this week

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RICHARD H SMITH

Let SAS doctors work as GPs, says GMC

Rules should be relaxed to allow thousands of skilled doctors in non-training posts to work in general practice, the GMC has recommended.

In its annual workforce report, the regulator said that specialty and associate specialist (SAS) and locally employed (LE) doctors offered a "fantastic resource" and were a partial solution to the fragile state of general practice. The GMC's latest data show that numbers of SAS and LE doctors have grown at almost six times the rate of GPs in the past five years. If that trend continues, they will represent the largest group on the UK medical register by 2030.

UK regulations prevent these doctors working in primary care, but GMC chief executive Charlie Massey told *The BMJ* that if reversed it could help solve the primary care workforce crisis relatively quickly. "We see this quite staggering growth in the number of SAS and locally employed doctors that has been fuelled largely by international migration. These are highly skilled doctors.

"Yet the odd thing is that the rules that govern who can work in primary care explicitly forbid non-GPs from working in primary care.

"Our view is that we need to be part of the solution, and we want to encourage others to think in fresh ways about resolving these challenges. We've all been waiting for a long term workforce plan from the government for a very long time. But here is a solution we can begin to act on quite quickly."

Massey said the GMC had proposed this solution previously but it had not progressed. "We have privately raised this question with policy makers in the past, but we're making more of it in this publication, as we just think there is an urgency to fix this.

"We need not be constrained by the forces of inertia. All of us [should be] much more solutions focused in terms of how we work our way through what is an incredibly complex and difficult set of workforce challenges across the NHS."

But doctors' representatives were cautious about the GMC's idea. Martin Marshall, chair of the Royal College of GPs, said, "SAS grade doctors, like other members of the practice team, must not be seen as a replacement for GPs, who are expert medical generalists."

Ujjwala Mohite, chair of the BMA's UK SAS committee, said, "Such a plan should not be a case of employing largely international medical graduates cheaply and on poor terms to plug staffing gaps."

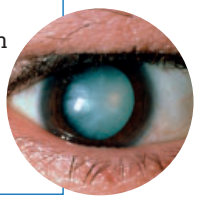
Adele Waters, *The BMJ*

Cite this as: *BMJ* 2022;379:o2505

Charlie Massey, GMC's chief executive, said the NHS needed "fresh ways" of thinking to resolve the workforce crisis

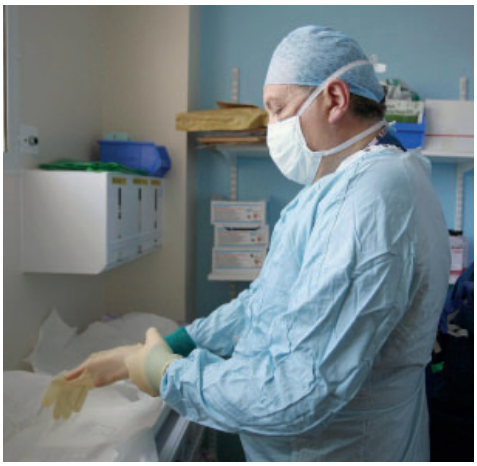
LATEST ONLINE

- UN warns of "devastating" effect of covid-19, conflict, and climate change on women's and children's health
- More than a third of US counties lack obstetric services as they are deemed unprofitable
- Cataract surgeon is struck off after missing NHS operations for private work



SEVEN DAYS IN

NHS at risk of "complete collapse" from exodus of consultants, BMA warns



CHRISTOPHER FURLONG/GETTY

The BMA has urged the government to avert a major exodus from England's hospitals after a survey of almost 8000 doctors showed that four in 10 consultants and half of surveyed consultant surgeons planned to leave or take a break from NHS work over the next year.

Such a "tidal wave" of resignations would leave the NHS in "danger of complete collapse," it warned, unless there is urgent action to improve pay, pension arrangements, and conditions.

Vishal Sharma, chair of the BMA Consultants Committee, said, "Our hospitals are full. Ambulances are frequently unable to attend to emergencies as they are stuck waiting to offload patients to emergency departments that are unable to take them. Patients are waiting months and even years to access the treatment that they need. This is not the NHS that our patients deserve or that our staff signed up to work in.

"We urge the government to talk to consultants about the changes needed before it is too late to stop the drain of doctors from the NHS."

The BMA calculated that since 2008-09 the average consultant in England has experienced a real terms fall in take home pay of nearly 35%, and 90% of NHS consultant respondents to its survey said this year's pay rise of 4.5% was "inadequate" or "completely unacceptable."

Zainab Hussain, *The BMJ* **Cite this as: *BMJ* 2022;379:o2465**

Public health

Government must tackle HRT "postcode lottery"

Prescription costs for hormone replacement therapy in England should be scrapped as in the rest of the UK, and all women aged 45 should be offered a health check to help diagnose menopause at an earlier stage, said the All Party Parliamentary Group on Menopause. It also advised action was needed to tackle delayed diagnosis and difficulties in accessing HRT, warning that a socioeconomic divide was emerging between women who could access the right care and those losing out in a "postcode lottery."

Scrap GDP as prosperity measure, says BMA

The government must regard the population's health as crucial to sustainable economic growth rather than being dependent on a prosperous economy, the BMA said in a report, *Valuing Health*. It said that the "little action" being taken on the "ticking time-bomb of deteriorating population health" was "narrowly focused on the NHS, rather than the wider determinants." The BMA called for a move beyond gross domestic product as the main measure of the country's fortunes, as "many contributors to this metric actively harm human and planetary health and contribute to climate change."

NHS pressures

Elective waiting list reaches seven million

Medical leaders have warned that the NHS faces pressure from all directions, as figures showed that 7 003 256 people in England were waiting for planned hospital treatment in August, though waits of over two years have fallen, from an all time high of 23 778 in January to 2646 in August. Tim Mitchell, Royal College of Surgeons vice president, said, "The health service still hasn't managed to return to pre-pandemic activity levels. The NHS is now under pressure from all sides."

Double mental health funding, BMA urges

The BMA asked the government to double a funding pledge made in April 2019 for mental health services in England from £2.3bn a year by 2023-24 to £5.2bn, as recent statistics showed that nearly 400 000 young people were in contact with mental health services each month. This was a fourfold increase since April 2016. More than a million adults are also in contact with mental health services each month, and one in seven psychiatric posts is vacant.

Regulation

Leading oncologist returns to practice after suspension

Justin Stebbing, a professor of oncology based at Imperial College London and a private practice in Harley Street, has been allowed to return to practice nine months after he was suspended from the medical register for his "cavalier approach" to 12 dying private patients from 2014 to 2017 and for being dishonest. The tribunal found he had remedied his failings and kept his clinical skills up to date. Stebbing told the tribunal, "I should not have treated any of these individuals; they were too sick to be treated."

NHS estates

Maintenance and repair backlog will cost billions

Saffron Cordery, interim chief executive of NHS Providers, called for a "step change" in the government's capital investment after figures from NHS Digital showed that it would cost £10.2bn to meet the backlog of upkeep and repairs to restore NHS buildings and facilities to safe standards. The bill is up 11% on last year. She also called for "urgent clarity and commitment about [the government's] delayed new hospitals programme." Nearly two thirds of trust leaders have said that delays to the programme affect their ability to deliver safe and effective patient care.

Patient safety

Consultation begins on improving safety alerts

The MHRA has launched a 14 week consultation on how healthcare professionals would like to receive safety information and to gather feedback on the Yellow Card safety reporting system. June Raine, the agency's chief executive, said, "We want to learn from a wide range of healthcare professionals and use this to develop an approach that improves how safety information and reporting systems are communicated and used." The consultation closes on 18 January.

MEDICINE

Africa needs the £88bn a year pledged by world leaders if it is to avoid societal crisis

Climate crisis

Health journals call for justice for Africa

More than 250 health journals, including *The BMJ* (*BMJ* 2022;379:o2459), published an editorial urging world leaders to deliver climate justice for Africa ahead of the UN Climate Change Conference (COP27) in Egypt next month. The authors say that Africa has suffered disproportionately despite doing little to cause the crisis. They argue that achieving the $100bn (£88bn) a year climate finance target is now "globally critical if we are to forestall the systemic risks of leaving societies in crisis" and that additional resources for loss and damage must now also be introduced.

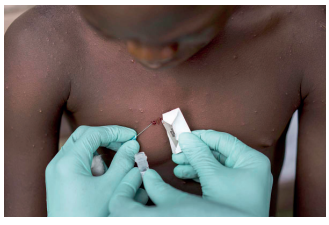
Overseas news

Cough syrups are probed after Gambia child deaths

The World Health Organization has issued a medical product alert relating to four contaminated cough syrups that have caused acute kidney injuries and are linked to the deaths of 66 children in the Republic of the Gambia. Promethazine Oral Solution, Kofexmalin Baby Cough Syrup, Makoff Baby Cough Syrup, and Magrip N Cold Syrup are made by Maiden Pharmaceuticals, based in the northern Indian state of Haryana. WHO's analysis of the products found unacceptable amounts of diethylene glycol and ethylene glycol as contaminants.

Monkeypox DNA is evident in treatment rooms

Healthcare workers treating patients with monkeypox should use PPE, regularly disinfect any frequently touched surfaces, and practise hand hygiene to protect against infection, researchers said after finding that viral DNA was circulating widely in the air in hospital isolation treatment rooms. Susan Gould, an author of the study published in *Lancet Microbe*, said that in addition to PPE and other infection control measures healthcare staff should "contain shed virus within hospitalised patients' isolation rooms, including the use of negative pressure rooms and doffing areas."



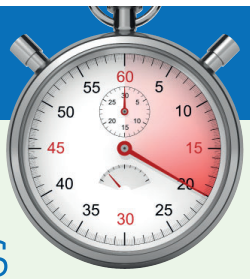
"Screen US children" for anxiety and depression

The US Preventive Services Task Force has recommended that children and adolescents aged 8 to 18 should be screened for anxiety and that those aged 12 to 18 should be screened for depression. "Too many children and teens in the United States experience mental health conditions, including anxiety, depression, and suicidal thoughts or behaviors," it said. The call came a year after US doctors' groups declared a national state of emergency in child and adolescent mental health. They and another 130 groups have now called on President Joe Biden to issue a "national emergency declaration in children's mental health."

Cite this as: *BMJ* 2022;379:o2493

GPs

The number of GPs in the UK rose by 7% between 2017 and 2021, from 60 690 to 65 160, far less than the overall doctor workforce, which increased by 17% *[GMC]*



SIXTY SECONDS ON . . . PANDEMIC BABIES

DID A BABY BOOM HAPPEN?

It was more of a baby bust. Despite predictions that the birth rate would rise as the pandemic forced people to spend more time at home, a study of 14 countries has found that Europe actually saw a 14% decrease in live births in January 2021, around nine to 10 months after the first lockdowns.

A BABY SHOWER, THEN?

Only a light drizzle. England and Wales had 13% fewer live births than expected in January 2021, and there were 14% fewer in Scotland. Perhaps taking part in Zoom quizzes, watching box sets, and baking sourdough bread were enough to occupy people during those long months.

SO "NETFLIX AND CHILL" ISN'T A EUPHEMISM?

The study, published in *Human Reproduction*, didn't cover that. But its authors noted that the decrease in births was more likely to be associated with lockdowns that were imposed in many European countries than with people becoming infected and encountering problems as a result, such as deaths, miscarriages, or stillbirths.

WHICH NATION WAS MOST AFFECTED?

The decline in births seemed to be more common in countries that struggled most to contain covid. Seven countries had intensive care units that were over-occupied (more than 100% full), and six of these (Belgium, France, Italy, Spain, England, and Scotland) saw substantial drops in birth rates.

DID PEOPLE FEAR HOSPITALS?

Léo Pomar, associate professor at the School of Health Sciences in Lausanne, Switzerland, and first author of the study, said the longer the lockdowns went on the fewer pregnancies occurred. "We think that couples' fears of a health and social crisis at the time of the first wave of covid-19 contributed to the decrease in live births nine months later," he said.

ARE THERE PRECEDENTS?

The authors noted that the 1918 Spanish flu pandemic and the 2013 Ebola and 2016 Zika outbreaks were also associated with a fall in birth rates nine months after their peaks.

Gareth Iacobucci, *The BMJ*

Cite this as: *BMJ* 2022;379:o2489

Hunt must keep promise to deliver NHS workforce plan, say leaders


Jeremy Hunt leaves No 10 after being appointed chancellor

STEFAN ROUSSEAU/PA/ALAMY

Healthcare leaders have urged the new chancellor, Jeremy Hunt, to make good on his previous commitments to fix the NHS's workforce and pensions crises and not to cut its spending.

Hunt was appointed to replace Kwasi Kwarteng on 14 October by the beleaguered prime minister, Liz Truss, whose premiership has unravelled since her government announced radical and unfunded tax cuts in its "mini-budget" last month.

Hunt was health secretary for England between 2012 and 2018 and more recently has served as chair of the House of Commons Health Committee since January 2020. In this most recent role he has been a vocal advocate for a full NHS workforce plan and for fixing the damaging pension taxation rules that are prompting many doctors to retire.

In a statement three days after his appointment he reversed most of Kwarteng's budget, while warning that "more difficult decisions" on tax and spending would be needed to regain economic and financial stability. "Some areas of spending will need to be cut," Hunt said.

Having to find yet more savings will be extremely hard and can only impact on patient care
Saffron Cordery

Cut to the bone

Saffron Cordery, interim chief executive of NHS Providers, said that, although trust leaders understood the need for economic confidence and stability, budgets were "already cut to the bone," as a result of the diminishing public funding caused by soaring inflation, the cost of pay awards not fully funded by the government, and cuts in funding for dealing with covid.

"Jeremy Hunt understands better than most the pressures on NHS staff and budgets," Cordery said. "He has been an advocate for a badly needed long term workforce plan, without which severe staff shortages will continue piling pressure on already overstretched services and affect the quality of patient care.

"Efficiency targets in the NHS are already very stretching. Having to hunt for yet more savings will be extremely hard and can only impact on patient care. It's vital that capital budgets aren't raided to fund day-to-day spending."

Matthew Taylor, chief executive of the NHS Confederation, said, "Carrying 132 000 vacancies and with an exhausted workforce grappling the huge weight of patient need, this is Mr Hunt's moment of truth. Put simply, to ensure economic growth and prosperity the government must now act for the long term and invest in the health service as the country's economic backbone and fully recognise it is a key driver to economic stability. The time to act is now."

Gareth Iacobucci, *The BMJ*

Cite this as: *BMJ* 2022;379:o2496

Covid boosters are rolled out as hospital admissions rise

Who is eligible, and how do you deal with patients' anxieties? **Elisabeth Mahase** answers your questions

Why is another vaccine booster being rolled out?

Booster doses are being given to enhance the immunity of people who have a raised risk of developing severe covid. While many people will have had three or four doses over the past couple of years, the protection provided by those could wane within around six months and fall even more rapidly among clinically vulnerable groups.

In a statement on the booster programme the Joint Committee on Vaccination and Immunisation said, "Although there are uncertainties regarding the size and timing of potential future waves of covid-19, winter remains the season when the threat is greatest."

Does the booster protect against new variants?

The main vaccine being used for the autumn booster programme is Moderna's mRNA bivalent vaccine, which combines the original wildtype virus vaccine with the BA.1 specific omicron vaccine. The MHRA said data showed that the vaccine triggered a "strong immune response" against both BA.1 and the original virus and a "good immune response" against the omicron subvariants BA.4 and BA.5.

Are covid hospital admissions rising?

Yes. Between 27 September and 3 October 7904 people were admitted to hospital with covid-19, a 33% increase on the 5930 in the previous seven days. On 5 October there were 9631 patients in hospital with covid, a rise of 37% from the 7024 on 28 September.

The UK Health Security Agency has also reported that the number of suspected outbreaks in England rose to 370 in the week beginning 3 October, up from 270 the week before. Covid hospital admission rates are the highest in the north east of England, with a rate of 15.84 per 100 000 population.

UKHSA's director of public health programmes, Mary Ramsay, said that there were also "early indications" that covid deaths were starting to rise.

Who can get the booster?

Around 26 million people in England are eligible for the

BLOOD SHORTAGES **Hospitals are asked to postpone some elective operations**

NHS hospitals have been asked to postpone some non-urgent elective operations to protect blood stocks, after NHS Blood and Transplant issued an "amber alert" over supplies on 12 October. NHSBT urged donors to come forward and help by filling empty appointments at donor centres.

Hospital bosses will decide which operations to postpone, but NHSBT advised procedures such as hip replacements could be swapped for operations such as hernia repairs, gall bladder removal, and eye surgery that don't require blood on standby.

The amber alert will last initially for four weeks. The service aims to hold more than six days' worth of stocks, but levels are currently predicted to fall below two days .

NHSBT said maintaining stocks had been an "ongoing challenge" since the pandemic, mainly because of staff shortages and sickness but also because of a fall in donors. Wendy Clark, its interim chief executive, said, "Asking hospitals to limit their use of blood is not a step we take lightly. This is a vital measure to protect patients who need blood the most. With the support of hospitals and the measures we are taking to scale up collection capacity, we hope to be able to build stocks back to a more sustainable footing."

The agency said it was also moving more of its staff to the front line to open up more appointments, speeding up recruitment, and helping people to return to work after absence.

Cheng-Hock Toh (above), chair of the National Blood Transfusion Committee and professor of haematology at Liverpool University Hospitals Trust, told *The BMJ* that more could be done to reduce demand for blood through better adherence to NICE guidelines, which in 2015 recommended tranexamic acid for blood transfusion. A quality standard in 2016 also recommended tranexamic acid for adults expected to have moderate loss during surgery. "However, a recent large national clinical audit shows that a large proportion (>30%) of eligible surgery patients do not get it," said Toh.

He added that results from the Poise-3 trial provided strong confirmation of the benefits of tranexamic acid and he said a steering group had been set up with royal colleges to try to increase its use. "The group estimates that compliance with the NICE guideline and quality standard would prevent over 15 000 major surgical bleeds, save 33 000 units of blood, and save many millions of pounds for the NHS each year," he said.

Gareth Iacobucci, *The BMJ*

Cite this as: *BMJ* 2022;379:o2478

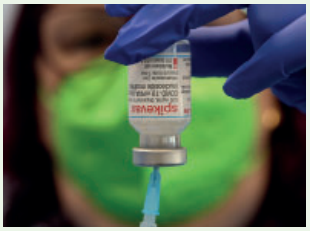
A recent large national **CLINICAL AUDIT** shows that a large proportion **(>30%)** of eligible surgery patients do not get tranexamic acid

autumn booster. It is available to all adults aged 50 years or over and to people aged 5 or over who are in a clinical risk group or are a household contact of someone with immunosuppression. People aged 16-49 who are carers, residents or staff of care homes for older adults, and patient facing health and social care workers can also get it.

Are people taking up the booster offer?

Around 30% of eligible people in England have had their autumn 2022 booster since its launch in early September, said UKHSA. London GP Azeem Majeed, head of primary care and public health at Imperial College London, told *The BMJ*, "Anecdotally, we are seeing more resistance to taking up booster doses compared with previous rounds of the vaccination programme, with many patients saying they feel they have had enough covid-19 vaccines. I do think the government should do more to encourage take-up, as we need to have high coverage before winter."

He added that the booster programme was "essential" for improving individual and population health outcomes and for reducing pressures on the NHS this winter.



Majeed advises people who are reluctant to get another vaccine dose about the benefits of boosters in terms of reducing risks of serious illness, hospital admission, and death.

"I also direct them to online sources of information from organisations such as the NHS and UKHSA they can review later," he said. He also works with local community groups that hold events to promote vaccine uptake.

Elisabeth Mahase, *The BMJ*

Cite this as: *BMJ* 2022;379:o2484

FEATURE, p 138

"Girl's life blighted by lack of mental health places"

A High Court judge has approved an unlawful, unregulated placement for a suicidal 13 year old girl who has spent three months in hospital, after concluding there was no other choice amid a "scandalous" lack of provision for children with complex needs.

The teenager, referred to as "J," has diagnoses of autistic spectrum disorder, attention deficit/hyperactivity disorder, and attachment problems. She was initially admitted to hospital after an overdose and self-harming but absconded from the hospital and threatened to jump off a bridge.

Therapeutic environment

In July a consultant child psychiatrist said she should not be an inpatient and urgently needed a therapeutic environment. But Manchester City Council has been unable to find a registered placement for her in the UK.

"Very sadly this case is not unique," said Mr Justice Poole. "J's plight highlights a problem that is blighting the lives of many children with complex needs whose behaviour presents very significant challenges." He added, "These children—children who are the most in need of support from skilled carers in safe and suitable placements—are accommodated in unsuitable places, homes that are not subject to any regulation, and sometimes, as in this case, even in hospitals where they do not belong."

In J's case the court was told a private landlord had been found who was prepared to let a three bedroom house to the council where care could be provided by agency staff at a cost of just over £9600 a week. There was no intention to apply for registration as a children's home, meaning there would be no regulation by Ofsted.

Poole said he was "satisfied that it is an imperative necessity and in [J's] best interests to move to the new placement even though it is not registered."

Clare Dyer, *The BMJ*

Cite this as: *BMJ* 2022;379:o2485

PUBLIC HEALTH **What does the future hold under current government plans?**

With a prime minister ideologically opposed to a "nanny state," and rumours of prevention policies being abandoned, **Jacqui Wise** asks the experts what we can expect in the coming months

It is choices made now that will determine if we are able to give our children the very best chances in life
Mike McKean

As millions prepare for a challenging winter, the support provided by a robust public health infrastructure is critical
Kevin Fenton

Medical organisations and charities are becoming increasingly concerned about the future for public health under the current government, amid reports that planned initiatives on obesity, smoking, and health inequalities will be delayed, radically changed, or abandoned altogether.

On 29 September the *Guardian* reported that the health and social care secretary for England, Thérèse Coffey, had decided not to publish a long promised white paper on health inequalities. The Inequalities in Health Alliance, a coalition of over 150 medical organisations convened by the Royal College of Physicians, immediately wrote to Coffey, urging her to maintain the government's commitment to publish the paper by the end of this year as promised.

An action plan to tackle smoking, promised for later this year, is also now in doubt, with Whitehall sources telling the *Guardian* the plan has been ditched. The government had committed in 2019 to make Britain smoke free by 2030, defined as getting the proportion of adults who smoke down from 14% to 5%. Labour accused Coffey of being "clueless" after she was unable to say whether she was scrapping the plan.

The *Guardian* report also quoted insiders who said there was "no chance" that recommendations included in a recent review by Javed Khan, former chief executive of the children's charity Barnardo's, will ever be acted on. One of the recommendations of this government commissioned review was raising the minimum age for buying tobacco products, by one year every year, to slowly phase out smoking.

Obesity strategy under review

Meanwhile, the Treasury has ordered a review of the government's strategy on obesity as part of the prime minister's stated mission to cut the burden on business and to help consumers through the cost of living crisis. The *Guardian* quoted Whitehall sources who said the review was "deregulatory in focus" and may result in ditching calorie counts on menus and lifting the ban on sweet snacks being displayed at checkouts and on "buy one, get one free" offers.

The review may even look at lifting the sugar tax, which has successfully reduced the amount of sugar in soft drinks. In response, the Obesity Health Alliance, a group of 50 health charities and medical organisations, wrote to the prime minister to express "profound concern that measures to promote children's health may be abandoned."

Mike McKean, the Royal College of Paediatrics and Child Health's vice president for policy, commented, "Prevention is key for all our children and for our society. These government promised strategies and action plans are critical in not only creating a healthier society now but also genuinely helping to save the NHS much needed funds in the future."

McKean told *The BMJ*, "Health is wealth for our nation. If our new government is serious about economic growth then it must prioritise, implement, and fund preventive health strategies around smoking, obesity, and health inequalities. It is the choices our government makes that will determine if we are able to give our children the very best chances in life. All our futures depend on how we support children and young people to develop into healthy, robust adults."

The Department of Health and Social Care for England said that decisions had not yet been made on initiatives on obesity, smoking, and inequalities. A spokesperson told *The BMJ*, "No actions have yet been taken, and next steps will be set out in due course."

Nanny state

Nevertheless, public health experts are concerned about the general direction of travel, given the opposition within the Tory Party to the "nanny state."

At the recent Conservative Party conference Liz Truss indicated that she would abandon Boris Johnson's approach to the obesity strategy. "I'm not interested in how many two-for-one offers you buy at the supermarket," she said. This echoed what she had said during the leadership debate, pledging that no new "nanny state levies" would be imposed on products that are high in fat, sugar, or salt if she became prime minister. She said that members of the public "don't want the government telling them what to eat."

Coffey, a smoker, has previously accepted hospitality from the tobacco industry. Since becoming an MP she has also voted against a range of measures to restrict smoking, including the ban on smoking in public places. And in a recent

IN 2019 the government committed to make Britain smoke free by 2030, defined as getting the proportion of adults who smoke down from 14% to 5%. Labour accused Coffey of being "clueless" after she was unable to say whether she was scrapping the plan

CHRISTOPHER FURLONG/GETTYIMAGES

interview with LBC Radio she said she hadn't backed banning smoking in cars on the grounds that the government shouldn't be telling people what to do.

Kevin Fenton, president of the Faculty of Public Health, said, "Public health programmes—including those promoting healthy weight, vaccination uptake, smoking cessation, mental health promotion, and protecting from infectious disease threats—save lives, are cost effective, and help keep communities safe."

He added, "As millions prepare for a challenging and uncertain winter, exacerbated by the cost-of-living crisis, the support provided by a robust public health infrastructure, workforce, and programmes remains critical. Government must continue forward motion on the prevention agenda."

Thérèse Coffey's extreme libertarian ideology is colliding with reality
Martin McKee

Martin McKee (below), professor of European public health at the London School of Hygiene and Tropical Medicine, cautioned against overinterpreting recent comments in light of Truss's "fluidity of views" and the scale and pace of her U turns. But he told *The BMJ*, "Her extreme libertarian ideology is colliding with reality, and her ability to enact policies is undermined by a combination of gross incompetence and rebellious MPs. For this at least we should be grateful. But we should also not underestimate the dangers."

Jacqui Wise, Kent
Cite this as: *BMJ* 2022;379:o2482

Integrated care systems face challenges to creating better services, says watchdog

New integrated care systems (ICSs) in England will struggle to deliver long term improvements to people's health amid "extreme" NHS and social care funding and staffing pressures, the public spending watchdog has warned.

The National Audit Office said in a report that for the local care systems to succeed ministers must tackle workforce shortages, ensure sustainable NHS finances, and coordinate measures across government to tackle wider determinants of ill health. It said that the government had made "little progress" on action to tackle matters beyond clinical healthcare that contribute to poor health.

The report examined the setting up of 42 ICSs, which became legal entities in July. They bring together health and care organisations within a geographical area to plan and provide collectively for local populations.

Broad support

The NAO said the systems had attracted broad support and, if given time to build relationships and sufficient capacity, could bring "real improvements" for their populations. But it highlighted risks and tensions between local needs based strategies and delivering on national priorities, including "stretching" efficiency targets (equivalent of 5% of ICS budgets).

It said ICSs were being set short term targets, such as tackling elective care backlogs, while health and social care providers faced high levels of staff vacancies, budget shortfalls, and rising demand. It said the immediate pressures had to be tackled alongside longer term objectives.

The report said, "At present, the tension between meeting national targets and tackling local needs, the challenging financial savings targets, the longstanding workforce problems, and the wider pressures on the system, particularly social care, mean that there is a high risk that ICSs will find it challenging to fulfil the high hopes many stakeholders have for them."

Gareth Davies, head of NAO, said the Department of Health and Social Care and NHS England must set "realistic" medium term objectives to take account of current circumstances. "They must also tackle pressures on ICSs that require action at a national level, including workforce shortages," he said.

Staffing shortages

An NHS plan to tackle staffing shortages should be published and progress against it measured at least annually, the NAO said.

Sarah Walter, director of the NHS Confederation's ICS network, said the bodies were eager to deliver "meaningful prevention plans" and effective clinical interventions. But local system leaders were increasingly concerned by the government's "lack of attention and coherence across its departments on actions to tackle the wider determinants of ill health," she said. "The pausing of its planned obesity and mental health strategies, in addition to the apparent disappearance of the white paper on health disparities and the rowing back on net zero targets, adds fuel to the fire, as does the government's fixation on narrow, short term priorities."

The DHSC said it had commissioned NHS England to develop a long term workforce plan to help recruit and retain more NHS staff. It said action was being taken to reduce health disparities and support people to live healthier lives, including work across government such as the levelling-up white paper.

Matthew Limb, London
Cite this as: *BMJ* 2022;379:o2481

THE BIG PICTURE

Health leaders pump up climate crisis action

Leaders of royal colleges and other medical organisations cycled across London on 13 October to highlight the effects of air pollution and climate change on health.

The 15 km route was coordinated by the UK Health Alliance on Climate Change as part of Ride for their Lives, a global campaign to inspire action. Representatives of royal colleges of general practitioners, psychiatrists, paediatrics, physicians, and surgeons, *The BMJ*, and the BMA were among the 30 cyclists.

Martin Marshall, chair of the RCGP, said it was an opportunity for the profession to show leadership on the climate crisis. "In some ways it's a small gesture, but it's really important we show our commitment to this agenda," he said. "The royal colleges have got a lot of respect: when we speak out, the public listen."

Rides will also take place in cities across the UK, other European countries, and the Americas in the run up to next month's COP27 in Egypt.

Tom Moberly, *The BMJ* Cite this as: *BMJ* 2022;379:o2494

JO ROGERS

EDITORIAL

Replenishing the Global Fund

The money must be spent wisely and promote equity

The replenishment conference of the Global Fund to Fight AIDS, Tuberculosis, and Malaria on 21 September aimed to raise $18bn from supporting donors. It got $14.25bn.[1] The UK (currently the fund's third largest donor) did not pledge but stated a commitment to the fund's work.

The Global Fund was formed in 2002 after a recommendation by the G8 group of high income countries[2] and represented a seismic change in how global health was financed: the fund aimed to ensure stable collective financing of essential health services to a coordinated group of public and private in-country providers, driven by country demand.[2] Together, AIDS, TB, and malaria cause over two million deaths a year globally.[19]

The Global Fund has helped to save around 50 million lives[5] since its inception; helped build a stable market for the development of new technologies, such as diagnostics to rapidly identify TB in people with HIV infection[6]; and promoted community led health services for all three diseases.[7]

Covid-19 set back the pace of these gains, however. By disrupting routine health services, it is likely to have caused hundreds of thousands of additional deaths from TB.[8] The pandemic also slowed the expansion of HIV testing and treatment,[9] and reduced condom supply for key populations living with HIV, which may have increased the number of new HIV infections.[10 11]

Furthermore, many countries are now grappling with financial instability, including the threat of economic recession, with substantial consequences for the public funding of health services.

Given these challenges, is the Global Fund still a good investment in a world facing multiple emerging disease threats and an ever growing burden of non-communicable diseases? The case for investment in HIV, TB, and malaria remains powerful—services for these three diseases offer some of the best value for money in terms of health impact per dollar spent.[12] And there is a broad consensus that investing in infectious diseases yields high returns in terms of sustainable economic development.[13]

The fund needs to be guided by priorities within countries when taking decisions about interventions

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Funding priorities

But this does not mean that every HIV, TB, or malaria technology or service should be funded for all populations. Although the recent malaria vaccine was a scientific breakthrough, it should not necessarily be prioritised over bed nets or diagnostics that are highly cost effective at preventing more malaria deaths.[14] Not all interventions are good buys, and the fund needs to be guided by priorities within countries when taking these decisions.

It needs to substantially increase its efforts to assess value for money, aligning with a country's priorities and supporting capacity in local health technology assessment.[15] Donors must continue to demand clear evidence that the fund's $14.25bn spending aligns with broader national health priorities, beyond the needs of specific grant applicants or interest groups.

As health systems are rebuilt after covid, the fund must ensure that its programmes contribute to strengthening health systems and pandemic preparedness more broadly. The fund has received substantial sums in the past to build stronger health and community systems, but this now needs to be routinely part of disease focused grant applications.

Ensuring synergy between investing in specific diseases and in health systems is not easy,[16] but the fund must incentivise actions targeting both. HIV, TB, and malaria programmes will need expert help to identify system-wide barriers to care and effective interventions to remove them. Programmes should be required to show the benefits (and costs) of their spending on other areas of the health sector and show effective service integration in their grant applications.

Finally, to remain sustainable, the fund has traditionally relied on transitioning away from countries that become able to pay for their own services.[15] We are now facing growing global inequity,[17] and the fund will need to adapt as countries make slower progress towards becoming self sufficient. To remain effective, it needs to become ever more efficient and equitable—exploring how it can best support national financing reforms that promote equitable redistribution of wealth and protect citizens against catastrophic health costs, for example.[18] This can be done only by ensuring national disease programmes fully engage with those who are working on areas such as health insurance or social services.

The Global Fund and those it funds must further embed their activities within domestic priority setting, further integrate disease programmes with health systems strengthening, and align fully with equity oriented reform of health sector financing.

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EDITORIAL

Promise of new malaria vaccines

Promoting acceptance is key to achieving expected public health gains

Throughout the covid-19 pandemic, global health scientists and professionals worried not only about this new and emerging viral infection but also about a potential diversion of attention and resources from other pressing tropical and infectious disease threats.[1] The greatest of those concerns was malaria, which remains one of the biggest killers of children, especially on the African continent.

Now, after decades of intensive research, there is some optimism that new malaria vaccines could start to reduce child deaths in Africa and elsewhere. RTS,S/AS0 (Mosquirix) is the first malaria vaccine to be licensed.[4] Research on this vaccine began with the cloning of the circumsporozoite gene from malaria parasites during the 1980s.[5] The vaccine was subsequently developed for human testing and, ultimately, large scale production and distribution by GlaxoSmithKline with technical and financial support from two US organisations, PATH (Program for Appropriate Technology in Health) and the Bill & Melinda Gates Foundation.[4]

In a randomised controlled trial against a comparator vaccine in 11 African sites (with varying degrees of malaria transmission), Mosquirix was found to have 46% efficacy against clinical malaria in young children, although it was less effective at preventing severe malaria and hospital admission.[3 4] A US biotech company is now developing a live attenuated sporozoite vaccine, hoping to improve protective immunity.[6]

The most compelling protective immunity may, however, be provided by a new R21/Matrix-M vaccine.[3 7] This vaccine uses a circumsporozoite antigen similar to the antigen in Mosquirix (but with less of a hepatitis B surface antigen component), together with a Matrix-M adjuvant derived from saponins, glycosides originally found in the bark of the soapbark tree.

There is some optimism that new vaccines could start to reduce child deaths in Africa and elsewhere

A recent phase 1/2b randomised controlled trial (with a rabies vaccine comparator) conducted in children aged 5-17 months in Burkina Faso, suggested that the R21/Matrix-M vaccine was safe and provided up to 80% protective immunity against clinical malaria. Children in the study received three immunisations at four week intervals, followed by a booster dose 12 months later. Overall, this high level of efficacy was maintained for two years after the primary immunisations and for a year after the boost.

Compelling mechanism

Notably, the vaccine met WHO's target for malaria vaccines of >75% efficacy for 24 months in African children.[3] Moreover, protection correlated with human antibodies directed against the NANP (asparagine-alanine-asparagine-proline) peptide in the circumsporozoite protein.[3] This suggests a compelling mechanism of action and the potential for identifying a downstream correlate of protection.

The R21/Matrix-M vaccine will now enter phase 3 testing with the hope that it might become licensed in African countries. Even if evaluation and licensing are successful, major hurdles can be expected in adopting this vaccine, especially in resource poor settings, including rural and semirural areas where endemicity is highest.

Given the multiple doses and boosting required for both Mosquirix and R21/Matrix-M, it will be essential to look carefully at current childhood vaccination practices in African countries and identify ways to deliver these vaccines through existing programmes. We also need to understand how best to provide these vaccines in the context of other malaria control measures. This may mean continuing to use insecticide treated bed nets, anti-malaria drugs, and other established prevention measures alongside vaccination programmes.

The protection offered by malaria vaccines is unlikely to match the greater than 90% efficacy or effectiveness we expect for vaccines against other viral diseases such as polio and measles.[8] The problem of partial vaccine protection, which necessitates continued use of companion control tools,[8] is new and may not be easily understood by affected communities, health ministries, healthcare workers, or even vaccine policy makers.

The recent rise in antivaccine activism is another factor for consideration.[9] Growing distrust of covid-19 vaccines (sent to African countries late in the pandemic) could spill over to other new vaccines. Authorities must respond quickly to any early signs of misinformation, disinformation, or other contributors to vaccine hesitancy observed during the pandemic.

Successful delivery—and expected gains in public health—will depend on learning the lessons from covid-19: partnering with affected communities and with experts in both health systems and communications (including social scientists) to develop and introduce next generation malaria vaccines that are acceptable and affordable to the communities that need them most.

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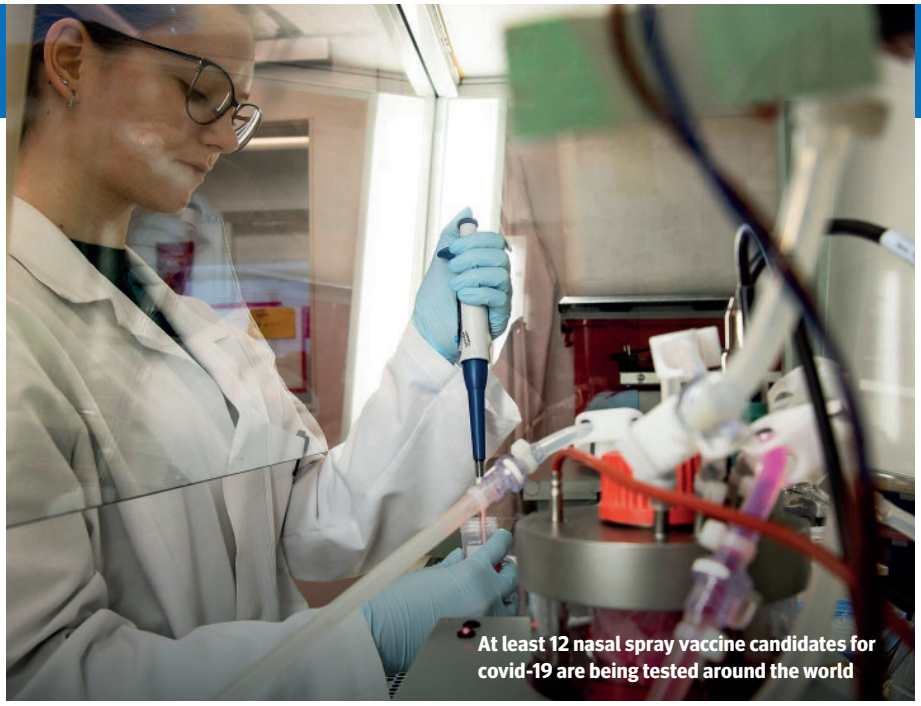
COVID UNANSWERED QUESTIONS

What next for covid-19 vaccines?

As omicron booster jabs are approved and rolled out for the first time, The BMJ asks how vaccines will evolve as we learn to live with the virus



At least 12 nasal spray vaccine candidates for covid-19 are being tested around the world

Will we continue to need annual covid boosters?

Eleanor Riley, professor of immunology at the University of Edinburgh, says, "It will be really interesting to see, when these new [variant] specific vaccines start to get rolled out at the end of the year, whether they make a huge difference or not."

All the main vaccines currently in use target the spike, which is susceptible to frequent mutation.

Other vaccines that target more of the virus do exist. For example, Valneva's vaccine—approved for UK use last April—uses an inactivated form of the whole SARS-CoV-2 virus that can't infect cells or replicate in the body but can still trigger an immune response. Two of the available Chinese vaccines, Sinopharm and CoronaVac, are also based on inactivated virus, as is Covaxin of India. Their published efficacy rates (from tests conducted before covid-19 variants arrived) are lower than those of the commonly used vaccines from Pfizer-BioNtech, Moderna, and AstraZeneca.

Sinopharm, CoronaVac, and Covaxin do not yet have enough publicly available data to judge their effectiveness against omicron variants (although CoronaVac has some observational study evidence showing effectiveness against the gamma variant). Initial results for Valneva show that it "produces fewer neutralizing antibodies against the delta and omicron variants, indicating it provides less protection against these variants," WHO reported.

Riley says, "We need to start thinking more broadly about some of the other types of vaccines that have more of the virus in them, that have some of the other viral proteins in them—the killed vaccines like those used in the live attenuated poliovirus.

"Vaccines in the long run are probably going to give us more durable immunity against different variants because they're so much like a virus, in that our immune response is going to be much more broadly based and therefore much less susceptible to occasional mutations."

Eric Topol, professor of molecular medicine at the Scripps Research Institute in California, says, "If we had a variant proof vaccine, if we had nasal vaccines to really put a major damper on infections and transmission, and if we had back-up drugs to the only pills that are available today, we'll be in much better stead and we'll finally get containment.

The US CDC say that the immune response from vaccines is more reliably consistent than that from infection

"I'm very optimistic, actually, as compared to influenza. We've never had vaccines with 95% efficacy for flu. Not even close. We're lucky with quadrivalent vaccines of influenza to be at 40%. This virus is so amenable to taking it down, scientifically as opposed to influenza. But we're just not acting like we can do this. We can."

Does an infection or vaccination afford better protection?

Generally, both offer lasting protection. The US Centers for Disease Control and Prevention (CDC) has reviewed the evidence and concluded in a briefing published in October 2021 that they both led to protection from subsequent infection for at least six months.

A 2021 paper from US researchers indicated that the neutralising activity of vaccine induced antibodies was more targeted to the receptor binding domain of the SARS-CoV-2 spike protein than antibodies elicited by natural infection. The authors say that this may be better for the immune system in coping with future evolved forms of the virus.

The CDC briefing states that the immune response from vaccination is more reliably consistent than that from infection, which can vary. So in terms of gaining and maintaining immunity, it's better to rely on vaccines.

One area of study is whether certain individuals may have stronger or weaker immune responses to vaccines depending on their genes. A 13 October *Nature Medicine* paper from the University of Oxford reported that, of 1076 participants in the Com-CoV study, some demonstrated "association of HLA type [variations of the Human Leukocyte Antigen] with COVID-19 vaccine antibody response and risk of breakthrough infection, with implications for future vaccine design and implementation."

What's so good about nasal spray vaccines?

In a nutshell, vaccines administered by nasal sprays generate an immune response in the upper respiratory system—the source of viral entry—whereas injected vaccines are administered into the muscle, generating virus destroying T cells and antibody producing B cells that are then circulated throughout the body in the blood.

More specifically, a vaccine in the nose

We need to start thinking more broadly about other types of vaccines
Eleanor Riley

I'm very optimistic for a variant proof vaccine, as compared to influenza
Eric Topol

FABRICE COFFRINI/AFP/GETTY IMAGES

It's scientifically quite feasible a pan-coronavirus vaccine will be developed
Soumya Swaminathan

activates localised mucosal immune cells, known as tissue resident memory T and B cells, which do slightly different things from the usual T and B cells: tissue resident memory B cells, for instance, make secretory immunoglobulin A (IgA) antibodies that are weaved into the respiratory tract (although it's still unknown how much this protects against SARS-CoV-2). Such functions could potentially prevent the virus from taking hold in the body and stop not just infection but transmission too.

How close are we to rolling out nasal vaccines?

At least 12 nasal spray vaccine candidates for covid-19 are being tested around the world. As well as being easier to administer, they have the potential to block the virus at the site of entry, stopping infection and reducing transmission. However, when compared with earlier in the pandemic, they haven't received much attention. "We haven't done anything to help these trials and to get production ready," says Topol. "We could see these vaccines later this year, but it could even be sooner if we got serious about this."

What about pan-coronavirus vaccines?

A pan-coronavirus vaccine could provide protection against SARS-CoV-2 and common colds. Nothing is close to market yet.

A team at the Walter Reed Army Institute of Research in the US has the only pan-coronavirus vaccine candidate to reach clinical testing so far, the journal *Science* reported. It uses the same spike protein as current vaccines but presents it to the immune system in a different way, binding it to ferritin, a protein that normally carries iron in the blood. In early in vitro studies the vaccine "neutralised" a broad range of SARS-CoV-2 variants. No data have yet been released from the phase 1 trial.

Another team, based at the Francis Crick Institute in London, is in the early stages of testing a candidate targeting a specific area of the spike protein known as the S2 subunit, which allows the virus to fuse with the host cell. In a paper published in *Science Translational Medicine* in July the team reported that mice had created antibodies able to neutralise other coronaviruses, including the common cold, the alpha, beta, and delta variants, the original omicron variants, and two bat coronaviruses.

And DIOSynVax, a biotech spinout from the University of Cambridge, is developing an mRNA vaccine that could protect against a number of coronaviruses including SARS-CoV-1, SARS-CoV-2, and MERS. In March it received a $42m (£38m) award from the Coalition for Epidemic Preparedness Innovations.

WHO's chief scientific officer, Soumya Swaminathan, told *The BMJ* in April that it was "scientifically quite feasible" that a pan-coronavirus vaccine would be developed in the next two years.

Others are less optimistic, however, believing that urgency has subsided as the approach to the pandemic has shifted to living with the virus. Moncef Slaoui, a vaccine developer who advised the US's Operation Warp Speed, told *Science*, "Current vaccines are effectively able to deal with the pandemic, because the number one priority is mortality and morbidity. Pan-coronavirus vaccines, whatever definition you use for them, are about preparedness, rather than dealing with the actual pandemic."

Science has also emphasised that the current stage of the pandemic also means that testing, whether for pan-coronavirus vaccines or new variant boosters, will be problematic. Much of the world has some immunity to covid-19 from vaccination, infection, or both, so proof of protection is difficult to establish. Assessing any new vaccine's ability to provide broader protection may require trials in people who have "no competition in the immune system," which in many countries would now mean infants.

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Valneva's vaccine uses an inactivated form of the whole SARS-CoV-2 virus

Do you have a Covid Unanswered Question? Email mlooi@bmj.com, and we'll try to cover it in a future instalment of this series

BREASTMILK SUBSTITUTES

Formula milk: why WHO has taken a hard stance on sponsorship

After a year of controversy the World Health Organization has toughened up. **Rebecca Coombes** reveals what prompted the change—and why it's so difficult to remove corporate money from health associations

In 2019 BMJ took the decision to end all marketing of breastmilk substitutes (BMS) in its journals. The move was based on extensive evidence of the harms to health caused by aggressive promotion of BMS products, as well as a desire to support the World Health Organization's code of practice governing the marketing of these substitutes.

But the code is about more than advertising in journals. It also recognises that health professionals and their associations are targets of marketing and are used as conduits by the BMS industry. The code's aim to end financial relations between industry and the health profession has become more and more explicit in World Health Assembly resolutions over the years. But sponsorship is still very common among colleges and associations—so much so that WHO and Unicef are developing new guidance for associations specifically focused on conferences, the most common form of BMS sponsorship.

The issues were explored in a webinar series last month organised by WHO, *The BMJ*, and the Partnership for Maternal, Newborn & Child Health, which is available to watch on *The BMJ*'s YouTube channel.

For Grainne Moloney, senior adviser at Unicef, industry influence comes in many forms, including "high visibility presence at conferences with free gifts, sponsored dinners, and also through training, sponsored meetings, and nutrition institutes and through to research and sponsored journal articles." A review of related websites found that over 50% of national paediatric associations reported receiving funds from commercial milk formula producers, she says.

Despite good intentions, it seems that saying no to the BMS industry can be difficult financially and that many ingenious ways of receiving money—through arm's length foundations, for example—can feel OK but are ethically far from it.

Many ingenious ways of receiving money from the BMS industry can feel OK but are ethically far from it

Funding dilemma

Franka Cadée, president of the International Confederation of Midwives, says that, although her organisation doesn't take BMS money, some of its member organisations do. "Our member associations are often very, very poor, and they're pushed in all kinds of ways to take funding for their local congresses," she explains. "It's really difficult—so, even though our principle is to refuse, refusing is virtually impossible for some of our members.

"As midwives, we don't get much funding. Midwives are generally there to promote normal birth, and so we are not that interesting as a group for pharma. The formula milk industry knows that we are the people in the community prenatally. And some of our associations in low income countries are just a few midwives sitting around a kitchen table, trying to organise the whole of midwifery within their country. They get told, 'Oh, you know, we can support you with this.' And that's the way that the formula industry gets in."

Similarly, Karen Walker, president of the Council of International Neonatal Nurses, says that her organisation doesn't accept BMS funding but that among membership associations the issue is "very complex and diverse."

She says, "When I went for a dinner at a conference in Africa, we weren't aware until we got there that it was actually sponsored by a formula company, which is against what we would think. But our colleagues who ran it didn't see any issue with this: they said, well, we use formula, so why does it matter?

"So, there's a lot of debate. One of our big national organisations reported they actually promoted relationships with the formula company, and the reason behind it was money."

For many associations, funding for education and events is hard without BMS support. "I think our challenges are huge," says Walker. "The cost and the support of education is really important. Where do you get the money from?"

Some of our associations in low income countries are just a few midwives sitting around a kitchen table
Franka Cadée

These guys are so quick to come with the shillings
Anne-Beatrice Kihara

Values

Since 2020 the International Paediatric Association refuses money not only from the BMS industry but also from any entities associated with it, such as foundations and institutes. Its president elect, Naveen Thacker, a paediatrician in Gujarat, India, says that issues still remain with member organisations spread across 160 countries.

"Some member societies have different views that they are not affected by these marketing practices," he says. "We cannot force anybody that is wanting to continue [with funding]." Thacker adds that it's very difficult to run scientific meetings without funding. "We may be better placed than midwives in getting other funding, [but] it's still a very limited space and getting more and more complicated. But we are very clear, and we will not be accepting funding for our congresses," he says.

The broadcaster Chris van Tulleken, an infectious disease doctor at the University College London Hospitals NHS Trust who chaired the webinar, believes that foundations and institutes should not escape scrutiny. He says, "I think we need to be inspecting whether

WHO Foundation refuses to take further financial donations from Nestlé

A foundation set up by the World Health Organization will no longer accept money from Nestlé, the world's largest formula milk company, after a multi-million dollar donation made last year, *The BMJ* can report.

The WHO Foundation received $2.2m from Nestlé in 2021 that was originally intended for the Covid-19 Solidarity Response Fund, a WHO fund to support its response to the pandemic. News of the contribution caused an internal furore at WHO, and the WHO Foundation told *The BMJ* that as a result of this "feedback" it had redirected the money to the Go Give One vaccine campaign, which funded the procurement of covid-19 vaccines by Covax.

Since then the foundation has published a "gift acceptance policy" and strengthened its "related processes," a spokesperson said. In future, the WHO Foundation will receive contributions only from companies that do not compromise "WHO's integrity, independence, credibility, and reputation."

The WHO Foundation is not accepting contributions from companies that are not in compliance with the International Code of Marketing of Breastmilk Substitutes, it said, confirming that this included Nestlé.

Commenting on the move, Laurence Grummer-Strawn of WHO's Department of Nutrition for Health and Development said that WHO was "very upset" on discovering the contribution and had demanded that the foundation return the money.

"The WHO Foundation was established to be distinct from WHO, to give it more flexibility to receive funding from the private sector, to not be constrained by the same bureaucratic constraints that we have," he said.

"When we found out about this, WHO was very upset and said, 'This can't happen. You have to reverse this now.' And we discovered we had no legal way of forcing [the foundation] to turn the money back or to change their policies.

"Since then, we have had discussions to say we can't legally force you, but you realise you are using the WHO name and you are doing something that is in violation of the World Health Assembly.

"And they said, OK, we won't do that again. So we've corrected it, but we didn't correct it fast enough that they were willing to turn the money back and say, 'We made a big mistake.' We're left with this mark against us."

Complexity of funding

Grummer-Strawn, who was speaking at a WHO/BMJ webinar on conflicts of interest with the breastmilk substitutes industry, said that it was a measure of the complexity of funding that even WHO "got stuck in the same situation" that it warned others against.

The donation potentially allows Nestlé to present as WHO partners
Robert Boyle

Robert Boyle, clinical reader in paediatric allergy at the Imperial College Healthcare NHS Trust, said the WHO Foundation had made a "significant error of judgment" in accepting the money in the first place.

"The donation potentially allows Nestlé, the world's largest formula company, to present themselves as WHO partners, which confuses public health messaging about the importance of limiting formula marketing," said Boyle. "The donation also potentially hampers WHO's attempts to ensure professional societies do not accept sponsorship from formula companies, since WHO can be viewed as having accepted funding from a formula company themselves.

"It is good to hear that the WHO Foundation have recognised this issue and, going forwards, have committed to not accept donations from formula companies that fail to comply with the International Code."

or not those channels do in some way launder or cleanse the money ethically."

Even WHO, which has led campaigning for healthcare to avoid conflicts of interest with companies that manufacture breastmilk substitutes, recently became embroiled in a furore when its foundation accepted a multi-million dollar contribution from Nestlé (box, p141).

Anne-Beatrice Kihara, the Kenya based president elect of the International Federation of Gynaecology and Obstetrics, which has 132 member societies, says that "there is only so much influence you can give as the leadership at the top. The issue is you have a congress, you have training, you have some travel to be made. And these guys are so quick to come with the shillings."

For Kihara, it's not just about rules and regulations but about a culture change. She explains, "Really, it boils down to you and your individualised value system. Should I? Should I not?"

There may be leadership at a global and country level, she adds, such as the legislation that already exists in Kenya, but you need to be motivated to change as a health professional. "It's very clear. Do not take BMS support at all. Do not be an advocate," she says.

Beyond "sponsorship"

The draft WHO/Unicef guidance tries to unpack what's meant by "sponsorship" of meetings. Laurence Grummer-Strawn, of WHO's Department of Nutrition for Health and Development, says sponsorship is too often narrowly defined as direct funding direct—"for example, a gold sponsor or a platinum sponsor which gives a blanket donation to the organising body for the conference."

But in-kind donations also count, he says, such as sponsoring lunches, breaks, apps, or a lactation room to show the company's connection to breastfeeding. "No actual money exchanges hands, but by supporting the various activities they get their name out there," he says. "They can sometimes be providing scholarships for people to travel to the meeting, funding for awards, or support that will waive your registration fee if you want to come."

One area that has provoked a lot of discussion is exhibition space, as WHO's code allows companies to share information as long as it's scientific and factual. Grummer-Strawn says, "We might not call that sponsorship. But sometimes you see just massive exhibitions of formula companies in the middle of the exhibition hall with fancy carpets and glitzy lights all over the place." He adds that exhibition space shouldn't be an opportunity for giving away gifts or samples.

Van Tulleken says navigating such issues is vital if the bonds binding the healthcare profession to the BMS industry are ever to be broken. "Even as experts, we are vulnerable to the power of marketing," he says. "The research also shows very few of us understand just how vulnerable we are. The formula industry knows that marketing works. It works on patients, and it works on us. That is why they spend twice the annual WHO operating budget—[nearly $3bn] every year on marketing."

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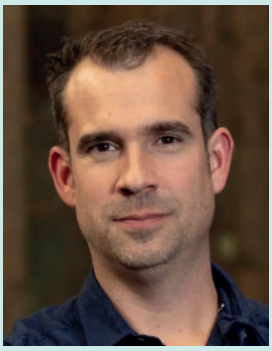
Agendas, acceptance, and access



Their agenda and our agenda are not aligned. They will inevitably collide
Chris van Tulleken

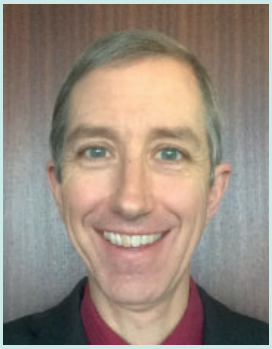
Chris van Tulleken, University College London Hospitals NHS Trust
"The associations have the responsibility of supporting patients, and they influence guidelines. The formula milk industry is committed to a very different agenda. They have legal obligations to increase sales, increase growth, and increase profit for their owners, the shareholders.

"So, their agendas and our agenda, even though they may feel sometimes that they are quite aligned, but they're not. They will inevitably collide."

Acceptance of funds purchases some of the reputational trust in the host organisation
Grainne Moloney

Grainne Moloney, Unicef
"Acceptance of funds other than from the membership themselves does create conflict of interest because it borrows or purchases some of the reputational trust that researchers and health professionals place in the host organisation, which then can actually compromise patient care.

"Studies have also demonstrated that health professionals exposed to targeted commercial activity have more positive attitudes to those products that are being marketed and are therefore more likely to recommend those to their patients."



The code is not trying to prevent access to formula
Laurence Grummer-Strawn

Laurence Grummer-Strawn, Department of Nutrition for Health and Development, WHO
"The code itself is actually not anti-formula. It doesn't want to prevent sales. It's not trying to prevent access to formula.

"It is a code about the marketing. And it makes a very big distinction between marketing and the product. The code says it is there to protect access to formula when it is needed, but it is also to protect families from the marketing that might dissuade from breastfeeding."