

WHO-Facts Sheet

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Compiled and edited by
Babichan K Chandy

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1. WATER FOR HEALTH ENSHRINED AS A HUMAN RIGHT

“Water is fundamental for life and health. The human right to water is indispensable for leading a healthy life in human dignity. It is a pre-requisite to the realization of all other human rights.”

With those words, the United Nations Committee on Economic, Cultural and Social Rights took the unprecedented step in November 2002 of agreeing a “General Comment” on water as a human right. A “General Comment” is an interpretation of the provisions of the International Covenant on Economic, Social and Cultural Rights. The 145 countries, which have ratified the Covenant will now be compelled to progressively ensure that everyone has access to safe and secure drinking water and sanitation facilities - equitably and without discrimination.

In the last decade, progress has been slow in providing “improved drinking water” (which may mean as little as a protected well or spring within half an hour’s walk) to the estimated 1.1 billion people who do not have access to it. Sanitation progress has also been slow and around 2.4 billion people still do not have access to, even, a safe latrine.

“Countries will be required to ‘respect, protect and fulfill ‘individuals’ rights to safe drinking water and sanitation. This is a major boost in efforts to achieve the Millennium Development Goals of halving the number of people without access to water and sanitation by 2015 – two pre-requisites for health,” commented WHO Director-General Dr. Gro Harlem Brundtland.

The General Comment states that “the human right to water entitles everyone to sufficient, affordable, physically accessible, safe and acceptable water for personal and domestic uses.”

It requires them to adopt national strategies and plans of action, which will allow them to “move expeditiously and effectively towards the full realization of the right to water”. These strategies should be based on human rights law and principles, cover all aspects of the right to water and the corresponding obligations of countries, define clear objectives, set targets or goals to be achieved and the time-frame for their achievement, and formulate adequate policies and corresponding indicators.

The General Comment is important because it provides a tool for civil society to hold governments accountable for ensuring equitable access to water. It also provides a framework to assist governments in establishing effective policies and strategies that yield real benefits for health and society. An important aspect of the value it provides is in focusing attention and activities on those most adversely affected including the poor and vulnerable.

Inadequate water and sanitation are primary causes of diseases such as malaria, cholera, dysentery, schistosomiasis, infectious hepatitis and diarrhoea, associated with 3.4 million deaths each year. Inadequate water and sanitation is also a major cause of poverty and the growing disparity between rich and poor.

Recognizing the importance of environmental determinants of health, the World Health Organization recently launched the Healthy Environments for Children Initiative. WHO is now pulling together an alliance of public and private bodies, together with non-governmental organizations, to support community based efforts to tackle the main environmental risk factors faced by children.

“It is estimated that almost one third of the global burden of disease (for all ages) can be

attributed to environmental risk factors. Over 40% of this burden falls on children under five years of age, even though they make up only about 10% of the world's population. This area is, therefore, an urgent priority for WHO's work. The fact that water is now regarded as a basic human right will give all members of the Alliance an effective tool to make a real difference at country level," added Dr Brundtland.

The General Comment also stipulates that water, like health, is an essential element for achieving other human rights, especially the rights to adequate food and nutrition, housing and education.

Contact for more information: Gregory Hartl, Communication Adviser, Sustainable Development and Health Environments, WHO, Geneva. Telephone +41 22 791 4458, mobile phone: +41 79 203 6715, Email: hartlg@who.int

2. NEW INTERNATIONAL COALITION AIMS TO EXPAND GLOBAL ACCESS TO HIV/AIDS TREATMENT

A new international alliance, the International HIV Treatment Access Coalition (ITAC), launched in December 2002 in Berlin and Dakar aims to boost efforts to provide access to antiretroviral drugs to the growing number of people with HIV/AIDS in low and middle income countries who need them.

According to WHO/UNAIDS estimates presented in a new report being launched by the coalition, millions of people living with HIV/AIDS in low and middle income countries face death within the coming years unless they can access these life-saving medicines.

Although they are not a cure, antiretroviral drugs (ARVs) inhibit replication of HIV, the virus that causes AIDS, and boost the immune system's ability to fight infections. In all countries where ARVs have become widely available to people living with HIV/AIDS since 1996, they have led to a dramatic reduction in HIV-related illness and death. Ninety-five per cent of the estimated 42 million people with HIV/AIDS live in low and middle income countries, and these countries accounted for over 99% of the 3.1 million AIDS deaths during the year 2002. WHO estimates that only about 300,000 people living with HIV/AIDS in these countries are currently using ARVs, that represents only 5% of those who need them.

Launching the Coalition, WHO Director-General Gro Harlem Brundtland said, "Does anyone deserve to be sentenced to certain death because she or he cannot access care that costs less than \$2 a day? Is anyone's life worth so little?

Should any family become destitute as a result? Should children be orphaned? The answers must be no, no, no and no."

ITAC currently unites more than 50 partners including NGOs, donors and governments, people living with HIV/AIDS and their advocates, the private sector, academic and research institutions and international organizations working to overcome the challenges of expanding ARV access. These include more efficient sharing of information and technical data about what works in successful programs, setting up reliable drug procurement systems, and training health care workers. The group also aims to galvanize and coordinate donor action and provide much-needed technical assistance to national HIV treatment programs. It will be served by a small secretariat at WHO's Headquarters in Geneva. "These drugs have saved hundreds of thousands of lives in Europe and the United States", said International AIDS Society President Dr Joep Lange. "They could do the same for millions more in developing countries. If we can get cold Coca Cola and beer to every remote corner of Africa, it should not be impossible to do the same with drugs."

With more donors coming on board and more countries committed to providing ARV treatment, the challenge now is to expand successful pilot programs. "There is a lot of action in different countries by governments, donors, the private sector, NGOs and other groups", said Stu Flavell, International Coordinator of the Global Network of People Living with HIV/AIDS, a member of the new coalition. "But we need these different players to pool their knowledge and work together. That is the only way we are going to move from treating 50 or 100 people in a village to treating hundreds of thousands across the country."

The Coalition has been created at a time of both crisis and opportunity. In the worst affected countries, over a third of the adult population is now infected with HIV. Although the number of people on ARV treatment increased by nearly two thirds in sub-Saharan Africa in 2002, only 1% of the 4.1 million people living with HIV/AIDS in the region who need treatment now can get ARV medicines. Many governments have reduced import taxes and duties on HIV-related drugs and commodities.

"Extending access to life-saving antiretroviral treatment is a moral, political and economic imperative," said Dr Peter Piot, Executive Director of UNAIDS, the Joint United Nations Programme on HIV/AIDS. "We know it is technically feasible to save lives with these drugs, even in the poorest

settings. We now have to marshal the political will, the resources and the infrastructure to make it a reality.”

Contact for more information: Chris Powell, Communications Officer, Family and Community Health, + 41 22 791 28 88; email: powellc@who.intAll

3. EIGHT QUESTIONS CONSUMERS SHOULD ASK ON THE THREAT OF MAD COW DISEASE

The World Health Organization published in January 2003, a new document to assist governments, consumers' associations and other concerned organizations to protect consumers from the dangers of consuming beef infected with Bovine Spongiform Encephalopathy (BSE or "mad cow disease"). The document provides governments and others involved in consumer protection with background information on the disease and how to prevent its spread.

BSE, or "mad cow disease", is a new disease from a mysterious family of related and mostly very rare diseases. Cases in cattle were first reported in the United Kingdom in 1986. In 1996, another new disease, variant Creutzfeldt-Jakob Disease, or vCJD, was detected in humans and linked to the BSE epidemic in cattle. Consumption of contaminated meat and other food products from cattle is presumed to be the cause.

Both diseases pose many difficult scientific challenges. Answers to all questions cannot be given with absolute certainty. However, a great deal is now known about the origins of the BSE epidemic, the reasons for its spread, the tissues that are most dangerous to consume, and the likely reasons for the appearance of a related disease in humans. Most importantly, intense research, backed by practical experience, has defined a series of measures that countries can use to keep the causative agent out of the food chain and thus ensure the safety of meat supply. When all appropriate measures to minimize human exposure are fully implemented and controlled, meat and meat-based products derived from cattle can be regarded as free from the BSE agent and thus free from any risk of causing vCJD in humans.

Here are some of the most important questions for consumers to ask their national public health and veterinary authorities. These questions are most important in countries where BSE cases have been reported. However, in view of the long incubation period and the fact that contaminated feed has been widely distributed in international trade, consumers and governments in other countries would be wise to consider these questions as well.

What are cattle being fed?

BSE is clearly linked to the practice of recycling bovine carcasses to recover the so-called "meat and bone meal" protein, and then feeding this protein back to other cattle. If cattle are not being fed protein derived from the carcasses of ruminants (cattle, sheep and goats), there is virtually no risk of BSE. If ruminant protein is fed only to pigs and poultry, and if this feed has no chance to mix with and contaminate cattle feed, at feed mills or on the farm, the risk of BSE in the country is insignificant.

Does the government have a system of active surveillance for BSE?

The recent introduction of rapid screening tests, compulsory in many countries, has greatly improved the detection of cases. Such "active" detection of infected cattle, followed by their destruction, prevents entry into the feed chain of a large proportion of infectious material. News of a few cases in countries with active surveillance is more reassuring than no reported cases in countries with poor surveillance.

Are cases of BSE imported or are they being born within the country's herds?

Within cattle herds, BSE is not contagious and does not spread from animal to animal. Isolated imported cases will not spark an epidemic if the affected cattle are destroyed and the carcasses are not recycled for use in feed. Of much greater concern are cases of BSE in cattle born within the national herd, as this implies that feeding practices within the country are at fault and that many other cattle have been exposed.

Does meat come from young cattle?

The incubation period for BSE is very long: 4-5 years. During this period, cattle exposed to the BSE agent show no symptoms and, until late in the period, have no infectious material in their tissues. If cattle are slaughtered at a young age (preferably under 30 months), the likelihood that veal or beef and other bovine products can transmit vCJD is greatly reduced.

Are high-risk tissues removed and destroyed?

The agent that causes BSE is not distributed evenly throughout the animal's body, but is concentrated in certain tissues, most notably the brain and spinal cord, related to the central nervous system. Stringent slaughter practices that remove and destroy these high-risk tissues have an immediate impact on food safety and can protect consumers even when BSE is established within a country.

Are procedures in place to prevent cross-contamination in slaughterhouses?

The agent that causes BSE, and presumably vCJD, has never been detected in bovine skeletal muscle tissues, from which most quality meat is derived. However, an extremely small amount of the causative agent - less than one gram of brain (the size of a peppercorn) from diseased cattle - is sufficient to cause infection in cattle. For humans, the amount capable of causing infection is unknown but could likewise be very small. For this reason, it is vital to guard against cross-contamination. Safe slaughter house practices ensure that high-risk materials have no chance to come into contact with otherwise safe materials and contaminate them.

Are there any other meat products that could contain BSE?

The use of wire brushes and other mechanical tools to recover meat scraps attached to bones and the vertebral column can pull out infectious nervous tissue and contaminate meat that is otherwise safe. Such "mechanically recovered meat" is used in processed meat products. Some experts believe that the BSE agent was transmitted to humans through products containing mechanically recovered meat contaminated with nervous tissue. Techniques that prevent the inclusion of nervous tissue in mechanically recovered meat confer important protection, particularly in high-risk countries.

Are safe practices stringently controlled?

It is not sufficient to recommend safe practices. Such practices must also be rigorously enforced, ideally through legislation, and controlled through inspection by veterinary and food authorities.

Safe to eat - On the basis of current knowledge, scientists agree that some bovine products are safe, regardless of the BSE status within a given country. Bovine products considered safe to eat or use include milk and milk products, gelatin prepared exclusively from hides and skins, and collagen prepared exclusively from hides and skins. Infectivity has never been detected in skeletal muscle tissues, from which most quality meat is derived. A number of scientists believe that skeletal muscle meat is as safe to consume as milk and milk products, provided that such meat has not been contaminated during slaughterhouse procedures.

Contact for more information: Iain Simpson, Communications Officer, Communicable Diseases Programme, WHO, Geneva. Tel. (+41 22) 791 3215; Fax (+41 22) 791 4821; Mobile: (+41) 79 475 5534; E-mail: simpsoni@who.int

4. PRESSING WORLDWIDE CHALLENGE OF LONG-TERM CARE FOR ILL AND DISABLED PRESENTS DIFFICULT ETHICAL QUESTIONS

Long-term care for people with chronic illnesses and disabilities presents an urgent challenge around the world, as existing systems of care have come under great strain and are unable to fully meet growing demands. The critical ethical issues related to long-term care? which all people are at risk to face during their lifetimes? are the focus of a new World Health Organization report.

The report, entitled "Ethical Choices in Long-Term Care: What Does Justice Require?", illuminates the many ethical and social issues at stake. Among key questions that need to be answered are the following:

- What urgent long-term care needs exist?
- Whose needs are at stake?
- What resources are available to meet those needs?
- What are families expected to do, how can they be supported and what would constitute an intolerable burden for these common caregivers?
- What discriminatory biases, e.g. gender, age, or geographic, are embedded in decisions about caregiving?

Answers to such questions discussed in the report will help in the design of long-term care systems that are responsible, accessible, efficient and accountable, and address the wide variety of human needs with dignity and respect. The WHO report is an outcome of a July 2002 consultation at the University of Chicago that brought together philosophers, experts in public health and long-term care and professionals knowledgeable about developing countries.

The universal problem of long-term care is intensifying, due to a combination of demographic and epidemiological forces. A recent WHO study estimates that in many developing countries, the need for long-term care will increase by as much as 400% in the coming decades.

Changes in social structure provide a partial explanation of the increased need for long-term care solutions. Many families are having fewer children and as more young people migrate from rural to urban areas, and from poorer to richer countries, they may not be available to provide care. Similarly, as women, the traditional caregivers in society, are pulled into the labor force by economic necessity or personal desire, they may be unable to continue providing those services.

Furthermore, much of the demand for long-term care arises from ageing populations, chronic health challenges, increasing dependency, the HIV/AIDS

epidemic, dietary and lifestyle habits, increased road injuries, and the rise in diabetes, cardiovascular disease and stroke.

There is a fundamental ethical obligation to provide care for all, particularly the weak and vulnerable, yet most societies are faced with resource limitations and difficult decisions about which of the competing needs are met. Governments have a crucial role as they must anticipate needs, ensure that resources are available and distribute them equitably and efficiently. Yet, strategies for providing long-term care have been low on government agendas everywhere and are completely absent in some countries. Little has been done to address the current challenges, much less to prepare for the future.

Existing systems of allocating the burdens and benefits of caring for the chronically ill and

disabled are often unfair and the inequity is likely to intensify. For example, care-giving tasks have fallen disproportionately on females who are not adequately compensated or protected. Removing a girl from school to care for an ailing relative may sentence her to a lifetime of poverty and unmet potential. The report suggests that care-giving should be redefined as gender neutral and that states should consider prohibiting depriving girls of an education.

The report calls upon societies to invite dialogue about the ethical framework within which equitable, fair, rational, and transparent decisions about long-term care can be made.

Contact for more information: Rola Egloff at the Ethics and Health Unit, Director General's Office, World Health Organization, Tel:(+41 22) 791 1207.