

# Global Health

MAY 2012

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INSTITUT DE HAUTES ÉTUDES  
INTERNATIONALES ET DU DÉVELOPPEMENT  
GRADUATE INSTITUTE OF INTERNATIONAL  
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GLOBAL HEALTH PROGRAMME

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Global Health Diplomacy Program

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# Global Health

MAY 2012



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# World Health Assembly offers the best prospects for global health diplomacy

**The great and the good from across the international health community have the perfect forum in the World Health Assembly, which helps promote leadership in deciding strategies to meet global challenges**

By Ilona Kickbusch, Global Health Programme, Graduate Institute, and James Orbinski, Global Health Program, Dalla Lana School of Public Health

**W**elcome to the inaugural edition of *Global Health*, which seeks to enrich the dialogue on how to address the many challenges currently facing organisations responsible for improving health and well-being worldwide. The publication includes contributions from leading global health institutions, many representatives of which will gather at the 2012 World Health Assembly (WHA) in Geneva, Switzerland, from 21-26 May.

The World Health Assembly has become the incomparable meeting point for global health diplomacy. It brings together all 194 member states of the World Health Organization (WHO) in the spirit of the United Nations – one country, one vote – to agree pathways to address pressing challenges.

For the five days of deliberation, the WHA attracts a formidable who's who of global health, all assembled to debate the issues on the formal agenda, make their own interests known, seek common ends and engage on other informal agendas. Health experts, advocates from civil society, business representatives and representatives of a multitude of other global health organisations interact with officials from health and foreign ministries and representatives of the donor community, development agencies and the large foundations, as well as with other UN bodies. At its best, the WHA helps shape the future of global public health.

Why is the WHA so attractive? Obviously in a global world, the relevant actors need a regular opportunity to meet face to face – to meet who matters, and find out what matters. But it is also the underlying formal authority of the WHA that is attractive: it is the only body that can adopt global health treaties. If it did not exist, it would have to be invented. Its values, norms and recommendations can shift approaches and investments, and contribute substantively to redefining sustainable development. This makes the WHA unique among other actors in global health.

Three cases from the past decade stand out. First, in the spirit of its history (which reaches back to 1851),

the WHA agreed in 2005 on the International Health Regulations (IHR), binding the 194 states to rules to enhance national, regional and global public health security.

Second, in 2003 the WHA set a foundational precedent for the protection of health in an era of accelerated globalisation, by adopting the WHO Framework Convention on Tobacco Control (FCTC). This first international treaty negotiated under the auspices of WHO entered into force on 27 February 2005. It has become one of the most rapidly and widely embraced treaties in UN history.

Third, in 2011 the WHA passed a resolution on the 'Sharing of Influenza Viruses and Access to Vaccines and Other Benefits'. This will enable all countries to better prepare for the global public health threat that an influenza pandemic presents, and share the benefits of improved international cooperation and preparation, including greater quantities of, and equitable access to, H5N1 and pandemic vaccines.

These cases exemplify a successful contemporary 21st-century role for WHO, soundly articulated in its 1946 constitution: "To act as the directing and coordinating authority on international health work."

These agreements were widely debated in the global health community over several years, in varied and carefully crafted forums. They affirm WHO's central role in global health diplomacy. Over the decades WHO has regularly adapted and changed the way it does business – one could not eradicate smallpox with the same strategy today.

The WHA is also significant in articulating and shaping health-related values, norms and standards, especially as the global community moves towards redefining sustainable development at the Rio+20 Summit in June. The 2011 World Conference on the Social Determinants of Health in Rio drew sharp attention to increasing health inequities. It warned that the world's poor will pay the price if greater equity in health is not a driving principle of sustainable development.

## Meeting ever-changing challenges

Through a constantly evolving context, WHO has often shown strategic foresight and global leadership: developing primary healthcare, advocating health promotion and control of non-communicable diseases (NCDs), and highlighting the need to address the societal determinants of health.

Throughout its 60-year history some have wanted a 'stronger' WHO focused on its normative and standard-setting role; others have wanted to weaken exactly this function to prevent interference in matters considered of economic or sovereign interest; yet others would have preferred that WHO became a development agency for health focused only on the poorest.

The latter is particularly tempting when health disparities still loom large and egregious inequities



Maternal and child health outcomes still vary enormously around the world and are a priority for many health campaigners

– such as in infectious disease and maternal and child health outcomes – mark much of the world.

But it would neglect other challenges such as NCDs, acknowledged by the UN General Assembly (as HIV/AIDS was a decade ago) as an issue that challenges not only the health sector but the whole of government and society. It would also neglect the fact that most of the world's poor people live in the emerging economies. Different strategies are needed for the bottom billion.

It also neglects those 'problems of the commons', such as global warming, that cross-policy silos and political and geographic boundaries, and demand common global solutions. For example, to address critical deficits in global health research and development of healthcare technologies, the 2012 WHA will consider recommendations from its Consultative Expert Working Group on Research and Development. Similarly, the health impacts and solutions to global warming will have – at some imminent point – to be squarely addressed by the WHA.

In a world of multiple power shifts – between states, between states and non-state actors, and within states between sectors – new challenges emerge for what is a vital and necessary organisation.

Over the past decade there has been great momentum for global health, and funding has increased substantially. Today, health enjoys unprecedented attention on the international level.

A few recent events are worth highlighting: the 2011 UN NCD High-Level Meeting during the 66th UN General Assembly, the 2010 UN MDG Summit, the 2010 G8 Muskoka Initiative on Maternal, Newborn and Child Health, and the annual UN General Assembly resolutions on global health and foreign policy.

There should be no fear that today there are so many more organisations and initiatives in global health – no

organisation could address the enormity of the challenge alone – and all should embrace and support the vitality, necessity and potential of WHO to authoritatively direct and coordinate international health work.

### The bigger picture

To this end, coherent global health strategies that focus on achieving greater health equity across sectors are vital. The WHO reform process must make the organisation 'fit for purpose', in a world where health has moved up the political agenda to be part of security and foreign policy, as well as a major factor in the economic and social development of states and the competition among them. With a clear vision focused on greater equity in global health, it is possible to imagine not simply coherence, but also convergence.

At the 2012 WHA, several resolutions will mark the culmination of agreements on key health challenges. But it is important to think about the bigger picture. Global health vision, leadership and coherence are required. But so, too, is

a desire to work together to ensure global public goods for health, and to lift the health of the most disadvantaged.

The year 2012 is a special one. The 65th session of the WHA will decide on the next WHO director general. The Executive Board has proposed Margaret Chan for a second term. She will have to take up challenging responsibilities in difficult times and bring to fruition the WHO reform process already under way.

Aimed at adapting the organisation for the complexity of the 21st century, WHO is called on to provide a strategic vision that builds on experience and lives up to expectations for delivering better health in a globalised world.

WHO is challenged to put forward a vision on global public health that is equal to the challenge that was set by Health for All three decades ago. ■

## Health has moved up the political agenda to be part of security and foreign policy, as well as a factor in the economic and social development of states



# Promoting health in all policies, an investment for future generations

**Faced with an ageing population, Finland is looking at ways to develop a society that looks after the health of its citizens, but which also takes its international responsibilities seriously. This involves looking beyond simple health policy and introducing a new, long-term vision and strategy**

By Jyrki Katainen, prime minister, Finland

**H**ealth is fundamental to Finns and is therefore at the core of Finnish government policy. It cuts across all the policy areas of the government's programme: poverty reduction, inequality and social exclusion, the consolidation of public finances and the strengthening of sustainable economic growth, employment and competitiveness.

Health is a human right and an essential element of well-being. It is also a motor of sustainable social development and linked with economic growth, employment and competitiveness. Inequality represents a challenge to society and the Finnish way of life. The government of Finland has made an explicit commitment to promote well-being and health as well as reducing inequality in all decision-making. Health considerations will be incorporated into the activities of all parts of government. This is what Health in All Policies is about.

The financial and economic crisis has hit Europe hard. The lesson learned from the deep economic recession that Finland experienced in the 1990s is that it is essential to invest in preventive measures: in health, education, employment, social services and welfare, with a particular emphasis on children and young people. We continue to be determined to develop and reinforce the basic structures of the welfare society. Equal access to high-quality public services and social

security, including pensions, for all will only be possible by maintaining well-managed public finances. It is an investment for future generations.

To do this, we need revenue. We are shifting the focus of taxation from taxing work towards taxing consumption and taking into account the negative impact on environment and health. While revenues for the state are increased, improved living conditions and new options for healthy choices will enhance health equity. We have already introduced taxes on soft drinks, sweets and ice cream and increased taxes on alcohol and tobacco. We are exploring the possibility of a generic tax on sugar, as a health-based measure.

Finland is ageing: and the demographic structure of the country is changing faster than elsewhere in Europe. This means that the dependency ratio is rising rapidly. To counter this trend, we need prolonged working careers and lower early retirement rates. Mental health problems, primarily depressive disorders, constitute

**Inequality represents a challenge to society and the Finnish way of life. The government has made a commitment to promote well-being and health as well as reducing inequality in decision-making**

about one-third of all disability pensions in Finland. Together with key administrative sectors, social partners, the private sector and non-governmental organisations, we have launched an intersectoral programme to promote practices to increase well-being at work, prevent depression, improve treatment, reduce disability related to depression, and promote staying at and re-entry to work for those who have depression.

We actively support the reintegration of the unemployed into society and its workforce. The health and social sectors contribute to these efforts by working together with Finland's Ministry of Employment and the Economy and other relevant bodies. We employ comprehensive measures to reduce the risk of young people being marginalised, and these include guaranteed access to work or education, as well as health, social and rehabilitation services.

## Alternative solutions

Finland will be developed as a society that not only looks after its own citizens, but also bears its international responsibilities, as part of the Nordic region, Europe and the world. The government's new development policy programme encourages the inclusion of health and well-being in all policymaking. The objective is to reduce poverty by supporting least developed countries and promote sustainable development. We want to enhance aid effectiveness by strengthening the ownership of developing countries and harmonising cooperation practices.

For decades, as a deliberate policy choice, Finland has engaged in health promotion and disease prevention, based on cross-sectoral activities and universal coverage of comprehensive healthcare services. The principle of Health in All Policies is based on the core values of Finnish society and the Nordic welfare system: democracy,





Senior citizens at an event in Salo, Finland. The country is facing up to the challenge of caring for its growing elderly population

equity and fairness. This approach seeks to improve population health and health equity through the determinants of health across sectors.

In practice, Health in All Policies aims to integrate health considerations into policies beyond health at all levels. This means advocating for health, providing information and evidence and, when needed, searching and negotiating for alternative solutions for proposed policies. Implementation is supported by several well-developed horizontal mechanisms that enable communication among policy areas and within democratic governance structures at all levels.

Our experience shows that successful implementation requires capacity, public health knowledge and a long-term vision and strategy. Identification of health-relevant policy issues through continuous policy scanning across sectors is essential.

So is a proper understanding of how other policy sectors function and what their objectives are. The stronger these enabling intersectoral structures, mechanisms and resources are, optimally with a legal basis, the better are the results. For Finland, transparent policy-making, public ownership and participation have been prerequisites for success.

#### Concrete guidance

In recent years, the notion that health is produced – or jeopardised – in the whole of society has increasingly been accepted in the international discourse on public health. The Commission on Social Determinants of Health of the World Health Organization (WHO) has put together a strong case for the links between health and its determinants. The translation of these findings into policies remains a challenge. Discussions are ongoing

about the best approaches to be adopted by the health sector and by society as a whole. The importance of the involvement of different sectors has created several concepts that seem to aim at the same goal: integration of health aspects in all policy areas. They all bring us back to the context of health promotion and the still relevant call of the 1986 WHO Ottawa Charter for healthy public policies.

In June 2013, Finland will host the eighth Global WHO Health Promotion Conference in Helsinki. The theme of the conference is Health in All Policies. The theme is a natural continuation of Finland's long-term approach to work systematically for health across sectors. The focus will be on implementation. The main objective is to give countries around the world concrete guidance on how to get all sectors of society to work for health. I look forward to seeing you in Helsinki. ■

# Improving health in an interconnected world: five steps to better global health

**Access to better medicine and care for everyone has helped to reduce mortality rates in many countries, but the world must not rest on its laurels. Increased investment, better understanding, collaboration and good policymaking are essential if this trend is to continue**

By Jonas Gahr Støre, minister of foreign affairs, Norway

**T**he first decade of this new century will be remembered for a number of things, but one that will certainly stand out is the dramatic leap forward in global health.

Between 2000 and 2010, a number of worrying – and sometimes catastrophic – trends in global health were arrested and reversed. For example, the child mortality rate, which had been stuck at 12 million per year in the 1990s, was reduced by more than a third to 7.6 million in 2010 thanks to improved vaccination rates and a dramatic improvement in malaria control and the treatment and prevention of AIDS.

Over the past few years, enhanced efforts to improve maternal mortality have also had an impact on the ground. From barely budging for decades, the number of maternal deaths has shown a significant decrease in the past few years.

And these are only some of the positive figures that are showing up in health statistics.

Most of this progress has been achieved through an increase in health investments: partly as a side effect of economic growth (particularly among middle-income countries), and partly due to a deliberate scaling up of health investments through aid.

In absolute terms, the increases have been modest: a single-digit billion dollar investment per year spread over nearly 150 countries. The fact that this

funding has caused such a dramatic leap in lives saved shows just how cost-effective health investments are.

As is so often the case, however, addressing one problem – in this instance by increasing global health investments – uncovers other challenges. Increased global health investments and an increased focus on health

**We are now hearing calls for austerity, the view that health improvements are a 'nice to have' luxury the world can no longer afford. This is cause for serious concern**

outcomes have placed tremendous strain on developing country health systems and have highlighted the complex and often detrimental effects of health worker migration.

It has also become clear that most health problems today are international in character, which means that national health systems and governments often have limited means of controlling health outcomes in their country.

Moreover, the interconnectedness between other factors and health, such as trade policies, global warming, armed conflicts, the legal, social and economic status of women and

vulnerable groups, and inequity within and among countries, has also been brought to the fore.

In fact, the interdependence between health and other factors is one of the most striking effects of globalisation.

There are two sides to this interconnectedness: political and corporate leaders need to understand how crucial health is to economic and social development; and those working inside the health sector need to understand how health outcomes often depend on decisions taken outside the sector. Altogether, there is a need for better understanding of how improving health helps to reduce glaring inequities, foster economic growth, reduce workforce costs, and even promote stability and security.

## Better advocacy is needed

The progress of the past decade has created a tremendous momentum for positive change. Today, well into the next decade, there is a danger that this momentum could be lost. We are now hearing calls for austerity, the view that health improvements are a 'nice to have' luxury the world can no longer afford, that a job half done is a job well done and that the money that has gone into health can now be directed to other areas. This is cause for serious concern.

We need to fight such complacency and short-sightedness. But we also need to use the momentum built up over the past decade to develop a more sophisticated structure for dealing with global health problems and to better exploit the opportunities for improving health outcomes through decisions taken outside the health sector.

I see five steps to driving forward such an agenda.

First, better advocacy is needed to focus attention on the interconnectedness of health and foreign policy. Experts within these areas should come together to



Improved vaccination rates have contributed to reducing child mortality from 12 million deaths per year in the 1990s to 7.6 million in 2010

identify the evidence and develop the language and arguments needed to help decision-makers fully understand the foreign policy implications of global health security.

Second, support must be built for political initiatives that promote an interconnected global response to health issues.

The Millennium Development Goals (MDGs), although not perfect, are making a huge difference. The G8's commitment to child, newborn and maternal health is another excellent example, as is the United Nations Secretary-General's Global Strategy for Women's and Children's Health.

It is time to look beyond the MDGs to plan how to continue working towards ambitious goals after 2015. Moreover, much more needs to be done to mobilise efforts against the slow tide of lifestyle diseases that will kill millions and drain state budgets in the years to come.

The World Health Organization's Framework Convention on Tobacco Control is an inspiration in this area, as was the UN General Assembly's High Level Meeting on Non-Communicable Diseases in September 2011.

Third, with the many initiatives taken – both inside and outside the UN family – it is time to look closer at the institutional global health

architecture. It is necessary to improve the understanding of how decisions made in one area, such as water management, climate change or trade policy, can affect health, and to plug into these decision-making processes in a coordinated and effective manner.

#### **The impact of foreign policy**

Fourth, everyone needs to engage. My colleagues from Brazil, France, Indonesia, Senegal, South Africa and Thailand and I continue to collaborate through the Foreign Policy and Global Health Initiative.

In 2007, we adopted the Oslo Ministerial Declaration and action plan on global health. It identified 10 key areas where we believe the international community needs to better understand the health implications of foreign policy. Six of these areas have been the subject of debates and resolutions at the UN General Assembly. This year we are working together on relevant aspects of the Rio+20 agenda.

Fifth, more knowledge and better documentation are required, in addition to an interconnected research model that can provide the necessary evidence base and support these efforts.

To this end, Norway and the Foreign Policy Health Initiative are supporting the new Commission on Global Governance for Health. This commission – a collaboration between Harvard University, the University of Oslo and the medical journal *The Lancet* – will examine the impact of various foreign policy domains on health and seek to identify what methods should be used to promote global health in international politics.

If the impressive progress of the past decade is to continue in the coming years, investments in health need to be accompanied by more sophisticated decision-making and cross-sector collaboration. It is a challenge I believe we can meet. ■



# The European Union and global health

## EU member states are working together to improve global health outcomes through policy frameworks that tackle wider issues in a coordinated and coherent way

By John Dalli, member, European Commission for Health and Consumer Policy

**G**ood health is central to everybody's daily lives and needs to be supported by effective policies and actions.

This is why good health is one of the values enshrined in the European Union's founding treaty, which says that a high level of human health protection shall be ensured in the definition and implementation of all EU policies and activities. The treaty further specifies that the EU and its member states shall foster cooperation with third countries and international organisations on public health. In this context, the EU's role is taken up in the EU Health Strategy, which emphasises the need for sustained collective leadership in global health to help achieve better outcomes in Europe and beyond.

We know the value of working together for better health. Cooperation among member states ranges from tackling health threats with a cross-border or international impact to simply sharing knowledge and best practices to prevent illness. It includes improving food safety and nutrition and the safety of medical products as well as tackling smoking and developing legislation to ensure that blood, tissues, cells and organs are safe across the European Union.

Working together is particularly important when we address challenges such as demographic change or the uptake of new technology such as eHealth – which is revolutionising the way we promote health and the ability to predict, prevent and treat

illness. It is particularly needed when we are faced with major cross-border threats to health, such as pandemics or bioterrorism.

Keeping people healthy and active not only ensures well-being but also has a positive impact on jobs and growth. It is important against the backdrop of today's harsh economic climate. By investing in health we can invest in growth and economic prosperity. This is why, now more than ever, we need a shift in focus towards more preventive approaches in health policy.

This is the message that I received from the world leaders gathering at the United Nations High-Level Meeting on Non-communicable Diseases in September 2011 in New York. The

### Working together is important in addressing challenges such as demographic change or the uptake of new technology such as eHealth, which is revolutionising the promotion of health

summit was a reminder of the need for commitment at the highest level to raise health prevention on the agenda and to take forward coordinated international action on global health issues.

The EU can add value in its contribution to global health by sharing common European values, as well as its experience in implementing health

policies that promote well-being, reduce inequalities and strengthen systems.

There are several examples of how the EU is contributing to global health. As a whole, the EU is the world's largest provider of development and humanitarian aid. Health is an important component of worldwide efforts to combat poverty, of work towards the Millennium Development Goals and of helping preserve the lives of people affected by humanitarian crises.

The EU supports the implementation of the International Health Regulations. They contribute to global public health security by providing a framework for coordinating the management of public health emergencies of international concern. They also improve the capacity of countries to detect, assess, notify and respond to public health threats.

### Bringing policies together

The EU is also a committed actor within the Framework Convention on Tobacco Control (FCTC), the first international health treaty negotiated under the World Health Organization (WHO) providing a comprehensive strategy for both tobacco demand and tobacco supply reduction. The EU supports financially the implementation of the convention in low- and middle-income countries to help them better integrate tobacco-control policies into their national health and development strategies and programmes.

Since 2010, the EU has had a policy framework on global health that brings together internal and external policies – such as health, development cooperation, external action, research and trade – to improve the EU contribution to global health.

The aim is to increase efficiency in the delivery of aid to health, to enhance global health knowledge, to ensure coherence in implementing policy and to continue dialogue with key global partners and stakeholders.



Health promotion is central to the EU ethos, and a crucial policy area for its inhabitants



Within this framework, the EU prioritises support to strengthen health systems in partner countries. This support seeks to ensure that all health systems, in all their main components – workforce, access to medicines, infrastructure and logistics, governance, financing and management – are effective enough to deliver universal coverage of basic quality care. The framework defines key areas to increase coherence in addressing global

health through dialogue and actions on trade, financing, development aid, migration, security, food security, research and climate change.

From the many UN bodies active in the global health arena, the EU looks primarily to WHO as the global leader on health.

WHO and the European Commission signed a memorandum of understanding in 2000 recognising the advantages of working together in

a complementary way in areas such as development and humanitarian aid, research, addressing the issue of the global shortage of health workers in developing countries and health security.

The EU cannot solve all global problems on its own. We therefore strongly support strengthened cooperation with WHO because we believe that, together, we can make a difference. ■

# China's health diplomacy: sharing experience and expertise

**As a major developing country, China has always believed that it is its responsibility to support developing countries, such as those in Africa, in promoting their health**

By Chen Zhu, minister of health, People's Republic of China

In the 21st century, globalisation has achieved unprecedented depth and breadth, exerting a profound influence on health. Health exists at every moment and everywhere. Its strategic relevance is increasingly highlighted in the global arena. Health has entered into the global development agenda and lies at the core of the Millennium Development Goals (MDGs). Diseases that transcend national boundaries threaten people's lives and have become important non-conventional security issues. Since a healthy population is the source of productivity, investing in health boosts economic growth. Health bears on social equity – and it is the responsibility of the international community to eliminate health inequity. As a component of a country's diplomatic policies, health reflects that country's soft power. Today, a health minister should not only protect national health from a biomedical perspective but must also view public health from a broader and global perspective. That person shoulders dual responsibilities: to ensure the health of his or her people and to contribute to the improvement of global health.

The two key tasks of global health are to achieve health development and safeguard health security. The year 2012 brings the target dates of achieving the MDGs ever closer. Yet there is clearly still a long way to go to meet the health-related MDGs. The countries that find it most difficult to achieve the

targets are indeed the ones that most urgently need globally coordinated help. In the past decade, emerging infectious diseases such as severe acute respiratory syndrome (SARS), avian influenza and H1N1 influenza have occurred one after another, indicating that no one can ever relax vigilance against health security threats. In a world of growing interdependence, no country can be immune from another's problems. Protecting national and global health security requires collective and coordinated action. To my great delight, as the global platform of health diplomacy, the 65th World Health Assembly in 2012 has listed global development and health security among the items for key debates. I am confident that the assembly will yield fruitful results.

## Dispatching medical teams

Conducting international cooperation in health development constitutes an important part of China's policies of health diplomacy. As a major developing country, China has always believed that it is its responsibility to support developing countries, such as those in Africa, in promoting their health. China's development cooperation for health includes dispatching medical teams, building hospitals, setting up malaria prevention and treatment centres, training health professionals and administrators, and providing medicine and medical supplies. China

has also been a strong supporter of international agencies such as the World Health Organization (WHO) and UNAIDS and global health initiatives such as the Global Fund to Fight AIDS, Tuberculosis and Malaria. Over the past six decades, since the founding of the new China, the country has made remarkable progress in strengthening health systems and improving health outcomes. The health-related MDGs have already been or are being achieved in China. We are ready to share with other countries our experience in developing health.

In the light of China's health diplomacy practices, I hold the following convictions. First, global health diplomacy should respect the norms of international laws and fully consider national situations. Countries are in different stages of development and they face different health problems and challenges.

While strengthening international cooperation and coordination, there must be adequate consideration given to the national conditions and different concerns, as well to as the acceptance of the stakeholders. Vigorous efforts shall be made to address pressing health problems. But, at the same time, efforts should also be forward-looking, should strengthen capacity building and follow the principle of balance.

Second, global health diplomacy should strengthen coordination. Health is closely linked to issues such as poverty, employment, education, trade, environmental protection, climate change and intellectual property. When formulating relevant policies and rules, countries and international organisations need to review the mutual impacts of the related factors and of public health in a general context. Health engages various government agencies and effective health diplomacy requires highly efficient domestic coordination. With the large number of international organisations that deal



Sudanese patients wait for eye check-ups from Chinese doctors, as part of China's policy to provide good healthcare throughout the world

with health, it is necessary to strengthen communication and coordination and fully mobilise resources. China supports the WHO reform and wishes to see WHO play a leading role in coordinating international public health. China also looks forward to the reform of organisations such as the Global Fund so that a coordinated, highly efficient, transparent and accountable framework for global health governance can be built.

Third, global health diplomacy should focus on real effects. At present, the deep impact of the international financial crisis still haunts the world, bringing unfavourable factors to the health undertaking of all countries, especially developing ones. It remains a priority for global health diplomacy to ensure inputs into global health and

to achieve the health-related MDGs as scheduled. Developed countries should honour their international commitments as soon as possible and provide more support and assistance to developing countries in areas such as technology transfer and the promotion of drug accessibility and affordability. Developing countries should enhance their health systems, increase fiscal

**Since the founding of the new China, the country has made remarkable progress in improving health outcomes. We are ready to share with other countries our experience in developing health**

inputs, coordinate resources and strengthen South-South cooperation.

It is the mission of China's peaceful foreign policy, and an important responsibility of its health diplomacy, to build a harmonious world of lasting peace and common prosperity with deepened mutual understanding and friendship between the Chinese and people around the world. China's health diplomacy will continue to develop South-South and South-North cooperation, enhance its own capacity building and gradually improve China's global health strategies. We will constantly review and share our experience gained in health reform and development, actively engage in global health, work hand in hand with all stakeholders and make our contribution to improving global health. ■



# Strengthening health systems in developing countries

**South Africa has taken the decision to improve its health outcomes by re-engineering its primary healthcare system, implementing a national health insurance system and fostering an ethical recruitment policy – an overall strategy could serve as a template for other countries, too**

By Aaron Motsoaledi, minister of health, South Africa

**M**any commentators have recently argued that without strong health systems, many of the health outcomes that we seek to achieve, including the Millennium Development Goals (MDGs), will not be achieved. However, this is nothing new. In South Africa, this was the basis on which the community-oriented primary healthcare movement was started in the late 1930s and early 1940s, which also fuelled the community health centre movement around the world.

In the 1970s, the world witnessed perhaps the most important global event related to health systems, namely the International Conference on Primary Health Care at Alma-Ata. Many countries and states adopted the primary healthcare approach with remarkable success, notably Cuba and the Indian state of Kerala.

Critically, the approach does not only focus on services but also on community involvement as well as intersectoral collaboration, recognising that health (and therefore health systems) cannot be reduced to treatment and care alone. This recognition has long been adopted by the international community, but perhaps not always remembered, given that the constitution adopted by the World Health Organization (WHO) in 1948 defines health as “a state of complete physical, social and mental well-being and not merely the absence of disease or infirmity”.

The importance of primary healthcare and health systems for developing countries was recently reaffirmed by countries in Africa, the Americas and South-East Asia.

In 2008, the WHO Africa region adopted the Ouagadougou Declaration on Primary Health Care and Health Systems in Africa: Achieving Better Health for Africa in the New Millennium. This declaration identified nine priority areas for strengthening health systems in Africa: leadership and governance; health services delivery; human resources; financing; information systems; technologies; community ownership and participation; partnerships for health development; and research.

## The importance of primary care

Similarly, the South East Asian Region (SEAR) of WHO in 2007 adopted a six-point strategy to strengthen health systems based on primary health care. Building on WHO's building blocks, SEAR's strategy focused on strengthening health service delivery, leadership and governance, financing, workforce, information systems, and the management of medical products and logistical supplies. The Pan American Health Organization adopted a similar approach in 2007.

These all point to the key elements of health systems for developing countries (as well as developed countries). There is therefore no argument about the

importance of primary healthcare, as well as the key inputs to a strong health system. What is required is action.

In 2010, prompted by a study tour of Brazil, a review of international best practice and WHO resolutions, South Africa adopted a three-stream approach to re-engineering primary healthcare. This was based on the acknowledgement that, as a middle-income country with relatively high levels of health expenditure, South Africa had unacceptably poor health outcomes.

The three streams include a municipal ward-based primary





outreach team for defined catchment areas, with community health workers supported by a nurse; a strong school health service; and the deployment of specialists (obstetricians, paediatricians, anaesthetists, advanced midwives, advanced paediatric nurses and primary healthcare nurses) to improve clinical governance in each health district.

These interventions were initiated to reduce maternal and child mortality in particular but also to empower communities to prevent ill health and ensure the early identification of disease and early treatment.



South Africa essentially has a private health service and a public one – the latter has significantly fewer resources

It is well known that South Africa has two health systems: one for the rich (private) and one for the poor (public), with expenditure in the former significantly higher than in the latter. Resources are skewed towards those who can afford to seek care in the private healthcare sector – which can be described as expensive, curative and unsustainable.

### Reforming the health budget

To address this, the country's leadership has decided to implement a national health insurance system that will both pool the total health budget and direct resources to areas of need. It will also restructure the health delivery platform to ensure equitable access.

In order to put the national health insurance system to achieve universal access to healthcare into operation, South Africa has identified 10 pilot districts in which a range of initiatives will be implemented to strengthen the quality of health services offered by the public sector. At the same time, initiatives to integrate the public and private sectors, through the contracting of private general practitioners, will begin.

As health involves a labour-intensive set of activities, no initiative can succeed without strengthening human resources for health. Given the global shortage of skilled healthcare workers (which is worse in developing countries), each nation needs to develop a robust human resource development and management plan.

In addition, given that healthcare workers are highly mobile, ethical recruitment practices are of paramount importance. South Africa has implemented a policy of country-to-country agreements to meet some of its needs, rather than accepting individual health workers from the rest of Africa in areas that are worse off in terms of meeting their needs. The

Kampala Declaration and Agenda for Action adopted by the Global Workforce Alliance in 2008 should be implemented by all countries to ensure that migration is done in a way that does not negatively affect developing countries.

Such health-system strengthening borrows from the successful experiences of other countries, but is being adapted to fit the local context. Many developing countries have embarked on similar initiatives, which the international community must support. Multilateral organisations such as WHO, the World Bank, the International Monetary Fund and bilateral development agencies as well as philanthropists, play an important role in supporting health-system strengthening initiatives.

However, global support for health-system strengthening in developing and middle-income countries should not result in prescriptions linked to donor support, whether technical or financial in nature. It must be led by the countries themselves.

### The principles behind aid

Assistance to developing countries to strengthen their health systems should be based on the principles embodied in the Paris Declaration on Aid Effectiveness, as well as the Accra Agenda for Action.

The former lists five principles to strengthen aid effectiveness: ownership, alignment, harmonisation, results and mutual accountability. Similarly, the Accra Agenda for Action also focuses on ownership, inclusive partnerships, results and capacity development.

Health systems are fragile in many countries and in dire need of strengthening. There are many ways to do this with great success in terms of increasing access, improving efficiency and generating better health outcomes. However, without the necessary leadership in health, much of this promise may not be realised. ■

# Maintaining a healthy lifestyle in today's Russia

**Healthy living has become a priority in Russia today, with a focus on preventive measures. The government has targeted resources into programmes designed to promote good habits, prevent disease and improve life expectancy**

**By** Tatyana Golikova, minister of health and social development, Russian Federation

**R**ussia has made the promotion of a healthy lifestyle and disease prevention priorities in its strategy to meet the twin challenges of both improving the health of its population and increasing people's life expectancy.

In 1978 in Alma-Ata, at the International Conference on Primary Health Care, a historic declaration was made that underlined the development of primary healthcare. The emphasis was placed on education, prevention, healthcare and immunisation.

More than 30 years later, in 2011 in Moscow, at the initiative of the Ministry of Health and Social Development of Russia and the World Health Organization (WHO), a conference on healthy lifestyles and non-communicable diseases (NCDs) was held.

This resulted in the Moscow Declaration, which defined a new key place in modern healthcare for promoting and maintaining healthy lifestyles, and especially in the fight against the burden of NCDs.

Russia is actively contributing to the global agenda for healthcare and the promotion of healthy lifestyles by carrying out its own programmes and developing a national healthcare system based on healthy living and disease prevention.

It regards the promotion of healthy lifestyles as offering both a national standard and personal value. This emphasis also restructures the

relationship between the doctor and the individual, so that the doctor interacts not with a patient, but a healthy person, and helps them to reduce the risk of various illnesses and to maintain good health and, consequently, a good quality of life for as long as possible.

A rather difficult situation had developed in Russia over past decades, because of the low value placed on health. There were high levels of tobacco and alcohol consumption, weak institutions engaged in health promotion and an inadequate

**Opinion polls regularly show the dynamics of changing attitudes. The number of people influenced by the Healthy Russia programme and motivated to maintain a healthy lifestyle has grown**

awareness of the importance of maintaining good health. The result had a negative impact on the life expectancy among the Russian population, at only 66.6 years in 2006.

However, political will, the introduction of legislative restrictions, the systematic organisation of preventive measures and the use of modern forms of communication have resulted in an increase of 3.7 years in just five years: in 2011, life expectancy reached 70.3 years.

Russia ratified the WHO Framework Convention on Tobacco Control in 2008 and began its implementation. Labels warning about the dangers of tobacco are on cigarette packets. Russia developed the Concept of State Policy on Combating Tobacco Consumption for 2010-15, and a federal law to protect public health from the effects of tobacco consumption is being prepared.

Experts point out that this bill is one of the most stringent in Russian history. However, opinion polls show that not only non-smokers but smokers themselves largely support the proposed law on limiting smoking in public places.

In addition to legal and tax constraints, a programme is being carried out to inform the public about the dangers of smoking. Medical help for treating tobacco dependence is being organised. As a result, the prevalence of smoking is likely to fall from today's 39.1 per cent to 25 per cent by 2020.

## Reducing alcohol consumption

In 2009, Russia implemented the Concept to Reduce Alcohol Abuse and Prevent Alcoholism, which has already produced its first results. Alcohol consumption declined from 18 litres to 14.96 litres per person per year between 2007 and 2010. By 2020, alcohol consumption is expected to decrease to 10 litres per person.

In 2010, the Strategy of State Drug Policy to 2020 was approved. In 2011, the Russian Ministry of Health and Social Development began a programme to provide drug treatment. It endorsed healthcare for people with drug addictions in a single system that unites, for the first time, prevention, treatment and rehabilitation. That year, a programme to modernise drug treatment services started that will continue until 2014. It will cover all of the country's drug treatment institutions, which will nearly triple by 2020 to increase the number



The T-shirt slogan 'Choose! Beer or us?' reflects changing opinion in Russia towards issues connected to alcohol consumption

of people receiving the necessary medical and social rehabilitation.

Russia is developing health centre programmes for in-depth examinations. They are effective in preventing diseases or identifying them at an early stage. Special programmes have been created for the clinical examination of adolescents, students, the working population and individuals with a high risk of occupational diseases. From 2013, medical examinations will be included in the country's compulsory health insurance system and will be available, free, to every Russian citizen.

In 2009, the 'Healthy Russia' programme started. For the first time, an infrastructure network of 502 health centres for adults and 193 for children was created to provide everyone with the opportunity to undergo free health assessments.

Among the tests the health centres offer are examinations for cardiovascular and respiratory function, blood cholesterol levels and metabolic rates. The centres' specialists provide individual recommendations to help minimise the risk of disease as a result of poor diet, a lack of physical activity or unhealthy habits in general.

To participate in the Healthy Russia programme, an informational and educational infrastructure was created and published at [takzdorovo.ru](http://takzdorovo.ru). It receives an increasing number of visitors every year, with a total of 14,450,000 users so far. As well as providing interesting and up-to-date information, and offering testing services, the site allows people with similar problems in the community to help each other overcome health-related challenges and live a healthy lifestyle.

#### Promoting lifestyle benefits

A healthy lifestyle in itself can bring contentment, therefore the basic approach of the Healthy Russia programme is not to frighten, but to engage and encourage. The site's content and the main public service messages are based on this approach.

To support the development of a healthy lifestyle at the community level, a nationwide design competition for a healthy lifestyle is being carried out at [zdravo-russia.ru](http://zdravo-russia.ru). The competition collects the best practices of government agencies, educational institutions, businesses, non-governmental organisations and citizens' initiatives to

promote healthy lifestyles for analysis and dissemination. The number of participants are growing here, too: in 2010, 314 best practice projects were registered and 385 in 2011.

As a result of these efforts, Russian values are progressively reflecting a healthier lifestyle. Opinion polls regularly show the dynamics of changing attitudes. The number of people influenced by the Healthy Russia programme and motivated to maintain a healthy lifestyle has grown to 31 per cent in 2011, from 28 per cent in 2010 and 25 per cent in 2009.

More than a quarter of the population (28 per cent) already know about the adult health centres; almost one in five knows of the health centres for children. Smoking remains a challenge, but a large number of those surveyed (24 per cent) would like to stop. One Russian in ten wants to give up alcohol completely, and another 12 per cent want to cut down on their drinking.

As a result of the programmes launched in Russia to promote a healthy lifestyle and disease prevention, the life expectancy of the average Russian is expected to increase to 75.7 years by 2020. ■

# Confronting the tobacco challenge through packaging regulations

**Australia's tough stance on tobacco control has led to one of the lowest smoking rates in the world. The government's latest legislation, which will require tobacco products to be sold in plain packaging, has been challenged by the tobacco industry, but ministers are determined to stand firm**

By Tanya Plibersek, minister for health, Australia

Australia has long embraced an ambitious tobacco control agenda, one that will soon see all tobacco sold in Australia presented in plain packaging – a world first and another significant step in the fight against smoking.

Australia's journey to plain packaging is built on a multi-faceted approach to tobacco control, involving a mix of regulation, public education initiatives and support for those trying to stop smoking.

This approach has had a direct and positive impact on reducing the prevalence and harmful health effects of tobacco smoking.

Australia now has one of the lowest smoking rates in the world. The daily rate among Australians aged 14 years and over fell from 30.5 per cent in 1988 to 15.1 per cent in 2010. The Australian government, however, believes that any tobacco smoking is too much. While the smoking rate in the general population may be falling, this is not the case for disadvantaged groups, including Australian aboriginal and Torres Strait Islander peoples. Smoking continues to kill 15,000 Australians each year and costs Australian society \$AUD31.5 billion annually.

Plain packaging and an expansion of graphic health warnings on tobacco product packaging are logical and consistent next steps as part of Australia's comprehensive package of tobacco control measures.

Australia's low smoking rate is the result of sustained, concerted and comprehensive public policy efforts developed over a long period by all levels of government, supported by action from public health organisations.

These efforts have resulted in widely accepted tobacco-control measures. These include: excise increases; graphic health warnings on packaging; minimum age restrictions on purchasing tobacco products; comprehensive advertising bans; retail display bans; bans on smoking in indoor public spaces; extensive and continuing public education campaigns; and smoking cessation support services, such as telephone help lines.

In April 2008, the Australian government established the National Preventative Health Taskforce, a group of Australia's leading public health experts, to develop a preventive health strategy focusing on obesity, tobacco and the harmful use of alcohol.

In response to key recommendations in the taskforce's 2009 report, the government announced a reinvigorated approach to tobacco control, introducing even stronger measures, including:

- a 25 per cent tobacco excise increase in April 2010;
- an investment of more than AUD\$85 million in anti-smoking social marketing campaigns;
- legislation to restrict internet advertising of tobacco products in Australia;

- government subsidisation of nicotine replacement therapies and other smoking cessation supports; and
- record investments (around AUD\$100 million) in support for Australian aboriginal and Torres Strait Islander communities to reduce smoking rates.

The recommendations also included the introduction of plain packaging and updating and expanding of graphic health warnings.

## Plain packaging and health warnings

The implementation of plain packaging for tobacco products is one of the means by which the Australian government will give effect to Australia's obligations under the World Health Organization's Framework Convention on Tobacco Control (FCTC).

Plain packaging is recommended in the FCTC's Guidelines for Implementation. Article 11 requires parties to implement measures to ensure that packaging does not promote a tobacco product by any means that mislead consumers about its health effects. Article 13 requires parties to implement comprehensive bans on tobacco advertising and promotion.

Australia has already implemented graphic health warnings, banned terms such as 'light', 'mild' or 'low tar', as well as implemented comprehensive advertising bans.

Tobacco packaging is now one of the last remaining forms of tobacco advertising in Australia. Plain packaging is therefore a next logical step in implementing both these articles. In developing the Tobacco Plain Packaging Act 2011, the government consulted widely with the public, industry and retailer representatives and trading partners.

It relied on strong scientific evidence that packaging of tobacco products glamorises smoking, targets younger



demographics and women, and uses brand imagery and innovation to appeal to consumers in an effort to promote tobacco products.

Under the legislation, tobacco products manufactured or packaged in Australia for domestic consumption from 1 October 2012 will be required to have plain packaging, and from 1 December 2012 all tobacco products are required to be sold in plain packaging.

The legislation on plain packaging prohibits the use of logos, brand imagery, symbols, other images, colours and promotional text. Retail packaging will be required to appear in a standard drab dark brown in a matte finish. Products will still be distinguishable by the brand and variant name in a standard colour, position, font size and style.

In addition, from 1 December 2012 the new standard for health warnings will apply to all tobacco products supplied in Australia. The size of graphic health warnings will increase from 30 per cent to 75 per cent of the

from the tobacco industry. Australia faces several challenges to its legislation – constitutional challenges in the High Court of Australia, an investor-state dispute from Philip Morris Asia under the Australia-Hong Kong Bilateral Investment Treaty, and requests for consultations from other countries through the World Trade Organization.

#### Implementing measures that work

The Australian government is defending its right to implement plain-packaging legislation. It is confident that the measures will work and that they are consistent with the Australian Constitution and Australia's international legal obligations.

Australia's High Court heard arguments from all parties to the constitutional challenges in April 2012 and has now reserved its decision. During the High Court proceedings, one tobacco company asserted that the Australian government is acquiring its "billboard" by requiring plain packaging,

### The Australian government is confident that plain packaging will reduce the appeal and attractiveness of tobacco products. It will increase the noticeability and effectiveness of graphic health warnings

front of the pack for cigarettes and cartons, with the current 90 per cent warnings for the back of packs retained.

The size of graphic health warnings for most other smoked tobacco products will increase to 75 per cent of both the front and back of the pack, and single-sale cigars will no longer be exempt from displaying health warnings.

The Australian government is confident that plain packaging will reduce the appeal and attractiveness of tobacco products, especially to younger people. It will increase the noticeability and effectiveness of graphic health warnings and reduce the ability of retail packaging of tobacco products to mislead consumers about the harms of smoking. In the long term, as part of a comprehensive suite of tobacco control measures, plain packaging will help reduce Australia's smoking rates.

Not surprisingly, this ambitious agenda has drawn an intense reaction

demonstrating just how important branding is as an advertising tool.

In addition to the legal challenges, the tobacco industry has also employed other tactics, such as freedom-of-information requests requiring the government to examine hundreds of files and tying up significant funds and resources. Other tactics involve nationwide media and correspondence campaigns by the tobacco industry against the plain-packaging legislation.

The tobacco industry's reaction has confirmed what the legislators have always suspected: packaging remains one of the last powerful marketing tools for tobacco companies to recruit new smokers to their deadly products. The industry knows that plain packaging will remove this option.

We know, as does the tobacco industry, that plain packaging will work. The industry is fighting to protect its profits, but we are fighting to protect lives. ■



Australians have been discouraged from smoking through a combination of education and legislation

# Health 2020: leadership for health and well-being in 21st-century Europe

**In an increasingly interdependent world, the development of a common public health strategy in Europe draws on a wide range of expertise and offers an opportunity to pool the continent's knowledge in the pursuit of common goals**

By Zsuzsanna Jakab, regional director for Europe,  
World Health Organization

**"The challenges facing public health, and the broader world context in which we struggle, have become too numerous and too complex for a business-as-usual approach."**

Margaret Chan, director-general,  
World Health Organization

Over the past 18 months, the 53 countries of the World Health Organization (WHO) European Region have been crafting a new common ('business unusual') strategy for public health called the Health 2020 policy framework. Health 2020 has reached out to many different people, inside and outside government, to provide inspiration and direction on how better to address the complex health challenges of the 21st century. The

strategy is in its final consultation phase, with members, hundreds of non-governmental organisations and partners across Europe and beyond and will go to the regional committee for approval in Malta in September 2012.

Health 2020 is a value-based action-oriented policy framework, adaptable to different realities in the countries of the WHO European Region. It puts forward common policy priorities and recommendations for action that reflect the current state of health and health systems in the region and draw on the best evidence on solutions that work. These priorities acknowledge and build on the region's diversity as a source of knowledge and inspiration for solutions and innovation. The framework confirms the values of Health for All and identifies two key strategic directions with four policy priority action areas (see table 1).

Health 2020 aims to engage ministers and policymakers across government and stakeholders throughout society who can contribute to health and well-being. Many individuals, sectors and organisations can provide leadership. It takes many forms and requires creativity and new skills.

Groups of stakeholders are coming together to address key health challenges at global, regional, national or local levels, as in the global movement on HIV.

## A matter of leadership

Similar movements are emerging around non-communicable diseases (NCDs), environmental health and health promotion. We here at WHO understand that we have a special responsibility, together with countries, to exercise such leadership and to support health ministries in achieving their goals.

Active leadership from health ministers and public health agencies is at the centre of the new framework. Such leadership in the 21st century requires new skills, often using influence, rather than control. Much of the authority of health leaders in the future will arise not only from their position in the health system but from their ability to convince others that health and well-being are highly relevant in all sectors. While health systems differ considerably from country to country no matter what a nation's organisational principles, public health leaders are faced with similar challenges and opportunities.

In most countries, political and economic pressures on ministries of health have increased. The health sector itself is undergoing major change. While facing significant economic challenges – such as cost-containment, financial sustainability and increasing healthcare costs – health systems need to be reoriented, not only to respond to the complex needs of chronic

## 1. Health 2020's strategic objectives and priority actions

### Strategic objectives

Improving health for all, and reducing the health divide

Improving leadership and participatory governance for health

### Priority action areas

Investing in health through a life-course approach and empowering people

Tackling Europe's major health challenges of non-communicable diseases and communicable diseases

Strengthening people-centred health systems and public health capacities, and emergency preparedness

Creating supportive environments and resilient communities.

See [www.euro.who.int](http://www.euro.who.int) for the full Health 2020 text

The well-being of future generations is at the heart of public health policies



and non-communicable diseases, ageing and mental health, but also to be more efficient, transparent and accountable, more gender-responsive and more people-centred. New leadership and professional roles and skill sets are required (see table 2).

### Creating the right conditions

Health ministries are increasingly engaged in initiating intersectoral approaches for health and acting as health brokers and advocates. Their leadership role for health highlights both the economic, social and political benefits of good health and the adverse effects of ill health and health inequalities on every sector, the whole of government and the whole of society. Exercising this leadership role requires using diplomacy, evidence, argument and persuasion.

The health sector also has a partnership role in other sectors, when strengthening health can contribute to achieving their goals. All countries at the United Nations High-Level Meeting on the Non-communicable Diseases and the World Health Assembly have endorsed such collaborative approaches – referred to as whole-of-government and whole-of-society approaches. Health promotion and disease prevention programmes in particular often get embroiled in the sometimes ideological and political

debate over the ‘right’ balance among the respective responsibilities of the individual, the state and the market.

Creating the conditions for people to take control over their lives and for communities to maintain their social cohesion is at the core of Health 2020. There is now a wealth of evidence from decades of tobacco and HIV/AIDS control that shows that a mix of strategies, including various types of collaboration, is the most successful and viable approach.

The big health challenges of the next decade – economic instability, environmental threats, social changes and demographic shifts, the increase of NCDs and mental health challenges – mean that ‘business as usual’ is not an option. The equity gap is real and likely to grow, bringing additional costs to people, economies and governments. Leadership and innovation are vitally important. The Health 2020 framework and process provide a unique platform for joint learning and sharing of expertise and experience between countries.

Health 2020 recognises that every country is unique and will pursue these common goals through different pathways. They will use different entry points and approaches but be united in purpose. Political commitment to this process is essential, and countries have set regional targets to express this.

## 2. Leadership roles for health and well-being in the 21st century

Leading development of strategies at different levels with clear goals and targets relating to health

Ensuring high-quality and effective healthcare services

Developing core public health functions

Acting as health brokers and advocates

Driving actions across sectors

Communicating risk and customised information to different target audiences in rapid, accessible and trust-enhancing ways

In an interdependent world, the need for countries to act together becomes ever more important. Today, a complex array of global and regional forces challenge people’s health and its determinants. Although more people than ever before now have the chance to attain better health, no country can harness the potential of innovation and change or resolve the challenges to health and well-being in isolation.

The future and prosperity of the world will depend on the willingness and ability to seize new opportunities for the health and well-being of present and future generations. Health 2020 encourages health ministries to bring key stakeholders together in a shared effort for a healthier, safer, fairer and more sustainable Europe. ■



# Africa's priorities to achieve its goal for the development of better health

**The challenge for Africa is to work towards achieving its goals for reducing disease, strengthening health systems and controlling HIV/AIDS. This can be done by sustaining the health gains that have already been made and focusing on a number of priorities, putting health at the top of its agenda**

By Luis Gomes Sambo, World Health Organization  
Regional Office for Africa

**A**chieving the Millennium Development Goals (MDGs) would dramatically reduce the burden of disease. However, most African countries have not made sufficient progress, attributed to several challenges that need to be addressed: weak health-system performance, inadequate inter-sectoral collaboration on addressing the broad determinants of health, insufficient investments in the health sector, inefficient use of existing resources, and weak monitoring and evaluation capacity.

## Africa's health priorities

To sustain and strengthen health gains made thus far, Africa's health priorities could include:

- strengthening health systems – based on the primary healthcare approach – towards universal health coverage;
- addressing the challenge of women's and children's health;
- combating communicable diseases, particularly HIV/AIDS, tuberculosis, malaria, neglected tropical diseases (NTDs), and mitigating the risks of new pathogens and emerging diseases;
- intensifying the prevention and control of non-communicable diseases (NCDs);
- improving surveillance, preparedness and response to public health emergencies; and
- leveraging health promotion to accelerate response to the

determinants of health (water supply, sanitation, hygiene, food and nutrition) and risk factors (tobacco, alcohol, food, physical exercise and sexual behaviour).

To strengthen health systems, countries would be supported to implement the Ouagadougou Declaration on Primary Health Care and Health Systems in Africa, the Algiers Declaration on Research for Health, and the Libreville Declaration on Health and Environment. Countries would be supported to develop national health observatories that would feed information for decision-making into the African Health Observatory. WHO would advocate for sustained commitments on human resource gaps, taking advantage of new technologies, including e-Health, to accelerate the attainment of national and international health goals.

Guidelines and tools to improve access, equity and quality of care and services would facilitate the decentralisation process. WHO would support country efforts in developing training materials for building the capacity of health workers at peripheral-level health facilities to deliver an integrated package of essential health services. Support for developing universal health coverage would be developed through social health insurance, tax-based health insurance or a mixture of both.

WHO would work with international health agencies such as the GAVI

Alliance, the Global Fund to Fight AIDS, Tuberculosis and Malaria, PEPFAR and Harmonization for Health in Africa (HHA) to leverage global health initiatives to strengthen national health systems.

On women's and children's health, WHO would use the report of the Commission on Women's Health in the African Region to raise the issues on the political agenda of states and regional institutions. Countries would be supported to define a minimum level of services, such as family planning, safe deliveries by skilled birth attendants and appropriate referral systems. They would also be supported to revise national policies, norms and protocols using evidence-based standards, and to produce a skilled workforce for maternal and child health services. Support would be provided to accelerate the implementation of the Child Survival Strategy for the African Region and other relevant World Health Assembly and regional committee resolutions.

International health partners would continue to support scaling up essential services, namely, newborn care, infant and young child feeding, provision of nutrition services including micronutrient supplementation, immunisation, prevention of mother-to-child transmission (PMTCT) of HIV, malaria, deworming and integrated management of childhood illness including HIV.

## Health system approaches

With regard to communicable diseases, in line with strategies for preventing and controlling HIV/AIDS, technical support and capacity building would be sustained to increase the uptake of antiretroviral medicines, promote evidence-based approaches including primary prevention, PMTCT, counselling and testing as well as voluntary and safe male circumcision. Application of WHO norms on early treatment and



progressive use of treatment monitoring would be promoted. Laboratory strengthening to facilitate early diagnosis and treatment of HIV/AIDS, culture and drug susceptibility testing for tuberculosis, monitoring of drug resistance as well as quality assurance programmes would be supported.

### Tackling tuberculosis

Improved norms and guidelines for tuberculosis would be provided towards detection, implementation of Directly Observed Treatment Short (DOTS) courses, treatment supervision and follow-up. Effective identification and the treatment of multidrug-resistant and extensively drug-resistant cases, implementing the tuberculosis/HIV collaborative activities and engaging other service providers including the private sector would be promoted. Development and support for adapting tools and guidelines for surveillance, monitoring and evaluating programmes, would be undertaken, as would joint comprehensive programme reviews to ensure consistency with norms and standards.

For malaria, the focus would be on promoting the use of insecticide-treated nets (ITNs) and indoor residual spraying, and measures to address low uptake of ITNs. Parasitological diagnosis and early treatment, especially in children, is recommended. Advice on generating the evidence to determine the stages reached and appropriate actions to take within the control-to-elimination continuum would be provided. Research to assess the drivers of epidemics and impacts of interventions would be supported. Vaccine development programmes would be promoted along with the discovery of more effective medicines.

Several health system approaches have demonstrated that when governments and communities take responsibility, health programmes can be successful. WHO therefore advocates high-level political commitment of governments and engagement with partners to mobilise the resources to eliminate or eradicate NTDs.

WHO would facilitate the establishment of the African Public Health Emergency Fund to enhance

responses to human-created and natural disasters, including epidemics. To speed up the reduction of under-five morbidity and mortality, it would improve immunisation through strengthening systems and accelerating the introduction of life-saving new vaccines. In addition, polio should finally be eradicated, and a stepwise approach to eliminate measles by 2020 would be initiated.

Countries would be supported to implement existing strategies to control NTDs including zoonotic diseases. Operational research and research on developing more efficacious medicines and use of new treatment protocols would be sustained.

On NCDs, support would be provided for assessing the burden and trends of priority diseases including cardiovascular disease, cancer, diabetes, sickle-cell anaemia, mental disorders,

security, governance, education, gender, food security, nutrition and environment, including their impacts on health development and outcomes, underscores the need to address health determinants in Africa. The regional strategy for health promotion tackling inequities through addressing health determinants and risk factors such as tobacco, alcohol abuse, unhealthy diet, physical inactivity and risky sexual behaviour, would influence national policies and legislation aimed at multisectoral and community actions. Countries would be supported to develop and implement policies and strategies that promote health across government sectors, respond to gender and are based on human rights.

In addition, support for regional strategies on food safety and health, nutrition, health promotion, alcohol, tobacco, environmental health, adaptation to climate change, and poverty and health would be sustained.

### For malaria, the focus would be on promoting insecticide-treated nets (ITNs) and indoor residual spraying. Parasitological diagnosis and early treatment, especially in children, is recommended

injuries and disabilities, and to identify risk factors and major determinants. The evidence gathered would contribute to action plans for combating NCDs. Countries would be supported to implement the global strategy to prevent and control NCDs, regional declarations and strategies on NCD prevention and control, and regional strategies for combatting mental disorders, diabetes and cancer and other priority NCDs.

The United Nations General Assembly resolution on preventing and controlling NCDs provides the much-needed high-level political impetus to these regional strategies. It calls for a whole-of-government and whole-of-society effort to reduce exposure to common modifiable risk factors, create health-promoting environments, strengthen national policies and health systems, encourage international cooperation, strengthen national capacity for research and development, and improve country-level surveillance and monitoring systems.

The strong inter-relationship between health determinants such as economic development, peace,

### Leadership role

The thinking about Africa's health priorities should articulate the guidance provided by the World

Health Assembly and the WHO Regional Committee for Africa. Translation into action involves updating the WHO/AFRO Strategic Directions 2010–2015 and WHO Country Cooperation Strategies, and more clearly specifying WHO responsibilities at headquarters, regional offices and country offices. The leadership role of health ministers in countries and within WHO governing bodies is fundamental.

Progress towards achieving national and internationally agreed health goals is possible if states use health resources efficiently, and invest additional resources from domestic and external sources, ensure universal health coverage for priority interventions, and effectively address key risk factors and broad determinants of health. The international development partners complement government and community efforts to achieve health development goals. ■

*The views expressed in this article are those of the author and do not necessarily represent the policy of the World Health Organization or its member states*

# The 'O Generation': tackling the childhood obesity epidemic

**Measures are in place to confront the problem of poor diet throughout the world, and reverse a health trend that holds deep economic implications for future generations**

By Mirta Roses-Periago, director, Pan American Health Organization

**W**ith childhood obesity rates doubling or even tripling over the past 20-30 years in most countries, the next generation could become the 'O Generation'. Many gains in child health would be reversed if present trends continue. Paradoxically, this overweight and obesity phenomenon is often accompanied by micronutrient deficiencies and anaemia from diets that are dense in calories but poor in nutrients, combined with lower levels of physical activity. This situation holds deep economic implications, in addition to the health problem: if the next generation is more overweight, less fit and less healthy, it will not learn as well and will incur higher healthcare costs over a lifetime, in turn affecting productivity and efforts to achieve fiscal consolidation.

The Region of the Americas is already the world's most overweight. The Let's Move! campaign launched in the United States by First Lady Michelle Obama aims to reverse the epidemic of childhood obesity in a single generation through joint action across government departments, the business community and civil society.

This is an example of political leadership to safeguard the next generation. But the problem extends well beyond the United States: most countries in Latin America and the Caribbean, and indeed in much of the world, are also experiencing upward trends in childhood and adult overweight and obesity, which are increasingly concentrated

among the poor and less educated population sectors and thus are deepening social inequality.

Obesity is simply a subset of a much bigger problem, the largely silent epidemic of non-communicable diseases (NCDs) – namely, cancer, diabetes, heart disease and stroke, and chronic respiratory disease. Fortunately, the world is now rising to the challenge. The historic United Nations High-Level Meeting (UNHLM) held in New York in September 2011 placed NCDs on the development and economic agenda for all countries.

## Rising costs of healthcare worldwide

While the most rapid increases in these diseases are taking place in the low- and middle-income countries, those countries that are members of the Organisation for Economic Co-operation and Development (OECD) also face a heavy burden of NCDs and an ageing population with increasing health costs, which will serve to undermine their fiscal consolidation agendas.

The UNHLM declaration sets out objectives for NCD prevention and control, including:

- By the end of 2012, the World Health Organization (WHO) will have developed a comprehensive global monitoring framework and voluntary targets, and the UN secretary-general will have developed proposals for global partnership;
- By the end of 2013, the members of the UN will have developed or strengthened multisectoral national plans; and

- In 2014, the secretary-general will have to report comprehensively on progress.

Having an accountability architecture is key to the success of summits, by providing metrics and setting responsibilities for action.

Thus, the process that WHO is leading to develop an effective global monitoring framework that includes goals and targets that countries are able to realistically adopt, is a crucial step forward.

The current global monitoring framework includes measures of changes in outcomes and exposures and the national response. Proposed voluntary targets to be achieved by 2025 and currently under consultation with WHO members include a 25 per cent reduction in mortality between the ages of 30 and 70 due to cardiovascular disease, cancer, diabetes and chronic respiratory disease; reductions in risk factors such as hypertension (25 per cent), tobacco (30 per cent), salt consumption (30 per cent) and physical inactivity (10 per cent); and disaggregating all indicators by gender, age, socioeconomic position and other relevant stratifiers.

## Preventive treatment

Given the need for a multisectoral response to NCDs, a clear corollary of the UNHLM declaration is that achieving these targets will demand 'all-of-government' and 'whole-of-society' approaches that confront head on the enormous health and economic challenges involved. Governments bring to the table their stewardship and responsibility for public policy, regulation and taxation, both at national and at local/municipal levels. Civil society brings its local know-how, legitimacy, networking, advocacy and community education efforts. The business sector brings



Campaigners in the US aim to reverse childhood obesity in a single generation, through joint action with government, local people and business communities

products and services, technical knowledge and capacity, as well as obligations for social responsibility. Media outlets bring their ability to create awareness and mobilise.

The international financial institutions have a responsibility for contributing to support development, and NCDs are an undeniable obstacle to the continued development that they all want.

So, all hands are needed on deck to succeed in translating the UNHLM declaration into action in order to confront the NCDs epidemic. That is why the Pan American Health Organization has launched the Pan American Forum for Action on NCDs, with the participation of core partners such as the Public Health Agency of Canada, the World Economic Forum, the Spanish Agency for International Development Corporation, as well as other organisations.

The forum brings together government entities, the scientific and academic community, the business sector, international organisations and civil society – including faith-based organisations. Together they will raise awareness, help to promote innovative initiatives and scale up successful

practices for NCDs prevention and control, as well as promote health at all levels, whether local, national or hemispheric. This strategy is relevant to each and every country's ability to intensify action on NCDs.

The forum will serve as an example of multi-stakeholder responses to the epidemic, called for by the UNHLM, and will work to raise NCDs to the highest level of political attention nationally and regionally.

### **In many parts of the world, countries are experiencing upward trends in childhood and adult obesity, which are concentrated among the poor**

It will also build capacity for mobilising partners and resources and will develop strategic alliances to support effective NCDs prevention and control measures and the promotion of healthy living and well-being.

Taking into account a core set of low-cost, high-impact NCD 'best-buy' interventions identified by WHO, the

forum's initial focus will include: communication and advocacy, dietary salt reduction and healthy nutrition, the scaling up of cardiovascular disease preventive treatment, the control and prevention of cervical cancer, and promoting physical activity and healthy workplaces.

The world can no longer afford a 'business as usual' mentality regarding NCDs. Inaction would result in a staggering cost. Over the next two decades, the toll from NCDs will exceed \$30 trillion in healthcare costs, lost productivity and personal medical expenses.

### **Time to act decisively**

Tackling this challenge is, therefore, fundamental to fostering the well-being of every country's populations, alleviating the fiscal pressures caused by rising healthcare costs, and preserving and stimulating the nation's productivity.

The time has come for all world leaders to take advantage of this opportunity to act decisively now, by promoting and adopting an all-inclusive multisectoral approach to the problem, one which will succeed in dealing with the silent epidemic of NCDs. ■



# Shaping the future of health in the Eastern Mediterranean: the role of WHO

## Indicators of health across the World Health Organization's Eastern Mediterranean Region have been showing marked improvements in recent years, but major challenges remain

By Ala Alwan, regional director, World Health Organization  
Regional Office for the Eastern Mediterranean

**T**he health status of the populations of the World Health Organization's (WHO) Eastern Mediterranean Region is changing rapidly, driven by socioeconomic development and the evolving demographic and epidemiological transitions. Life expectancy increased by more than 12 years between 1980 and 2007. Fourteen countries are now considered malaria-free, 20 are polio-free and routine immunisation against vaccine-preventable diseases has been consistently above 85 per cent for the region for the past five years.

However, there are still major challenges to health. Under-five mortality is still high despite major achievements, and some countries in the region are still among those with the highest infant and neonatal mortality rates in the world. The regional maternal mortality ratio is also high. Protracted humanitarian emergencies and the complex dynamics of sociopolitical change affect much of the region, with almost 37 million people in 13 countries affected. Nearly a third of male deaths in the age group 15 to 59 years are attributable to injuries, 40 per cent of which are war- and violence-related and 31 per cent due to road traffic events.

The region is also affected by an epidemic of non-communicable diseases (NCDs). Over 60 per cent of the regional disease burden and over 50 per cent of mortality are now due to these diseases – mainly cardiovascular diseases, diabetes, cancers and chronic lung disease. The

changing pattern of morbidity in the region is aggravated by a seriously rising trend in the prevalence of risk factors. Overall, the prevalence of three key risk factors for NCDs – tobacco use, unhealthy diet, lack of physical activity – is high in most countries. Smoking among men is as high as 50 per cent in some countries. More than half of women are overweight. The Eastern Mediterranean and Americas regions have the highest rates of insufficient physical activity and diabetes.

### Regional challenges

In recent years, the region has witnessed the building of extensive modern networks of health infrastructure, an increasingly skilled health workforce and wide deployment of medical technologies. However, the gains are not shared evenly across the region and within countries. Individual countries differ widely in regard to the specific health challenges they face.

In health systems, inequities in health represent a major challenge, requiring clear vision and strategies to achieve universal coverage and equitable health financing policies. A long-term perspective for strategic health workforce planning is needed in many countries. There is a pressing need to invest and strengthen national capacity in human resources and appropriate information technologies. Health information systems require strengthening. A major challenge for the region is to scale up action to meet the Millennium Development Goals (MDGs) through health-systems strengthening.

In health promotion and disease prevention and control, the ability of countries to implement good public health practice and their capacity to target cost-effective solutions varies widely. Countries also differ in the extent to which they have implemented recommended strategies and committed to international health treaties and guidelines. The magnitude of unhealthy lifestyles and risk factors for NCDs continues to escalate at a rapidly increasing rate. Comprehensive programmes to prevent and control cardiovascular diseases, diabetes and cancers, the leading causes of morbidity and premature mortality, are still not in place in some countries.

Several serious challenges are also impeding regional progress towards communicable disease control. In some countries, the capacity for surveillance to detect outbreaks, evaluate programmes and project future needs is limited, and financial resources for strengthening and scale-up of communicable disease surveillance, prevention and control are inadequate.

Finally, despite an increasing number of major emergencies and crises in the region over the past five years, the level of emergency preparedness in the health sector remains inadequate in a substantial number of countries.

### Priorities for scaling up

WHO has an important role in addressing the region's health challenges. By working closely with member states, WHO in the region will focus on five areas have been identified for priority action between 2012 and 2016.

In health-systems strengthening, the Regional Office for the Eastern Mediterranean will aim to support countries in their initiatives to achieve universal coverage with quality health services. Collaboration will focus on the key elements of health-systems



strengthening, building national capacities in health governance and development of evidence-based national health strategies and plans; health financing; health information systems and research for health; health workforce planning, production, training and retention; health service delivery; and improved access to essential technologies and medicines.

### **Greater attention to the private sector**

Policies and plans need to target universal health coverage with affordable quality primary healthcare services that are financed through mechanisms that assure accessibility and protection from unaffordable expenditures. The role of the private sector will require more attention than it has been given up to now. While special emphasis will be given to normative guidance to enhance the contribution of the sector to universal health coverage, there is a need for providing strategic directions in regulating and monitoring its functions, practices and quality of services.

With regard to maternal, reproductive and child health and nutrition, special emphasis will be placed on countries with a high burden of maternal and child morbidity and mortality. WHO will promote a primary healthcare and life-course approach to maternal, reproductive and child health and nutrition in order to ensure universal coverage with evidence-based interventions to reduce mortality, and will support countries in strengthening vital registration and surveillance to monitor interventions and progress. Internal coordination and collaboration in the regional office will be strengthened, particularly in health information systems, health-systems strengthening, immunisation and improved access to vaccines, and externally with partners such as the United Nations Population Fund

(UNFPA) and UNICEF. The regional office will need to review its approach to capacity-building, and strengthen its own capacity at the country level to have positive impact on maternal and child health outcomes.

In the area of NCDs, the key direction is to focus on the implementation of the Political Declaration of the General Assembly on the Prevention and Control of Non-communicable Diseases. The priorities are, therefore, to advocate for higher levels of political commitment and multisectoral engagement, to provide technical support to member states in developing multisectoral plans and implementing the actions recommended in the declaration, and to develop monitoring frameworks including a set of national targets and indicators. The gaps that exist in surveillance of NCDs and their

### **Policies and plans need to target universal health coverage with affordable quality primary services**

risk factors need to be addressed. Work needs to be coordinated with the health-systems strengthening initiatives to ensure universal coverage with essential healthcare services for NCDs, particularly at the primary healthcare level. Policymakers require guidance on effective mechanisms for facilitating multisectoral action that is essential for the implementation of preventive interventions.

Support in communicable disease control will have to be prioritised in accordance with the particular needs of individual and groups of countries, focusing on achieving the disease-related MDGs and enhancing capacity for prevention and control of communicable diseases. WHO's priorities are to support the

establishment of integrated disease surveillance systems, advocate for more investment in immunisation programmes, and provide technical support for developing regional pooled vaccine procurement systems, improving data systems and establishing well-functioning national immunisation technical advisory groups.

To strengthen emergency preparedness and response, there are substantial opportunities to increase the involvement and the role of the health sector, and to enhance the level of its performance. Internationally adopted instruments, like the United Nations Inter-agency Standing Committee transformative agenda and the WHO emergency response framework recently endorsed by member states, can guide and facilitate the strengthening process. With the goal of increasing the resilience of countries to emergencies, disasters and other crises, and subsequently ensuring effective public health responses to risks and threats, a new set of strategic priorities outline the way forward programmatically. These include offering support to countries in developing clear policies and legislation in this area based on an all-hazard and 'whole-health' approach, and paying special attention to safeguarding health facilities and the health workforce in times of emergency. WHO will be expected to work with countries in the region to promote regional self-reliance in the area of emergency and crisis management and implement a systemic approach to the management of emergency events.

While the implementation of the strategic directions and response should be tailored to the individual needs of countries in the region, WHO is committed to the development and implementation of special initiatives to scale up interventions in countries that have the highest disease burden and have weaker health systems. ■

# South-East Asia's global health priorities and contributions in 2012

**International efforts have led to the eradication of several diseases in parts of South-East Asia. Spreading this success elsewhere can bring dramatic economic and social effects**

By Samlee Plianbangchang, regional director,  
WHO Regional Office for South-East Asia

**S**ince the beginning of this millennium, the world has passed through turbulent times with multiple crises on numerous fronts, which have affected the health of the people.

The global economic downturn, several natural calamities, the appearance and spread of new pathogens, such as severe and acute respiratory syndrome (SARS), influenza pandemics, the emergence of lifestyle diseases, the looming threat of climate change, rapid modernisation, inequities and inadequate access to health services and the availability of expensive – and at times difficult to afford – technologies, have severely challenged health systems.

Yet substantial progress has been made in promoting health and combating illnesses in the South-East Asia Region (SEAR) of the World Health Organization (WHO). The region comprises 11 member states – Bangladesh, Bhutan, North Korea, India, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka, Thailand and Timor Leste – and has an estimated population of 1.72 billion. The Guinea worm disease and leprosy have been eliminated from the region, and yaws stands eliminated from India. Due to unprecedented global efforts, poliomyelitis is on the verge of eradication. The last case from a country in SEAR was reported from India in January 2011. Similar success in Nigeria, Afghanistan and Pakistan should culminate in the glorious achievement of eradicating this scourge, making the world safer for children all over.

An effective public health response was mounted in 2009 in combating an influenza pandemic. SEAR countries had been preparing for an influenza pandemic since 2003. All countries had national influenza preparedness plans in place before the pandemic swept the region, and indeed the entire world. This demonstrated that preparedness always pays.

The influenza pandemic was the first Public Health Emergency of International Concern since the International Health Regulations (IHR) came into force in 2005. The voluntary, rapid and transparent sharing of information across national boundaries was critical in containing the influenza. It showed the IHR to be an effective tool for global health security.

## **Making communities healthy**

Ever since the Millennium Development Goals (MDGs) were articulated by the global community, SEAR has been contributing generously towards the global achievement of MDG 6, which pertains to communicable diseases. The prevalence and mortality of tuberculosis has declined by 39 per cent since 1990. The HIV epidemic is being contained, with a decline in the number of cases in India, Myanmar and Nepal, and a reversal in Thailand. Malaria deaths have also shown a significant decline. Extensive immunisation has reduced mortality due to measles by almost 50 per cent.

The region has also advanced its pharmaceutical and biotechnological manufacturing capacity. Among several





Testing the blood sugar levels of a patient. Non-communicable diseases such as diabetes are a growing problem

pharmaceutical products, SEAR is well recognised for its contribution of low-cost but quality antiretroviral drugs (ART) and vaccines against measles and meningitis to mitigate the impact of these diseases all over the world.

### **Vulnerability of developing countries**

The burgeoning burden of disease due to non-communicable diseases (NCDs) has brought a new paradigm for the health of the people in SEAR. The increase in NCDs is attributed to powerful global forces, demographic ageing, rapid unplanned urbanisation and the globalisation of unhealthy lifestyles. Developing countries have the greatest vulnerability and least resilience to NCDs. Between 1970 and 2005, the prevalence of diabetes has increased many fold in Indonesia, India and Thailand. Currently 55 per cent of all deaths in SEAR are due to NCDs. This translates into 7.9 million deaths every year, of which one-third are people under 60. This has far-reaching economic implications. SEAR has the highest level of out-of-pocket expenditure on health: the expenditure that can drive the spenders into poverty and the poor into a poverty trap. Primary prevention of NCDs and health promotion are key in averting this huge threat and must be undertaken in earnest.

The confluence of several facilitating factors, a teeming population and a host of socioeconomic parameters will always make SEAR a hot spot for diseases that can spread worldwide or influence the course of epidemics in 2012 and beyond.

Strong, well-managed and adequately funded public health systems and efficient intersectoral coordination – especially between human health and veterinary services, as well as planned urbanisation and the preservation of the environment, plus effective core competencies as enunciated in the IHR, will pre-empt the explosion of communicable diseases and facilitate global health security



by restricting the spread of diseases and protecting travel and trade. A full 3.5 million people continue to live with HIV in the region, half of them co-infected with tuberculosis; 60 per cent are still to be provided with ART. Each year nearly three million children under the age of five lose their lives due mostly to preventable conditions such as diarrhoea and pneumonia. Improving access to available simple and cost-effective interventions is the challenge in 2012. These interventions can reduce under-five mortality as well as the infant mortality rate in SEAR, which is two to three times higher in the poorest quintile than in the richest quintile. Those interventions can accelerate the achievement of MDG 4. Unfortunately, the regional situation related to MDGs 4 and 5 continues to be a cause for concern.

The achievement of MDG 6 is also threatened by the emergence and spread of antimicrobial resistance. This is considered the greatest threat in humankind's fight against infectious diseases including HIV, tuberculosis and malaria.

The impact of climate change on human health is yet to be fully understood and recognised. Climate change is the price paid for the economy-driven policies that ignored the planet's ecological health. Dengue fever and several other vector-borne diseases are spreading rapidly to newer areas. In 1960, dengue fever was seen in only seven countries of the world. By 2000 this number increased to 60. Climate change is incriminated as responsible for the occurrence of dengue fever in Bhutan and Nepal, which are above 1,200 metres above sea level. Climate change is expected to challenge food production, exacerbating malnutrition and acute water shortages, thus affecting the fundamentals of good health.

SEAR continues to be prone to natural disasters, with 62 per cent of global deaths due to natural disasters occurring in the region. This necessitates more sustained and advance planning and preparation. More than 600 million people in SEAR live in overcrowded and underserved areas. A quarter of them are estimated to be poor. Poverty breeds ill health and ill health in turn breeds

poverty. Poverty remains the number-one killer. The evidence generated by the Commission on Macroeconomics of Health conclusively showed that health is not only a fundamental right but can also be the driver for improving the national and individual economy.

Global economic crises adversely affect the health of the world's population. These crises lead to reduced internal allocations for health in countries. The financial support from developed countries also gets reduced. Budgetary allocations for health in most countries in SEAR continue to remain below the recommended level of five per cent of gross domestic product. Most is spent on curative medical care rather than on health promotion and disease prevention. While a lack of robust information and evidence hampers the formulation of effective health policies, weak professional public health capacity restricts their effective implementation.

### **Vaccines are the most cost-effective interventions to prevent diseases. Every child deserves the right to protection against six childhood killers using the basic set of vaccines**

Improvements in universal access to primary healthcare and assuring the quality of this critical concept of public health must be advocated as the foundation for any national health system. Awareness among communities of their health prerequisites needs to be heightened on a sustainable basis to promote community empowerment, leading to inclusive, healthy settings.

#### **Looking beyond the health sector**

Making communities healthy is not the sole responsibility of health ministries. There is an urgent need to advocate in the sectors beyond health to have them incorporate policies that preserve and promote health. The global leadership needs to galvanise efforts towards "health in all policies" or "healthy public policy".

Vaccines are the most cost-effective interventions to prevent diseases, reduce child mortality and minimise the overall burden of disease. Every child deserves the right to protection against six childhood killers using the basic

set of vaccines. Based on this tenet, SEAR has made 2012 the year for the intensification of routine immunisation.

The roadmap to improving the health of people in 2012 and beyond covers several actions. These include enhancing financial allocation, improving equitable access to quality health services – especially for women and marginalised sections of society – and assuring a responsive and strong health system, developing and deploying a health workforce for the efficient delivery of health services, and promoting research to understand the dynamics of disease. They also include discovering, developing and delivering solutions as well as scaling up appropriate cost-effective technologies, empowering communities, and establishing partnerships with private sector, non-governmental organisations and non-health stakeholders.

The international funding agencies have been providing critical resources. There is, however, a need to harmonise their contributions and to align these with national health policies. WHO's continuous leadership role within the global health architecture is to assure that health remains high on the global

agenda. Its role as convenor and coordinator for developing a global consensus on the broad structure, functions and regulations of health systems have been well recognised.

In modern times, WHO must also lead various development partners to align them with robust national health development policies and plans to pave the way to health for all. The implementation of these public health actions requires strong collaborative efforts from various developmental partners and stakeholders at community, national, regional and global levels.

The world will be a better place in which to live in 2012, and beyond, if preferential attention is paid to poor, underserved, vulnerable, underprivileged and marginalised people and communities. Health should be at the centre of all policies. People must be kept central to all health policies and these policies must emphasise health promotion and disease prevention. ■

# Health is not a commodity to be ransomed for the cause of austerity



**As the international community continues to struggle with the global economic crisis, leaders must find new ways to sustain investment in health**

**By Michel Sidibé, executive director, UNAIDS;  
under-secretary-general, United Nations**

**T**he world is undergoing rapid transformation. New and extraordinary geopolitical dynamics, patterns of growth, altered demographics and technological advances are solving old challenges and creating fresh ones. Across this landscape, fundamental new debates are emerging with profound implications for global health in the coming years. It is essential that ministers of health are actively involved in shaping this

future so that the lives of billions of people are protected and improved.

Against the backdrop of the persistent economic crisis, developed and developing countries alike face difficult choices as they implement austerity-oriented budgets. Development agencies large and small are confronting critical questions of how to reinforce country leadership, how to hold one another accountable for commitments made and how to deliver the greatest

value for money with public finances. Trade-offs have become very complex, requiring a focus on quick, measurable results, while also promoting the fundamentals of equity, human rights and systems strengthening.

The international community has started a debate over future development priorities in the form of a post-2015 agenda. Negotiations on 'The Future We Want' in preparation for the Rio+20 Summit in June 2012 already raise a red flag for the meagre and weak content of health issues in the draft outcome document.

The economic crisis, in addition to driving millions of people back into poverty, has also produced the first declines in development assistance since 1997. It threatens to dramatically reverse positive trends in development assistance for health. This slowdown has been particularly severe for the AIDS response, with global investments for AIDS falling by 13 per cent – from \$8.7 billion in 2009 to \$7.6 billion in 2010.

## Strategic approach

The world faces a deprioritisation of health masked by the logic of 'austerity' and endorsed by the mantra of 'scarcity'. The world must reject this. As Mahatma Gandhi memorably put it, "Earth provides enough to satisfy every man's need, but not every man's greed".

Priorities reflect values and principles. But in this period of economic stagnation, the value of good health and the principles of fairness, equity and solidarity are relegated to the status of commodities that society can no longer provide for all. In reality, however, health is an essential investment, not simply a product or service. To keep it high on the global agenda, these times require a more strategic, concerted approach, uniting national and worldwide leaders under a single purpose. Ministers of health are uniquely

positioned to promote this agenda. But they must exercise urgent and coordinated leadership in three areas.

First, they must foster a new debate about health financing. The global health community knows that ill health forms a stark barrier to economic growth, and that investments in health are essential to protect and promote national stability and security – even during financial hardship. Now we must convince the individuals and powers who are leading the austerity debate.

Current debates on budgets must be informed by the powerful evidence and arguments developed by the Commission on Macroeconomics and Health concerning the impact of good health on economic growth and productivity – and the crippling costs of inaction. There is extensive evidence that AIDS had a severe impact on labour participation and productivity across Africa, yet this situation dramatically improved when antiretrovirals became more widely available.

investments in health and AIDS are channelled through national budgets. This shift can create opportunities for increasing fiscal space and the use of innovative financing in the context of overall taxation policy.

At the international level, health ministers should urgently engage development partners in a dialogue to determine the optimal balance of development assistance and domestic funds, and to explore how ‘country compacts’, rooted in principles of mutual accountability and shared but differentiated responsibility, may be developed. The African Union has called for a roadmap for shared responsibility for the African AIDS response. This provides an opening for a broader discussion on sustainable health financing that, significantly, is led by governments in developing countries.

Second, health ministers must focus on high-impact health ‘wins’ while maximising synergies for broader health and development gains. They

### One ‘win’ stands out: eliminating new HIV infections in children and keeping their mothers alive. Better treatment regimens and a stronger commitment are making an AIDS-free generation a realistic goal

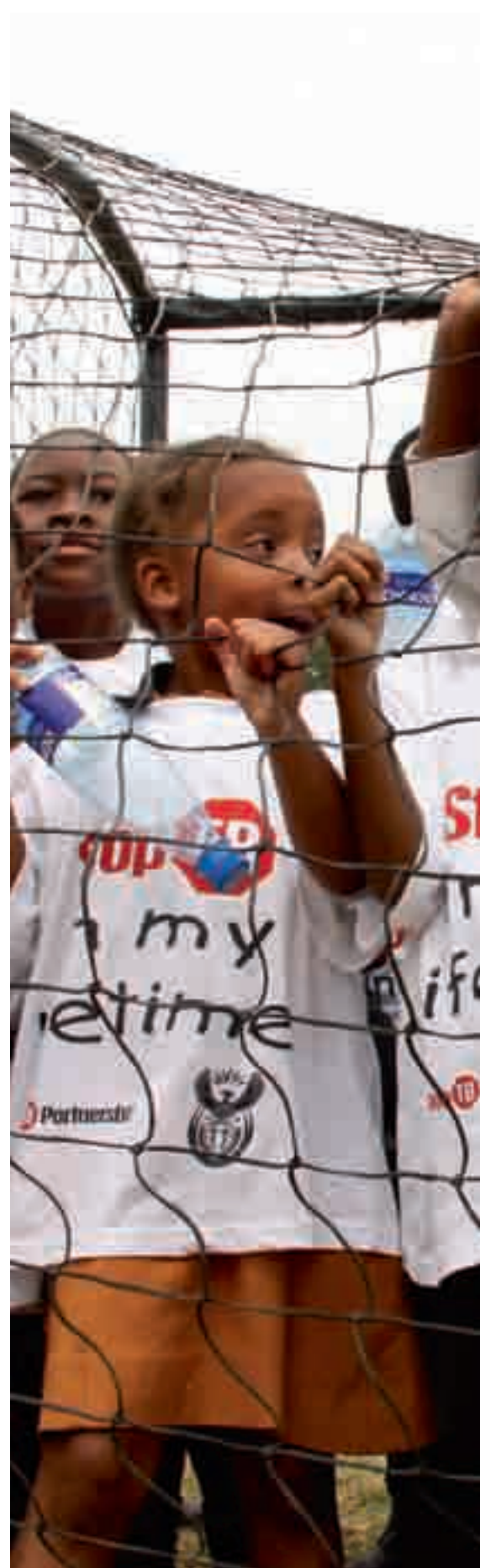
Even though domestic spending on health has seen marked increases in low- and middle-income countries in recent years, policymakers need to prepare for more moderate growth. Health ministers should spearhead a debate with their counterpart finance ministers on the financial sustainability of health programmes, particularly those that depend heavily on external resources.

#### Create opportunities

Dependence is particularly high for funding the AIDS response. In Africa, more than 80 per cent of all treatment costs are financed by international partners – most significantly, the Global Fund to Fight AIDS, Tuberculosis and Malaria and PEPFAR. For many developing countries, there is no quick-fix solution because they are not in a position to increase their domestic budgets rapidly. However, health ministers should insist that a greater proportion of international

must identify how best to target limited resources to deliver results. This requires innovative, evidence-based approaches and making financing channels more effective, especially to improve the health of women and children, as promoted by the United Nations Secretary-General’s Global Strategy for Women’s and Children’s Health. Investing in children’s health yields high economic returns. Evidence suggests that between 30 per cent and 50 per cent of Asia’s economic growth from 1965 to 1990 is attributable to improvements in reproductive health and reductions in infant and child mortality and fertility rates.

As 2015 approaches, one ‘win’ stands out – eliminating new HIV infections in children and keeping their mothers alive. Better, simpler treatment regimens and a stronger commitment to a comprehensive response are making an AIDS-free generation a realistic goal within reach by 2015. The Global Plan to Eliminate New Infections in Children







South African children participate in the launch of a global plan to stop tuberculosis, in Alexandra township, north of Johannesburg

and Keeping Their Mothers Alive is mobilising leadership and concerted action among 22 priority countries, with the broad support of donors, technical partners, people living with HIV and the private sector. The prevention of new HIV infections in children can further act as an entry point to advance maternal and child health services, such as identifying high-risk pregnancies; detecting tuberculosis, congenital syphilis and other sexually transmitted infections as well as cervical cancer; and actively engaging men and boys. This focus on impact can shift attention from process to measurable outcomes. Demonstrating returns on investment will garner the attention of finance ministers and the public.

Third, health ministers must make health programming more equitable. Tragically, the financial crisis is driving social exclusion and inequality to new heights. Social disparities, marginalisation, stigma and discrimination continue to block people's access to health services. This is particularly vivid in the case of HIV, but is equally pertinent for young people accessing sexual and reproductive health services and people living with disabilities. These forces deprive individuals and communities of opportunities and incentives to protect their health and to create healthy and secure futures for themselves and their children. The principle of the 'right to health' was central to the dramatic gains in improving people's access to effective antiretroviral drugs in low- and middle-income countries.

### Future generations

Activists, academics and renowned leaders around the world are now promoting a manifesto in support of a 'Framework Convention on Global Health'. Such a framework could represent a major step forward in realising the human right to health for all. Proponents of the manifesto are looking to ministers of health to support this charge as their legacy to future generations.

At present, the obstacles may seem insurmountable. Yet there can be no sustainable development without health, and no health without investment. If we do not make the case, the competing interests of others will dominate the great debates shaping our future. ■

# Trade and health: making synergy a practical reality

**Countries have to work together to ensure the world has access to up-to-date medical care. This is where trade comes into its own, opening up markets for vital medicines**

By Pascal Lamy, director general, World Trade Organization

**'S**ynergy' can sound like a management buzzword, too vague to have practical use. Yet at root it has a precise, technical sense that helps clarify how international rules and institutions can support public health policy: 'synergy' suggests diverse elements working together, achieving results that could not be obtained by individual actions.

Synergy is not merely desirable – it can be essential, even a positive responsibility. This surely applies to the diverse set of international factors, rules and institutions that have an impact on human health. Health is an essential public policy goal, reflected in human rights law as a right to the highest available standard of health. The need is fundamental in character; but the systems that respond to that need are unavoidably complex and multifaceted. Health represents the highest form of aspiration for international cooperation, and is a pressing issue in international policy debates. Yet actual health outcomes ultimately flow from concerted action at the grass roots level: practical steps to ensure the sick have access to effective clinical facilities that are supplied with appropriate technologies and medicines, and to ensure the application of necessary resources to sustain vital medical research and development.

International trade is undoubtedly part of this complex picture. For most countries, trade is a vital lifeline to essential medicines; self-sufficiency in medical supplies and equipment is not a practical or desirable option. Still

less can new and adapted technologies be developed and applied in isolation from international partners. The commercial environment influences such basic factors as cost and availability, a concern especially for developing countries. International trade beneficially stimulates competition, and competition reduces prices; openness to international trade offers a wider range of suppliers, and thus greater security of supply.

The international trade policy framework, shaped by the trade agreements administered by the World Trade Organization (WTO),

## Open and competitive tendering for government procurement of medicines helps ensure scarce funds go further

recognises that countries need regulatory space to take care of their citizens' health while curbing isolationist tendencies that would perversely hinder health programmes.

WTO agreements – touching on trade in goods and services, technical regulations and sanitary measures – foster beneficial trade in health-related products and services, while ensuring that necessary regulations and limitation measures are justified by health concerns. Openness to international trade does yield better health outcomes. High tariffs on

medicines, pharmaceutical ingredients and medical technologies affect crucial determinants of access. Trade policy settings, such as tariffs, and the economics of global production systems are also key factors in strategic plans to build domestic production capacity for medicines.

## Eliminating a tax on healthcare

A number of WTO members have chosen to open markets under the WTO Pharmaceutical Sectoral Initiative, which aims at full liberalisation of over 6,500 pharmaceutical products and inputs covering an estimated 79 per cent of global trade of these products – eliminating what is, in effect, a tax on healthcare. They also committed to a regular review of tariff elimination on additional pharmaceutical products. Further steps in that direction – such as a WTO sectoral initiative for open access to enhanced healthcare – would be a tangible contribution to improving health outcomes.

Ensuring that domestic regulations are not discriminatory and are founded on sound health policy is not a simple matter of complying reactively with WTO trade rules – it is a concrete means of leveraging improved opportunities for access to health products. Equally, the right of countries to determine the level of protection of health that they consider appropriate in a given situation was recognised in a key finding of the WTO Appellate Body in a case concerning asbestos. At a difficult time for national budgets, open and competitive tendering for government procurement of medicines and medical technologies helps ensure that scarce funds go further in meeting health needs – those countries that have elected to join the WTO's Agreement on Government Procurement have overwhelmingly opted to open up procurement of medicines and medical technologies to international competition.



For most countries, self-sufficiency is not an option when it comes to medical supplies and equipment

A decade-long international debate about patents and access to medicines has also highlighted the importance of a vibrant, competitive marketplace. Competition among innovative medicines to treat the same health condition in ever more improved ways drives research and development. Generic competition helps reduce pharmaceutical prices, which is why encouraging competition is part of the policy toolkit of many governments.

Exceptions to patent rights to facilitate generic entry have been confirmed in the application of WTO rules on patents. The patents and health debate has also affirmed that innovation is itself a crucial, integral contribution to health outcomes. It is of no use only to leverage improved access to a static stock of existing, proven medicines. The current array of medicines needs constant expansion and improvement, and past medical innovation has not effectively addressed major diseases endemic in the developing world.

### The fruits of innovation

The disease burden continues to evolve – policymakers have recently turned to the growing burden of non-communicable diseases in the developing world. New strains, and drug resistance, challenge the efficacy of existing vaccines and treatments. The current complex, but vital, debate over the role and proper balance of

intellectual property systems has illuminated how governments can work within the international legal framework to take positive initiatives both to sustain vital innovation and safeguard the public interest.

Since the WTO's creation in 1995, its rules in this area, principally the Agreement on Trade-Related Intellectual Property Rights (TRIPS), have been scrutinized closely, extensively debated and even litigated. This experience has shown how these rules serve as a sound framework for domestic intellectual property systems that enable beneficial innovation and promote the availability of the fruits of innovation. The landmark Doha Declaration on the TRIPS Agreement and Public Health in 2001 set WTO rules on intellectual property squarely in the context of public health: TRIPS was “part of the wider national and international action to address” grave public health problems afflicting developing countries. It encouraged institutional and policy synergies that have since been achieved through greater cooperation on public health matters between the WTO and its multilateral partners, notably the World Health Organization and the World Intellectual Property Organization.

The Doha Declaration captured the essence of the intellectual property and health debate in one succinct paragraph, recognising the importance of intellectual property protection for

the development of new medicines, but also concerns about its effects on prices. Since then, a richer debate has unfolded about innovation systems and the synergistic combination of those diverse factors – technological, regulatory, commercial, financial, infrastructural – to produce new, safe and effective medical technologies. How to innovate in the ways to innovate is a momentous issue in the international public health debate today – new ideas evolve and spur debate; established models of innovation and product development are under scrutiny. This vital debate is thankfully informed by a growing body of empirical data and practical experience.

The kind of synergies to work for and how diverse factors can be most effectively integrated will doubtless evolve and diversify, as policymakers seek new pathways for medical innovation and access. Yet there is already a sure foundation in the form of a transparent, open, competitive and non-discriminatory international trading system, built on rules informed by sound policy principles and guided by the practical experience of policymakers.

This multilateral framework is a firm base for concerted international action to address the demand for enhanced public health outcomes for all. Its principles simply need to be put into practice ever more effectively. ■



# Confronting challenges in maternal health: a human rights imperative



Access to proper care during pregnancy and childbirth improves the health of both babies and their mothers

**Women are still dying needlessly in childbirth, but the issue is not just a medical problem, it is the result of multiple unfulfilled human rights that must be tackled as a whole**

By Navi Pillay, United Nations High Commissioner for Human Rights

**T**he Millennium Development Goals (MDGs) set a target for reducing maternal mortality by three-quarters by 2015.

This is widely acknowledged to be one of the most off-track goals. It is also an issue with significant implications for a range of human rights.

The Human Rights Council stated in Resolution 11/8 that there are multiple human rights dimensions to maternal mortality, namely those related to the right to life, to being equal in dignity, to education, to health, to seeking, receiving and imparting information, to enjoying

the benefits of scientific progress, and to being free from discrimination.

In 2010, the Office of the High Commissioner for Human Rights prepared a report on preventable maternal mortality, morbidity and human rights for the consideration of the Human Rights Council.

Analysing the human rights dimensions of the issue, the report emphasises that maternal mortality is not simply a matter of public health, but is the consequence of multiple unfulfilled rights. The report highlights seven principles of a human rights-based approach to

maternal mortality and morbidity, namely accountability, participation, transparency, empowerment, sustainability, international cooperation and non-discrimination.

A woman suffering from chronic malnutrition, who lives in a slum without access to safe water and sanitation, and who does not have an education, is at a much higher risk of dying during pregnancy or childbirth. The same woman is at an even higher risk of dying if she is aged between 15 to 19, or has suffered female genital mutilation, an early or forced marriage, gender-based violence, or sexual exploitation.

She would be more exposed if she has HIV/AIDS or if she is discriminated against in her private and public life because she belongs to an indigenous group or because of her race, or for being an irregular migrant worker. In order to ensure that women and girls, including those in remote rural areas, have access

to family planning, skilled attendance at birth and access to emergency obstetric care without delays, public policies must address broader human rights issues, rather than simply deliver a set of technical interventions. A failure to do so will contribute to the continued loss of life that is entirely preventable.

### A broader issue of equality

Indeed, the human rights principles of equality and non-discrimination call for radical reforms in the legal and institutional fabric of a country in order to remove barriers that prevent access to basic services, to change social attitudes and to stop tolerating discriminatory practices in all spheres of life. States and policymakers need to adopt adequate measures to this effect.

From policy conception to implementation, it is crucial to collect disaggregated data on how different groups are affected by discrimination and exclusion and by policies aimed at alleviating these conditions. This information allows for the capture of discrepancies in the way the MDGs are pursued and their impact on different groups. To improve the quantity and quality of data, states must invest in strengthening their capacity for collecting, monitoring and evaluating information, as well as in bolstering statistical expertise.

Access to education and to information enables women to make informed choices with respect to nutrition and their sexual and reproductive lives, including family planning and the number and spacing of their children. Applying a human rights lens to issues relating to maternal health also requires a broad understanding of access, acknowledging that health services that are, in theory, accessible may not actually be available because of a lack of staff or unaffordable fees.

Participation and choice depend on states' accountability and on their willingness to make pertinent information available in clear and comprehensible terms. The oversight role of parliaments and the judiciary, as well as independent national human rights institutions, are also key in enhancing participation.

Whenever necessary, states must ensure that educational

tools are deployed and outreach strategies put in place to bolster awareness of public allocations and expenditures. Women's involvement in policy analysis, planning, and MDG costing exercises and expenditure tracking can greatly contribute to the development of national health systems in countries where social spending is low, health spending even lower and programmes on obstetric care are severely underfunded.

The establishment of the independent Expert Review Group to provide global oversight on the results and resources related to the United Nations Global Strategy for Women's and Children's Health and on progress in implementing the recommendations of the Accountability Commission is a very important development in holding states accountable for addressing maternal mortality. The accountability framework outlined in the report of the Accountability Commission is

### Applying a human rights lens to issues relating to maternal health requires a broad understanding of access, acknowledging that health services that are, in theory, accessible may not actually be available

grounded in human rights standards related to maternal health.

The human rights treaty bodies are also playing a vital role in holding states accountable for human rights failures related to women's rights and maternal mortality and morbidity.

In late 2011 the Committee on the Elimination of Discrimination against Women handed down a decision on an individual complaint against Brazil concerning the death of an Afro-Brazilian woman following complications during her pregnancy. The lack of access to quality healthcare services for Alynne da Silva Pimentel Teixeira and the lack of appropriate judicial remedies constituted violations of the Convention on the Elimination of All Forms of Discrimination against Women. This case was the first one on maternal mortality to be decided by a human rights treaty body. It sets an important precedent for state accountability for human rights violations related to maternal deaths.

My office has also collected good practices on applying a human rights-based approach to interventions to reduce maternal mortality and morbidity. These practices address five common features: enhancing the status of women; ensuring sexual and reproductive health rights; strengthening health systems to increase access to and use of skilled care; addressing unsafe abortion; and improving monitoring and evaluation.

With discussions about the post-2015 development agenda already under way, it is essential that the human rights dimensions of pressing public health issues be fully addressed in the international negotiations.

### Confronting the challenge

Understanding maternal mortality and morbidity as an issue of discrimination against women provokes a shift in how we design responses to this urgent issue. At the request of the Human

Rights Council, my office is preparing, in consultation with other UN agencies and leading experts, technical guidance on the application of a human rights-based approach to policies and programmes aimed at reducing preventable maternal mortality and

morbidity. This technical guidance will offer advice on operationalising the human rights principles. It will assist states in meeting their human rights obligations and preventing more needless deaths of women.

Effectively confronting challenges related to maternal health requires a holistic approach. Attempts to confine maternal health to technocratic or purely medical interventions will fall short because they do not adequately grasp the underlying factors of discrimination and exclusion.

As legally binding obligations, human rights are a powerful tool for addressing violations of women's rights leading to maternal deaths. Human rights also bring compelling moral arguments to discussions about maternal mortality and morbidity. It will be crucial to build upon the international consensus around maternal health as a human rights issue, and to place women's human rights at the centre of our responses. ■

# Migrant workers: healthcare for all

**The healthcare needs of the world's one billion migrant workers – both documented and undocumented – are at last receiving regional and international recognition, but much still needs to be done to ensure these vulnerable people are properly cared for by their host communities**

By William Lacy Swing, director general,  
International Organization for Migration

**W**ith more than one billion migrants worldwide, 214 million of them international migrants, every country and region in the world depends on the labour, skills and knowledge that migrants bring and on the estimated \$400 billion that they send home in remittances every year.

Globalisation, ease of travel and the viral spread of information have brought a new reality to the concept of a 'small world', with both positive and negative impacts on migrants, their communities of origin and their countries of destination.

## Hazardous working conditions

One of the challenges in today's increasingly mobile and interdependent world is to ensure migrants' safety and health throughout the migration cycle, from their place of origin, in transit, in communities of destination and on their return.

Different studies show that migration can expose migrants to ill health. When they leave their homes to work abroad, migrants are usually healthy and strong. However, over time, ill health can set in, especially among those who cannot access adequate healthcare and are exposed to unsafe working and living conditions.

The key barriers to migrants accessing health services include linguistic or cultural differences,

discrimination and anti-immigrant sentiment, a lack of affordable health services or health insurance, administrative hurdles, absence of legal status, and the extremely long and unsocial hours that migrants often work.

Furthermore, migrant workers are disproportionately affected by occupational accidents as they are often employed in high-risk and hazardous sectors such as mining, agriculture, construction or domestic work, in which a lack of safety equipment and protective measures makes them particularly vulnerable to accidents.

Low literacy, limited language skills and lack of enforcement of occupational health and safety standards are other key factors that increase their exposure to work-related injuries.

These risks are particularly acute among irregular or undocumented migrants, who are often forced to take on dirty, dangerous and difficult work to make a living in under-regulated sectors, such as domestic work or agriculture.

The potential health effects of migration are not limited to physical health, as long-term family separations and exploitative or abusive working conditions can also take a toll on many migrants' mental well-being.

The crisis in Libya in 2011 underlined the acute vulnerability of migrant workers, both documented and undocumented, who had few or no rights, including their right to health.

Many of the tens of thousands of African and Asian migrant workers whom the International Organization for Migration (IOM) assisted in 2011 recounted endless stories of exploitation, non-payment, beatings and theft of their money and possessions. Others witnessed the brutal killings of friends and fellow migrant workers.

Yet the economy of Libya and other countries in the Middle East and North Africa region will at some point need migrants to rebuild. Migrants are clearly an integral part of today's interconnected world.

Now is the time to call on governments to take action to ensure better migration management that will benefit both migrants and societies.

## Meeting migrants' needs

This is particularly needed for addressing the health needs of migrants. Governments should ensure that national health systems take into account the health needs of migrant workers and make health services available to them.

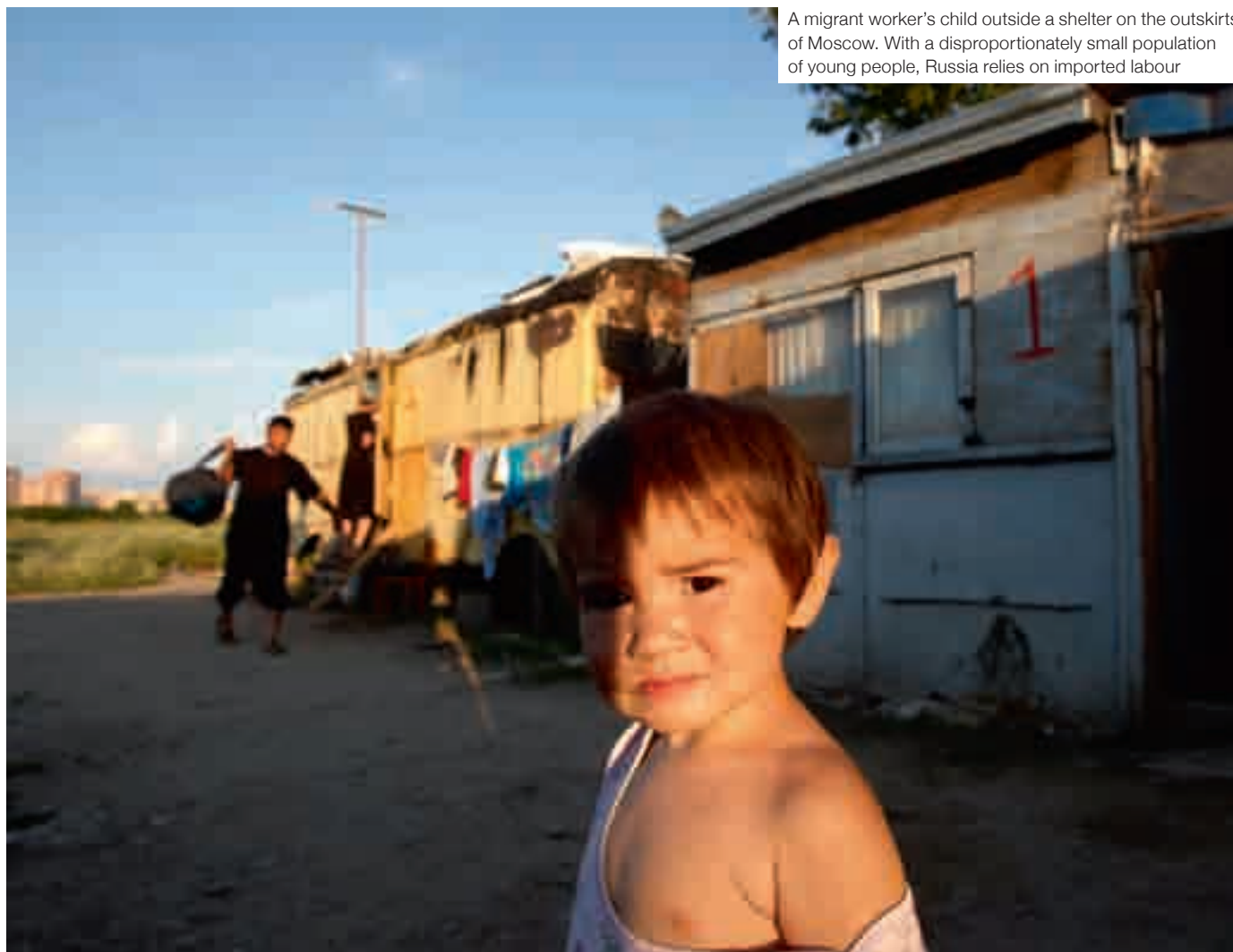
In the workplace, employers should offer migrant workers equal treatment with national workers with regard to safety and health protection, including measures to address occupational risks in sectors such as agriculture, construction, mining, services and domestic work.

Migrants should be encouraged to access health services in a timely manner, and governments should promote cost-effective primary healthcare for migrants. This could contribute to reducing health costs and would be in line with public health and human rights principles.

IOM is pleased to note that migrants' health is receiving increased attention at both global and regional levels. The 2008 World Health Assembly resolution on the health of migrants



A migrant worker's child outside a shelter on the outskirts of Moscow. With a disproportionately small population of young people, Russia relies on imported labour



has been instrumental in providing global recognition of the issue and furthering the debate at regional levels.

At the Fourth Ministerial Consultation for Asian Labour Sending Countries, which took place in Dhaka in April 2011, participating governments took a major step forward that could have a positive impact on the health of millions of Asian migrant workers. The adopted Dhaka Declaration recommends that countries 'promote the implementation of migrant-inclusive health policies to ensure equitable access to health care and services as well as occupational safety and health for migrant workers'.

For a region that, according to some estimates, sees more than 2.5 million people leave their countries each year to work abroad, the Dhaka Declaration is a clear recognition of the importance of migrant health.

In 2011, the European Parliament adopted a resolution on reducing health

### **Many migrant workers recounted stories of exploitation, non-payment, beatings and theft. Others witnessed the brutal killings of friends and fellow migrant workers**

inequalities in the European Union. It calls on member states to tackle inequalities in access to healthcare for undocumented migrants. This is a significant move towards ensuring equitable access to healthcare for all, with no discrimination linked to the administrative status or financial resources of migrants. IOM believes that this text carries an important message from the European Union to policymakers at the national level on the right to healthcare for undocumented migrants.

Nevertheless, as significant as these commitments are, there is an urgent need to turn these declarations and resolutions into concrete, tangible action. IOM urges leaders to indicate clearly to the rest of the world that providing equal access to health services for all not only is the right thing to do, but also makes good economic and social sense.

Migrants have proven time and again their positive contribution to the development of societies and economies. Their exclusion from health services and policies is a denial of the basic human right to health. It is also a misguided pandering to public fears and perceptions of migrants as a burden on social services.

This is an opportunity to take a bold step forward to ensure that Health for All does not become just another slogan, but becomes a real, shared responsibility among all countries of the world. ■

# Warning: harming the environment can be bad for your health

**The detrimental effects to the planet caused by human activity have been widely publicised, but the damage that such actions are causing to our health are less well known. By creating the conditions in which infectious insects can breed, old diseases have returned and new ones are emerging**

By Achim Steiner, under-secretary-general, United Nations; executive director, United Nations Environment Programme

It is well known that pollution can damage human well-being. But environmental degradation is increasingly recognised as having a link to the emergence of new and the re-emergence of old infectious diseases.

The recent movie *Contagion* documents the spread of a fictional virus from bats to pigs to humans. There has been longstanding concern that a globalised, interconnected world, with megacities and intercontinental travel, is fostering the conditions for a repetition of the kind of influenza outbreak that claimed more than 50 million lives in the great pandemic of 1918.

But increasingly, scientists are concerned that another factor is in play: environmental change. In the movie, it is environmental strain that causes the virus to make the inter-species leap in the first place.

Laurie Garrett, an expert in emerging diseases, teamed up with the screenwriter of *Contagion* to create a scenario that, while fictional, was scientifically plausible. The starting point was the true-life case of the Nipah virus, which emerged as a human disease in Malaysia in 1999, causing over 100 deaths. That, too, started in fruit bats and leapt to pigs before infecting the human population.

'Fruit bats are so stressed by the combination of apparent rising temperatures in the upper canopy of the rain forest and human encroachment

that they are increasingly going into human areas in search of food', says Garrett. 'They're starving, basically – and passing ancient viruses, via either their saliva or their urine.'

Other experts have linked the spread of Nipah virus into humans to deforestation, which forces bats into cities where fruit trees can still be found.

It is not just the emergence of new diseases as a result of environmental degradation that is worrying experts. In the last quarter century,

**Fruit bats are so stressed by the combination of apparent rising temperatures in the upper canopy of the rain forest and human encroachment, they are going into human areas in search of food**

the World Health Organization estimates, seven per cent of malaria cases in some parts of the world are attributable to climate change.

Degraded ecosystems can harbour malaria-carrying mosquitoes and even lead to mosquito population booms. In the Peruvian Amazon, bites from malarial mosquitoes are 300 times as common in deforested areas as in untouched woodland. Cleared areas allow the insects to live longer and breed

faster. Studies have shown that artificial fertilisers leaching into the water system create vegetation growth and a perfect habitat for breeding mosquitoes.

An even more stark case study emerged from the southern Indian state of Kerala. In the space of just a few weeks in 2006, tens of thousands of people reported fever, joint pains, nausea and diarrhoea. State medical officials confirmed 125 deaths from chikungunya, a previously little-known disease. Subsequent investigations revealed that the mosquito-borne virus arrived in Kerala because the ecosystems in the state's famous backwaters and lagoons had become so polluted that the natural predators were no longer able to keep the mosquito population under control.

The draining of wetlands is also cause for concern in regard to the spread of avian influenza. Migratory birds rely on these networks of natural freshwater for food and resting sites on their heroic journeys.

Today they are forced onto paddy fields and farm ponds, often putting them in direct contact with ducks, geese and other fowl that are part of the human food chain. This increases the risk of infectious diseases spreading from the wild into society.

A J McMichael, in the paper 'Environmental and Social Influences on Emerging and Infectious Diseases: Past, Present and Future', says that environmental factors have overtaken all other considerations in planning and predicting pandemics. This includes war, trade and travel, which were the key elements in the major outbreaks of the past.

'Nature is always trying out new genetic variants', concludes McMichael. 'Ecological niches open and close; human society's defences wax and wane. Environmental and ecological change, local pollutants, the widespread loss of top predators, economic and

Technicians spray an anti-mosquito treatment in woodland following an insect-borne disease outbreak in France



social changes, and international travel, which drives a great movement of hosts, continue to change the profile of infectious disease occurrence, affecting pathogens across a wide taxonomic range of animals and plants’.

The United Nations Environment Programme (UNEP) has identified a number of environmental factors that can increase the risk of epidemics. These range from climate change (which has been linked to the spread of malaria and cholera, among other diseases), to road building (which encourages the bush-meat trade, allowing more opportunities for diseases to leap from animals to humans).

#### **Effort from all sections of society**

Ironically, some of the early successes of the new science of epidemiology in the 20th century are now thought to contribute to the growing menace of an environmentally caused pandemic. Medical interventions have been

unable to keep up with all infectious diseases because many disease-causing agents and vectors have developed resistance to available drugs and pesticides. Resistance to antibiotics has been fostered by their overuse or misuse medically and in animal husbandry.

Because environmental change in many cases plays a major role in the emergence and re-emergence of infectious diseases, environmental policy can have a significant impact on the incidence and cost of these diseases.

Areas of potential environmental policy action are very wide-ranging, covering many fields and potentially affecting the incidence of many diseases. They include protection of land, air, water and natural habitats, and regulation of industrial chemicals and pesticides use.

Effective disease prevention requires an effort from all sections of society: environment, public

health, industrial, agricultural and urban policies need to be developed and implemented in concert.

These efforts should occur in the context of existing national and international activities including those focused on global climate change and reversing the rate of loss of biodiversity.

In June, governments meet in Brazil, 20 years after the Earth Summit of 1992. One of Rio+20’s overarching themes is a green economy in the context of sustainable development and poverty eradication.

There are many reasons why the world needs to find a pathway towards a more intelligent development path.

Perhaps understanding the links between the accelerating environmental changes sweeping the world, and the rising risks to human health, could be the powerful and compelling trigger that will catalyse today’s generation of leaders to fulfil the promises and aspirations of a previous one. ■



# Too poor to pay for treatment? The race to beat disease and reach those in need



A nurse holds a vial of vaccine at an outreach point in Ghana. Immunisation is crucial in the fight against child mortality

**The economics of health in the intensely competitive world of the pharmaceutical industry, set against the need to ensure vaccines and treatments are available to everyone, is at the heart of the debate over access to medicine**

**By** Christian J Wichard, deputy director general,  
global issue sector, World Intellectual Property Organization

**P**romoting the health of all its citizens is a primary function of any government. The right to the highest attainable standard of physical and mental health is not only a human right, but, as Sir Thomas More observed in *Utopia*, is a precondition to the enjoyment of all other things. It is for that reason that UN member states,

in agreeing on the eight Millennium Development Goals, chose to focus three of them directly on health outcomes.

## **Battling nature's innovators**

Unfortunately for governments, human beings are not the greatest innovators on the planet. That title should go to the viruses, bacteria and parasites

that prey upon us. In the arms race between disease and cure, human beings are usually one step behind. Diseases prove themselves to be very difficult to eradicate, with the notable exceptions of smallpox and, hopefully soon, polio and guinea worm.

So, if humans are to develop new vaccines, diagnostics, therapies and devices for treatment, they need to be at least as agile as the diseases they are trying to tackle. Governments are facing significant funding constraints, and will require lower-cost healthcare, at the same time as society is demanding more effective, targeted tools for diagnosis and treatment.

Innovation, bringing to the market timely and effective treatments to improve the health of the population,

has to be a priority for governments. Creating a policy environment where innovation can flourish is an outcome that all governments should be looking to create. Intellectual property (IP) is a powerful encouragement towards, and framework for, this innovation.

One critical component of an effective innovation framework is IP protection, which provides a powerful tool for stimulating innovation. The IP system enables the rapid mobilisation of a diverse array of resources to develop new ways to tackle the healthcare needs of populations. It stimulates investments in solutions to health challenges, by enabling innovators to commercialise the fruits of their efforts if successful, ensuring a balance between the incentive to innovate and the diffusion of the social benefit of the innovation.

Striking that balance in the field of health is an extraordinarily difficult challenge because it involves attempting to resolve contradictory realities – the realities of health economics, the economics of innovation and the intensely competitive world of the pharmaceutical industry, as well as the need to ensure that vaccines, diagnostics and treatments reach those in most need and not just those with the greatest ability to pay. This is the heart of the access to medicines debate. Intellectual property, being a market-based mechanism, has all the advantages that markets bring, but also all of these shortcomings.

### Successful examples

How can governments best ensure that the virtues of the IP system, rapidly mobilising a diverse array of resources to create new ways to tackle the healthcare needs of the population, are not compromised by market failures? Market failures are created most notably

when populations are too poor to pay for potential treatments for the diseases afflicting them. Some point to the so-called 10/90 gap, where 10 per cent of the world's diseases attract 90 per cent of the world's research and development (R&D) and while 500,000 people die each year from neglected tropical diseases (NTDs), it is estimated that only \$1 out of every \$100,000 invested in biomedical R&D is spent on NTDs.

A number of instruments have been developed in recent years to address the problem of market failure. Public-private partnerships are one such instrument, with the public and private sectors aligning their respective interests to create new ways to approach medical research and development, as well as creating new ways to deliver healthcare. There are a number of successful

**While 500,000 people die each year from neglected tropical diseases, it is estimated that only \$1 out of every \$100,000 invested in biomedical research and development is spent on fighting them**

examples of such partnerships, including the Meningitis Vaccine Project, launched to respond to the need for a better vaccine for epidemic meningitis, the Global Fund to Fight AIDS, Tuberculosis and Malaria, and the GAVI Alliance to strengthen immunization systems among many others.

In October 2011, the World Intellectual Property Organization (WIPO) launched WIPO Re:Search. This new platform brings together public- and private-sector partners, with the aim of overcoming the hurdles to innovation in this crucial area. WIPO and BIO Ventures for Global Health, together with the world's leading pharmaceutical firms, have created this new consortium, through which public- and private-sector

organisations around the world can share valuable intellectual property, compounds and know-how with the global health research community in order to spur them into research and development for new drugs, vaccines, and diagnostics by offering royalty-free licenses for proprietary information.

### Balancing policy

The changing landscape emphasises the need for empirical approaches to the policy task of determining the point of equilibrium in the balance. In Geneva, the directors general of the World Trade Organization (WTO), the World Health Organization (WHO) and WIPO have initiated cooperation between their three secretariats for this very purpose of encouraging an empirical approach and for bringing to

bear, within that empirical approach, the different policy perspectives of trade, health and innovation.

The policy balance between encouraging innovation and ensuring the widespread enjoyment of the social benefit of innovation in the field of

health will always be a high-wire act for governments, at the intersection of economics, health and innovation policy in a fiercely competitive market environment. Staying on the tightrope without losing balance is critical for an innovative health sector that advances the fight against disease and illness and, of course, our most fundamental desire, the enjoyment of good health.

Intellectual property is part of the answer, but there is no simple legislative fix. Legislation has its function and place – but equally, if not more important, are the complex interactions of practical cooperation, essential in the achievement of the balance between creation and the diffusion of its social benefit. ■

# Improving the negotiating process in preparing for an influenza pandemic

**Many health threats facing the world today know no boundaries – viruses do not recognise borders. The challenge for policymakers is to find a common approach, given countries' differing social and economic resources**

**By** Juan José Gómez Camacho, ambassador of Mexico to the United Nations in Geneva

**A**t seven o'clock in the morning of Saturday 16 April 2011, after 22 hours of non-stop negotiations, Ambassador Bente Angell-Hansen of Norway and I declared the Pandemic Influenza Preparedness Framework approved. Months of complex, controversial and highly sensitive negotiations had come to a successful conclusion. Here I explain, from my own experience and point of view, why and how it was accomplished and what the lessons are for global health negotiations.

**Multilateral negotiations often have either technical experts with a limited understanding of diplomacy and politics and diplomats with a very poor technical understanding**

Globalisation is a concept that often seems to have lost its full meaning. This is perhaps the expected result of its trivialisation or of the fact that it is now part of the ordinary landscape. Whatever the case, globalisation is what best defines today's times: namely an era of frontierless, interconnected, socioeconomic phenomena as opposed to sovereign, isolated, self-contained ones.

Fields that exemplify this are abundant; however, health is one area

that neatly captures the full concept of globalisation. Likewise, in order to fully grasp and successfully address health challenges and threats, no time or effort should be wasted in embracing the international nature of globalisation.

Throughout history much has been written about influenza viruses and pandemics. Influenza viruses have a limitless ability to spread, multiply, infect and kill human beings globally. This results in a critical political reality, in addition to incurring obvious human, social and economic costs. It renders irrelevant, both materially and practically, the national origin of the virus as well as any sovereignty considerations.

Indeed, once a pandemic is in full swing, its threat becomes genuinely global, and the damages and losses can unequivocally affect all of us. Unlike other international situations where perhaps 'zero sum' approaches could be plausibly applied, in health – and particularly in pandemics – such a notion would be utterly self-destructive.

This fundamental conviction guided the vision and work led by Ambassador Angell-Hansen and myself.

## **The process, logic and inner workings**

Multilateral intergovernmental negotiations, and indeed the negotiation process in general, are not mechanical, predictable processes – even if diplomats may believe them to be or behave as if they were. Multilateral negotiations are, primarily and

fundamentally, human interactions. Hence, together with government's positions and stated interests, there is a complex mesh of emotions, psychology and ideology that quietly but effectively play a prominent role.

To build an effective process, therefore, a real sense of collective endeavour and purpose must be instilled in the decision makers, negotiators and other legitimately interested parties.

This is done by developing a firm recognition of principles that thus help to create a deeper sense of responsibility, a more sophisticated interpretation of long-term national interests, courage and, ultimately, political will.

It is also accomplished by ensuring a thorough technical understanding of the phenomenon (how viruses behave, how are they identified, the role of laboratories and the World Health Organization (WHO), how antivirals and vaccines are manufactured by industry and what is it required to do so, how the industry functions, etc.) and by establishing a government-led, multistakeholder-inspired process.

## **Technical knowledge and understanding**

Multilateral negotiations of this nature often have either technical experts with a very limited understanding of diplomacy and politics and diplomats with a very poor technical understanding of the subject in hand.

Instead of combining the strengths of both, often the opposite happens, thus widening the gap of perceived differences. So rather than creating value for all, a clash of seemingly opposing interests emerges. To correct this, we worked with the ambassadors in a joint effort to improve our technical education.

The more we jointly learned about all aspects of pandemics – nature, consequences, solutions – the more politics, mistrust and ideology



gave way. This became not only part and parcel of the process but, more importantly, its mentality.

Another issue concerns the global pharmaceutical industry, which triggers strong political and ideological views. Nonetheless, in the face of the massive challenges posed by the threat of pandemics, governments must recognise that this industry is not only a legitimate actor, but also a critical and much-needed one.

The pharmaceutical industry, for its part, needs to recognise that the manufacturing and trading of antivirals and vaccines, without which in times of pandemics millions of people would die, bring major social and ethical responsibilities. As in the interaction among governments, in the interaction between governments and industry, a zero-sum approach would lead everyone to lose.

Keeping these grave considerations in mind, Ambassador Angell-Hansen and I engaged in informal and private individual conversations with the chief executive officers of major pharmaceutical companies involved in manufacturing vaccines. These encounters turned out to be a fascinating confidence-building and mutually educating experience.

Gradually and critically, we all began to speak the same language. Soon thereafter, meetings between ambassadors and representatives of industry and non-governmental organisations were held, pursuing the same single purpose: mutual understanding.

### Reaching agreements successfully

This process allowed for a fairly common understanding of the challenges and what was required to address them from all angles, be it the needs of least-developed countries, developing countries or developed countries to prepare and

Easier communications today mean that a pandemic could become truly global



react effectively, collectively and cohesively; the needs of industry to be able to manufacture affordable antivirals and vaccines and to make them truly accessible and effective; or the needs of the WHO laboratory network to enable it to expand its coverage and operation globally.

To achieve all this while maintaining the spirit of the common goal, a 'package' approach was taken. We tried to build a system with multiple pieces.

Each piece had a relatively independent value but, as part of the system and in interaction with one another, the pieces became powerful far-reaching solutions.

Negotiating to confront global challenges is the art of construction: to have the ability to understand the legitimate interests of each country, each region and each stakeholder and to have the skills to translate them into common goals and collective value. This is what we managed to do. ■

# Global risks, environmental solutions: how the world can help to heal itself

**As the long-standing causes of death in the developing world are slowly eradicated, non-communicable diseases and injuries will pose an ever greater threat. Adopting the preventive public policies of developed countries can help to protect the global population from these risks**

By Thomas A Farley, New York City Department of Health and Mental Hygiene

**G**lobalisation integrates much more than economies. People have become accustomed to the rapid flow of information, ideas, money, products and services across borders. But uniting the world into one global business network generates similar health benefits and risks across countries. So, increasingly, the disease profiles of countries are converging.

For decades, the leading causes of death in the world's richest countries have been chronic diseases – such as heart disease, cancer, chronic lung disease and diabetes – and injuries. Lower-income countries suffered far higher mortality rates from diarrhoeal diseases, respiratory infections and malaria. As these countries install the infrastructure of clean water and sewage systems, improve housing conditions and establish economies that can feed their citizens, their mortality rates from infectious diseases plummet and they are left facing the non-communicable diseases (NCDs) and injuries of their richer neighbours.

## Preventing NCDs and injuries

In India, NCDs now account for 53 per cent of deaths; they account for 82 per cent in Egypt and for 83 per cent of deaths in China – nearly as much as the 87 per cent in the United States. An estimated 72 per cent of cancer deaths globally occur in low- and

middle-income countries. If the national health challenges of the last 200 years were quelling infectious disease epidemics, then the global health challenges of the 21st century will be reducing rates of NCDs and injuries.

All governments will have to deal with the treatment of these health problems. As more people develop heart disease, cancer and chronic lung, liver and kidney disease, they will make ever-increasing demands for medical care. There is a risk that the demand will be so great that governments will divert spending on essential infrastructure in an attempt to meet it. It would be a mistake, though, for governments to respond to NCDs only by attempting to meet the demand for treatment, because these health problems are just as preventable as infectious diseases.

The key risk factors for common non-communicable diseases are well known. Smoking causes both cardiovascular disease and cancer. Unhealthy diets (such as those high in calories, saturated and trans fat, and sodium) lead to obesity, diabetes, hypertension and heart disease; physical inactivity increases the risk of those conditions as well. Air pollution increases the risk of chronic lung and heart disease. Alcohol consumption increases the risk of interpersonal, self-inflicted and unintentional injuries. These risks are already global and are increasingly prevalent in

low- and middle-income countries.

In Africa, nine per cent of adults smoke, and in India, 25 per cent of adult males do. One quarter of adults in China and two thirds of adults in Mexico are overweight or obese.

How to reduce many of these risk factors for entire populations – leading to dramatic improvements in health – is also known. In New York City, with its eight million inhabitants, the prevalence of smoking has been reduced by more than one third and the consumption of cigarettes by more than a half over the last decade, preventing an estimated 1,500 deaths per year already and some 50,000 deaths over the next 40 years. The key to altering these risks is recognising that, like the risk factors for cholera or malaria, ultimately they stem from the environment. Cholera strikes populations with inadequate sanitation systems, and malaria attacks those living near mosquito breeding sites. Smoking is a plague caused by the marketing of tobacco, including placement in convenience stores and advertising of all types. This plague can be reversed by smoke-free air policies, taxes to increase retail tobacco prices, limits on advertising and promotion, graphic pack warnings and counter-advertising.

## Government intervention

Similar government policies that alter modern environments can have similar effects. Alcohol consumption and the injuries caused by it can be reduced with taxes and sales restrictions. Diets will be healthier if government food policies incentivise the production and sale of fresh produce rather than commodity crops and processed food, and if the use of unhealthy ingredients – such as trans fat, salt and sugar – are restricted. People will be more physically active if transportation policies incorporate physical activity into designs. Road traffic injuries can be reduced by



Installing the infrastructure of clean water and sewage systems has enabled lower-income countries to reduce mortality rates from infectious diseases substantially

automobile safety requirements, better road design, speed limits and mass transit infrastructure. Gun violence can be reduced by restrictive gun-permitting laws. Air pollution can be controlled through emission controls and the use of cleaner energy sources.

More important, the actions required to produce a dramatic reduction in risk factors and mortality, unlike medical care, are not necessarily costly. Smoke-free air laws cost the government essentially nothing, and may save government funds through reductions in medical care for sick smokers. Some of the most effective policies – most notably cigarette taxes – can actually generate substantial government revenue. This revenue can be used for the health-promotion actions that do carry a cost, such as counter-advertising, while still leaving extra for other government needs.

Far more than funding, public policies to prevent NCDs and injuries require political resolve. If the adversaries in the days of cholera were merely unsanitary conditions, which did not have a political constituency, the

adversaries today are industries that profit from selling unhealthy products. Today the tobacco industry, having been fought at least to a stalemate in many high-income countries, is taking advantage of weaker governments in lower-income countries, with devastating consequences to the future health of those countries' citizens. Other industries sell products that are not nearly as toxic as tobacco but contribute to such problems as the global burgeoning of obesity; these too are resisting government efforts to protect their citizens from aggressive marketing.

In many countries, though, governments are successfully taking bold political steps to prevent NCDs.

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**The principle behind tobacco control can be applied to other health risks: protecting citizens from modern environmental dangers, including the marketing of unhealthy products**

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The greatest progress has been in the fight against tobacco. Since 2007, 22 low- and middle-income countries, from Turkey to Mauritius, have passed comprehensive smoke-free air laws. Seven low- and middle-income countries have passed tobacco advertising and sponsorship bans. Egypt, Mexico and Ukraine have passed large cigarette excise taxes. New York's experience is that although these moves can be controversial at the time they are taken because of industry resistance, once implemented they are extremely popular with citizens.

These successes by themselves will prevent millions of deaths. Even more, though, they illuminate a pathway to prevention for countries that are only just being exposed to NCDs and injuries. The principle behind tobacco control can be applied to other health risks: protecting citizens from modern environmental dangers, including the marketing of unhealthy products. This principle is the key to addressing today's global health challenges in a world of limited resources. ■



# Taking control of tobacco: nations unite to address a growing health concern

**A framework convention to curb the use of tobacco has become one of the most rapidly and widely embraced treaties in the history of the United Nations. With more than 80 per cent of Parties adopting tobacco control laws, or strengthening existing legislation, expectations are high**

**By** Haik Nikogosian, head of the Secretariat of the WHO Framework Convention on Tobacco Control

**P**ublic health instruments have been under constant development and renewal for many decades.

Globalisation and the growing impact of transnational factors on health have accelerated the demand for and the development of new public health instruments aimed at broad international coverage and compliance.

## Radical and creative measures

The WHO Framework Convention on Tobacco Control (FCTC), the first international treaty negotiated under the auspices of World Health Organization (WHO), has a unique place in this development. In the late 1990s, the global tobacco epidemic had become a public health challenge that called for radical and creative measures, triggering the first use of WHO's constitutional treaty-making power. After three years of negotiations, it was adopted by the World Health Assembly in May 2003 and entered into force in February 2005. Since then it has become one of the most rapidly and widely embraced treaties in the history of the United Nations, acquiring more than 170 Parties to date.

Expectations from the WHO FCTC as a new type of public health instrument have been understandably high. The seven years after its entry into force have indeed seen major progress.

At the national level, more than 80 per cent of Parties have adopted tobacco control laws or have

strengthened existing legislation after ratifying the Convention. This underlines the special role played by national legislation in translating treaty obligations into national action. At the international level, the principal treaty bodies – the Conference of the Parties and the permanent Secretariat – are established and fully functional. Key implementation tools, such as the first protocol and several guidelines covering more than 10 articles of the Convention, have been adopted or are in an advanced stage of development. In addition, support to Parties in meeting their obligations is gradually being put in place through a variety of tools and mechanisms such as provision of legal and technical assistance, convening of needs assessments, facilitation of expertise and technology transfer, and promotion of access to internationally available resources.

Work undertaken so far in relation to the WHO FCTC underscores the new features and opportunities linked to the treaty as a new type of public health instrument. First, the Convention elevated the creation of national multisectoral coordination mechanisms, generally a key but challenging feature of national public health action, as a legal obligation under the treaty. Likewise, reporting on implementation, another key feature for international public policy instruments, was established as a binding obligation. This enables a stable monitoring and



review system of global implementation progress, based on a biennial reporting cycle established by the Conference of the Parties. More than 85 per cent of Parties have reported on the progress in implementation, most of them more than once.

The FCTC also recognises that protection of tobacco control policies from the interests of the tobacco industry is an important obligation of the Parties. This aspect of the Convention has since become an important public health tool, binding but also strengthening governments in counteracting the challenge posed by the tobacco industry.

Finally, technical and legal cooperation and the transfer of expertise and technology among the Parties are key elements of the



Agreement has been reached on a draft protocol on illicit trade in tobacco products, with many Parties ready to take action

approach in the development of public health instruments. It also provides a new legal dimension to international health cooperation and a model for an effective response to the negative effects of globalisation on health. As such, the Convention has marked a landmark in public health. In a further development of the treaty approach, the Intergovernmental Negotiating Body established by the Conference of the Parties has now reached agreement on a draft protocol on illicit trade in tobacco products. Once adopted by the Conference of the Parties, it would become the first protocol to the FCTC and an international treaty in itself. The portfolio of legally binding instruments in public health may therefore expand, this time under the umbrella of the parent Convention.

### **Success depends directly on the leadership, vision, courage and political will of governments, civil society and international organisations to meet a growing public health challenge**

There should be little doubt that the international health instrumentarium of the 21st-century will further grow and develop, with binding and voluntary instruments alike, to address the changing landscape of public health.

One important lesson from the WHO FCTC is that success depends directly on the leadership, vision, courage and political will of governments, civil society and international organisations to meet a growing public health challenge. This is also a lesson to be remembered as the new century unfolds, with its own new challenges to public health. ■

treaty implementation regime. This exchange has substantially boosted intergovernmental cooperation in combating the global epidemic.

#### **A major risk factor**

Recent developments have underlined the new opportunities linked to the FCTC. The Conference of the Parties called for a close integration of the implementation of the Convention within the United Nations Development Assistance Framework as a strategic direction. Work in this regard has already started internationally. Consequently, at the request of the UN Economic and Social Council (ECOSOC), the recent special meeting of the UN Ad Hoc Interagency Task Force on Tobacco Control reviewed the potential of the UN interagency

cooperation mechanism to address the needs arising from implementation of the FCTC. Using the potential of the UN interagency cooperation mechanism and Development Assistance Framework at country level – a recognised feature of the work of many international treaties – will further support the work of the FCTC and its role in promoting public health. This is also linked to the implementation of the political declaration adopted by the UN General Assembly's high-level meeting on the prevention and control of non-communicable diseases (NCDs) in September 2011. The pioneering work of the FCTC, as the first treaty addressing a major risk factor for NCDs, will no doubt strengthen the evolving international framework in this area. The FCTC represents a new

# Violence against healthcare: a global concern

**Access to medical care may be a right protected under international law, but in many modern conflicts healthcare staff are now facing the threat of violence themselves**

By Jakob Kellenberger, president,  
International Committee of the Red Cross

**A**t the beginning of March 2012, Syrian authorities gave permission to a joint team of the International Committee of the Red Cross (ICRC) and the Syrian Red Crescent to enter the Baba Amr district of Homs to respond to the humanitarian needs there.

The situation was known to be very serious, and getting worse, with people unable to access food and water, or obtain medical care. A fleet of ambulances with medical personnel stood ready to evacuate the wounded, the seriously ill and the dead. The ICRC reiterated its call to all those involved in the violence to ensure at least a two-hour cessation of fighting daily to allow the prompt delivery of humanitarian assistance. Yet several days after permission was given to enter Baba Amr, the team was still prevented from accessing the district, unable to help those in urgent need. It may never be known how many lives were lost and how much suffering was caused as a result.

The case of Baba Amr – just one area of the numerous towns and cities affected by fighting in Syria alone – received considerable international media attention. Yet most incidents that in one way or another deny the right of wounded and sick people to healthcare go unreported. The scale of this problem in armed conflicts and other situations of violence around the world is alarming.

Ambulances or hospitals are in some cases directly targeted, killing

or wounding healthcare staff and patients. Earlier this year mortar shells hit the ICRC-supported Keysaney Hospital in the Somali capital, Mogadishu – a facility clearly marked with the red crescent emblem. While no one was injured or killed, previous incidents at the same hospital have caused deaths and the disruption of services.

In many more cases, health workers are harassed or threatened by fighters, sometimes seeking to obstruct treatment for their wounded enemies or demanding supplies.

**A single violent incident against healthcare infrastructure or workers can have immeasurable long-term repercussions on entire communities with war-related or chronic health problems**

Ambulances are deliberately blocked from accessing wounded people or held up for hours at checkpoints.

In sum, a blatant disrespect for the neutral status of healthcare facilities, transport and personnel has become all too common.

Over two and a half years, starting in 2008, the ICRC documented and analysed hundreds of violent incidents affecting healthcare in 16 countries where it operates. The results of the study – published in

2011 – show that while the number of recorded incidents is striking, these represent only the tip of the iceberg.

A single violent incident against healthcare infrastructure or workers can have immeasurable long-term repercussions on entire communities with war-related or chronic health problems. The bomb blast that killed two doctors and many medical students at a graduation ceremony in Mogadishu in December 2009 resulted in much more than a tragic loss of life. It also represented the loss of many thousands of potential medical consultations per year in a country where healthcare infrastructure and services were already under persistent stress.

Beyond the impact of specific incidents, the general insecurity created by armed conflict or violence – while hard to measure – undoubtedly has a massive impact on the provision of healthcare. Studies suggest that vast numbers of people in the Democratic Republic of Congo have died from diseases that are easily treatable because insecurity arising from the armed conflict has seriously hampered access to treatment. The flight of health personnel can also be catastrophic: Iraq's health ministry has reported that 18,000 of its 34,000 doctors fled the country between 2003 and 2006. In Afghanistan and Pakistan, insecurity due to fighting has impeded the vaccination of hundreds of thousands of children against polio. Such disruptions and obstacles can be just as deadly as overt attacks for all the wounded and sick who never manage to reach the help they require.

Violence against healthcare facilities and personnel is clearly illegal under international law. The Geneva Conventions and their Additional Protocols set out the right of the wounded and sick – combatants and civilians alike – to





Regardless of the circumstances, the only priority of medical staff is to attend to the wounded

be spared further suffering during armed conflict and to receive timely assistance. Accordingly, healthcare facilities, personnel and transport have a protected status as long as they retain a neutral function and treat all patients equally, irrespective of political, religious or ethnic affiliation.

Protective symbols such as the red cross, red crescent and red crystal clearly identify medical installations, transport and personnel. Furthermore, all parties to a conflict are obliged by law to search for and collect the wounded after battle and to facilitate access to healthcare facilities.

### The wider human cost

In situations of violence other than armed conflict, international human rights law stipulates that states must refrain from deliberately withholding or delaying healthcare to the wounded and sick in life-threatening circumstances, and that everyone has a right of access to essential healthcare facilities and services on a non-discriminatory basis.

Whenever the use of force is unavoidable, law enforcement officials must ensure medical assistance to

those affected as early as possible. The overriding problem is the widespread lack of respect for these laws by parties to conflict and armed groups. This issue requires urgent international attention. When protective symbols are blatantly ignored, physical protective measures such as sandbags and bomb-blast film on windows can have only a limited effect.

The real challenge is to develop methods of preventing violations from happening in the first place. To achieve this, awareness must first be raised of the terrible human cost of violence against healthcare. A culture of responsibility must be established among all concerned.

Primary responsibility for this issue lies with states and with combatants. In addition, national legislators and courts must fulfil their responsibilities of ensuring that domestic legislation recognises the criminal responsibility of those who violate international humanitarian law and of actually enforcing such legislation. Perpetrators of violations must be held accountable.

The ICRC, for its part, works at all levels to create an environment of respect for international humanitarian

law, both during conflict and during peacetime, and for the wide range of humanitarian activities it carries out in the field, often in partnership with national societies. The 31st International Conference of the Red Cross and Red Crescent, held in Geneva in November-December 2011, saw the adoption of a far-reaching resolution on 'healthcare in danger' that demands an effective response from states, national societies and the healthcare community at large.

The resolution calls upon the ICRC to initiate consultations with all major stakeholders in order to identify and agree upon concrete measures for making the delivery of healthcare safer in dangerous situations worldwide.

This is an important step towards ensuring that violence, both real and threatened, against healthcare workers, facilities and beneficiaries is more widely acknowledged to be one of the most serious yet neglected humanitarian concerns today. The more the urgency of this issue is recognised and its humanitarian consequences deplored, the less excuse those responsible for safeguarding healthcare will have for inaction. ■

# Tackling health inequities: the work of the Red Cross and Red Crescent

**Although a great deal of progress has been made in improving access to healthcare, some of the poorest communities are still not receiving basic services**

By Tadateru Konoé, president, International Federation of Red Cross and Red Crescent Societies

**M**any of the Millennium Development Goals (MDGs) aimed at improving the health of women, children and the poor will be largely, if not fully, achieved. These achievements are clearly a success story for the international and national public health communities.

However, these global achievements disguise what remains the reality of inequitable access to basic health services for many. Many low- and middle-income communities are not yet on track to achieve the MDGs. Even in developed countries, there are still disparities among communities that lead to dramatic personal suffering and hamper an effective public health response.

Many of the systematic differences in health are judged to be avoidable by reasonable action. Reducing health inequities is an ethical imperative for us all.

## Contributing factors to inequities

Individuals are marginalised because of their ethnicity, gender or sexual orientation, or because they are struggling with a serious illness. We must work to minimise cultural obstacles to access and to reduce the stigmatisation and fear of criminalisation that drug users, sex workers or undocumented migrants face.

All mothers, caregivers, children and elderly people are entitled to receive our attention and care,

regardless of their ability to pay or to access health services.

In 2011, the International Conference of the Red Cross Red Crescent – which every four years brings together the International Red Cross and Red Crescent Movement and all states that are signatory to the Geneva Conventions – adopted a resolution to eliminate health inequities.

It “strongly encourages States and calls upon National [Red Cross and Red Crescent] Societies to work together and commit to action in the following

authorities. They offer governments and decision makers their collaboration for the benefit of vulnerable communities around the world and in order to contribute to resilience at local, community, national and global levels.

More specifically, National Societies are committed to bridging gaps between communities and health facilities and between pre-pregnancy and child care, and to improving access to prevention, treatment, care and support to women and children as well as adolescents and young adults who would otherwise have limited or no access.

National Societies are already using their status as auxiliaries to their public authorities at all levels to engage in dialogue, review existing health plans and, where necessary, to advocate for equity. As they continue to establish and improve links with governments and civil society organisations, they monitor and evaluate progress towards

**As a community of health practitioners and humanitarians, we cannot sit on our laurels following some successes in the health-related MDG targets. We must understand that significant health inequities remain**

three key areas, articulated to guide a needs-based and strategic approach to health inequities: 1) provision of health-care services, 2) promotion of knowledge and 3) commitment to gender equality, non-discrimination”.

With its worldwide network of 187 National Red Cross and Red Crescent Societies, the International Federation of Red Cross and Red Crescent Societies (IFRC) is well placed and committed to tackle the real threats that individuals and communities in situations of vulnerability confront.

National Red Cross and Red Crescent Societies operate at grassroots levels while being auxiliaries to their national

equitable health, including access to and quality of reproductive, maternal, newborn and child health, as well as the health of adolescents and young adults.

Another source of health inequities are non-communicable diseases (NCDs). Indeed, the impact of NCDs is greater in poor communities, as disadvantaged populations are at greater risk as a result of unhealthy lifestyles and unfavourable environments. At the United Nations High Level Meeting on Non-Communicable Diseases in September 2011, the IFRC advocated for community-based prevention of the leading chronic diseases. However, the global health community will be

Survivors of the 2007 Peruvian earthquake receive help from Red Cross Red Crescent



unable to prevent communicable and non-communicable diseases while marginalised populations remain excluded from basic health services.

The IFRC urges governments and decision-makers to act decisively to reduce health inequities by addressing the underlying factors and creating an enabling policy environment with more capable health systems.

### **Tackling gender discrimination**

Tackling health inequities also requires commitment to gender equality and non-discrimination. Women must play a far greater role in decision-making and men must take on more of the

responsibility linked to sexual activity and fatherhood. The IFRC encourages governments to adopt the principle of equity in legislation and public policies, and to lead by example in ensuring children's rights by considering the needs and rights of children in programme and policy-making.

Meanwhile, the Red Cross Red Crescent will continue to promote and encourage greater social inclusion through anti-discrimination programming and advocacy for ending violence against women and children.

As a community of health practitioners and humanitarians, we cannot sit on our laurels

following some successes in the health-related MDG targets.

We must understand that significant health inequities remain around the globe and seek to do all we can to improve the conditions of daily living through community-based health programming that builds the resilience of communities and individuals alike.

The IFRC, with all its members, is determined to partner with national governments and health organisations to tackle the health issues of today and tomorrow, and to eliminate health inequities by reaching out to more vulnerable populations and marginalised groups. ■



# Child nutrition leads to global growth: advancing maternal and infant health

**Good nutrition and proper healthcare are crucial in the first 1,000 days of life if a child's full potential is to be realised, and special programmes are targeting this critical area**

By Kevin J Jenkins, president and CEO, World Vision International

**E**very year, the lack of good nutrition contributes to the deaths of more than 2.5 million children under the age of five.

It stops tens of millions more children from growing up healthy and strong.

Only recently have we acknowledged the full impact of malnutrition on almost every aspect of a child's life – and on his or her nation. It contributes to poor educational outcomes, lower lifetime earnings, weakened economies and reduced opportunities to escape poverty. In a world with more food than it can use, we are starving children of their dreams.

There are solutions to the worst health threats facing babies and infants. We know how to support parents and caregivers so that children receive the care they need. Therefore, it is unthinkable not to do all that is possible to help every child receive that care.

World Vision is working with partners in thousands of communities across nearly 100 countries to emphasise nutrition and health in its development activities.

I pledged that World Vision would invest \$1.5 billion in this area in the five years following the launch of the United Nations' 'Every Woman Every Child' campaign in 2010.

This has translated into huge investments in health and nutrition for children, pregnant women and mothers. The impact is felt where our reach is greatest – in the most vulnerable communities. At the same time we have advocated widely for sustained funding and better health

systems through our 'Child Health Now' campaign. At the height of the Horn of Africa food crisis at the end of 2011, I saw for myself that good nutrition is not just about a lack of food, but about enabling children to get the right food, health support and care at home.

I met Chaltu Begna, a 25-year-old mother of three, whose two-year-old Megersa had been saved from starvation. In her case, there simply had not been enough to eat. Relief food bridged the gap.

That same day I saw a development project in which local leaders had learned how better, balanced diets for children improved school

**To get adequate food, health and care practices is the birthright of every child. But it requires the careful application of knowledge. The global and national health architecture will have to change**

attendance. This, they agreed, protected girls from early marriage.

I spent time with mothers who had received microfinance loans and whose business success meant they were able to access healthcare and add vegetables and fruit to their children's meals.

Those three different approaches will have a huge impact on all the children they reached, because each includes good nutrition as a component. A child's first 1,000 days

– from conception to the age of two – determines the course of his or her life.

Without the right food and nutrients during this critical growth period, vital functions are affected. As the brain's growth is impaired, movement and thinking skills are compromised. The child's body matures more slowly, and the ability to fight illnesses is reduced.

Malnutrition turns easily prevented and treatable diseases, such as diarrhoea and pneumonia, into killers. It also makes it harder for those who survive to thrive and prosper. By having the right nutrients available – and encouraging parents to provide them – children can be spared from much of that harm.

Many countries are eating far better than they did just 20 years



ago. They have vastly improved the quality and coverage of healthcare systems. But the problem that remains is stubborn – sometimes just in pockets of people within a country.

To get adequate food, health and care practices is the birthright of every child. But it requires the careful application of knowledge on a wide scale. The global and national health architecture will have to change. That will take political will – which is still surprisingly lacking in some countries.

As a commissioner on the 2011 World Health Organization's (WHO) Commission on Information and Accountability on Women's and Children's Health, I experienced firsthand the difficulties of putting plans in place to reach those with the least access

to existing health systems. I also found tremendous grounds for optimism.

New approaches and technologies can produce practical solutions to global health problems. World Vision is among several organisations experimenting with mobile telephones to provide health support in remote communities, for example.

Our work should not just be well meaning, but must be informed by evidence. A growing library of research now guides our approach to malnutrition and considerable global momentum is building.

The Scaling Up Nutrition (SUN) movement emerged from this trend. It asserts that nutrition is the responsibility of national leadership and unites 200 organisations in support. It

promotes proven interventions in an unprecedented effort to create global commitment for measurable action.

### Launching 'The Best Start'

We invited David Nabarro, the UN Secretary General's Special Representative on Food Security and Nutrition, and the driving force behind SUN, to launch World Vision's own research contribution, 'The Best Start', in New York in 2011. David has provided excellent leadership to SUN, and we wanted to show that World Vision's efforts are aligned in support of the global movement.

We have placed technical experts in the Nutrition Centre of Expertise, linked to learning centres worldwide, to help link global momentum with results on the ground. These centres are rooted in practical work in poor communities, providing a unique resource for the global nutrition movement. The research and findings they produce will be freely available.

This year's World Health Assembly presents a ground-breaking opportunity to capitalise on the progress being made in global and national efforts on nutrition, by establishing the very first 'Comprehensive Implementation Plan on Maternal, Infant and Young Child Nutrition'. It will provide a clear action plan with time-bound targets for member states. It will outline how their international partners, led by WHO, can improve progress and results.

Our hope is that all parties will endorse the plan and put it into action. It will lead to coherence in our efforts to strengthen health systems and multiply our effectiveness in promoting good child nutrition.

Achieving this goal is everybody's business. By addressing the root causes of poor health and malnutrition, we can rise to our generation's challenge of providing health, hope and a brighter future to every child in the world. ■



In the Horn of Africa in 2011, the crisis was not only the lack of food for children but also whether the right type of food was available

# Creating global health: a role for national public health associations

**In the battle to achieve adequate healthcare for all, non-governmental organisations can take the lead, providing communities with the opportunity to make healthy choices**

By James Chauvin, president,  
World Federation of Public Health Associations

**A** robust dialogue on global health is needed to engage both politicians and citizens alike in defining a strategy to address the threats to the health and well-being of nations, regions and the world and to find a national consensus on the principles, values, intent and direction of global health action.

Such a global strategy could define necessary action on problems that directly or indirectly threaten national populations, as well as how a state can contribute to progress on global health. More importantly, it would highlight the interface between global and local. In today's world, what we do locally affects us globally – and what happens globally affects us locally.

Can national public health associations lead in proposing the development of a 'national global health' strategy? This question is personally highly relevant as my two-term as president of the World Federation of Public Health Associations (WFPHA) has just begun. The WFPHA is the only global civil society organisation representing the world's public health community. Created in 1967, its members include more than 60 national and regional public health associations and regional associations of schools of public health, as well as several academic and health-oriented institutions or organisations. The WFPHA advocates for a strong civil society voice and the active participation of national public health associations and

allied groups in national and global discussions and decision-shaping for evidence-informed, effective public health policy and practice.

## Health begins at home

Public health creates conditions in which people can live healthy, productive lives. The opportunity for people and their communities to be healthy, productive and resilient starts long before they need medical care. By starting where health begins, at home, at school, in workplaces and in communities, opportunities arise for people to make healthy choices within health-supporting environments, regardless of their income, education, ethnic background or where they live. By preventing injury, disease and sickness, public health helps mitigate disease burdens and associated costs.

National public health associations are the unique non-governmental, politically independent voice for public health. In some countries, they are its only voice. The past four decades have witnessed the expansion and the maturing of the global public health association community. From

**National public health associations are the unique non-governmental, politically independent voice for public health. In some countries, they are its only voice**

a handful of countries in 1967, there are now public health associations in more than 80 countries. Their number continues to grow.

Public health associations have an impressive impact on policy advocacy and on public health programmes and practice.

Several have played leadership roles in tobacco control, by influencing governments' decisions to ratify and apply the Framework Convention on Tobacco Control (FCTC), the world's first public health treaty, and by successfully promoting smoke-free workplaces and healthcare facilities. Many have focused on public health education and training, the expansion, quality and access of health services such as immunisation, health services for mothers and children, water supply and sanitation, solid waste disposal, the introduction of insecticide-treated bednets before their use became widespread, the prevention and control of infectious and non-communicable diseases, the prevention and treatment of HIV and AIDS, and access to essential medicines.

## Taking on unpopular causes

Several have championed politically unpopular causes, even arguing successfully for a public health approach to safe facilities for those who inject drugs. One testament to the growing importance of the public health movement was the establishment of the Asia-Pacific Regional Network of Public Health Associations in 2010, as well as the African Federation of Public Health Associations in 2011 through the combined efforts of more than two dozen African public health associations. These two regional networks complement the existing European Public Health Association and emerging networks in Latin America, advancing action on



priority regional public health issues and building a strong collective voice for public health.

In 2011 the WFPHA canvassed its members about creating awareness of and promoting action on the social determinants of health in achieving health equity and identifying relevant opportunities, successes, failures and challenges. Respondents felt the primary roles of a public health association in this regard were to advocate for effective policy or programme interventions ('agenda setting') and to provide evidence to decision-makers. They also felt that they should play an important role in raising awareness among the public, the media and politicians about health equity and practical means to address the social determinants of health.

### Need for improved information exchange

Members felt that the WFPHA plays a special advocacy role with multilateral agencies and governments, and should be more vocal. They were concerned about the lack of political commitment and national action on social determinants. They cited the need for better means for exchanging information about promising practices on applying policies and strategies that promote health equity.

Public health associations are proven catalysts for change and development in their respective countries. The WFPHA has been a leader in global public health advocacy. It has produced more than 40 resolutions, declarations and position papers on a range of public health topics – including climate change and environmental health, conflict/peace and health, globalisation, trade and public health, tobacco control, health systems sustainability, universal and equitable access to primary healthcare services, health human resources, and the prevention of non-communicable

diseases. The declarations from recent World Congresses on Public Health have focused on health as a global public good (Brighton, 2004), eliminating social inequalities as a result of globalisation and recognition of the importance of the social determinants of health (Rio de Janeiro, 2006), and health as the first human right (Istanbul, 2009). A declaration calling for action on global health equity was released at the 13th World Congress on Public Health in Addis Ababa in April 2012.

### Leading the way

So who will take the lead in engaging politicians and citizens in a robust dialogue on health, from the national, regional and global perspectives, to define what is best for their communities, their country, their continent and the world?

National public health associations play a critical role in convening people, facilitating the discussion and promoting the adoption, implementation and monitoring of national global health strategies.

But they also face challenges to influence thinking and action along the 'policy to practice' continuum. Many have overcome considerable organisational and contextual obstacles, such as fragile organisational capacity, heavy reliance on volunteer input and resources, difficult political environments where speaking out on issues is minimally if at all tolerated, national contexts wherein governments have not committed to the concept of health equity or where investment in public health is decreasing, and difficulty in securing funding support, especially when they have to compete with larger, better-funded international non-governmental organisations in their countries. Whatever the challenges, national public health

associations are making their voices heard. They are galvanising their national public health communities to deal with health, health system sustainability, health equity and the social determinants of health. Transforming this dialogue into one that includes the concept of national global health necessitates defining a supportive strategy.

The most fundamental determinants of health are personal and community well-being, resiliency, and self-esteem or self-value. A community and a country are only as strong as their weakest and most vulnerable member. If national public health associations are to build consensus and shape the content of national global health strategies, they should follow two primary principles: health for all and health equity for all.

I recommend the adoption of the following objectives:

- Shift the emphasis of discussion and of government policies and strategies from healthcare to health equity.
- Adopt and apply a 'health lens' to public policy development and monitoring.
- Involve civil society in a participative partnership in the process.
- Ensure the existence of a firm foundation of public health law to support strategies and actions.
- Apply an 'ecosystem' perspective, the capacity to adapt to constantly changing contexts and environmental factors, be they physical, geographic, socioeconomic or political.

The ultimate goal is good health and well-being for all, not just for some. The global community of public health associations plays a role in achieving it. The WFPHA will be more proactive in this regard and will support its members in moving in this direction. Together, we can close the gap in a generation. ■

# Maintaining the momentum in the fight against HIV, malaria and tuberculosis

**The inroads that have been made in recent years in tackling some of the world's greatest scourges are at risk of going into reverse as donor nations cut back on funding essential programmes. Governments need to act to ensure money is made available and that generic drug production is protected**

By Unni Karunakara, international president, Médecins Sans Frontières

**T**he past 10 years have been called a 'golden decade' for global health. There has been unprecedented international solidarity, focusing on people in need of care. As a result, the world is nowhere near where it was back in 2000, when there were only a few, very expensive, drugs to treat HIV, and no one knew whether there would ever be a malaria vaccine, or a rapid test for tuberculosis.

Today, antiretroviral (ARV) treatment not only saves lives, but also prevents new HIV infections. A groundbreaking study released in 2011 showed that putting people on ARV treatment earlier can reduce infectivity by 96 per cent. As Anthony Fauci, of the US National Institute of Allergy and Infectious Diseases, has said: "The fact that treatment of HIV-infected adults is also prevention, gives us the wherewithal, even in the absence of an effective vaccine, to begin to control and ultimately end the AIDS pandemic."

There is now a more rapid, sensitive diagnostic tool for tuberculosis. People can be more accurately tested, including for drug-resistant tuberculosis, and can receive proper treatment faster.

Death rates from malaria have fallen by more than 25 per cent since 2000. More people are sleeping under long-lasting insecticide-treated nets. Rapid diagnostic tests are improving diagnoses. More doctors are prescribing artemisinin-based combination therapies – the most effective treatments available. A malaria vaccine is on the horizon.

While there is still no miracle cure for HIV, tuberculosis or malaria, the question is simpler than ever: is there the political will and the necessary financial commitment to bring the existing tools to those who need them most? It is not clear that the answer is yes. Progress is stalling. Funding is faltering, donors are retreating, and political promises are being broken.

**Governments point to the global recession. But people living with HIV, tuberculosis and malaria do not have time to wait. The world needs to build on the momentum of the past decade, not retreat**

Some 34 million people are still living with HIV, and seven million of them are in urgent need of ARVs. Treatment can only become prevention if access to ARVs is scaled up. ARV scale-up is just as crucial to beating tuberculosis: 1.1 million people with HIV developed tuberculosis in 2010. Malaria claimed 655,000 lives in 2010 – most of them young children.

In 2000, the world made a commitment to achieving the Millennium Development Goals by 2015. These goals include combating HIV and malaria and other diseases, reducing child mortality rates, and improving maternal health. A year

later, political leaders came together at the United Nations to recognise that HIV was an emergency, and set in motion policies to commit funds to make progress.

Leaders continue to make ambitious promises, and have committed to placing 15 million people on treatment by 2015. Just before World AIDS Day in 2011, Hillary Clinton stated that, at last, an "AIDS-free generation" was possible.

## A growing crisis of funding

Unfortunately, what one sees on the ground is significantly different from what one hears. In 2011, the Global Fund to Fight AIDS, Tuberculosis and Malaria – which has put 3.3 million people on ARVs and ensured the detection and treatment of 8.6 million cases of tuberculosis, and the distribution of 230 million mosquito nets – cancelled its next round of funding because of a shortage of money, due in part to donors scaling back or withdrawing their commitments.

Six months later, the Global Fund has announced that it is back open for business. This is good news, but the new funding window must be as large as possible, and be opened as soon as possible, because this crisis at the Global Fund is just part of a wider trend of damaging cuts to global health financing. In 2010, for the first time since the epidemic began, HIV funding decreased. Donors now tell aid recipients to "do more with less".

We at MSF are witnessing at first hand what this funding crisis means for HIV, tuberculosis and malaria programmes. Some 300,000 people urgently need ARVs in the Democratic Republic of Congo. Other countries are delaying or rationing implementation of the latest guidelines because there simply is not enough money to treat people sooner, or give them drugs that have fewer side effects or reduce the risk of developing resistance.

Governments point to the global recession. But people living with HIV, tuberculosis and malaria do not have time to wait. The world needs to build on the momentum of the past decade, not retreat. Donors must continue to show solidarity. The Global Fund must continue to lead the way.

### Addressing the financial issues

Other funding mechanisms should be considered, such as the model provided by the UNITAID airline tax, or income generated from potential financial transaction taxes, to fund health and development.

But ultimately, governments must take responsibility. They must implement the best programmes available, and there must be the money to do so. The crisis of the Global Fund, and global health financing generally, should wake up recipient countries to take strong political and financial leadership.

Governments must protect generic drug production. Generic drug production brought the price of ARVs down by 99 per cent. This has made a huge contribution to enabling scale-up. Since then, time and again, true generic competition – not voluntary licensing, or tiered pricing – has been the greatest catalyst to bringing down prices. But pressure is increasing from countries and companies seeking to protect trade and intellectual property. The prices of expensive new treatments are not falling as fast as their predecessors.

This is not just a concern for the millions of people living with HIV, but for millions more who have or will develop all kinds of diseases and medical conditions. As the incidence of non-communicable diseases rises in developing countries, the need for cheaper generics will only increase.

Developing countries must be flexible regarding the Agreement on Trade-Related Aspects of Intellectual Property. Wealthy countries and pharmaceutical companies must respect their right to do so, as enshrined under international law. Public health concerns must take priority over the protection of intellectual property.

Adapted, affordable drugs and diagnostics are needed. But the current model of drug development, bound up as it is with potential profits on sales, is unlikely to provide the



Millions of lives have been transformed – and saved worldwide – as a result of having access to the necessary drugs

tools and drugs any time soon. For example, treatment for paediatric HIV is so inadequate, with so little invested, that MSF now considers HIV in children a neglected disease, like sleeping sickness. For children with drug-resistant tuberculosis, our doctors must crush pills to break them into acceptable doses – because proper paediatric formulations are unavailable.

### Incentives for research and development

Why is treatment so inadequate? Because drug companies see no profit in developing anything better. A new research and development paradigm – not incentivised through profits – is needed, so that new medicines and diagnostics will be made for, and accessible to, those who need them most.

Models of care that work in remote, rural areas and overcrowded urban slums are needed. Decentralised HIV treatment has already improved

access and saved thousands of lives. Task shifting has helped. In South Africa, 'expert patients' are trained to support and counsel their peers, and also carry out HIV testing. This frees nurses to do other tasks, such as initiating ARV treatments which, in turn, frees overburdened doctors.

Increased patient literacy and self-management has enabled more people to access treatment and live more 'normal' lives. This kind of innovation can reach more people.

The world is at a turning point. The tools are there, and these diseases can be eradicated. Or the world can choose to disinvest and watch the achievements of the past 10 years fall by the wayside. Yes, times are tough, but the world can make the choice to invest now and make a measurable impact on global health. ■

*This article is based on a speech made at the Economist conference on Healthcare in Africa, in Cape Town, South Africa, 6-7 March 2012*



# Mobile phones connect patients to vital healthcare information

**The rise of mobile phone technology provides health workers with new ways to treat patients and make contact with people wherever they are. Known as 'mHealth', this innovative system can help to prevent the spread of disease**

**By** Patricia Mechael, executive director,  
mHealth Alliance, United Nations Foundation

**T**he ubiquity of mobile phones is creating a stir in global health. With nearly six billion mobile phone subscriptions spread across a world population of seven billion people and over 90 per cent of the world's population with mobile network coverage, it is easy to understand why. However, achieving the potential for mobile phones to have a global impact on improving health outcomes is a complex process. What is the potential of mobile health – mHealth – and the current evidence, barriers in growth and knowledge gaps? How is the mHealth Alliance helping? What are the opportunities for greater involvement in the mHealth movement?

## Education and awareness

mHealth has been defined by the World Health Organization (WHO) as the medical and public health practice supported by mobile devices, such as mobile phones, tablets, patient-monitoring devices, personal digital assistants (PDAs) and other wireless devices. Mobile technology is used in disease prevention, health promotion and education awareness. It is useful for treatment adherence and appointment reminders, data collection, health worker training and decision support tools, and also for emergency medical response systems, supply chain management and health financing.

Users who benefit from mHealth vary from healthcare providers to

patients, as well as health system administrators and global health experts throughout the world.

For patients, the increasing popularity of mobile phones makes it possible to reach more segments of the population than ever before, even people living in rural areas and those who may not be able to access the health information or healthcare they require.

Additionally, innovative strategies to extend health services to patients are being created, such as for education and awareness and improving patient disease management (as in treatment adherence and appointment reminders). The Project Masiluleke promoted HIV testing in South Africa while breaking down stigma and discrimination barriers by enabling a more open discussion about HIV/AIDS. Several controlled studies have reported increased adherence levels, particularly for HIV, when text messages are sent to remind people to take their medication.

For community- and facility-based health workers, equipping them with

**The popularity of mobile phones makes it possible to reach more segments of the population than ever, even people in rural areas who may not be able to access the healthcare they require**

mobile technologies for communication, training and decision support means improving workloads in health systems, particularly for those struggling with human resource shortages.

One example of an mHealth decision support tool is e-IMCI, a version of Integrated Management of Childhood Illness (IMCI) guidelines viewable on a mobile device.

For child health diagnostic and treatment support, clinicians have found e-IMCI to be better and faster than using traditional chart booklets.

Similarly, wireless sensors connecting to mobile networks allow providers to monitor patients remotely and intervene if necessary.

For health system administrators, mHealth strengthens communication and the flow of information, allowing for better informed decisions tailored to the health needs of a population.

The additional benefit of being able to link mobile technologies to software applications and back-end systems permits real-time or near-real-time data collection and analysis for tracking medications and supplies, electronic health records and disease surveillance. Early evidence has shown time and cost savings, as well as improvements in data availability, data accuracy and health worker satisfaction.

On a global health level, mHealth is helping global health experts meet their responsibilities to define best practices and make recommendations on how to allocate resources to the most cost-effective programmes.

Additionally, mobile devices provide a quick way to obtain vital information for disease and epidemic outbreak surveillance, as well as disaster relief and response.

For both, mHealth allows data to be sent in a timelier manner, which enables coordination of public health responses to contain an outbreak or to dispatch an emergency response in an organised



Mobile technology offers a quick way to send out vital information, such as advice on treating childhood illnesses

and effective manner, in contrast to hand-delivering paper reports where lag times can be as long as six months.

In the end, the evidence increasingly shows that mHealth improves patient health outcomes. As in the examples above, there are many benefits to overcoming existing challenges in health communication and information through the strategic use of mobile technologies.

However, most evidence is still new. More is needed to convince decision-makers to incorporate mHealth into health policy agendas. To accomplish this, efforts must go towards making the mHealth field less fragmented and to encourage more collaborative large-scale projects with built-in evaluations and, in turn, to support more scalable and sustainable policy development and financing.

Other barriers hindering mHealth from realising its full potential include the lack of systematically applied technological standards and interoperability between systems. These barriers must be eliminated,

information gaps must be filled and the evidence base must be strengthened for mHealth to reach its true potential.

#### How is the mHealth Alliance helping?

With its mission to catalyse the power of mobile technologies to advance health and well-being throughout the world, with a focus on low-income countries, the mHealth Alliance is building 'the mHealth commons' – public goods that would accelerate the impact and mainstreaming of mHealth. With improved health outcomes as the ultimate goal, the alliance can facilitate the mobilisation of strategic priorities that reflect the rapidly developing state of the field. Core activities include setting the agenda to build mobile health commons, building the mHealth knowledge base, and using it to communicate and advocate to players in global health. They also include connecting, convening and facilitating the mHealth ecosystem to address strategic priorities and providing catalytic funding to promote the advancement

of mHealth and accelerate the building of the mobile health commons.

By leveraging productive and functional collaboration across stakeholders, the mHealth Alliance is also responding to existing barriers by strategically building capacity for mHealth, a necessary step in realising its full potential. Five specific core programme areas have been identified as having the need and potential to accelerate development. These areas include evidence, technical standards and interoperability, sustainable financing models, capacity building and policy. These programmes will be facilitated through in-country engagement.

#### Getting involved

There are several ways to get involved in the discussions taking place around mHealth. First, membership in the mHealth Alliance is open to organisations through a quick application process. Another place to engage is HealthUnbound (HUB – [www.healthunbound.org](http://www.healthunbound.org)), an interactive network and online knowledge resource for the mHealth community. Within HUB, online forums called Communities of Practice (CoPs) are being created to correspond with each of the strategic priority areas. The aim is to create an enabling environment where members of the mHealth community can together advance discussion and collective action aimed at overcoming barriers to mHealth scale and sustainability.

The current state of mHealth is exciting and rapidly developing with a very strong potential to enhance global health. However, for mHealth to reach its full potential, we must learn from the past and chart a stronger, more strategic and effective course to create the enabling environment needed for the field to thrive and generate improved health outcomes and quality of life for all. The mHealth Alliance has been created to do this through collaboration with stakeholders throughout the mHealth ecosystem. Through systematic efforts to mainstream proven mobile technologies into global health, mHealth may live up to the promise that it can transform public health and health service delivery worldwide. ■

# Non-communicable diseases: a silent global epidemic

**Diseases caused by preventable factors such as tobacco use, poor diet, physical inactivity and harmful alcohol consumption kill millions around the world each year, but building consensus on how to tackle the problem is one of the greatest impediments to progress**

By Ann Keeling, chair, NCD Alliance

**F**or too long, non-communicable diseases (NCDs) such as diabetes, cancer, cardiovascular disease and chronic respiratory diseases have been a silent and hidden epidemic. Largely caused by tobacco use, unhealthy diet, physical inactivity and the harmful use of alcohol, these diseases cause nine million preventable deaths before the age of 60 each year. They are a major cause of poverty, a barrier to economic development and a serious threat to the achievement of the Millennium Development Goals (MDGs). The World Economic Forum and Harvard University estimate that NCDs, including mental health, will cost the world \$47 trillion over the next 20 years, representing 75 per cent of global gross domestic product and surpassing the cost of the global financial crisis.

Behind these staggering statistics are the stories of the people affected by these conditions. Teenagers like 16-year-old Ashok in Nepal, whose family had to choose between his education and medicines to treat his type 1 diabetes. Or Francine, a 15-year-old Rwandan who developed mouth cancer and had no access to treatment. Simple, cost-effective solutions exist that every government can implement with the right policies and adequate resources. These same solutions helped people like Ashok and Francine overcome their conditions and go on to lead productive and healthy lives. No child, for example, need die from diabetes.

To bring global attention to these neglected conditions, the International Diabetes Federation, the Union for International Cancer Control, the International Union Against Tuberculosis and Lung Disease, and the World Heart Federation joined forces to create the NCD Alliance.

It launched a worldwide campaign to put NCDs on the global health and development map, calling on world leaders to take four actions:

1. Convene a United Nations High-Level Meeting (HLM) on NCDs;
2. Include NCDs in the MDGs;
3. Ensure universal access to essential medicines and technologies for those living with NCDs; and
4. Integrate NCDs into health systems, particularly at the level of primary healthcare.

As a result of the work of the NCD Alliance and the leadership of Caribbean heads of state and government, world governments held the UN HLM on NCDs in New York from 19-20 September

**The message to policymakers is simple – you cannot talk about economic and human development without talking about diabetes and other non-communicable diseases**

2011 to agree to actions to address the growing NCD crisis. Leaders unanimously adopted a political declaration, agreeing that “the global burden and threat of NCDs constitutes one of the major challenges for development in the 21st century, which undermines social and economic development throughout the world”.

There can be no doubt that 2011 and that political declaration were major turning points in the global response to NCDs. The declaration is the strongest statement of intent for action to date by governments. It encompasses 22 action-orientated commitments covering the spectrum of prevention, care, health systems, research and development, monitoring and resourcing required for accelerated action. It defines a united global response to stem the tide of NCDs and, critically, demonstrates consensus on the part of the world’s governments that NCDs are everybody’s business and therefore require a collective response.

## What happens next? Beyond 2012

While the UN HLM was a major political turning point, it was just the beginning. The NCD Alliance is leading two major campaigns to ensure those gains are sustained.

The first campaign focuses on delivering the time-bound commitments of the summit. We are calling for the building blocks of a global framework to drive future action on NCDs. This framework will be spearheaded by a multisectoral global NCD partnership. Coordinated action by the UN, governments, the private sector and non-governmental organisations is essential. This NCD partnership, similar to the Partnership for Maternal and Newborn Child Health (PMNCH), should develop a global plan for NCDs, including a global monitoring framework with global targets and indicators, and catalyse effective financing mechanisms for NCDs.





Non-communicable diseases cause nine million preventable deaths before the age of 60 each year

By the end of 2012, governments will agree upon the first ever set of global NCD targets. Every government will report against those targets to show progress and indicate change. As World Health Organization director general Margaret Chan said in April 2011, “what gets measured gets done”. For the first time, many governments will have to confront the fact that they do not know how many people have NCDs, let alone how many of those people are diagnosed and receiving treatment. This will be a major breakthrough.

The second major campaign focuses on ensuring NCDs are prioritised on the global development agenda and integrated into development assistance to low- and middle-income countries. The absence of NCDs in the MDGs has been a major obstacle in mobilising political leadership and resources. As the world begins to plan for the new development framework after their expiry in 2015, and looks towards

new Sustainable Development Goals at the Rio+20 Summit in June 2012, there is a unique opportunity to ensure NCDs are at the heart of future health and development planning. The message to policymakers is simple – you cannot talk about economic and human development without talking about diabetes and other NCDs.

#### Global recognition of the problem

NCDs have been absent from the global development agenda and have therefore not received adequate development assistance. At the HLM, governments committed to exploring bilateral and multilateral channels for NCDs. Yet most of the bilateral aid agencies do not fund NCD prevention or control as a matter of policy because the diseases do not feature in the MDGs. Donors thus ignore the calls of low- and middle-income countries for development assistance for NCDs, and are neglecting their commitments to

aid effectiveness. The NCD Alliance is advocating for integrating NCDs into the post-2015 development framework and targeting bilateral and multilateral donors to reorient funding priorities to match the NCD disease burden.

#### Change is a marathon, not a sprint

Six months after the HLM, the world sees the green shoots of the ‘NCD spring’. But change for NCDs is a marathon, not a sprint. There are no overnight solutions for this epidemic, and the unfinished business must be tackled together as a global NCD community. NCD prevention may have no political constituency, but governments are responsible for creating a healthy environment in which their citizens can live, work and play and can ensure the well-being of future generations.

The challenge is to operationalise NCD prevention and control on the ground – solutions need to be customised for different contexts, cultures and resource levels. The fight for increased resources will continue, and funding agencies that say they are integrating NCDs into their health system-strengthening programmes will be challenged. Those results need to be checked.

Above all, the NCD Alliance will catalyse the people’s movement for NCDs – a new level of activism rooted in outrage at the lives lost and suffering caused by neglect of NCDs. Type 1 diabetes and some cancers, for example, kill only people in poor countries. They are not killers in the developed world. Ninety years after the discovery of insulin, that is an outrage. Governments still need to hear people – very large numbers of people from all walks of life – say in unison that neglect of NCDs is an outrage that we will not tolerate for our own generation or for generations yet to come. ■

# Making their voices heard: the People's Health Movement

## A worldwide organisation of grassroots health activists is campaigning on behalf of local communities to ensure that the ideal of 'health for all' becomes a reality

By Fran Baum, Dave McCoy, David Sanders and Amit Sengupta  
(on behalf of the Global Steering Council of the People's Health Movement)

In December 2000, health activists gathered in Savar, Bangladesh, at the first People's Health Assembly.

This assembly led to the formation of the People's Health Movement (PHM), which is now a worldwide health movement of networks and activists.

PHM was conceived as an alternative voice to the World Health Organization (WHO), which many believed had ceased to reflect the health concerns of people at the grassroots level. It grew out of concerns that the target of 'Health for All by 2000' had not only been missed, but also that health outcomes in many parts of the world were moving into reverse.

Since its formation, PHM has worked to ensure that people's voices are heard in formulating international and national health policies, in training health workers and in organising against powerful interests that threaten health. Its strength is based on numerous national and local networks of activists.

### The People's Charter for Health

The philosophy and focus of the PHM is articulated in the People's Charter for Health (PCH). This document was produced through participatory processes leading up to the first People's Health Assembly, and was endorsed by the assembly. Health activists from around the world drew on their experiences of working with local communities to distil the key messages about health. The visionary document

asserts that "equity, ecologically sustainable development and peace are at the heart of our vision of a better world – a world in which a healthy life is a reality; one that respects, appreciates and celebrates all life and diversity; a world that allows people's talents and abilities to flower; a world in which people's voices guide the decisions that shape our lives. There are more than enough resources to achieve this vision."

The PCH foreshadowed the work of the Commission on Social Determinants of Health by detailing the impact of

## Global Health Watch 3 argues that the current financial, food and fuel crises (the 'three Fs'), as well as two 'slow-burn' crises – climate change and the crisis of development – are not transient

the broader determinants of health, including economics (especially issues around the unfair global trade regime and privatisation); social and political issues (including denial of human rights in respect of education and health); and environmental factors (including the impact of the practices of transnational corporations and the externalisation of environmental costs and overconsumption of natural resources).

It also called for implementation of comprehensive primary healthcare to form the basis of a people-centred health sector. This charter has been translated into more than 40

languages and remains as relevant today as when it was drafted.

PHM has developed a range of activities, despite operating with very modest external funding, raised to support a secretariat based successively in Bangladesh, India, Egypt and South Africa. PHM circles are the centre of local and national campaigns and struggles. Forging global solidarity among activists is a key aim. Websites and a networking system – PHM Exchange – promote the sharing of knowledge.

### What the PHM does

The International People's Health University (IPHU) is the main educational arm of the PHM. The IPHU resources and organises short courses for health activists, especially from low- and middle-income countries. Learning is supported by extensive resource materials and a network of

mentors. Sponsors research the barriers to, and strategies for, Health for All.

Up to 60 students are selected from applications received in response to a public call. Key criteria for the selection of candidates include geographic location, a history of health

activism and the potential to effect change. They work with voluntary, experienced international faculty members over one to two weeks on several topics: the practice of activism; working with communities; health systems and comprehensive primary healthcare; the political economy of health; the right to health; health and the environment; the social determinants of health; and research.

Teaching is highly interactive, drawing heavily on participants' experience. To date, 20 IPHU courses have been held on all continents and have produced more than

800 alumni, many of whom are now active in their nations.

The PHM organises global People's Health Assemblies (PHAs) approximately every five years. PHAs provide a unique space for analysing global health, sharing experiences and devising strategies for future actions towards Health for All.

The first PHA was held in Savar, Bangladesh, in 2000 and was attended by more than 1,500 people from around 90 countries. PHA2 in Cuenca, Ecuador, in 2005 attracted similar numbers.

PHA3 will be held in July 2012 in Cape Town, South Africa. As with previous assemblies, more than 1,000 health activists, and representatives of social movements, academics, policymakers, non-governmental organisations and community-based bodies from around the world, and particularly from Africa, are expected to attend.

### PHM and the WHO

The PHM actively monitors WHO's role and mandate. As the closest thing the world has to a democratically mandated ministry of health, WHO has always featured strongly in the activities of PHM. The gradual decrease of WHO's influence since the 1980s, and its inability to provide decisive leadership to the global health community – notwithstanding several important accomplishments – is a major concern for PHM.

WHO's decline is emblematic of many challenges facing the progressive health community. These include the replacement of the broad vision of the 1978 Alma Ata declaration on primary healthcare with a narrow and biomedical vision of selective primary healthcare. To this can be added the capture of decision-making powers by corporations and the influence of unaccountable private foundations and the 'neo-liberalisation' of public policy.

Yet for all its weaknesses, WHO remains a vital terrain for battles over ideas and ideologies, forms of global governance, property rights and the use of international law to protect people's health. PHM spends a considerable amount of time and energy trying to uphold the vision of Alma Ata and the WHO's founding constitutional principles. The capacity building that PHM has conducted under the IPHU is shown through

the work of a cadre of young activists spearheading PHM's advocacy work at WHO's headquarters in Geneva and at its regional and national offices.

Since 2005, the PHM has worked with partners to publish three Global Health Watches (in 2005, 2008 and 2011). These were conceived as "alternative world health reports" and explored a range of issues. The most recent report contains a critical analysis of global health systems development, the climate crisis and its impact on health equity, trade and health, and the global food crisis and its political and economic roots. Each contains a 'watching' section designed to assess the policies and actions

increasing global economic inequality; in the dominant role played by finance capital; in unequal and asymmetric global economic integration and in a system of ineffective and undemocratic global governance.

The PHM has initiated a global Right to Health campaign that makes use of the legal framework to not only promote health but also the conditions that ensure good health. Particularly active campaigns have been run in India and South Africa. The campaign is the focus of activity in many national movements. Strategies have included marches, mock trials of state governments, and community assessments of and

A recent vaccination campaign in Somalia utilised the help of both community health workers and village elders



of key institutions including WHO, UNICEF, the Bill and Melinda Gates Foundation, bilateral aid programmes and multinational corporations.

For instance, Global Health Watch 3 argues that the Gates Foundation is an example of how the alignment of corporate interests and philanthropic investment may have adverse effects on health policy. Global Health Watch 3 argues that the current financial, food and fuel crises (the 'three Fs'), as well as two 'slow-burn' crises – climate change and the crisis of development – are not transient but indicate a deep 'systems failure' that plagues the practice of capitalism that is informed by neo-liberal theory and practice.

This failure manifests itself in different ways: in persistent and

documentation of denials of rights. PHM has provided a voice for the unheard in global and national health debates since 2000. Its strength lies in its clear and unambiguous philosophy (articulated in the People's Charter for Health) and in mobilising, organising and building solidarity in communities around the world.

The many crises faced globally mean the struggles for health that PHM is involved in will continue to be of vital importance. On the basis of its experience of the movement of people, the PHM critiques global health policies and the ways in which they can threaten health. It offers an alternative for a more democratic world in which people's health and that of the environment flourish. ■



# Financing health promotion through dedicated taxes

**By levying taxes on tobacco and alcohol, Thailand has been able to institutionalise and fund health promotion initiatives aimed at preventing non-communicable diseases**

**By** Krissada Raungarrearat, Thai Health Promotion Foundation

**T**hailand is a Southeast Asian country with a population of about 70 million people. In common with other Southeast Asian countries, the burden of disease has been shifting to non-communicable diseases (NCDs) in Thailand. Between 2002 and 2008, deaths caused by NCDs increased from 59 per cent to 71 per cent of the total. This rapidly progressing epidemiological transition has imposed high health, social and economic costs on the government and society.

The risk factors for NCDs are related to the social, economic and political environments in which people live. Health promotion, rooted in the 1986 Ottawa Charter, provides guidance for coordinated actions aimed at reducing those risk factors and promoting the overall well-being of the population. Thailand has made advances in concretising the concept of health promotion through the innovative work of the Thai Health Promotion Foundation (ThaiHealth).

In the past, health promotion programmes were given a low priority. The Thai government provided a small budget for programmes such as controlling tobacco and alcohol and reducing traffic accidents. Yet these health risk factors were causing a serious burden on society and healthcare systems. Between 1979 and 1999, per capita alcohol consumption increased at an average rate of three per cent per year. Alcohol consumption was a major cause of traffic accidents, domestic violence, suicides and crime. In

1999, it ranked as the second leading cause of death after unsafe sex. Thailand also saw escalating public health expenditure: from 3.8 per cent of gross domestic product in 1980 to 6.1 per cent in 2002.

Many health promotion advocates in Thailand were thus seeking systematic reform outside the established healthcare system. They looked to innovative institutional reform, particularly in Australia, where the Victorian Health Promotion Foundation (VicHealth), was leading in health-promoting policies and programmes. VicHealth, established in 1987, was the first health promotion organisation in the world to be funded by a tax on tobacco.

In Thailand, momentum for change was already growing. Civic groups such as the Anti-Smoking Foundation and the Rural Doctor Society were leading the way, addressing tobacco consumption as the main risk factor for NCDs. These tobacco control advocates lobbied for an increase in the tobacco tax between 1988 and 1993. After 1995, their movement shifted towards focused advocacy for institutionalising a health promotion organisation through a dedicated tax.

## Establishing ThaiHealth

Many different sectors were mobilised to establish an independent health promotion organisation with funding from a dedicated tax. Within government, two working groups were established – one to draft the







The ThaiHealth model provides stable and adequate funding to promote the overall well-being of the population

# Key achievements catalysed by the Thai Health Promotion Foundation

## Cigarette consumption

2005	Pictorial warnings required on cigarette packs. Advertisements of cigarettes banned at the point of sale
2006	Smoking banned in government buildings. Voluntary campaign for smoke-free hotels. Support unit for quitting cigarettes (national 'quit line') set up
2007/09	Effectiveness of pictorial warning on cigarette packs improved
2010	National Tobacco Control Strategy passed by the National Committee for Control of Tobacco Use

## Alcohol consumption

2003	A ban on alcohol advertising between 5am to 10pm on radio and television. 'No Alcohol during Buddhist Lent' campaign was initiated. A road safety unit was set up to implement road safety action plans
2004	Sports associations denied sponsorship from the alcohol industry
2007	Submission of 12.8 million signatures to the prime minister in support of the Alcohol Control Act. Research findings as inputs into policy studies that resulted in increased excise taxes on alcohol
2008	Alcohol Control Act 2008 passed. Office of National Buddhism declared all temples be alcohol-free
2009	'A Gift of Alcohol = A Curse of Death' campaign initiated ban on sale of alcohol to young people under 20 years of age
2010	Alcohol-free petrol stations campaign launched
2011	Alcohol-free New Year Pray Countdown promoted as an alternative to conventional New Year countdowns

Health Promotion Fund Act and the other to study the feasibility of implementing a universal health insurance policy. A succession of commissions, committees and working groups were formed, and research papers were commissioned to study the impact of a change in the excise tax for cigarettes and to review the experiences of establishing health promotion organisations overseas.

It was estimated that Thailand could save \$500 million each year if health promotion efforts succeeded in reducing the costs of diseases caused by alcohol, cigarettes and traffic accidents by 10 per cent. The leading proponents of health promotion also lobbied hard for support from different high-level officials and political groups. The proposal for a health promotion foundation went through several drafts and navigated around numerous obstacles.

## Long road to legislation

It took eight years of campaigning before the Health Promotion Foundation Act was passed and enacted in 2001. The act established the Thai Health Promotion Foundation and a sustainable source of funding for the foundation, earmarked from

a two per cent surcharge tax on top of an excise tax imposed on tobacco and alcohol products.

ThaiHealth's working model is based on Prawase Wasi's philosophy of the 'triangle that moves the mountain'. The three sides of the triangle are the creation of relevant knowledge through research, social movement or social learning, and political involvement.

ThaiHealth uses this model to catalyse and fund crucial, systematic changes that reverse the trends

organisational structure, ThaiHealth has been able to serve as a bridge to facilitate work across government departments, and between the government and other sectors in Thai society. This successful model has become an inspiration in the network of health promotion foundations. Since 2004, the World Health Organization (WHO) Western Pacific Regional Office has initiated capacity-building programmes to transfer learning from ThaiHealth and other successful

foundations in Asia. This has led to important progress in institutionalising sustainable health promotion financing in the Philippines, Malaysia, Mongolia and Tonga.

As NCDs pose a growing threat, successful health promotion activities are

## Health promotion activities are more important than ever. Thailand has taken an important step in setting up a health promotion foundation with dedicated funding from taxes on tobacco and alcohol

in cigarette consumption, alcohol consumption and traffic accidents (see table). The rate of cigarette smoking among people older than 15 years declined from 25 per cent in 2001 to 21 per cent in 2009. Household expenses on alcohol consumption declined from \$5,000 million in 2007 to \$4,495 million in 2010. ThaiHealth's work has also led to important social health outcomes in education, public broadcasting, community empowerment and consumer protection.

Due to its stability of funding sources and its autonomous

more important than ever. Thailand has taken an important step in setting up a health promotion foundation with dedicated funding from taxes on tobacco and alcohol. Stable and adequate funding enables ThaiHealth to undertake programmes not possible through conventional means. For these reasons, ThaiHealth is collaborating with WHO to share knowledge and transfer its experience to countries looking to establish similar mechanisms to ensure that health is promoted with sustainable resources on a multisectoral platform. ■



# Towards decent work environments: improving health in the workplace

**Deteriorating working conditions and the effects of stress are of increasing concern among workers. Governments, enterprises and employees can collaborate to create an environment that not only protects workers' physical health, but also encourages improved psychological well-being**

By Juan Somavia, director-general, International Labour Organization

**O**ccupational safety and health (OSH) is integral to the Decent Work Agenda of the International Labour Organization (ILO). Decent work is defined as the right to productive work in conditions of freedom, equity, security and human dignity – and work can only be decent when it is safe and healthy.

The protection of workers against sickness, disease and injury arising from their employment is at the core of ILO's creation in 1919 and one of its main objectives. This goal is as relevant as ever in today's troubled world of work. More than 2.3 million people die annually from work-related accidents or diseases – an average of 6,300 work-related deaths every day. Moreover, much of the daily tragedy involving millions of workers plays out unseen, unheard and unreported in the informal economy.

It is too soon to determine the long-term effects of the current economic and jobs recession in advanced economies and the slowdown in emerging economies. Evidence, however, suggests that OSH and working conditions are deteriorating, albeit with significant variations by country and economic sector. Joblessness, alongside employment, income insecurity and greater job strain, already takes a toll on workers' mental health with detrimental implications for

their well-being and that of their families and for productivity, and carries negative consequences for the sustainability of social security regimes. Advances in OSH in many countries risk being eroded.

Reinforcing strategic and systematic action by all countries is needed urgently. Many accidents, illnesses and deaths could be prevented with appropriate managerial measures. It is a matter of respecting the dignity of the human being through the dignity of work; of shaping policies that reflect the central role of work in people's lives, in peaceful communities, in stable societies and in resilient economies.

## International labour standards

The ILO's international labour standards on OSH have been providing policy principles, guidance on legislation, and strategies for safer and healthier

**ILO policy reflects three core values: work should take place in a safe and healthy environment, conditions should be consistent with workers' well-being and human dignity, and work should offer real possibilities for personal achievement, self-fulfilment and service for society**

workers and working environments since the ILO's inception. Early on, the OSH instruments addressed specific hazards such as anthrax and benzene; later, they became industry-specific and, more recently, have embraced a more comprehensive and integrated approach.

## Involving workers

The ILO Convention on Occupational Safety and Health and its Recommendation provide for the adoption, implementation and review of a coherent national policy on OSH, mechanisms for consultation and participation of employers and workers and their organisations, and measures for its implementation at national and enterprise levels. The Occupational Health Services Convention and its Recommendation define the role of occupational health services as multidisciplinary services with preventive and advisory functions. They are also responsible for assisting employers, workers and their representatives in establishing and maintaining a safe, healthy working environment, including the adaptation of work to the capabilities of workers to facilitate optimal physical and mental health at work.

The Promotional Framework for Occupational Safety and Health Convention and its Recommendation are adapted to today's needs and latest trends. They incorporate the core principles from ILO standards on OSH and provide guidelines for a coherent and effective national management system.

All ILO standards on OSH and ILO's policy reflect three core values: work should take place in a safe and healthy working environment, working conditions should be consistent with workers' well-being and human dignity, and work should offer real possibilities for personal achievement, self-fulfilment and service for society.

The employer's primary responsibility to provide safe and healthy working conditions and the worker's participation in managing OSH are embodied in all relevant ILO standards. The active participation of workers and their representatives in establishing preventive measures at the workplace is essential for successful programmes.

#### **Workplace health promotion**

In past decades, the scope of occupational health has expanded beyond protecting workers from workplace hazards to include promoting their psychological and social well-being and

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**A successful enterprise is based on the people who work in it and its organisational culture. Workers in a safe environment feel better and are healthier, leading to reduced absenteeism, enhanced motivation, improved productivity and a positive image for the enterprise**

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ability to conduct socially and economically productive lives.

There is a growing concern about work-related stress that can contribute to musculoskeletal disorders, hypertension and cardiovascular diseases. More widely, it can lead indirectly to problems such as violence, abuse of drugs and alcohol, strained family relationships, depression, physical and mental health disorders, and even suicide. Similarly, many harmful effects of lifestyle behaviour, such as smoking, alcohol and drug abuse, nutritional deficiencies and physical inactivity can also interact with workplace

hazards. Taken together, they can result in accidents, injuries, illnesses, incapacity and death. However, early detection and appropriate treatment of incipient occupational and non-communicable diseases will reduce mortality and lower the frequency and extent of residual disability from many of such diseases.

Recent occupational health programmes, particularly in developed countries, have been incorporating health promotion, which is designed to encourage healthy behaviour, especially in relation to stress, alcohol and drugs, tobacco, nutrition and physical activity. The growth in workplace programmes for promoting healthy lifestyles reflects the recognition of the importance of healthy workers for sustainable enterprises. This corresponds with the definition of the aim of occupational health adopted by the Joint Committee on Occupational Health of the ILO and the World Health Organization in 1995: "The promotion and maintenance of the highest degree of physical, mental and social well-being of workers in all occupations".

#### **Strategic and systems approach**

Despite efforts by governments, employers and workers to improve the protection of employees from work-related hazards, reinvigorated strategic and system action is needed at national levels. As part of its strategic policy framework, the ILO promotes social dialogue and joint action in formulating and implementing national OSH programmes as a collaborative effort of governments and social partners in all countries. These programmes are based on the situation analysis and priorities established by ILO's tripartite constituency, through a process of dialogue, and reflected in national OSH profiles. Those profiles summarise the existing situation and

progress made towards achieving a safe and healthy working environment in areas such as occupational injury and diseases statistics, laws and regulations, compliance assurance mechanisms, OSH training and occupational health services. National OSH programmes focus on priority areas of action with measurable indicators for continual improvement.

#### **Benefits of collaboration**

It is essential to empower enterprises to identify and control hazards as a collaborative effort of employers and workers. Such management systems should integrate health promotion programmes as they benefit both workers and employers by improving the long-term well-being of workers and their families, increasing productivity and performance, and reducing pressure on health, welfare and social security systems. Integrating health promotion measures into workplace OSH management systems enhances occupational health practice and contributes to building a global preventive culture. For this reason, the ILO designed the SOLVE training package to focus on preventing psychosocial risks and integrating workplace health promotion into OSH policies and action.

ILO experience shows that a successful enterprise is based on the people who work in it and on its organisational culture. Workers in a safe, supportive environment feel better and are healthier, leading to reduced absenteeism, enhanced motivation, improved productivity and a positive image for the enterprise. Preventing occupational accidents and diseases, promoting a healthy working life and building a preventive culture are responsibilities shared by governments, employers and workers, health professionals and society as a whole. ■





