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**Pandemic H1N1 in Canada and the use of evidence in developing public health policies - A Policy Analysis**

The purpose of this study is to examine the H1N1 pandemic decision-making process in Canada with an emphasis on the use of evidence for public health decisions. Using semi-structured key informant interviews conducted after the pandemic (July–November 2010) and a document analysis, we examined four highly debated pandemic policies: use of adjuvanted vaccine by pregnant women, vaccine priority groups and sequencing, school closures and personal protective equipment. [... The authors'] analysis revealed that pandemic pre-planning resulted in strong beliefs, which defined the decision-making process. Existing ideological perspectives of evidence strongly influenced how information was used such that the same evidentiary sources were interpreted differently according to the ideological perspective. Participants recognized that current models for public health decision-making failed to make explicit the roles of scientific evidence in relation to contextual factors. Conflict avoidance theory explained policy decisions that went against the prevailing evidence. Clarification of roles and responsibilities within the public health system would reduce duplication and maintain credibility. A more transparent and iterative approach to incorporating evidence into public health decision-making that reflects the realities of the external pressures present during a public health emergency is needed.*

RESEARCH ON HEALTH & STATES IN CRISIS/CONFLICT:

Madness or sadness: Local concepts of mental illness in four conflict-affected African communities

Concepts of ‘what constitutes mental illness’, the presumed aetiology and preferred treatment options, vary considerably from one cultural context to another. Knowledge and understanding of these local conceptualisations is essential to inform public mental health programming and policy. Participants from four locations in Burundi, South Sudan and the Democratic Republic of the Congo, were invited to describe ‘problems they knew of that related to thinking, feeling and behaviour?’ […] While remarkable similarities occurred across all settings, there were also striking differences. In all areas, participants were able to describe localized syndromes characterized by severe behavioural and cognitive disturbances with considerable resemblance to psychotic disorders. Additionally, respondents throughout all settings described local syndromes that included sadness and social withdrawal as core features. These syndromes had some similarities with nonpsychotic mental disorders, such as major depression or anxiety disorders, but also differed significantly. Aetiological concepts varied a great deal within each setting, and attributed causes varied from supernatural to psychosocial and natural. Local syndromes resembling psychotic disorders were seen as an abnormality in need of treatment, although people did not really know where to go. Local syndromes resembling nonpsychotic mental disorders were not regarded as a ‘medical’ disorder, and were therefore also not seen as a condition for which help should be sought within the biomedical health-care system. Rather, such conditions were expected to improve through social and emotional support from relatives, traditional healers and community members.*


GLOBAL HEALTH NEWS:

UN says it will not pay compensation for Haiti’s cholera victims

The Secretary-General of the United Nations Ban Ki-moon has released a statement saying the U.N. will not pay compensation for the victims of the 2010 cholera outbreak in Haiti. Citing section 29 of the 1946 convention, the U.N. will use its legal immunity to avoid claims that it is responsible for the spread of a disease that killed around 7,750 Haitians. The Institute for Justice and Democracy in Haiti (IJDH), a group based in Boston, brought the call for compensation to the U.N. in November 2011 […]. The group argued that the cholera infection arrived in Haiti in the form of U.N. peacekeepers from Nepal and spread following the country’s epochal 2010 earthquake and humanitarian disaster. A report from Centers for Disease Control and Prevention (CDC) revealed in mid-2011 that “there was an exact correlation in time and places between the arrival of a Nepalese battalion from an area experiencing a cholera outbreak and the appearance of the first cases in Meille a few days after.”*

Source: Pollak, S. 2013. UN says it will not pay compensation for Haiti’s cholera victims. Time online (22 February).
RESEARCH ON HUMAN RIGHTS & GLOBAL HEALTH:

Access to health care for undocumented migrants from a human rights perspective: A comparative study of Denmark, Sweden, and the Netherlands

The aim of this study is to address undocumented migrants’ access to health care in Denmark, Sweden, and the Netherlands from a human rights perspective. Based on desk research in October 2011, [the authors] identified national laws, policies, peer-reviewed studies, and grey literature concerning undocumented migrants’ access to health care in the three involved countries. Through treaties and related explanatory documents from the United Nations and the Council of Europe, [they] identified relevant international laws concerning the right to health and the rights of different groups of undocumented migrants. [...] Undocumented migrants in Denmark have the right to emergency care, while additional care is restricted and may be subject to payment. Undocumented migrants in Sweden have the right to emergency care only. There is an exception made for former asylum-seeking children, who have the same rights as Swedish citizens. In the Netherlands, undocumented migrants have greater entitlements and have access to primary, secondary and tertiary care, although shortcomings remain. All three countries have ratified international human rights treaties that include right of access to health care services.*


GLOBAL HEALTH NEWS:

UN report highlights abuse as ‘drug treatment’

A United Nations report about torture and other abuses in healthcare settings points to the need for donors to withdraw funds to compulsory drug detention centers [...]. The report was presented to the UN Human Rights Council in Geneva on March 4, 2013, by the special rapporteur on torture, Juan Mendez. It says that people identified as drug users are held without due process in government-run detention centers where they face serious abuse – including physical and sexual violence and forced labor – all in the name of “rehabilitation.” Human Rights Watch has done extensive research on the subject in Vietnam, China, Cambodia, and Lao PDR, and Harm Reduction International has also reported on donor support to centers in these countries. “Illegal detention, forced labor, and sexual violence are not drug dependency treatment,” said Rebecca Schleifer, health and human rights advocacy director at Human Rights Watch. “The UN’s expert on torture has made it clear that governments should close down these centers and donors should stop subsidizing these abuses.” International donors have provided funding and other assistance to these centers, which deny effective drug treatment and operate without adequate human rights oversight.*

Source: __________. 2013. UN report highlights abuse as ‘drug treatment.’ Human Rights Watch online (3 March).

RESEARCH ON GLOBAL HEALTH GOVERNANCE & INSTITUTIONS

Who should pay for global health, and how much?

Mechanisms to establish the expected financial contribution from each country to achieve the health Millennium Development Goals (MDGs) could encourage scaling-up of contributions. Mirroring global carbon permit markets to mitigate climate change, [the authors] propose a cap-and-trade system consisting of a global cost-effectiveness criterion and a disability-adjusted life year (DALY) global credit market. Under this system, high-income and middle-income countries should contribute, respectively, 74% and 26% of the additional US$36–US$45 billion annually needed to attain the health MDGs. The change relative to current contributions would vary, with some countries needing to scale-up substantially their expected annual contributions under the proposed market (e.g., US, US$7–US$10 billion; China, US$2–US$3 billion; Japan, US$2 billion; Germany, US$1.5–US$2 billion), while a few already meet or exceed their required contributions (i.e., Norway, the United Arab Emirates, Luxembourg, and the UK). A DALY tradable credit market offers the potential to increase the efficiency of global health investments while promoting international obligations to the pursuit of an agreed global common good.*

RESEARCH ON HEALTH & DEVELOPMENT, HEALTH SYSTEMS:

Utilization of a population health survey in policy and practice: A case study

There is growing interest by funding bodies and researchers in assessing the impact of research on real world policy and practice. Population health monitoring surveys provide an important source of data on the prevalence and patterns of health problems, but few empirical studies have explored if and how such data is used to influence policy or practice decisions. Here the authors provide a case study analysis of how the findings from an Australian population monitoring survey series of children’s weight and weight-related behaviors (Schools Physical Activity and Nutrition Survey (SPANS)) have been used, and the key facilitators and barriers to their utilization. [...] They found that the survey findings were used for agenda setting (raising awareness of issues), identifying areas and target groups for interventions, informing new policies, and supporting and justifying existing policies and programs across a range of sectors. Reported factors influencing use of the findings were i) the perceived credibility of survey findings; ii) dissemination strategies used; and, iii) a range of contextual factors. [...] The findings highlight the importance of population monitoring programs being conducted by independent credible agencies, researchers engaging end-users from the inception of survey programs and utilizing existing policy networks and structures, and using a range of strategies to disseminate the findings that go beyond traditional peer review publications.*


GLOBAL HEALTH NEWS:

WHO and the future of disease control programmes

Huge increases in funding for international health over the past two decades have led to a proliferation of donors, partnerships, and health organisations. Over the same period, the global burden of non-communicable diseases has increased absolutely and relative to communicable diseases. In this changing landscape, national programmes for the control of HIV/AIDS, tuberculosis, malaria, and neglected tropical diseases must be reinforced and adapted for three reasons: the global burden of these communicable diseases remains enormous, disease control programmes have an integral and supporting role in developing health systems, and the health benefits of these control programmes go beyond the containment of specific infections. WHO’s traditional role in promoting communicable disease control programmes must also adapt to new circumstances. Among a multiplicity of actors, WHO’s task is to enhance its normative role as convener, coordinator, monitor, and standard-setter, fostering greater coherence in global health.*


GLOBAL HEALTH NEWS:

WHO/World Bank convene ministerial meeting to discuss best practices for moving forward on universal health coverage

Top officials from health and finance ministries from 27 countries joined other high-level health and development stakeholders at a two-day meeting [18-19 February] in Geneva to discuss ways that countries are progressing towards universal health coverage. The meeting was convened jointly by the World Health Organization (WHO) and the World Bank and took place just weeks after the United Nations General Assembly adopted a resolution supporting universal health coverage. Delegates at the Geneva meeting expressed strong support for the ideas underlying universal health coverage: that everyone, irrespective of their ability to pay, should have access to the health services they need, without putting their families at financial risk. Many speakers stressed the importance of getting political commitment to universal health coverage at the highest level. Some countries described how they are focusing their limited resources initially on providing coverage to the poor and vulnerable, while others have taken a more universal approach from the start. The use of general revenues to provide such coverage was a recurrent theme; but there was also some discussion about using earmarked revenues such as “sin taxes.”*

Source: WHO & World Bank, 2013. WHO/World Bank convene ministerial meeting to discuss best practices for moving forward on universal health coverage. WHO online (19 February).
RESEARCH ON HUMAN RESOURCES & MIGRATION OF HEALTH WORKERS:

**Human resource governance: What does governance mean for the health workforce in low- and middle-income countries?**

This paper examines health system strengthening as it occurs in the intersection between the health workforce and governance by presenting a framework to examine health workforce issues related to eight governance principles: strategic vision, accountability, transparency, information, efficiency, equity/fairness, responsiveness and citizen voice and participation. [...] A qualitative analysis of Health System Assessment (HSA) data, a rapid indicator-based methodology that determines the key strengths and weaknesses of a health system using a set of internationally recognized indicators, was completed to determine how 20 low- and middle-income countries are operationalizing health governance to improve health workforce performance. [...] Strengths highlighted include increasing the transparency of financial flows from sources to providers by implementing and institutionalizing the National Health Accounts methodology; increasing responsiveness to population health needs by training new cadres of health workers to address shortages and deliver care to remote and rural populations; having structures in place to register and provide licensure to medical professionals upon entry into the public sector; and implementing pilot programs that apply financial and non-financial incentives as a means to increase efficiency. Common weaknesses emerging in the HSAs include difficulties with developing, implementing and evaluating health workforce policies that outline a strategic vision for the health workforce; implementing continuous licensure and regulation systems to hold health workers accountable after they enter the workforce; and making use of health information systems to acquire data from providers and deliver it to policymakers.*


RESEARCH ON TRADE POLICY & HEALTH:

**Multidrug-resistant bacteria among patients treated in foreign hospitals: Management considerations during medical repatriation**

The repatriation of patients from foreign hospitals can foster the emergence and spread of multidrug-resistant bacteria (MRB) acquired in high-resistance prevalent areas. The ever-growing international tourism industry coupled with the repatriation of patients who become ill during their travel has enhanced this phenomenon. Studies systematically screening repatriates from foreign hospitals, however, are scarce and relatively out-dated. Recent case reports as well as limited epidemic occurrences involving MRB with extensive media coverage have forced French Health Authorities to consider the problem and develop a strategy aimed at the appropriate repatriation of these patients. Thus far, these efforts have been marginally effective. Further, the French Health Authorities have forced the hospitals to follow very strict mandatory guidelines when admitting patients from abroad; these hospitals have isolated these patients upon repatriation and admission followed by rapid attempts to detect MRB—in fact, the guidelines employed include travelers who have been hospitalized for more than 24 hours in a foreign country within the last year. While these measures aim to limit MRB exposure to the greater French population, they also dramatically complicate the procedure of repatriation of patients; hospitals are reluctant to offer admission to these individuals immediately after repatriation. Medical repatriation and evacuation services must deal with this new challenge.*

RESEARCH ON ACCESS TO EFFECTIVE MEDICINES:

**Does access to medicines differ by gender? Evidence from 15 low and middle income countries**

[This paper set out to] examine gender differences in access to prescribed medicines in 15 lower and middle income countries. The proportion of consultations with at least one prescription for women in three age groups (<15, 15–59, 60+ years) with acute respiratory infections (ARI), depression and diabetes in routine audits was compared to the expected proportion calculated from WHO Global Burden of Disease estimates. Newer oral hypoglycaemic medication prescribing was also analysed. Differences reported by country, age group, and condition. 487,841 consultations examined between January 2007 and September 2010 in low (n = 1), lower middle (6), and upper middle income (8) countries. No country favoured one gender exclusively, but gender differences were common. Taking the 15 countries together, only diabetes treatment revealed a significant difference, with women being treated less often than expected (p = 0.02). No consistent differences found across countries grouped by World Bank income category, WHO region or Global Gender Gap Index. Overall, women had equal access to newer oral hypoglycaemics. Gender differences in access to prescribed medicines for three common conditions are common, but favour neither gender consistently. This challenges prevailing hypotheses of systematic disparities in access to care for women. Evidence about gender disparities should influence policy design.*


GLOBAL HEALTH NEWS:

**WTO, WHO, WIPO examine intersection of public health, intellectual property, trade**

More coherence is needed between public health, intellectual property (IP), and trade policies in order to advance innovation and improve access to medicines, according to a joint report released by the WTO, the World Health Organization (WHO) and the World Intellectual Property Organization (WIPO) on Tuesday. The study, entitled “Promoting Access to Medical Technologies and Innovation: Intersections between Public Health, Intellectual Property, and Trade,” was designed to bring together the three organisations’ respective areas of expertise with the goal of better informing policy-making decisions, especially in developing countries. […] The study therefore calls for appropriate and creative patent licensing strategies to ensure that drugs and medical technologies are made both affordable and available in poorer countries. […] The organisations also list various flexibilities aimed at safeguarding the public interest that are already available in the international IP regime.*


GLOBAL HEALTH NEWS:

**UN takes on organized crime and fraudulent medicines**

The United Nations has become a focal point for global efforts to fight organised crime’s trafficking of fraudulent medicines that put millions of people – especially the poor – at risk. And a recent pharmaceutical industry report on such medicines recommended some solutions. “[W]hat really matters is that fraudulent medicines are a severe public health risk. They deserve our full attention,” said Yury Fedotov, executive director of the UN Office on Drugs and Crime (UNODC). […] Fedotov said the basis for the work will be the UN Convention on Transnational Organized Crime (UNTOC), which provides for “the exchange of information, the application of investigative powers, and information sharing that is often invaluable in these types of criminal operations.” He called on governments to ratify and implement the convention. Fedotov also urged the early adoption of an efficient review mechanism for the implementation of UNTOC, and to integrate local national crime strategies and our overall international approach.*

Source: New W & Caulier TN. 2013. UN takes on organized crime and fraudulent medicines. *Intellectual Property Watch online (15 February).*
RESEARCH ON RESPONSE TO HIV/AIDS, TUBERCULOSIS & MALARIA:

Toward an understanding of disengagement from HIV treatment and care in sub-Saharan Africa: A qualitative study

The rollout of antiretroviral therapy in sub-Saharan Africa has brought lifesaving treatment to millions of HIV-infected individuals. Treatment is lifelong, however, and to continue to benefit, patients must remain in care. Despite this, systematic investigations of retention have repeatedly documented high rates of loss to follow-up from HIV treatment programs. This paper introduces an explanation for missed clinic visits and subsequent disengagement among patients enrolled in HIV treatment and care programs in Africa. Eight-hundred-ninety patients enrolled in HIV treatment programs in Jos, Nigeria; Dar es Salaam, Tanzania; and Mbarara, Uganda who had extended absences from care were tracked for qualitative research interviews. Two-hundred-eighty-seven were located, and 91 took part in the study. […]

Findings reveal unintentional and intentional reasons for missing, along with reluctance to return to care following an absence. Disengagement is interpreted as a process through which missed visits and ensuing reluctance to return over time erode patients' subjective sense of connectedness to care. Missed visits are inevitable over a lifelong course of HIV care. Efforts to prevent missed clinic visits combined with moves to minimize barriers to re-entry into care are more likely than either approach alone to keep missed visits from turning into long-term disengagement.*


GLOBAL HEALTH NEWS:

Letter shows US pressure on Global Fund for compulsory licensing, generics

A 2011 letter from the top Republican on the United States Senate Finance Committee condemned efforts by the Global Fund to train public health officials on the use of flexibilities to the patent system contained in international trade rules. The letter, which also attacked the purchase of generic medicines over brand-name drugs, came just months before the US helped remove the head of the Global Fund, ultimately replacing him with an American official. The Global Fund to Fight AIDS, Tuberculosis and Malaria, based in Geneva, was created to raise resources to fight those diseases and direct those resources toward the greatest areas of need. It has raised billions of dollars but ran into difficulties during the global financial crisis. The 13 April 2011 letter from Sen. Orrin Hatch, a Utah Republican, to US Secretary of State Hillary Clinton, asserted that the Global Fund had paid more for generic drugs than for brand name versions, which amounted to a US-funded program “making inefficient and unnecessarily costly procurement decisions that come with dire consequences.” It also criticised the Global Fund’s training efforts for promoting the use of compulsory licensing, suggesting that it is an abuse of the patent system and goes against the World Trade Organization Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS).*

RESEARCH ON GLOBAL ACTION ON NON-COMMUNICABLE DISEASES:

**Tackling non-communicable disease in low- and middle-income countries: Is the evidence from high-income countries all we need?**

Non-communicable diseases (NCDs, e.g., cardiovascular disease, diabetes, cancers, chronic respiratory diseases, neurological diseases) have been the commonest cause of death and disability globally for at least the last three decades. Even in sub-Saharan Africa, NCDs contribute a third of the disability-adjusted life year burden. However, research resources allocated to NCDs in low- and middle-income countries (LMICs) are trivial. [The authors] analyse the interplay between applied health research in NCDs in high-income (HICs) and LMICs and demonstrate that there are opportunities for mutual advantages. [Specifically, they find that] applied health research and development for non-communicable diseases (NCDs) in low- and middle-income countries (LMICs) is limited, and despite repeat calls for action, the NCD burden is increasingly unchecked. NCD research in high-income countries (HICs) and LMICs can result in mutual advantages in the areas of replication and extending findings; discovering new causes of NCDs; studying health effects of exposures rare or ubiquitous in HICs; and exploring links between infectious diseases and NCDs. Different NCDs are at varying stages of needing research, policy development, and action. These stages range from not knowing the population burden of many NCDs to knowing all we need to take action. Changes in the global and national funding agendas will be required to strengthen the research and health system capacity for NCDs, which should reduce deaths and disability attributable to NCDs and yield economic dividends.


GLOBAL HEALTH NEWS:

**IARC in the dock over ties with asbestos industry**

Does asbestos corrupt more than just DNA? That is the question now being asked of the International Agency for Research on Cancer (IARC) after a series of recent decisions triggered a storm of protest from governments, non-governmental organisations, and health campaigners and left the agency, which is an arm of WHO, open to accusations that range from the relatively benign charge of poor judgment to allegations of corporate capture by the asbestos industry. The row erupted late last year, when IARC accepted an invitation to send one of its scientists, Valerie McCormack, to present data at a conference in Kiev, Ukraine, entitled Chrysotile Asbestos: Risk Assessment and Management. That decision sparked a flurry of emails and letters to the Director-General of IARC Christopher Wild, including one seen by The Lancet from the Italian Minister of Health Renato Balduzzi, on behalf of the Italian Government, entitling Chrysotile Asbestos: Risk Assessment and Management. That decision sparked a flurry of emails and letters to the Director-General of IARC Christopher Wild, including one seen by The Lancet from the Italian Minister of Health Renato Balduzzi, on behalf of the Italian Government, imploring IARC to shun the conference over suspicions that the organisers were in cahoots with the Russian asbestos industry. Sources inside WHO tell The Lancet that in the days leading up to the meeting, high-ranking WHO officials urged IARC to cancel its attendance at the Kiev conference. A spokesperson for WHO’s Director-General Margaret Chan declined to comment; however, speaking on behalf of IARC, Nicolas Gaudin denied that Margaret Chan nor any other senior WHO officials had tried to intervene, and continued that “IARC is not privy to possible discussions internal to WHO on this subject.”

The *Health and Foreign Policy Bulletin* is a monthly publication of the Norman Paterson School of International Affairs and the Centre for Trade Policy and Law. Its objective is to promote evidence based policy making by summarizing and disseminating the latest research on the intersection between global health and foreign policy. The Bulletin also identifies key events and developments of importance to policy makers. We are always looking for ways to improve the Health and Foreign Policy Bulletin and to expand its readership. If you have any suggestions or would like to subscribe, please contact us at jacob_hall@carleton.ca. The Bulletin is also available on the website of the Global Health Diplomacy Network (GHD-NET).

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