence” quotable opinions
- Access and speed of response to queries

Suggestions were then invited for making press releases more informative, useful and interesting. Comments received included:

- “We often receive press releases too late for our deadlines and by the week later, they are too old so we don’t use them at all then.”
- “Staffing issues in publications has changed so much and I think we all have much less time to read things through. It would be much more helpful if we could have a concise and interesting press release that is more finished and is not just one long report.”
- “I would always say that the most important thing is to produce human interest, such as case studies—especially when dealing with the more generalist media. They want to be able to tell the story in a way that is interesting to non-specialists.”
- “Patients suffer all over the world and I think it’s easy to forget that the stories are really about patients’ welfare. Everyone, including medics and journalists, are patients, so things need to be brought to a personal level.”

## 2. HUMAN RESOURCES FOR HEALTH—MIGRATION

### Introduction

The issue of the migration of health workers from their own countries has been a major issue for years, particularly in developing countries, and was the main focus of the World Health Report 2006 issued by the World Health Organization (WHO). The full Report can be accessed on WHO’s website: <http://www.who.int/whr/2006/en/index.html>.

### Some Migration Facts

There are 192 million migrant people in the world.

This equates to one in every 35 people being an international migrant.

65 per cent of these people go to industrialised countries.

One in ten people in industrialised countries is a migrant.

48 per cent of these are female.

Many are nurses who have moved away from their homes to find a better life.

Out of the approximately 100 million migrant health workers there are in the world, about 25 per cent of them are registered professionals.

It was explained that it is not known exactly how many people are working in the health sector because there is no international recording system, but in many countries it is the biggest employer. Many health professionals are migrants and research reaffirms that they are looking for learning opportunities, professional advancement, improved quality of life, and personal safety.

Health workers also often migrate in a “carousel” pattern, working in a number of different countries before reaching their chosen one. On a micro level this often results in families being separated for long periods of time, which in turn is damaging to communities.

### MIGRATION PATTERNS

- Industrialised to industrialised
- Developing to developing
- Developing to industrialised
  - More Ethiopian-trained MDs in Chicago than in all of Ethiopia
  - Increased number of supplier countries (71/1990 vs 95/2001)
  - More foreign-educated new registrants than domestically educated (UK, NZ)
- « Carousel » movement
  - 40% Filipino nurses in the UK previously in SE Asia and ME

Solutions involved redistribution of global wealth, a quick “fix” for destination countries, transcultural exchange, improved quality of life, and gender emancipation. However, in the long run migration is only the symptom of the underlying causes, as no matter how attractive the “pull” factors, migration only takes place when there are strong “push” factors. Therefore, to remedy the situation involved a paradigm shift in thinking, to reduce the need to migrate rather than artificially curb the flows of migrants.

#### Discussion:

WHEN members said that while they understood the problems faced globally, it would be extremely difficult to achieve a joined-up campaign on this problem globally because “every country would look after themselves”.

Responses included:

*“I don’t think you’ll have much luck sorting this out. People in the media are also patients and all we can try and do is solve our own problems as individual countries.”*

*“Pointing out the problem is the tough bit because you can only find the solution by getting the right target audience, the right publications, to cover it. However, the solution is more powerful than the problem and the health sectors anywhere in the world and their people only really care about their own services.”*

*“In the media we are interested in solutions where they affect policy directly—not just abstracts.”*

Manuel Dayrit said he believed that the media had to keep talking about it but also provide time for the solutions that are being put in place to work. He said it was key to have multi-sector involvement and one of the roles of the media was to help find the solutions.

*“I don’t have to find the solutions. Presenting and making known the information is the role of a journalist and by doing that we are working for the solution. However, it is clear the solution is that we need more nurses and that’s the role of professionals.”*

### 3. AVIAN FLU’ UPDATE—CASE STUDY, TURKEY

Presenters from ECDC, UNICEF and WHCA reflected on communication lessons learned from the Avian Flu’ outbreak response in Turkey in January 2006.

#### ECDC LESSONS LEARNED

- Need to separate “bird flu” and “pandemic flu”
  - Do not mention both terms in same sentence
  - Preface all remarks about pandemic with statement that A/H5N1 is not (yet) human pandemic strain
  - Be careful when and how you raise pandemic preparedness
- Big demand from media for expert opinion
- ECDC and national public health authorities well placed to influence how issues are reported
  - In most European countries CMOs/senior public health officials are trusted by media and the public
- Public health authorities need to get their message out quickly
- We are capable of doing this ... though it’s hard work!

The need for coordination of messages between international and national agencies was emphasised.

#### UNICEF Lessons re: communication

There were problems with:

- mixed messages to the public
- cluttered messages in Turkish designed for marginalised (not usually Turkish-speaking) communities;
- message dissemination also hampered by harsh weather;
- not enough synchronisation of messages from different UN agencies; and
- some messages sent out were conflicting and confusing, promoting misinformation and often leading to inaccurate perception of risk.

There were several actions that the government of Turkey put in place to respond to the outbreak. In terms of communication, this included a mass media blanket, 24/7 hotlines, mobilising imams and village heads to pass the message to communities, and producing leaflets for schoolchildren, which were handed out on the last day of school.

The UNICEF response included taking the lead in setting up a communication task force and offering immediate communication support to UN partners and government. UNICEF also contracted a public relations firm to develop materials—a television spot, posters, leaflets etc,—and provided journalists’ training. UNICEF coordinated an integrated communication approach ([http://www.unicef.org/avianflu/index\\_31607.html](http://www.unicef.org/avianflu/index_31607.html)).

## AN INTEGRATED COMMUNICATION STRATEGY

### *Rationale:*

- Protecting children and families
- Being prepared for every stage
- Minimizing duplication of efforts and filling gaps
- Speaking with one voice
- Building trust for action



### **Discussion:**

It is best to look at the communication aspect from the perspective of two provinces. The perspective from Van finds that communication was exemplary, with everyone knowing about avian flu’ and how to protect themselves, and children very well informed. Television was the primary channel used and considered effective in delivering the right messages, telling cullers not to accept help from people, especially children, and for people to stay away from birds and wash hands with soap.

In comparison, the perspective from Urfa was that there was inadequate communication with no one knowing how to prevent animal to animal transmission, unclear information about compensation, and little mention of prevention behaviours. The single communication channel (television) was not effective, especially for women and children, and the message that people get avian influenza from eating chicken or eggs was incorrect.

It was noted that Van was the epicentre of the problem, as there were many Kurdish speakers there. UNICEF used innovative ways to try and deal with the communication problems. The organisation of the TV health announcements were being transmitted from Denmark and the Netherlands and being broadcast in Kurdish. They were able to translate the messages in this way.

The lessons learned in Turkey have made it clear that there needs to be a clear strategy for all countries, and for countries as a whole. WHO is aware that this can only come from within countries themselves but there is a lot of activity and support work being done in developing countries around the issue. The Global Outbreak and Response Network (GOARN) (<http://www.who.int/csr/outbreaknetwork/en/>) exists to address these issues.

It is also necessary to address the ethical challenges faced by the problems in H5N1 around containing people in areas where outbreaks have been reported, and to take on board how media is changing and how to plan this into communication strategies. For example, in China no one was reporting there was a problem, but the word got out through “new media” such as text messages—in one day the same text message was re-sent 40 million times. This approach was utilised in reverse by the Egyptian government using the SMA texting service to send out a counterclaim to the myth that the Nile was infected with the avian flu’ bug after an avian flu’ fatality was confirmed.

The question was raised whether there is enough trust in governments for them to be the principle providers of information. It was noted that trust in the Turkish government response was helped by their openness to work with international/independent bodies.

#### **4. THE GLOBAL FUND TO FIGHT AIDS, TB AND MALARIA—AN UPDATE**

The Global Fund presentation began by looking at the history of global pandemics and noted that whilst the biological avenues for transmission had decreased, the potential human and economic devastation of global pandemics had increased dramatically:

- In 1347, out of a global population of 0.4 billion, the Black Death left 34 million dead in Europe
- In 1918, out of a global population of 1.8 billion, Spanish Flu’ caused 50-100 million deaths worldwide
- In 2006, with a global population of 6.5 billion, how many deaths in the next pandemic?

HIV/AIDS is already the largest pandemic in human history, and it is growing rapidly (see chart, next page). The huge impact of the HIV/AIDS pandemic was spelled out in human, economic, social and security terms.

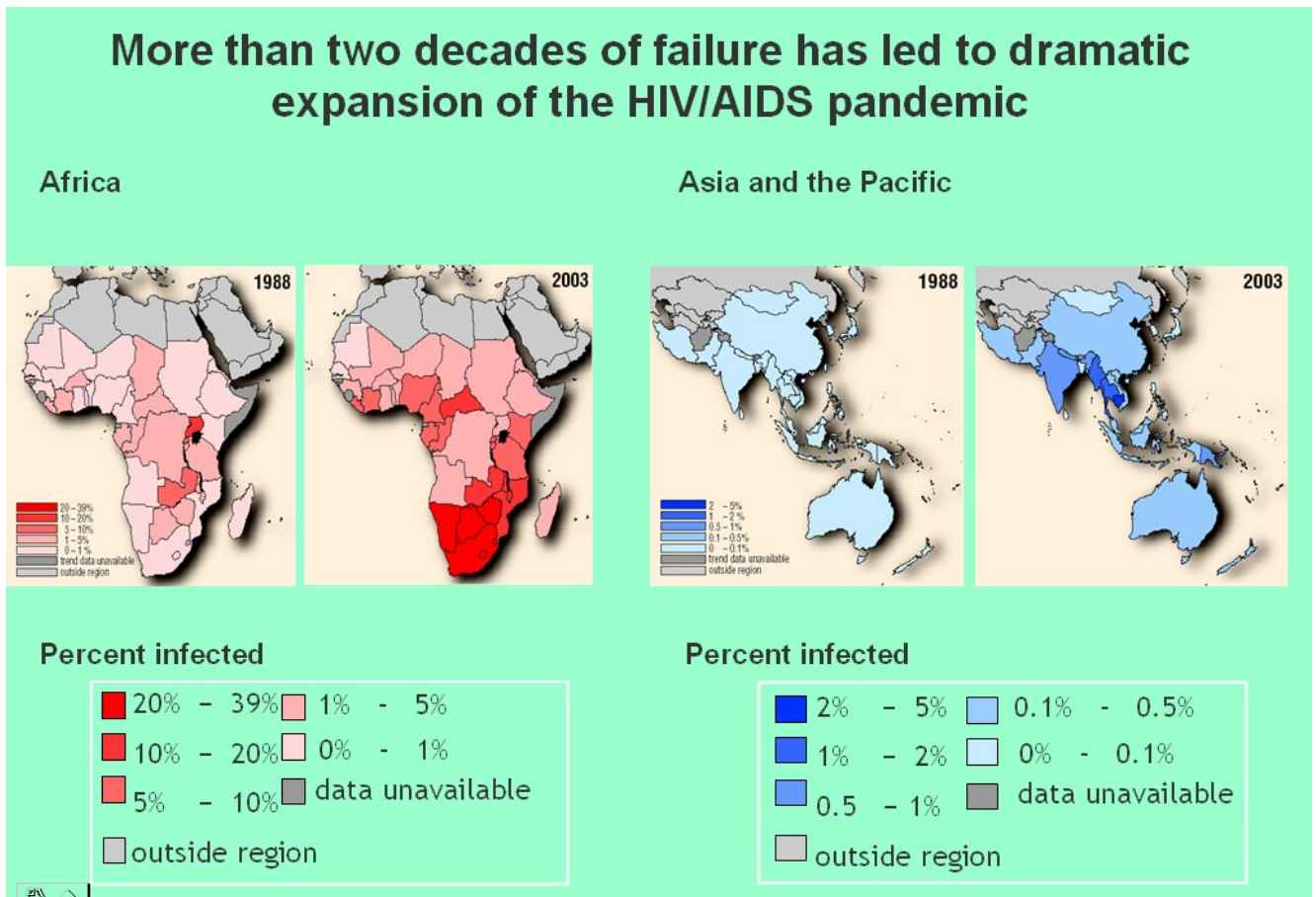
##### Human Impact

- *65 million have been infected; 25 million have already died*
- *5 million are newly infected every year*
- *Pandemic will not peak until at least 2025*

##### Economic Impact

- *Conservative estimate of 2-4 percent loss of annual GDP in Africa*

- “If nothing is done to combat the epidemic [in South Africa], a complete economic collapse will occur within three generations” (study by the World Bank and Heidelberg University)



### Social Impact

- 15 million children already orphaned by the disease

### Security Impact

- 25% or more of soldiers in some African countries infected

The presentation then moved on to look at the structure of the Global Fund and how it operates. The Global Fund was created specifically to mobilise large amounts of additional financing to combat AIDS, TB and malaria and is currently supporting grants in 130 countries, with the majority of financing going to sub-Saharan Africa. With \$5.2 billion going to 385 programmes, the GF is the largest funder of global HIV, TB and malaria efforts.

The operations of the Global Fund are distinguished by a number of innovative underlying principles, and the composition of its governing Board and grant portfolio reflects its recognition that governments alone cannot stop the pandemics.

## GLOBAL FUND—UNDERLYING PRINCIPLES

- *Empowerment*  
Grants by the Global Fund are country-driven, not donor-driven, with proposals reflecting the input of public and private partners participating in CCMs.
- *Accountability*  
The Global Fund rejects 60% of proposals, only writes a cheque after assessing the capacity of the recipient, and continues to disburse based on demonstrated performance.
- *Public Private Partnership*  
The Global Fund depends on non-governmental organizations and the private sector, from its governance to its grants (with roughly half of funds awarded to non-governmental recipients).
- *Efficiency*  
The Global Fund has no country presence and focuses only on being a financing mechanism, allowing more than 97% of the money it receives to go directly to recipients.
- *Transparency*  
All grants, reports on results and information about prices paid for drugs are available for public perusal online (<http://www.theglobalfund.org/en/>).

Global Fund investments are already having a significant impact on the burden of HIV/AIDS around the world, but there is still a great deal more to be done. With current trends, by 2025 the number of people infected in Sub-Saharan Africa could total c115 million; with best case intervention to date (as in Uganda), this number could be reduced to c90 million; but with comprehensive intervention the number could be reduced still further to under 75 million.

What do we need? / What do we have?		
	World Government	Current Global System
<b>Communication &amp; Coordination</b>	Centralized global agency with full legal authority	World Health Organization (WHO) has mandate but lacks ability to enforce
<b>Effective Resource Distribution</b>	Global taxation & distribution of resources based solely on need and effectiveness	Voluntary contributions do not match need. Distribution often based on politics (exception—The Global Fund)
<b>Ensuring Science &amp; Technology</b>	Comprehensive incentives to stimulate private sector	New initiatives, but nothing ambitious and global
<b>Global Intervention Capacity</b>	Central agency with full authority to intervene (similar to U.S. CDC)	No agency with authority to intervene in sovereign nations

## Discussion :

In response to questions from journalists, it was confirmed there is no research in place to monitor the impact the money is having—the Global Funds works in a “hands-off” fashion, leaving it up to countries to make an approach for funding.

The Global Fund produces a summary after every proposal review, which gives reasons why it was rejected. The question was asked, why there are so many rejections (about 60%). Some of it is due to the proposal development procedure—the forms can be 80 pages long, and not always clear. However, it is also too often the case that governments are over-ambitious in their bid to get their hands on such large quantities of money. There is a ratings system in place for assessing programmes—1 is good, 2 is concerned, 3 is basically failing but has potential, and 4 is no chance. Funding would only be pulled without giving a project the chance to recover in the case of a 4 rating. At 3, it may be possible to turn it around.

It is important that more people understand what the Global Fund does, and how it differs from other organisations. A recent survey showed that only 8% of Americans know about the Global Fund, and there is a lot of misunderstanding about what they do.

## 5. COUNTERFEIT DRUGS AND PATIENT SAFETY

The presentation talked about IMPACT (International Medical Products Anti Counterfeiting Taskforce), WHO’s initiative to combat counterfeit medicines, and also gave a personal perspective on the problems of counterfeit medicines in African countries.

The term “counterfeit drug” is used to describe a drug made by someone other than the genuine manufacturer, by copying or imitating an original product without authority or right, with the absolute intention of deceiving and defrauding. This involves marketing the copied or forged drug as the original. However, one problem is that a counterfeit drug is defined differently in different countries.

### WHO SAYS ...

([www.who.int/medicines/services/counterfeit](http://www.who.int/medicines/services/counterfeit))

The absence of a universally accepted definition not only makes information exchange between countries very difficult but it also limits the ability to understand the true extent of the problem at global level. In order to address this problem the following definition has been developed by the World Health Organization:

*A counterfeit medicine is one which is deliberately and fraudulently mislabeled with respect to identity and/or source. Counterfeiting can apply to both branded and generic products and counterfeit products may include products with the correct ingredients or with the wrong ingredients, without active ingredients, with insufficient active ingredients or with fake packaging.*

Counterfeit drugs is not an intellectual property issue—it is a public health issue. It threatens everybody’s life and undermines the credibility of our health systems. The development of counterfeit drugs is a “murderous attack on the sick” and is a problem that affects us all.



In the EU, there have been about 50 cases of counterfeit medicines. Although this gives the impression that the problem is not severe here, it must be remembered that in one case there can be many thousands of tablets. The number of cases has already grown by a factor of five in the past few years—and the problem is still growing.

The Rome International Conference in February (Combating Counterfeit Drugs: Building Effective International Collaboration) recommended two main aims:

- Strengthen international cooperation and ensure coordinated effort of all the different public and private stakeholders that are affected and are competent for addressing the different aspects of the problem.
- Develop legal framework, and implementation capacity commensurate to the impact of this type of counterfeiting on public health and providing the necessary tools for a

coordinated and effective law enforcement (i.e. resources and deterring punishment).

The latter is especially important because of the leniency shown by the courts in dealing with the problem. For example, dealing in counterfeit drugs may attract a two-year sentence, whereas counterfeiting a trademark will get ten years.

Everything has been counterfeited, from paracetamol to growth hormones, but there were two “ends” to the market—at one end cheap drugs that have a huge market and at the other end very expensive drugs with a limited market. Many of these drugs—related to building up muscles, looking younger, losing weight, sexual impotence for the more affluent countries—are pedalled through the internet.

It is not known exactly where the largest markets are; what is known is that there is massive production and there are people marketing it, but it is very difficult to find out who and where, although it is known that there are some distribution systems and drivers passing through borders in China/Conga/Nigeria.

### Case Study : Malawi

Malawi has one of the highest death rates from Malaria in the world. One batch of anti-malarial tablets was found to be only 50 per cent effective, but the government told them they would have to accept it. The important issue as far as the government is concerned is financial resources—they can buy anti-malarial tablets in Asia for one cent each, and they buy those rather than the more expensive, but more effective, drugs. They are not concerned about the effect this is having on the patients.

Shortages of health care staff in African countries are making the problem worse. Drugs are available on the open market and can be purchased on street corners. Many of these countries are heavily burdened by malaria and TB and the people have an urgent need for drugs—which is being exploited by the counterfeit medicines trade. This has also led to a two-tier system, where the richest people go to South Africa for their treatment because they will not use the drugs the governments buy for the rest of the population.

The point was made that if the people in Malawi are being given 50 per cent lower doses, this means their resistance will be much lower. It also raised questions about levels of transparency, because if the government is buying them, then there should be traceable elements to the source of supply.

It was pointed out that there are differences between counterfeit drugs and these lower dosages. Substandard drugs is a much bigger problem than counterfeit drugs.

This is a big health issue but patients are different in every country and it is not possible to use the same kind of approach everywhere. As regards messages to give to the public, the generic message is that if you have any doubts, go back to where you got the medicines. As an example, one patient in the UK was given caffeine tablets and realized they were the wrong ones so took them back to the GP.

Unfortunately, many people do not have a choice and have no chance to change things. It was suggested that this was a political problem, and pressure should be put on governments to take seriously these problems of the “haves and have nots”. People are dying because of the neglect they suffer at the hands of policy-makers—it is up to everyone to remember that we are the “voice of the people” and we should join together in condemning these governments and shaming them into taking action.

#### Discussion:

The strong “human interest” element of this topic makes it of interest to journalists:

*“In Malawi we had research and we think we are working with one drug but we are not. I work with the Nurses Association and there was a terrible incident where they were giving vaccinations and the drug turned out to be something else. By the time the nurses had realized, four children had died. We said: ‘There is something wrong with the vaccination’ and started to find out what the problem was, but we lost four children that day simply because they were given the wrong drug for the vaccinations.”*

*“I don’t see any difficulty in this being a media story. In the scope of global media it is a very saleable story as it has such a strong human interest at its centre and directly affects so many people.”*

## CONCLUSIONS

WHEN participants raised several suggestions and the priority tasks identified included:

1. Engaging journalists in countries outside Europe

*“We are all European in this group and I was hoping to have more people from the developing world. At a meeting like this we’ve not got many developing world journalists coming because of money and the distance, perhaps, but there are now possibilities through the Internet and new IT that we could utilize to link up with other countries.”*

2. Engaging mainstream health editors, not just professional association journal editors

*“I was wondering if it would be possible to include more specialist journalists from some of the newspapers, health and science correspondents would be extremely interested in these issues.”*

*“Health journalists could be incorporated.”*

3. Enhancing interest in international health reporting

*“One of the things that we all have to remember about the problems in reporting health all over the globe is that there is a lack of interest. For example, in the UK the Mirror and the Sun don’t have health correspondents at the moment. It’s not a high priority.”*

*“We should be thinking about the stories that are engaging right now on a global level and talking about how to get those out in a way that is interesting.”*

4. Developing “low” resource platforms for on-going exchange, and establishing links with other networks

*“WHEN could form some major links with other journo networks, such as Reuters, and other organizations that are working on developing issues.”*

**Action recommendations included:**

- **Convening of potential Regional coordinators and then Regional meetings**
- **Exploring use of Skype and other low-cost web-based meeting tools**
- **Invite mainstream editors to meetings**
- **Establish international health briefings in key cities, e.g. London**
- **Establish links with other networks**