Court File No. **T-1301-09**

FEDERAL COURT

BETWEEN:

Nell Toussaint

Applicant

and

Attorney General of Canada and Minister of Health

Respondents

APPLICATION UNDER section 18.1 of the *Federal Courts Act*, R.S.C. 1985, c. F-7

Affidavit of Manuel Carballo

I, Manuel Carballo, of the City of Geneva, Switzerland, epidemiologist, make oath and say as follows:

Qualifications

1. I am an epidemiologist with a PhD and MPH in epidemiology and a post doctoral diploma in social psychiatry. My current research specialty is in health issues of mobile populations such as refugees, regular and irregular migrants, with a particular focus on diabetes and migration, and on how these impact on public

health and health systems. I am the Executive Director of the International Centre for Migration, Health and Development (ICMHD) in Geneva, and also Professor of Clinical Public Health at Columbia University in New York, and Adjunct professor of Public Health at Tulane University in New Orleans.

2. The mandate of ICMHD is to generate and provide to governments, UN agencies Non-Governmental Organizations (NGOs) and other interested parties the type of information that will permit evidence based policies to be developed on migration (of all kinds) and health and health system. My work as Executive Director is to develop and direct research, training and policy formulation on all types of population movement and to study how this affects the people who move, those they leave behind and those they come into contact with.

3. My further qualifications and a list of my publications are contained in my curriculum vitae which is attached and marked as "Exhibit A" to this affidavit.

Health for All

4. In the fight for better global health the World Health Organization (WHO) has proposed a goal of 'Health for All'. This goal has been accepted by all countries, including Canada, and many countries have already taken important policy and programmatic steps towards its achievement. The concept of 'Health for All' represents a convergence of human rights and health policy, building on the evidence that access to health is not only a human right, but is also epidemiologically sound. It acknowledges that if and when access to health care

is denied to any persons or groups, health problems that may develop can impact on the larger population in a number of ways.

5. The price of not responding in a timely and comprehensive manner to non-communicable as well as communicable diseases can be significant in terms of costs of subsequent care needed, work days lost and economic and social contributions thus not made.

6. The principles embodied in the WHO goal of Health for All are especially relevant to the question of access by documented and undocumented migrants to health care.

Migration and development

7. Migration has always been a central part of the social and economic development of countries, especially European and North American countries, such as Canada. Today it is becoming a more important issue than ever and is growing in response to changing demographic conditions, emerging industries, a need for new types of workers, and improved transportation and better communications across borders and cultures.

8. Undocumented migration, (that is to say the movement of people who do not go through procedures of requesting and waiting for official permission to move to new countries) is also growing. The reasons behind undocumented migration vary but in general political unrest and poverty continue to be important push

factors. In addition, the international media's promotion of shared values and expectations is creating an environment in which people see moving across borders in search of new opportunities as normal and straightforward. Some people who are unaware of the official procedures thus move without knowing they are contravening regulations. Others choose not to go through what they see as time-consuming and difficult formalities. There are still others who move to visit friends and family without the intention of staying but who then progressively extend their stay because they see or are given to believe there is a need and a place for them.

9. Even states that define undocumented migration as "not permitted" do in fact tolerate the presence of the migrants. Receiving countries benefit from the arrival of migrants because migrants help to populate countries and meet the need of new and old industries that need workers. In post-industrial countries migrants are increasingly compensating for rapid decreases in fertility and the growth of aging populations. They constitute a work force that is willing to take on jobs that nationals are no longer interested in, or available to do. The demand and the opportunities for migrant labor tend to be communicated by national governments or private industry through formal requests for labor. Migrant networks also communicate them informally through their own social networks. The supply and demand nature of the process also means that when and if the supply of migrants is not met by job openings, documented and undocumented migration tends to dwindle. This has begun to be the case in the EU in the context of the recent economic recession.

10. Source countries meanwhile benefit because the out-migration of people helps to relieve pressure on economic structures and employment situations. Modern day migrants, be they documented or not, send back remittances that help to sustain the families they left behind and hence contribute to the overall economic welfare of their communities and countries. In many ways this apparent "win-win" situation has helped to further legitimate the growth in worker migration.

Migration and Health

11. The vast majority of economic migrants, both regular and irregular, tend to move while they are young, healthy and active. Indeed youth and health are almost pre-requisites of contemporary migration, especially undocumented migration. Unlike retired people who migrate later in life looking for better climates and more pleasant social environments, and who are likely to take health care options into account, economic migrants, be they documented or undocumented are unlikely to be in need of health care or take it into account when deciding to move. Their migration is often referred to in the scientific literature as the "healthy migrant effect" because they move at the peak of their intellectual and physical lives.

12. Although undocumented migrants are likely to arrive in good health, there are nevertheless reasons why their health can become fragile. In many settings the work they do, the number of hours and conditions in which they work, as well as the psychosocial atmosphere they function in, are often not compatible with

maintaining good health. Undocumented migrants tend to live in highly insecure situations that are characterized by perceived social marginalization, little job stability, very low wages that are set by employers with no regulation and which are often irregularly paid. Undocumented migrants remain at the bottom of the socio-economic ladder in the countries they move to, and cope with poverty in ways that at times are bad for health. Poor housing, overcrowding, inadequate nutrition and unhealthy eating combined with sudden change to sedentary life can lead to poor health, including chronic diseases such as type 2 diabetes and cardiovascular problems. If, in addition, their access to regular and quality health care is limited, the health of undocumented migrants can deteriorate rapidly.

Stress and health of undocumented migrants

13. Studies have shown that undocumented migrants tend to suffer from chronic stress. They leave behind families for whom they have a sense of responsibility, but do not have any idea of where they will end up or what job, financial or legal security they will find. Once they arrive they are typically unable to get good jobs, and in many cases the jobs they do find, are inconsistent with their education or experience, and contribute to their loss of self-esteem. Their capacity to communicate with family members at home is meanwhile limited because of the costs involved, and even though they often take more than one job at a time to make ends meet, their economic situation tends to remain precarious. Many undocumented migrants also live in constant fear that they will be found out and sent back or elsewhere. In many cases they curtail extra-work social life so as not to risk this, and often fail to seek health care for the same reason.

14. Chronic stress is a complex phenomenon that impacts on physical health in a variety of ways. It can reduce the body's immunological capacity to fight common diseases and can prompt physical as well as psychological disorders. It can lead to eating and drinking problems, reliance on cheap fast foods and other behaviors that contribute to the development of type 2diabetes. Short-term or acute stress in people with diabetes can destabilize glucose levels and offset their capacity to manage the disease. Meanwhile the self-management of health and health problems requires knowledge, confidence and time that is often lacking. Undocumented migrants often lose self-esteem and confidence, and real and perceived pressures compete for their time. Studies have shown that in migrants with diabetes this can mean they are unable to measure and/or control their blood sugar levels, and in the absence of good counseling and follow-up (which is rare in the case of undocumented migrants) they often fail to understand or to act on advice given by health care providers. Costs of care and medication also limit the extent to which they are able to cope. This overall theme is the subject of on-going research in Canada and other countries.

Undocumented migrants and health care services

15. Undocumented migrants rarely abuse health care services. Indeed if anything, they tend not to make use of health care services when they should. When they do it is usually late in the progression of disease. Undocumented migrants are often unfamiliar with what health services are locally available and what they can expect from them. Even if and when they do know, they may try to avoid them

because of anticipated costs, administrative procedures associated with seeking care and the fear their names will be referred to legal authorities. In the case of chronic illnesses such as diabetes, this can lead to serious complications.

16. Over time, migrants - just like all other people – are likely to develop problems that come with age and which require care. The longer migrants are in a country the more likely they are to develop many of the same health problems as the host group. In undocumented migrants this is not well monitored because they tend to be unknown to health authorities, do not seek care as often as other people, and are residentially very mobile, moving from one cheap temporary dwelling to another to cope with costs. Their response to illness, moreover, may depend on whether the illness in question is a very common in the countries they come from and what has been done at a national level to combat it. If little has been done and the disease has become endemic, people may see it as relatively "normal" and not feel an urgency to deal with it. If in their countries of migration they also feel that their options for care are limited, they may try to "live with" the illness until it becomes so pronounced that they are forced to seek emergency care.

17. Illness in migrants, especially undocumented ones, is often exacerbated if they have difficulties following the advice given by health care providers. Language, culture, and poor familiarity with the concept of secondary prevention are all common problems in people from countries or socioeconomic backgrounds that have less-well developed health care. They may also be put off using services by

a perception (right or not) that health care providers and health administrative staff in hospitals and clinics do not like them.

Principles of Public Health and Human Rights

18. The central rule of thumb in public health is that prevention is more cost-effective than treating disease later. Another is that if and when health problems do occur, their early diagnosis and timely treatment helps to avoid more complex problems later. These two rules have become the core of the principle of health promotion and protection that countries have espoused. The principle of health promotion and protection through ensuring access to prevention, early diagnosis and timely treatment is one that Canada has long been a vocal proponent of in World Health Organization debates on Health for All.

19. In light of the growing economic and socio-demographic importance of migrants, a better understanding of the potential fragility of migrants, and the recognition of a need for shared international norms for the provision of healthcare for migrants, a number of international instruments have been adopted. Monitoring of state compliance with these instruments by international, regional and domestic human rights bodies and courts has become increasingly important in promoting Health for All both as sound health policy and as a matter of fundamental human rights.

20. The International Convention on the Elimination of All Forms of Racial Discrimination adopted in 1965 and which came into force in 1969 prohibits discrimination based on "race, color or national or ethnic origin" in health care

and other social programs. Canada ratified this Convention in 1970. The UN Committee overseeing compliance with it has stated that States have an obligation "to respect the right of non-citizens to an adequate standard of physical and mental health by, *inter alia*, refraining from denying or limiting their access to preventive, curative and palliative health services." At its most recent review of Canada in 2007, the CERD Committee expressed concern about the fact that undocumented migrants do not have ready access to healthcare in Canada and recommended that measures be taken to correct this.

21. The International Covenant on Economic, Social and Cultural Rights, adopted by the UN General Assembly in 1966, and which came into force in 1976, guarantees, in Article 12(1) "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health." Canada ratified the Covenant in 1976. The U.N. Committee on Economic, Social and Cultural Rights which reviews the implementation of this Covenant has established that state parties, of which Canada is one, are under an obligation "to respect the right to health by refraining from denying or limiting equal access for all persons, including ... asylum seekers and illegal immigrants, to preventive, curative and palliative health services."

22. The UN Convention on the Protection of the Rights of all Migrant Workers and Members of Their Families (1990), which entered into force on 1 July 2003 has been strengthened by the actions of a number of countries and explicitly extends human rights safeguards to all migrants, including undocumented ones. Article

28 of the Convention states that "migrant workers and members of their families shall have the right to receive any medical care that is urgently required for the preservation of their life or their avoidance of irreparable harm to their health on the basis of equality of treatment with nationals of the State concerned. Such emergency medical care shall not be refused then, by reason of any irregularity with regard to stay or employment." Although Canada has not ratified the Migrant Workers' Convention, it has stated that it agrees with its goals but has noted that the rights of migrants are protected in Canada by a number of other international instrument and by the Canadian Charter of Rights and Freedoms (CERD/C/SR.1790, 28 February 2007)

23. All of the above human rights instruments have played and continue to play an important role in promoting improvements in government policies and programs, in line with principles of prevention, early diagnosis and timely treatment, without exclusion of any groups from access to healthcare.

Country Situations

24. There is considerable variation in the extent to which different countries meet their obligations under international human rights law to ensure equal access to healthcare for undocumented migrants. As more countries implement changes to ensure better compliance, however, it is increasingly evident that compliance with human rights norms is also sound and rational healthcare policy, resulting in significant public health benefits and economic savings over the longer term.

25. A number of countries in Europe have, in recent years, adjusted their healthcare policies to better ensure the rights of undocumented migrants to access to healthcare. These countries are providing useful models for other countries to follow.

26. **In Italy**, for example, the 1998 national law on migration removed all barriers to health care for undocumented as well as documented migrants. The law stipulated that medical care including diagnosis, essential treatment (including long-term care), and rehabilitation must be guaranteed to undocumented migrants. The treatments can be received at a district public health centre or at a public hospital.

27. Care provided without any fee to undocumented migrants in Italy includes: emergency care, "basic" essential care (i.e. primary care and all kinds of inpatient hospital care, including inpatient treatment of contagious diseases such as tuberculosis and chronic diseases such as HIV/AIDS), maternity care, any care for the elderly (over 64 years) and any care for children (under 6 years). The state subsidizes (fully or partially) access to other types of care, including "urgent" and "essential" medical care (both including continual treatment), preventive care, care provided for public health reasons including prenatal and maternity care, care for children, vaccinations and diagnosis and treatment of infectious diseases.

28. To address the fears of undocumented migrants about disclosing their status to public authorities, a system has been established in Italy of an anonymous "STP code" (straniero temporaneamente presente - Temporarily Present Foreigner") for accessing healthcare. A non-national without an identification card has only to provide his or her name, date of birth and nationality to receive an STP number.

29. The cost incurred for providing medical care to undocumented migrants in Italy is covered by the Ministry of Interior. The hospital or the district health center administration where undocumented migrants have been treated informs the local heath administration which is in turn reimbursed by the Ministry of Interior. The STP code corresponding to the patient (assuring non-traceability) is provided, along with information about the diagnosis, the care provided and the sum to be reimbursed.

30. The reform in Italy, designed to ensure access to health services by migrants, regardless of their status, has produced important public health successes in Italy. For instance, Italy has observed among migrant populations reduced rates of AIDS; the stabilization of those infected with TB; and a reduction of adverse outcomes in maternal and child health.

31. **In Spain** where the universal right to enjoy health protection and care is laid down by the Constitution and the General Health Act, free and holistic health care is available to "all Spanish citizens and foreign nationals residing in the national territory." There is a tax-based national health system in Spain that has been

largely decentralized to the autonomous communities. Whilst the Ministry of Health defines the minimum standards and requirements for health care provision, the autonomous communities' health departments have the power to decide how to organize or provide health services and implement the national legislation.

32. The health care system is financed by general taxation such as VAT and income tax as well as regional taxes. Public financing is complemented by out-of pocket payments to the public system (for example co-payments for pharmaceuticals) as well as to the private sector (for example private outpatient care) and by contributions to voluntary insurance. Changes made to the national health legislation in 2003 gave undocumented migrants the same access to healthcare in Spain as documented migrants and nationals.

33. In most of the Autonomous Communities of Spain, undocumented migrants (except for children and pregnant women) must obtain the "individual health card" by registering at their local civil registry and prove that they lack necessary economic resources. Undocumented migrants have to provide proof of habitual residence and a valid passport. Those undocumented migrants who are unable to obtain the "health card" because they cannot comply with these requirements, can access the treatment in some regions with the "*Documento de asistencia sanitaria*- DAS" (the"health care document") that allows them to access the needed treatment without the "individual health card". To obtain the "DAS" it is not necessary to have a valid passport. Undocumented migrants with chronic

diseases such as HIV/AIDS or diabetes can also access care without the individual health card.

34. To avoid difficulties in accessing health care, some Autonomous Communities (for example, Andalusia, Valencia, Murcia, Extremadura) have developed a more welcoming system consisting of providing undocumented migrants with a health card without prior registration in the town hall. Once a health card is obtained, undocumented migrants receive all health services on the same conditions as nationals.

35. **In the Netherlands** there is an insurance-based health system that has been operated since 2006 by private health insurance companies. The new Health Insurance Act from 2006 has, however, sets some public limiting conditions in order to guarantee that health care insurance is affordable for all, including those on low incomes or with high care costs. Children up to the age of 18 access health care free of charge and people who cannot pay for the standard premium can apply for public allowance. Employees and people receiving benefits also pay an income- related contribution in addition to the premium.

36. Since January 2009, a government health fund, the CVZ (Collegie Voor Zorgcversicheringen) has been established in the Netherlands. The CVZ covers "medically necessary care" of undocumented migrants. The health care provider will decide what defines "medically necessary care" in each case. In general, it covers all care which is covered in the basic health insurance package for Dutch

nationals and regular migrants. The content of the basic package is determined by the Health Insurance Act and is comprised of all essential health services: primary and secondary care, hospitalization, dental care for children below the age of 22, maternity care, medical transport etc.

37. There are 27 hospitals contracted by the CVZ to facilitate access to health care for undocumented migrants in the Netherlands. The hospitals are obliged to demonstrate to the CVZ that they have made efforts to receive the payment from the patient first and only if they were unsuccessful, may they apply to the CVZ for the reimbursement of the costs incurred. The CVZ issues reimbursements when the hospital declares that they issued a bill and requested the payment but the patient was unable to pay. The reimbursements vary from 100% to 80% depending on the type of care.

38. **Belgium,** similarly ensures that undocumented migrants have access to urgent medical assistance that is financed through a parallel administrative system, and which provides for a wide range of medical services including longer term care.

39. **In France** undocumented migrants can access health care free of charge (with some minor exceptions) through a parallel administrative system which is termed "Aide Médicale État" (state medical assistance) if they have been resident in the country for more than three months and are able to show that they are living under a certain economic threshold.

40. **In Portugal** where health care costs are not charged if the treatment is deemed necessary for safeguarding public health, a similar approach is taken that requires undocumented migrants to show they have been in the country for more than ninety days. The cost of care is to be covered by the patient where possible, but if this is not possible it is borne by the health facility.

41. **In Switzerland** where all persons are required by law to be insured for health care the authorities of Geneva encourage employers of undocumented migrants to pay into a health insurance fund. Irrespective of this they also allocate funds to pay 40 private physicians in the city to provide health care to undocumented migrants. The University Hospital is also funded to provide care to undocumented migrants through a number of well established out-reach mechanisms.

42. In the **Czech Republic, Turkey, Switzerland, Sweden, and Portugal** occupational accidents and diseases are covered if the employer has paid contributions to the social insurance system, even if the worker is an undocumented migrant.

Conclusion

43. Documented and undocumented migrants continue to be an integral and growing part of the social and economic development of countries. Documented migrants are sought and encouraged to arrive; undocumented ones are often tolerated with a sense of benign neglect. The latter are proving to be just as indispensible as documented migrants. The extent to which they are cared for by the state nevertheless leaves much to be desired,

and they are often treated as third class citizens whose rights to such things as health and health care can be dispensed with. But undocumented migrants are humans with the same needs and aspirations as all other people. They have the same vulnerabilities as others and in the domain of human rights and health it is essential that those vulnerabilities and the needs associated with them be respected and responded based on the same principles as apply to all other people.

44. In a world of countries that are becoming increasingly inter-dependent and at a time when the movement of people from one location to another in search of work and the opportunity to contribute is becoming more feasible and accepted, basic public health and human rights principles provide us with a road map to successful social insertion of people and the sharing of essential goods such as health care.

45. Those who would argue against the equal provision of essential health care to undocumented migrants do so without due reference to the evidence. Undocumented migrants are a small proportion of all migrants and will always be a very much smaller proportion of national populations.

46. To deny this vulnerable group access to health care is both contrary to the principles of universal access and human rights and short-sighted in terms of public health and sustained socio-economic development. This is being increasingly recognized and the number of countries committed to providing health care to undocumented migrants is growing. They are doing so not only out of a spirit of humanitarianism, but also on the basis of the evidence that undocumented migrants do not abuse health care services, do

not arrive looking for health care, and are eager to work and "fit in". Further, they recognize that prevention, early diagnosis and treatment of illness in this vulnerable population will provide savings in the longer term, both in terms of relieving suffering and stress and reducing healthcare costs associated with longer term health problems in a population without which many local economies would quickly flounder.

47. A country such as Canada would be well served to respond constructively to the concerns and recommendations from United Nations human rights bodies, and to adopt measures to ensure access to healthcare for undocumented migrants.

TIMBRE CANTONAL 2010 Fr. 2.50

Sworn before me at the
Notary Office
City of Geneva, Switzerland
on February 2nd, 2010

.....

Manuel Carballo

.....
name and seal of notary public

François COMTE * Notaire à Genève *

ETUDE DELESSERT ET COMTE
NOTAIRES
QUAI DE L'ILE 15 - 1204 GENÈVE
TÉL. +41 (0)22 311 22 11 FAX 311 32 22

Vu pour la légalisation de la signature de
M.e F. Comte Notaire.-
à l'exclusion du document lui-même.

Genève, le 02 FEV. 2010

CANTON DE GENÈVE DSPE

Céline FAVRE

ETUDE DELESSERT ET COMTE
NOTAIRES
QUAI DE L'ILE 15 · 1204 GENÈVE
TÉL. +41 (0)22 311 22 11 FAX 311 32 22

"EXHIBIT A" TO THE AFFIDAVIT OF MANUEL CARBALLO
SWORN BEFORE ME ON FEBRUARY 2, 2010

François COMTE * Notaire à Genève *

.....
Notary Public

CURRICULUM VITAE and RESUME

Dr Manuel Carballo is an epidemiologist who has a PhD and MPH in epidemiology and a post doctoral diploma in social psychiatry. In recent years he has specialised in HIV/AIDS, TB, reproductive health, and psychosocial health issues, especially with respect to mobile populations such as refugees, regular and irregular migrants, humanitarian and post-conflict reconstruction. Dr Carballo is the Executive Director of the International Centre for Migration, Health and Development (ICMHD) in Geneva, and is also Professor of Clinical Public Health at Columbia University in New York, and Adjunct professor of Public Health at Tulane University in New Orleans. Before joining ICMHD he was a senior staff member of WHO where he was first of all Coordinator of the Infant and Young Child Feeding Program and the first International Study on Breast feeding and Infant and Maternal Health which then led to the International Code on Marketing of Breast Milk Substitutes. In 1986 he was part of the three-person team that was asked to set up the WHO Global Program on AIDS (GPA) where he remained until 1991 as Chief of Behavioural Research. From 1993-95 he was Public Health Advisor for WHO based in Sarajevo and with special responsibility for displaced people. After the war he continued as advisor to the Minister of Health of Bosnia and Herzegovina. In addition to Bosnia and Herzegovina, he has worked in Tunisia, Guatemala, Cambodia, Namibia, DRC and Sierra Leone and has been on health evaluation missions for the UNFPA to Palestine (OPT) in 2002 and 2003, Iraq in 2003 and Afghanistan in 2005 and 2006. Following the Tsunami he was responsible for organizing the UNFPA relief response in the Maldives again with reference to displaced populations. Dr Carballo is currently coordinating four international studies on: type 2 diabetes in migrants; hepatitis B and C in migrants; TB in migrants; gestational diabetes in Jamaica, Panama and Mexico.

Vu pour la légalisation de la signature de
M. Me F. Comte, Notaire
à l'exclusion du document lui-même.

Genève, le 02 FEV. 2010

CANTON DE GENÈVE DSPE

Céline FAVRE

NAME	Manuel Carballo
NATIONALITY	Gibraltarian - British
LANGUAGES	Fluent English, Spanish, French Working knowledge of Portuguese
ACADEMIC APPOINTMENTS	1995-present Executive Director, International Centre for Migration and Health (ICMH) 2008-present Adjunct Professor of Public Health, Tulane University, New Orleans, USA

1998-present, Professor Clinical Public Health, Columbia University Mailman School of Public Health, New York

1999-present, Lecturer, Fordham University, New York International Diploma Humanitarian Assistance

1998-present Lecturer, American University of Beirut and Makerere University Kampala, in Public Health in Complex Emergencies

1995-97 Special Adviser to MoH, Federation of Bosnia and Herzegovina

1993-95 WHO Public Health Development Adviser, Sarajevo, for Bosnia

1993 Consultant, American Research on AIDS Foundation, Nepal

1992-93 Chief, Research and Development, Health Protection and Promotion, WHO Geneva

1991-92 Chief, Research and Development on Substance Abuse, WHO

1986-91 Chief, Social and Behavioural Research, Global Programme on AIDS, WHO, with responsibilities for all WHO regional offices

1986 Member of three-person team selected to establish and manage the WHO Global Programme on AIDS (GPA) WHO

1976-86 Coordinator, WHO Research Programme on Infant and Young Child Feeding and Child Rearing, Unit of Maternal and Child Health WHO, with responsibilities for all Regional Offices

1975-79 Scientific Coordinator, WHO Inter-country Collaborative Study on Breast-Feeding, Fertility and Infant Health, WHO with responsibilities for all WHO regional offices

1979-81 WHO Coordinator, WHO/UNICEF Inter-Agency Team development of the Code of Marketing of Breast Milk Substitutes

1973-75 Field Coordinator, HEW Project on MCH, Le Kef, Tunisia

1971 73 Visiting Assistant Professor, Tulane School of Public Health and Tropical Medicine, Department of Epidemiology and Biostatistics

1970-71National Institute of Mental Health Post-Doctoral Fellow in Social Psychiatry, (USA)

1965-69 Research Fellow Tulane University, New Orleans, USA

1963-65 Tulane University Research Fellow, International Centers for Medical Research and Training, Cali, Colombia

HONORARY APOINTMENTS

Fellow of the Royal Society of Medicine (UK)
Member Executive Board, Wyeth Foundation Switzerland

ADDITIONAL EXPERIENCE

Special Technical Advisor to WHO Deputy Director General 1988-1991
Member of Scientific and Organizing Committee for all International AIDS Conferences, 1987-1992
Scientific Director for development and coordination of AIDS behavioural research projects in all six WHO regions, 1987-1990
Member of WHO team responsible for setting up National AIDS Committees in African and Asian countries, 1986-1988
First WHO staff member to testify before 1978 US Congressional Hearings on Health and Scientific Research (Marketing and Promotion of Infant Formula)
Member of Coordinating team PAHO/INCAP earthquake relief operations Guatemala, including follow-up with donors and other organisations, 1976

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