Report

Meeting of the European Chapter of the International Medical Parliamentarians Organization

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The Irish Senate, Dublin - Ireland

31 March – 1 April 2005

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Introduction

On 31 March and 1 April 2005, parliamentarians with a medical background from 11 countries in Europe met upon the invitation of the Chairmen of Houses of the Oireachtas, the Dail and Seanad in Dublin to discuss the whole range of health issues on European agenda. International Medical Parliamentarians Organization brings together members of parliament with a medical, nursing or public health background and aims to share their experience and knowledge of the development of health issues. The meeting was attended by experts from UN agencies such as UNFPA, WHO and non-governmental organizations in order to discuss global health in general and the fight against malaria, sexual and reproductive health, infertility, HIV/AIDS and banning smoking in the workplace in particular. The meeting itself was kindly hosted in the Senate of the Irish Parliament, participants were also warmly welcomed in the official residence of the Parliament of Ireland, Farmleigh. A reception and a guided tour of the beautiful building were hosted by Dr. Jimmy Devins, TD, Vice-Chairman of the Joint Committee on Health and Children.

Parliamentarians were welcomed by the Senator Mary Henry, MD, the host of the meeting as well as by Hon. Yoshio Yatsu, MP from Japan, President of the Asian Forum for Population and Development. During two days of meetings participants had an opportunity to discuss very thoroughly issues related to Europe facing new challenges with regarding HIV/AIDS, European dynamics with regards to sexual and reproductive health and rights, maternal mortality, smoking ban in Ireland, main causes of infertility and problem of declining population as a consequence, the global initiative to combat malaria as well as adopt a declaration calling to action in all mentioned areas.

I. European Parliamentary perspective

Health in Sweden
Presented by Catherine Persson
Member of Swedish Parliament

Legislation

Public health and medical facilities in the entire country is based on a horizontal directive for the Swedish Public Health Service, as decided by the Public Health Service Act. The health care system is obliged to offer citizens a wide range of medical facilities of high standards while respecting the autonomy and integrity of the patient.

The Public Health Service Act has been approved by the Swedish parliament, the Rikdsdag. Special legislation is geared at specific health care in the field of drugs addiction, infectious disease control, psychiatric treatment, facilities for disabled people and dental care.

Structure of health care

Health care is organized around the three administrative levels of government: national, regional and local. The provision of health care is based on the principle of decentralization. The national level has the general political lead, whereas 20 county boards and 290 municipalities finance and provide health care. The Swedish welfare services are financed through progressive income taxes and VAT on goods and services. The health care system is run by the state in order to ensure the principle of equality and proper access. The public character of the Swedish health system has to produce affordable tariffs for medical consultations, operations and medicine.

Future of the health service in Sweden

There is hardly any scope for private initiative in the health care sector. Health care financed on a private basis in Sweden is insignificant in scale. It is possible to sell hospitals to private parties but they will not be allowed to split up services in order to promote only the profitable ones. Hospitals, even in private ownership, have to offer the full range of services. There is consensus among left wing political parties that health care must remain state-owned and that the participation of the private sector should not be encouraged.

The concept and practice of family planning are generally accepted among the population. Child mortality continues to decrease and is now 3,4 per 1000 during the first year of life. The Swedish health sector is confronted with future challenges. The most important one is the ageing of the population. The average life expectancy is now 77,1 years for men and 81,9 for women. Around 18 percent of the population of 9 million people is now over 65 years. The health care system has to be adjusted to this process, in particular by stressing the importance of primary care and preventive treatment. At the moment new dangers appear on the horizon, such as obesity, the widespread consumption of alcohol and smoking among women. Insomnia has become one of the worrying features during the nineties. These developments deserve intensified attention from the health care system.

Vietnam field visit

Presented by Eleni Theocharous,
Member of Parliament from Cyprus

From August 28 until September 6 2004 the Dutch Presidency of the European Union and the United Nation Population Fund organized a joint field mission to Vietnam of decision-makers from 10 new member states of the European Union in order to evaluate the health system, assess the level of reproductive health programs and to assess the level of respect for human rights. The delegation also looked at the capacity of Vietnam to absorb possible program funding.

The delegation met different NGO's working in the field of AIDS prevention and Sexually Transmitted Diseases, ordinary citizens in homes, schools and community centers. However, the delegation did not visit hospital's operation theatres

The main conclusion is that Vietnam faces many challenges in the field of primary health services and in its ability to serve the general population. Also others levels of health care are at a very low level. All members of the delegation shared this impression, although the view on the issues of human rights varied considerably.

World Fact Book 2004

Conclusions

It is necessary to focus more on the rights of childhood well being, including the prenatal period and then move to the issue of reproductive health and rights. In developing programs certain criteria should be taken into consideration, such as:

1. Respect for local customs.
2. Understanding the role of the ruling party.

3. The importance of reliable information.
4. Issues surrounding HIV/AIDS (drugs addiction, homosexuality, prostitution) need to be brought into focus.
5. Data concerning abortion, miscarriage, birth mortality, maternity mortality and morbidity were controversial.

It would be advisable to focus on developing and improving the primary health services of Vietnam in co-operation with the Vietnamese government and NGO's willing to participate in the programs. In particular the transfer of knowledge and competence is needed to ensure the proper use of medical equipment and supplies.

SRHR in Albania

Presented by Valentina Leskaj
Member of Parliament from Albania

Albania is located in the Southeastern Europe (SEE) in the west of the Balkan Peninsula. About 40% of the 3.5 million people of Albania live in urban areas, and approximately 20% of the population inhabits the capital of Tirana. Albania has the youngest population in Europe with an average age of 29 years old and 40% of the population is under 18 years old.

Since the collapse of communism in 1991-1992 the transition from centralized government to a more developed free market economy brought social, political and economic changes to the country. During the period 1990-95 it is estimated that the number of emigrants ranged from 300,000 to 600,000. During the past 12 years Albania has faced continuous political and social changes, and after a period of transition, interrupted many times by social crises such as those of the years 1991-1992, 1997 and the Kosovo crisis in 1999, Albania is now a country under profound economic and structural reforms. The economy of the country is changing from a central economic planning system to a free market system.

National Strategy for the Economic and Social Development

The policy of social welfare is highly conditioned by the economical situation. The National Strategy for the Economical and Social Development, which aims at poverty reduction, social and economic development of the country and placing an important role on HIV/AIDS prevention efforts has been recently adopted.

The Albanian Government has signed the Millennium Declaration and hereby is committed to achieve the Millennium Development Goals. These global goals, each to be achieved by 2015, reflect many of the priorities already identified by the Albanian National Strategy for Socio-Economic Development (NSSED,

an expanded Growth and Poverty Reduction Strategy). Another long-term policy framework in Albania is the Stabilization and Association process (SAp) of integration into the European Union.

Albania has made considerable efforts to establish the legal framework as well as in implementing policies towards decreasing the burden of maternal mortality and improving general situation with reproductive health and rights. A critical problem remains, however, when it comes to linking policy priorities to other stages of the policy cycle: the priorities are not properly quantified in terms of measurable indicators. This creates gap between lawmaking efforts and their practical delivery mechanisms. Much is still to be done in this respect.

HIV/AIDS & Women

Women are especially vulnerable to HIV for biological, social-cultural and economic reasons. Gender barriers and women's lack of power to negotiate sexual relationships, limits the use of the condoms. Prostitution, as one of the forms of human trafficking also represents in combination with the low use of condoms among sex workers, a potential threat for the spreading of HIV/AIDS. The most vulnerable categories, aside from women trafficked for sex work, are: the wives of migrant workers and girls and women who live in rural and urban surrounding areas. Albanian women present a lower level of participation in decision-making processes. In recent years the phenomenon of family violence has increased especially in rural areas. Most of employed women work in agriculture and public sector, both sector characterized by low wages and prestige.

The tradition of male dominance within the family has been revived and has placed women at risk of abuse and limits their power to control their reproductive lives through the use of contraceptive methods. Services that only focus on STI treatment carry stigma which creates a barrier for access to women. Norms that prescribe the preservation of female virginity discourage STI treatment and information seeking in order to avoid being identified as sexually active. The burden of care for HIV affected family members, often falls on females and HIV is still seen as a sign of sexual promiscuity. Therefore gender norms shape the way men and women infected by HIV are perceived and an HIV positive woman can face greater stigma and rejection than an HIV positive man (UNAIDS). Women possess a low level of knowledge in HIV/AIDS and IST, and also a poor health care culture in general and poor reproductive health in particular. The level of awareness on how to prevent HIV/AIDS is low. Knowledge about sexually transmitted diseases need to be improved.

Family planning and use of contraceptives

Contraceptive use, including condom, was introduced in Albania for the first time in 1992 when the Albanian Government approved family planning activities with the "Decision No.226-date 27.05.92". No political or legal barriers to sell or promote condom use exist in the country. Since 1993 contraceptives are distributed in all the public health services for family planning free of charge, provided by UNFPA. In 1996, programmes for social marketing of contraceptives started in Albania. From the supervision done from the Ministry of Health in the public family planning clinics results that the preferences for condom

use are increasing. Every health care facility offers contraceptives within family planning programmes. Recently a law covering issues of reproductive health and rights has been adopted. Receptiveness to condom use is plagued by barriers, including embarrassment or timidity to obtain condoms from sources that require person-to-person contact. For this reason Health Centers and particularly family planning clinics may not obtain the desirable results. Training programmes with health service providers to change attitudes and condom use are on-going.

Infant and maternal mortality

The use of contraception is positively correlated to the reduction of maternal mortality cases in Albania and fFamily planning is easily accessible for over 60 percent of women in Albania. Although family planning services in the country are free of charge, the number of people, especially teenagers, attending the centres is not very high. This low attendance is indicative of the social and cultural barriers that exist in Albanian society and the necessity to improve the quality of care offered by these services.

There is a significant decrease in the infant mortality rate in the country, however, a significant difference exists between urban and rural areas. This is caused by: (i) a higher level of poverty in rural areas as compared to urban environments and (ii) a lower level of the health services provided in rural areas. One important factor supporting the reduction of maternal mortality is due to the reduction of illegal abortions and an increase in the contraceptive use in Albania. The prevalence of abortions has fallen by approximately 24 percent from 1990 to 1999. Maternal mortality caused by abortion was at level of 55% in 1989, current figures suggest that this figure dropped to 0%. This can be largely attributed to success of family planning activities in the country.

II. Europe's response to health burden

Response to global burden of health
Presented by Vincent Fauveau
Senior Maternal Health Advisor, UNFPA

The burden of sexual and reproductive health can be expressed in absolute numbers: 60 to 80 million infertile couples, 120 million couples with unmet need for contraception, 4 million newborn deaths, 8 million life-threatening maternal morbidities, 529.000 maternal deaths, including 68.000 deaths from unsafe abortion. In a global context it is necessary to focus on three main issues:

- The contribution of women's health to the global health burden.
- Benefits from investing in reproductive health
- Contribution of poverty reduction to better reproductive health.

The Disability-Adjusted Life Years (DALY's) is aimed as a measure of the burden of disease in the form of a unit that will allow comparison across different health conditions. This will make DALY's an effective tool for priority setting. According to the WHO, at the moment 18 percent of all DALY's is lost. But for women in their reproductive years (15-44) it is 32 percent of DALY's which is lost. Of this figure, sexually transmitted infections, including HIV, account for 16 percent. The burden of sexual and reproductive health conditions has worsened mainly due to the rise of HIV/AIDS. As a result pregnancies are sometimes unwanted or mistimed which has a considerable impact on health conditions for women and children alike. Undesired fertility also contributes directly to the level of maternal mortality. Also unsafe abortions are a category of fatal obstetric complications. A strategy against these dangers must consist of the following pillars: universal access to contraception, skilled attendance at all births and access to emergency obstetric care.

There are various benefits from investing in reproductive health. The most important is that good reproductive health is an effective instrument to break the poverty cycle and promote economic and cultural development. Reproductive health lies at the basis of sound economic development; healthy children are good pupils, eager students and skilled workers. The lack of reproductive health hampers economic development and feeds the cycle of poverty. In most countries women are the backbone of social and cultural life, they are also at the heart of economic development. Poverty reduction starts with improving reproductive health by ensuring access – both financial and physical – to health services and proper information. Progress in meeting the MDG's is only likely and possible if poor people have the opportunity to have proper access to reproductive health services.

Roll Back Malaria Initiative
Presented by Dr. Jane Crawley, Senior Advisor of The Roll Back Malaria Initiative

Malaria kills 3000 children every day in spite of the fact that it is a preventable and a treatable disease. The burden of malaria includes mortality, morbidity and economic devastation. Over 40 percent of the world's population is exposed to malaria – transmitted through the bite of a female anopheles mosquito. In particular children and pregnant women and HIV-infected people are at risk. Each year there are 300

to 500 million cases and one million deaths, which makes malaria the world's most lethal parasitic disease. The majority of deaths occur in tropical Africa. Mortality from malaria has been rising since the 1970s of which the spread of anti-malarial drug resistance is main factor. In addition to mortality there is an increased risk for pregnant women and children: anaemia, low birth weight and neurological consequences.

The estimated economic cost of malaria is 12 billion US dollars of GDP each year in Africa. In some countries, malaria accounts for as much as 40 percent of total government spending on public health. In malaria-endemic countries in Africa, malaria accounts for 20 to 50 percent of all outpatient clinic visits and hospital admissions. For households an increasing part of the budget is spent on means to fight malaria, such as Insecticide-treated nets or anti-malarial drugs. Malaria makes the poor even poorer. A study in Ghana showed that malaria care accounted for 1 percent of the income of the rich, but 34 percent of the income of the poor. In 1998 the WHO, UNICEF, World Bank and the UNDP launched a roll back programme in order to provide a global approach. The goal of the partnership was to halve the world's malaria burden by 2010. Controlling malaria is one of the contributions to reaching the MDG's. The Roll Back Malaria Partnership (RBM) is now well under way. Global awareness-raising campaigns also show first results. Malaria remains high on the global development agenda.

The RBM strategy aims at strengthening preventive measures and providing proper treatment. Insecticide-treated nets (ITN's) play an important role in preventing malaria, provided they are 'used properly'. In some cases white nets have been used to make wedding veils. Now nets are provided in blue. The use of ITN's is safe and cost-effective. Also the Intermittent Preventive Treatment (IPT) plays an important role. IPT is the administration of a curative dose of an effective anti-malarial drug on 2 or 3 occasions during the second half of pregnancy. IPT is safe, well tolerated and cheap. Mosquito control is also important, for example by spraying people's houses and has been very effective in densely populated urban settings.

Malaria is a rapid killer. Anti-malarial drugs recommendations have changed radically during the past 4 years because of spreading resistance. The use of two different anti-malarial drugs is more effective than mono-therapy. A malaria vaccine would be the ultimate protection and scientists continue to search for a vaccine. Now different measures are needed. In particular a rapid scale-up in coverage of key interventions: ITN's, IPT and artemisinin-based combination treatment. The target is a high-risk group such as pregnant women and young children. The Global Fund to fight malaria disbursed more than 200 million dollars worldwide in 2003-2004. However, it is estimated that 3 billion is required each year to finance effective malaria control.

III. SRHR and HIV/AIDS Europe

SRHR and HIV/AIDS Europe

Presented by Dr. Gunta Lazdane, WHO Advisor on Reproductive Health Issues in Europe.

Sexual Reproductive Health and Rights (SRHR) needs more intensive campaigning in Europe. There are various problems related to SRHR in Europe, such as lack of reproductive choice, weakness of family-planning, dangers to safe motherhood. As regards to the latter, sexually transmitted infections (HIV), sex-abuse, and trafficking are of particular concerns. Cases of cervical cancer are high among adolescents, refugees, migrants and ageing population. Poor socio-economic circumstances contribute to a deficient SRHR, which are directly related to the percentage of GDP per capita spent on health services. Apart from this WHO has developed 17 reproductive health indicators, for example maternal mortality which helps in assessing the situation. Georgia suffers from the highest maternal mortality in the European region, 52/1000.

What are the main trends in having children in Europe? The first group consists of women over 35, which is notoriously high in Nordic countries where it reaches 25 percent. Unfortunately various health risks are inevitably connected to this trend. The second group consists of women under 20 who get pregnant accidentally. This percentage is in particular high in Belarus and Ukraine (15 %). In Baltic countries it is 10 %. This is due to bad socio-economic conditions. Sweden and Finland show the lowest use of contraceptives among adolescents in European countries. Due to the fact that sexually transmitted infections are low on the political agenda the infertility rate grows. Europe severely suffers from women trafficking of which Moldova, Belarus, Lithuania and Ukraine are main source countries.

In Western Europe the main target group for promotion of sexual and reproductive health should be adolescents. Specific problems relate to the rising pregnancy rates among teenagers and the growing number of migrants. Each year about 2 million migrants come to Europe and most of them live in precarious conditions, which are conducive to higher risks to their sexual and reproductive health.

HIV incidents are characterized by two trends: increase in hetero-transmission, mainly stemming from migrants, and an increase in homo- and bi-men sexual behaviour. Central and East European countries show the highest increase of HIV in the world, for example Russian Federation and Ukraine where the prevalence is as high as 1,3 million. In the Russian Federation the fertility rate is 1,2. There are two million abortions per year. Every fifth case of maternal mortality is a result of abortion. In some regions maternal mortality is as high as thirty percent (Yekatarinenburg) and fifty percent of complications are due to abortions whereas 25 percent of abortions are carried out at a very late stage.

Regarding this context, politicians should remember the Cairo and Beijing commitments, which ensure access to sexual reproductive health services through primary health care facilities by 2015. This commitment is closely linked to the MDG’s. WHO has developed a sexual and reproductive health strategy, which identifies the following goal: health sector reform and change of legislation. For example, in the Russian Federation the situation with regard to abortion is alarming. WHO’s Global Health Strategy was approved by the World Health Assembly, which shows unanimous political commitment of all European countries.

In most cases all necessary laws are already in place, but given the deteriorating situation the issue of their proper implementation rises on the horizon. There is a clear need to foster the partnership in development. The main focus should be on the role of the Members of Parliaments and the NGO's. National funds should be made available in order to improve the situation in a sustainable manner, which decreases the need for external financing in the long run. It is important to refer to the wise words of the German author Goethe who once said: Knowing is not enough, we must apply. Willing is not enough, we must act. Main issues of maternal health are: alcohol consumption and teenage pregnancy. Regular alcohol consumption by young people can lead to infertility. Regarding the current dominant policy of the US, which promotes sexual abstinence, many regions - in particular Africa – are likely to suffer the consequences because the use of condoms is not actively promoted.

IV. Infertility in Europe and Europe's declining population

Presented by
Dr. Karl Gösta Nygren, IVF-Unit, Sophiahemmet, Stockholm
Dr. Anna Pia Ferraretti, S.I.S.M.E.R. s.r.l., Italy
Prof. Arne Sunde, IVF-Unit, Dept of Ob. & Gyn. University Hospital of Trondheim, Norway

General Situation.

At the moment fertility is low throughout Europe, lower than ever before or elsewhere. Fertility is often determined by socio-economic factors, rather than by medical factors. The problem of infertility remains stable over time on a level of 10 to 15 percent. Infertility is being tackled following excellent diagnostic skills and medical treatment. After the 1980s treatment options showed a sharp increase with IVF as a leading procedure. About 2 million IVF children have been born so far, of which 1,2 million in Europe. IVF appears on three levels: molecular, individual and societal. Although IVF is the dominant medical treatment in clinical application, availability of services differs greatly between European countries. In particular the Nordic countries show high percentages of infants born after artificial reproductive treatment (ART) between 1997 and 2001. In 2001 Denmark the percentage of infants born after ART was 3,3, followed by Sweden, Iceland, Finland and Norway. Slovenia belongs also to this group, with 3,3 percent of infants form ART, whereas in the UK the percentage is only 1,1. Demand for treatment is driven by confidence in the applicable methods whereas the availability of treatment may be limited as a result of ethical or socio-political considerations. From a global view Europe is in the lead of infertility treatments with 60 percent, research is on a high level and demographic decline is likely to put the need of population increase higher on the political agenda.

ESHRE

The issue of human reproduction is promoted by ESHRE, the European Society for Human Reproduction and Embryology, which was founded in 1985. ESHRE has about 4650 members from 101 countries of which 70 percent is European and 50 percent from the EU. About 50 percent of the members work in the field of reproductive health. ESHRE's mission is to relieve the individual burden of infertility by co-operation between all actors and providing the best treatment available. Besides the human and medical aspects there are also socio-economic reasons to fight infertility: demographic decline and the loss of economic benefits. Investment in fertility pays off very well.

Demographic trends in Europe underscore the need to fight infertility. At the moment fertility rates are below replacement levels (2,1 children per couple) in all European countries. As a result the population is ageing whereas the burden for the economically productive part of the populations steeply increases. In Italy and Spain the trends risk being dramatic with sharp population decline. By 2050 the EU will have 44 million people less than in 2000, a loss of 12 percent. The EU of 15 member states has 100 million people more than the US, in 2050 it will be 18 million less. All countries will face demographic decline, except Ireland, Luxembourg and France. The populations of Italy, Spain and Greece will decrease with 20 percent.

The consequence of this trend is: ageing population (fewer children and a higher life expectancy), pressure on the social security system, higher tax burdens and both quality and access to medical services endangered. One of the options to escape from this political and demographic scenario is to increase fertility. A growing population can be brought about in two ways: having the first child earlier (in the twenties rather than in the thirties) and having more children per couple. This target puts prophylactic measures and access to proper infertility treatment on a higher political ranking.

Worst-case scenario: Italy

Italy is worst hit by demographic decline. A loss of 20 percent of the population during the decades to come will result in ageing population, unaffordable pension schemes, overburdened health services, depopulation of the countryside and higher taxes to finance the public sector. The Italian example is unmatched in Europe. However, in terms of artificial reproductive treatment Italy is underdeveloped. Italy was one of the European countries without a law or comprehensive regulation on ART until 2004. Between 1950 and 2003 about 100 legislative proposals on ART were tabled, none was adopted. The legal basis for ART comes from circulars and ordinances of the Ministry of Health. The legislative gap stems from several factors: a society divided between Catholicism and secularism, internal division between medical organizations, lack of strong patient organizations, political polarization between center-right and center-left. As a result the law on ART passed in 2004 was the most restrictive one in the world.

The Italian legal framework of ART shows how conservative and traditional cultural views prevail over socio-economic, medical and technological considerations. The Italian law on ART is the only one in the world, which grants the human embryo the right of a person. As a result experimentations on human embryos are banned. The scientific development in the field of human reproductive physio-pathology, genetic diseases and embryonic stem cells is considerably hampered. Furthermore, embryo selection can only be made by observation and embryos can only be discharged in case of clear signs of degeneration. The consequence of current Italian ART legislation is that the fight against infertility is severely weakened and demographic decline will continue unabatedly to the extent that the Italian worst-case scenario will be entrenched.

V. Smoking ban

Presented by Dr. Fenton Howell,
M.P.H., F.F.P.H.M.I., F.R.C.P.I.

On 29th of March 2004 Ireland was the first country to introduce a total ban on smoking in all enclosed working places, including in the more than 10.000 pubs. Ireland followed the example of some states in the US, like New York and California, which intended to increase health and safety in the workplace. In Ireland the measure was applauded because 70 percent of the population does not smoke. The government expected compliance of over 90 percent of all workplaces, which is being enforced by a fine of about 3,900 dollars. Although pub-owners feared a decline in business turnover most pubs have installed heated outdoor terraces.

The introduction of the ban has taken many years. The preparation and promotion of the ban have been embedded in a comprehensive strategy for health and safety. The damaging impact of smoking, in particular passive smoking, became evident in the course of the 1980s. It took until 2004 to achieve an overall ban. One of the main arguments to support a ban was that everybody has a right to clean air. One of the main arguments in defense of the smokers is that everybody has a right to smoke, although it is detrimental to a person's health. Therefore, the discussion focused on smoking in public places, like offices, bars and restaurants. In a public place the right of the non-smoker to clean air prevails over the right of the smoker to smoke.

The smoking ban was promoted by politicians, public servants, trade unions and non-governmental organizations. In the end there was a cross-party consensus in both houses of parliament to introduce the ban. The government declared a 'tobacco-free society' as one of its major commitments. The ban was accompanied by a complete ban on tobacco advertising in print media. Furthermore, media spreads information on the danger of smoking to health. Opponents from the hotel, restaurant and café sector considered the ban as too far-reaching and damaging for business. They labeled the ban as unnecessary, unworkable and unenforceable.

So far, results of the ban in New York and Boston have shown the opposite. Turnover in restaurants and bars have not shown a steep decline, on the contrary non-smokers (a majority in society) feel more attracted than before. Separate sections of smokers and non-smokers in pubs, restaurants or airplanes do not work. Both the smoke and the smell of it penetrate everywhere. The conclusion is that the ban in Ireland has shown: over 90 percent compliance, increase of health of staff, brings people (family, children) together in public places, less cost on cleaning. The ultimate aim is to convince people to quit smoking and install nicotine replacement therapies.

Conclusions

This was the first meeting of the European Chapter of International Medical Parliamentarians Organization after a long break. Delegates called for this initiative to be strengthened and assured of necessary funding in the future in order to allow regular meetings of the IMPO-European Chapter. Parliamentarians with a medical background can play a supportive role to guide politicians, parliaments and the media searching for a proper, well-founded approach of sexual reproduction issues. Parliamentarians mastering medical language are well placed to communicate the importance of sexual reproduction to a wider audience. They have both the knowledge and the credibility.

IMPO recalls that 7 April is the World Health Day and 25 April is Africa Malaria Day. In September the UN will review the MDG's. In the light of this review it is important to note that the recommendations of the Jeffrey Sachs report on malaria and sexual reproductive health must be supported. Equally, co-ordination between donor countries and donor organizations must be encouraged. Given the scope and spread of malaria, there is an urgent need to scale up efforts to control it by providing insecticide treated bed nets, intermittent preventive treatment and artemesinine treatment.

Sexual Reproductive Health and Rights and HIV/AIDS deserve closer attention in Europe. A pan-European initiative may be explored because there has not been any awareness campaign in many years. National governments should allocate a greater part of the health budget to the issue of reproductive health and HIV/AIDS in order to reduce reliance on external donor funding. It is in particular regrettable that the US government restricted sexual reproductive health services, which casts gloom on efforts in poor countries to set out family planning policies and awareness campaigns with the regard to HIV/AIDS. The absence of such policies often leads to maternal mortality as a result of unsafe abortions. There is also an urgent need for closer co-operation in the fight against trafficking for sexual exploitation.

In many European countries infertility is a problem in relation to the demographic decline, which will provoke social tensions, such as the question: who will carry the cost of the ageing population? In particular, the affordability of pension schemes and a massive use of health services by the elderly will have a decisive impact on taxes paid by the decreasing working population. This trend in the foreseeable future requires sound consideration of demographic trends. The issue of fertility must be approached through regular dialogue, by involving all interested parties and by considering a pan-European campaign. It is advisable to explore the possibility for creating a standing network of interested parties and look at the issue from a wider perspective such as childcare, parental leave, cost of living and child benefits.

A landmark success in the field of health policy has been the ban of smoking in the workplace. The pioneering example of Ireland has shown that the ban of smoking does not lead to the economic disadvantages, which opponents feared. On the contrary, if embedded in a wider and well-communicated strategy a smoking ban produces far-reaching results. It improves health, social contact, keeps business intact and discourages the use of tobacco products. In fact, the smoking ban in Ireland has proved that close co-operation between governmental health institutions; parliamentarians and social organizations can lead to widespread public awareness. Parliaments should continue to press for the autonomy of the media to address the negative effect of smoking. In particular certain target groups, such as teenagers,

are increasingly receptive to the advertisement of the tobacco industry. IMPO will engage in wide consultations with trade unions, politicians, public officials and NGO's and ask for continuous awareness. Finally, any campaign or ban should be accompanied by measures, which help smokers to quit.

Annex I Final Declaration

Parliamentary Declaration

International Medical Parliamentarians Organisation – European Chapter

Dublin, 1 April 2005

On 31 March and 1 April 2005, parliamentarians with a medical background from 11 countries in Europe met upon the kind invitation of the Chairmen of Houses of the Oireachtas, the Dail and Seanad in Dublin as the European Chapter of the International Medical Parliamentarians Organisation (IMPO). IMPO is open to members of parliament with medical, nursing and/or public health background and offers a unique platform where parliamentarians with a medical background come together and share their experience and knowledge of the development of health issues around the world. The Dublin meeting of the European Chapter of the International Medical Parliamentarians Organisation brought together leading parliamentarians with medical background from many European countries to meet in the Irish Senate to discuss with experts from UN agencies such as UNFPA, WHO and non-governmental organisations burning issues and challenges we are facing, including global health in general, the fight against malaria, experiences related to banning smoking in the workplace, infertility, sexual and reproductive health and rights & HIV/AIDS.

As parliamentarians with a medical background we believe that

1. IMPO can play a supportive role as an organisation to guide politicians and parliaments towards more up to date, international and applicable legislation. Policy-making should not be left in the hands of ministries and governments alone.

2. medical language, as the most international means of communication regarding humanitarian issues, can assist peace and the sustainable development of the planet.

3. IMPO as an organisation should be strengthened and deserves the economic support of parliaments and governments.

Global Health

In relation to global health,

Recall that

- 7 April is World Health Day dedicated to maternal and child health
- 25 April is Africa Malaria Day
- in September, the UN will review the Millennium Development Goals (MDGs)

Underline that

- sexual and reproductive ill health accounts for up to 20% of the global health burden
- sexual and reproductive ill health is the most common cause for families to fall into poverty
- the MDGs can not be attained without investing in malaria control and sexual and reproductive health
- all infectious diseases are international by nature in a globalised world

Resolve to

- support the recommendations in the Jeffrey Sachs report on malaria and sexual and reproductive health
- encourage coordination among donors countries and donor organisations
- address the issues of brain drain and health sector human resources capacity and the need for donor policies to support development of indigenous health sector capacity

Malaria

In relation to Malaria, recognise that

- malaria kills 3000 Children every day
- costs the African continent USD 12 Billion every year
- malaria is a completely preventable and treatable disease
- can be controlled for the cost of USD 3 Billion per year

Call on donor governments and the international community

1. recognise the need to scale up efforts to control malaria by providing insecticide treated bed nets, intermittent preventive treatment and prompt access to effective artemisinin-based combination therapy

2. prioritise interventions aimed at high-risk target groups such as pregnant women and children

3. support the recommendations in the Jeffrey Sachs report on addressing malaria control in the UN review of the MDGs

Sexual and Reproductive Health and Rights and HIV/AIDS

In relation to SRHR and HIV/AIDS

1. note with concern the increasing prevalence of new HIV/AIDS cases in the European region, and the decline in use of condoms and the lack of visibility of sexual and reproductive health and rights and HIV/AIDS on the political agenda in Europe

2. note that while the policy and legal framework exists, for example the WHO sexual and reproductive health global and European strategies, more efforts need to be made in the field of implementation to address persisting cases of elevated maternal mortality in European countries, particularly in the former Central and Eastern Europe

3. emphasise the need to address the sexual and reproductive health and rights of young people particularly in terms of awareness, access to sexual and reproductive health services and related social and economic issues for example teenage alcohol abuse and pregnancy

Resolve to

1. explore the potential for a pan-European initiative / campaign on HIV/AIDS, noting that there has not been such a campaign in many years

2. strive to allocate a greater percentage of national funding to sexual and reproductive health and HIV/AIDS in national health budgets, to increase allocations to overall health budget and, where applicable, reduce reliance on external donor funding for sexual and reproductive health programmes

3. regret the restrictions on sexual and reproductive health services imposed by the current US administration and call on European governments to take concrete measures to offset the loss of funding

4. encourage discussion on the link between the availability of legal and safe abortion and the incidence of maternal mortality, particularly in countries where there persists a high incidence of maternal deaths

5. encourage cooperation among countries on the issue of trafficking for sexual exploitation, including men's responsibility in purchasing sexual services from women who are exploited

Infertility

In relation to infertility,

1. note that the World Health Organisation considers infertility to be a disease affecting millions of Europeans which is a result of a combination of factors, including smoking, body mass-index, stress and sexually transmitted infections, as well as socio-economic conditions

2. deplore the social stigma which accompanies infertility and the politisation of debate based on religious beliefs which can limit couples' access to infertility treatment services

3. encourage exploring the link between increased public expenditure on infertility treatment with greater accessibility and greater success of treatment and permissive conditions for offering treatment

Resolve to

1. recommend to parliaments, including the European Parliament, to urgently consider demographic trends in Europe
2. raise the issue of infertility through regular dialogue with interested parties
3. look to involve all interested parties in discussion on infertility
4. consider a pan-European campaign on infertility
5. explore the possibility for creating a standing network of interested parties on infertility
6. look at broader social measures, such as childcare, parental leave, cost of living, child benefits

Smoking ban

In relation to the banning of smoking in the workplace,

1. note with satisfaction the successful and pioneering experience of the Irish Smoking ban in the work place

2. recognise the solid body of scientific evidence concerning the ill-effects of passive smoking in existence since the 1980's, which has not been sufficiently addressed by parliaments in Europe

3. highlight that the success of the Irish experience is based on dealing with smoking as a health and safety issues, supported by solid scientific facts, widespread consultation and preparation; and characterised by public acceptance

Resolve to

1. raise in parliament the link between banning cigarette advertisement in print media and the autonomy of the media to address the negative effect of smoking

2. engage in wide consultations with trade unions, politicians, public servants and NGOs on the health, social and economic benefits of smoking ban and public awareness campaigns

3. that smoking ban should build consensus across all parties

4. that measures to help smokers quit should accompany any ban

Acknowledgments

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IMPO-European Chapter notes with gratitude the financial contribution to hold this meeting by the Asian Forum of Parliamentarians on Population and Development and the Inter-European Parliamentary Forum on Population and Development.

Annex II Programme of the meeting

Date: 31 March and 1 April 2005
Venue: Irish Senate

Day 1 – Thursday, 31 March 2005		
10:30	11:30	*Registration*
		Chair: Senator Mary Henry, MD, Ireland
11:30	12:30	Opening Ceremony Purpose of the Meeting: - Senator Mary Henry, MD Welcome remarks: - H.E. Mary Harney, TD, Minister of Health and Children, Ireland - Hon. Yoshio Yatsu, MP - Japan (AFPPD) - Vincent Fauveau, Senior Maternal Health Advisor, UNFPA
12:30	14:00	*Lunch* - *Hosted by H.E. Mary Harney, TD, Minister of Health and Children, Ireland*
14:00	15:00	European Parliamentary Perspectives on Health Challenges - Valentina Leskaj, MP – Albania - Catherine Persson, MP – Sweden - Eleni Theocharous, MP - Cyprus
15:00	15:30	Coffee Break
15:30	16:30	HIV/ AIDS & SRHR - Dr Gunta Lazdane, WHO – Europe - Discussion
16:30	17:30	Smoking ban in Ireland and Europe - Dr Fenton Howell, M.P.H., F.F.P.H.M.I., F.R.C.P.I - Discussion
17:45	18:00	Return to Hotel: bus from Senate to hotel
19:00	19:15	Bus from hotel to reception in Farmleigh
19:30	20:30	Reception in Farmleigh Hosted by Dr Jimmy Devins, TD, Ireland, Vice-Chairperson of the Joint Committee on Health and Children

20:30	20:45	Return to Hotel
Day 2 – Friday, 1 April 2005		
Chair: Hon. George Tsereteli, MD, Chair of the Georgian Parliament Committee on Health and Social Affairs, Former Minister of Health of Georgia		
9:30	10:30	Infertility in Europe & Europe's Declining Population - Dr. Karl Gösta Nygren, IVF-Unit, Sophiahemmet, Stockholm - Dr. Anna Pia Ferraretti, S.I.S.M.E.R. s.r.l., Italy - Professor Arne Sunde, IVF-Unit, Dept of Ob. & Gyn. University Hospital of Trondheim, Norway
10:30	11:00	*Coffee Break*
11:00	12:30	The Global Initiative to Combat Malaria - Dr Jane Crawley, Roll Back Malaria Initiative
12:30	14:00	*Lunch*
Chair: Senator Mary Henry, MD, Ireland		
14:00	14:45	Europe's response to the Global Health Burden - Vincent Fauveau, Senior Maternal Health Advisor, UNFPA
14:45	15:30	What Role for Medical Parliamentarians Debate on Declaration
15:30	15:45	Closing session - Senator Mary Henry, MD

Annex III List of participants

PARTICIPANTS			
Ms	Valentina	LESKAJ	Albania
Ms	Arte	DADE	Albania
Ms	Eleni	THEOCHAROUS	Cyprus
Ms	Nurmi	TUIJA	Finland
Mr	George	TSERETELI	Georgia
Mr	Josef	KARDENAKHISHVILI	Georgia
Ms	Elke	NEUWOHNER	Germany
Mr	Payam	KATEBINI	Germany
Mr	Yoshio	YATSU	Japan
Ms	Sarmite	KIKUSTE	Latvia
Mr	Vitālijs	ORLOVS	Latvia
Ms	Carmen	MONTON	Spain
Mr	Eugenio	CASTILLO	Spain
Ms	Fatima	ABURTO	Spain
Ms	Catherine	PERSSON	Sweden
Mr	Mehmet Ugur	NESSAR	Turkey
Lord	Nic	REA	United Kingdom
SPEAKERS			
Ms	Gunta	LAZDANE	Latvia
Mr	Arne	SUNDE	Norway
Ms	Anna	PIA FERRARETTI	Italy
Mr	Karl	GÖSTA NYGREN	Sweden
Ms	Mary	HARNEY	Ireland
Mr	Vincent	FAUVEAU	UNFPA
Ms	Jane	CRAWLEY	Roll Back Malaria Initiative
GUESTS / OBSERVERS			
Dr	Sheila	JONES	Day 1 and Farmleigh*
Dr	Mary	CRONIN	AIDS Session
Dr	Kate	O'DONNELL HPSC	AIDS Session
Dr	Darina	O'FLANAGAN	AIDS Session
Dr	Colm	BERGIN	AIDS Session
Dr	Fiona	MULCAHY	AIDS Session
Mrs	Emilia	MARTINEZ HITA	Spain
Mrs		REA	United Kingdom
Ms	Ludi	SCHLAGETER	Weber Shandwick
ORGANISERS			
Mr	Neil	DATTA	IEPFPD
Ms	Marianna	MATAKOVA	IEPFPD
Ms	Karen	GRIFFIN	IFPA
Ms	Enda	DOWLING	Leinster House
Ms	Patricia	O'MOORE	Leinster House
INTERPRETERS			
Mr	Jonathan	BAUM	Interpreter JP

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The Irish Family Planning Association

UNFPA

WHO

ESHRE

Roll back Malaria Partnership

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The Asian Forum of Parliamentarians on Population and Development

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