**RESEARCH ON GLOBAL HEALTH SECURITY:**

**Performance of case definitions used for influenza surveillance among hospitalized patients in a rural area of India**

[This paper set out to] assess case definitions for influenza in a rural community in India. Residents of the study area who were hospitalized for any acute medical condition for at least one night between May 2009 and April 2011 were enrolled. Respiratory specimens were collected and tested for influenza viruses in a reverse-transcription polymerase chain reaction (PCR). The PCR results were taken as the “gold standard” in evaluating the performance of several case definitions. Of the 3179 patients included in the final analysis, 21% (665) were PCR-positive for influenza virus, 96% reported fever and 4% reported shortness of breath. The World Health Organization (WHO) case definition for severe acute respiratory illness had a sensitivity of 11% among patients aged <5 years and of 3% among older patients. When shortness of breath was excluded from the definition, sensitivities increased (to 69% and 70%, respectively) and corresponding specificities of 43% and 53% were recorded. Among patients aged ≥5 years, WHO's definition of a case of influenza-like illness had a sensitivity of 70% and a specificity of 53%. The addition of “cough and reported or measured fever” increased sensitivity to 80% but decreased specificity to 42%. The inclusion of shortness of breath in WHO's case definition for severe acute respiratory illness had a sensitivity of 11% among patients aged <5 years and of 3% among older patients. When shortness of breath was excluded from the definition, sensitivities increased (to 69% and 70%, respectively) and corresponding specificities of 43% and 53% were recorded. Among patients aged ≥5 years, WHO's definition of a case of influenza-like illness had a sensitivity of 70% and a specificity of 53%. The addition of “cough and reported or measured fever” increased sensitivity to 80% but decreased specificity to 42%. The inclusion of shortness of breath in WHO's case definition for severe acute respiratory illness may grossly underestimate the burden posed by influenza in hospitals. The exclusion of shortness of breath from this definition or, alternatively, the inclusion of “cough and measured or reported fever” may improve estimates of the burden.*

**Global Health News:**

**Push needed for pandemic planning**

Three years after the H1N1 influenza pandemic, there is a reluctance to talk about it – even among health officials – as, despite widespread alarm, it was far less devastating than the 1918 Spanish flu. Pandemic fatigue has set in and is difficult to overcome in the current economic crisis. “It’s vital for the global health community to take in what happened during the 2009 outbreak and learn from it,” says Dr Nahoko Shindo from the World Health Organization’s (WHO) Global Influenza Programme. She warns that if this is not done soon, countries will lose momentum and the memory of what happened will fade. “We need to fix the things that didn’t work so that we can tackle similar threats better in future.” Top of her list is the fact that, during the early phase of the 2009 pandemic, some countries were following their national guidance based on an older version of WHO pandemic preparedness guidance while WHO was following the updated version. […] The process of revising WHO pandemic preparedness guidance in line with lessons from the 2009 H1N1 pandemic started this year and involves consultation with WHO’s 194 Member States. Initially the Organization will report progress on this to countries at the Executive Board meeting in January next year and then at the World Health Assembly in May.*


**Research on Health & States in Crisis/Conflict:**

**Adherence to antiretroviral therapy and treatment outcomes among conflict-affected and forcibly displaced populations: A systematic review**

Optimal adherence to highly active antiretroviral therapy (HAART) is required to promote viral suppression and to prevent disease progression and mortality. Forcibly displaced and conflict-affected populations may face challenges succeeding on HAART. […] The authors screened 297 records and identified 17 reports covering 15 quantitative and two qualitative studies from 13 countries. […] The reviewed reports showed promise for conflict-affected and forcibly-displaced populations; the range of optimal adherence prevalence reported was 87-99.5%. Treatment outcomes, measured using virological, immunological and mortality estimates, were good in relation to non-affected groups. Given the diversity of settings where forcibly-displaced and conflict-affected persons access ART, further studies on adherence and treatment outcomes are needed to support scale-up and provide evidence-based justifications for inclusion of these vulnerable groups in national treatment plans. Future studies and program evaluations should focus on systematic monitoring of adherence and treatment interruptions by using facility-based pharmacy records, understanding threats to optimal adherence and timely linkage to care throughout the displacement cycle, and testing interventions designed to support adherence and treatment outcomes in these settings.*


**Global Health News:**

**United Nations: Ordinary people paying the price in Syria**

As the situation in Syria deteriorates on a daily basis, risks faced by those in and leaving the country continue to mount. The increasing insecurity is making it more difficult for humanitarian actors to operate and to address the needs of affected people. “We are looking at how we can adjust our methods of work so that we continue to reach as many people in need as we can throughout the country,” said Radhouane Nouicer, the Regional Humanitarian Coordinator for Syria. “To that end, we are currently reviewing our contingency plans, as well as updating the Syria Humanitarian Assistance Response Plan (SHARP). Most of all, we need an end to the unrelenting violence. All calls, from all sides, for parties to honour their obligations to protect civilians in Syria have had little effect, and ordinary people are paying the price,” he said.*

*Source: UN Office for the Coordination of humanitarian Affairs. 2012. United Nations: Ordinary people paying the price in Syria. Reliefweb online (3 December).*
**Human rights research and ethics review: Protecting individuals or protecting the state?**

Recently there has been a dramatic expansion in research conducted in low- and middle-income countries, as well as research ethics committees (RECs) in these countries. RECs in low- and middle-income countries have little experience overseeing human rights research and may be subject to government control or influence that may favor the interests of the state over the interests of individual research participants. Many human rights investigators are trained in disciplines with ethical codes and professional norms, but do not typically engage RECs nor see human rights documentation as research, and they tend to view REC approval as counterproductive to the protection of research participants. Case studies of human rights research can provide important lessons on navigating conflicts of interest posed by some local (i.e., in country) RECs. Expanding the use of community engagement and developing strong ethical operating principles can help ensure that individuals and researchers are protected in human rights research and investigations.


**The long-term health consequences of child physical abuse, emotional abuse, and neglect: A systematic review and meta-analysis**

Child sexual abuse is considered a modifiable risk factor for mental disorders across the life course. However the long-term consequences of other forms of child maltreatment have not yet been systematically examined. The aim of this study was to summarise the evidence relating to the possible relationship between child physical abuse, emotional abuse, and neglect, and subsequent mental and physical health outcomes. A systematic review was conducted using the Medline, EMBASE, and PsycINFO electronic databases up to 26 June 2012. [...] Out of 285 articles assessed for eligibility, 124 studies satisfied the pre-determined inclusion criteria for meta-analysis. [...] This overview of the evidence suggests a causal relationship between non-sexual child maltreatment and a range of mental disorders, drug use, suicide attempts, sexually transmitted infections, and risky sexual behaviour. All forms of child maltreatment should be considered important risks to health with a sizeable impact on major contributors to the burden of disease in all parts of the world. The awareness of the serious long-term consequences of child maltreatment should encourage better identification of those at risk and the development of effective interventions to protect children from violence.*


**Access to contraception a human right would cut health costs, UN says**

Canada needs to do more to make family planning tools, resources and services more widely available to people in the developing world, say advocates for a new United Nations report on the plight of the global population. The UN Population Fund’s annual report, released Wednesday in Geneva, calls access to contraception a universal human right that could dramatically improve the lives of women and children in poor countries. It is the first time the report has explicitly described family planning as a human right. The [Canadian] federal government should be doing more to ensure contraception is readily available to women in developing countries, said Action Canada for Population and Development, an Ottawa-based advocacy group. The government promised $1.1 billion over five years to the G8 Muskoka Initiative, an international deal Prime Minister Stephen Harper brokered in 2010 for maternal and child health initiatives in the developing world. Only a fraction of that money — about $16 million — was earmarked for family planning in the current fiscal year, said Sandeep Prasad, Action Canada’s executive director.*

**RESEARCH ON GLOBAL HEALTH GOVERNANCE & INSTITUTIONS**

**Transforming governance or reinforcing hierarchies and competition: examining the public and hidden transcripts of the Global Fund and HIV in India**

Global health initiatives (GHIs) have gained prominence as innovative and effective policy mechanisms to tackle global health priorities. More recent literature reveals governance-related challenges and their unintended health system effects. Much less attention is received by the relationship between these mechanisms, the ideas that underpin them and the country-level practices they generate. The Global Fund has leveraged significant funding and taken a lead in harmonizing disparate efforts to control HIV/AIDS. Its growing influence in recipient countries makes it a useful case to examine this relationship and evaluate the extent to which the dominant public discourse on Global Fund departs from the hidden resistances and conflicts in its operation. Drawing on insights from ethnographic fieldwork and 70 interviews with multiple stakeholders, this article aims to better understand and reveal the public and the hidden transcript of the Global Fund and its activities in India. [The authors] argue that while its public transcript abdicates its role in country-level operations, a critical ethnographic examination of the organization and governance of the Fund in India reveals a contrasting scenario. Its organizing principles prompt diverse actors with conflicting agendas to come together in response to the availability of funds. Multiple and discrete projects emerge, each leveraging control and resources and acting as conduits of power.*


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**GLOBAL HEALTH NEWS:**

**A manifesto for the world we want**

The era of sustainable development that is currently being debated for post-2015 represents a revolutionary change that goes beyond the current framework of the Millennium Development Goals (MDGs) and the driving ideal of ending poverty. [...] As we look to the future, [the authors] see five priorities. [They are: 1) women, who remain the dominant face of poverty; 2) early child development; 3) adolescent health; 4) people living with non-communicable diseases; and 5) a globally ageing population. [...] Progress on all of these priorities will only happen if important cross-cutting issues are also addressed at the same time. First, increasing access to high-quality health care—universal health coverage. Second, ensuring equity. [...] Third, tackling the social determinants of health, including the multiplicity of sectors affecting health—eg, water and sanitation. Fourth, establishing systematic accountability mechanisms that will hold countries and donors to their promises and commitments. [...] Fifth, the need to defeat stigma and discrimination that limits people's access to health care—eg, among men who have sex with men and people who inject drugs. [...] There is one final objective, perhaps the most important of all—confronting the escalating threat to human health, even to human survival, from climate change. The era of sustainable development is perhaps the last opportunity our species has to engage with this catastrophic danger—solving the challenge of climate change is the most important foundation for our planet's sustainability, bar none.*

Factors influencing the provision of public health services by village doctors in Hubei and Jiangxi provinces, China
The Chinese central government launched the Health System Reform Plan in 2009 to strengthen disease control and health promotion and provide a package of basic public health services. Village doctors receive a modest subsidy for providing public health services associated with the package. Their beliefs about this subsidy and providing public health services could influence the quality and effectiveness of preventive health services and disease surveillance. [This paper set out to] understand village doctors’ perspectives on the subsidy and their experiences of delivering public health services, [the authors] performed 10 focus group discussions with village doctors, 12 in-depth interviews with directors of township health centres and 4 in-depth interviews with directors of county-level Centers for Disease. The study was conducted in four counties in central China, two in Hubei province and two in Jiangxi province. Village doctors prioritize medical services but they do their best to manage their time to include public health services. Township health centre directors, village doctors’ willingness to provide public health services has improved since the introduction of the package and a minimum subsidy, but village doctors do not find the subsidy to be sufficient remuneration for their efforts. Improving the delivery of public health services by village doctors is likely to require an increase in the subsidy, improvement in the supervisory relationship between village clinics and township health centres and the creation of a government pension for village doctors.*


Global Health News:
Anything goes on the path to universal health coverage? No
In its 2010 world health report, the World Health Organization noted that there is no single, best path for reforming health financing arrangements to move systems closer to universal health coverage, i.e. to improve access to needed, effective services while protecting users from financial ruin. However, this lack of a blueprint for health financing reforms was not meant to convey the message that “anything goes” on the path to universal health coverage. Indeed, concerns have been raised that some reforms, often implemented in the name of expanding coverage, may actually compromise equity. Theory and country experience yield important lessons on both promising directions and pitfalls to avoid. Interpretation of health financing reform experience requires getting beneath commonly used labels such as “tax-funded systems” or “social health insurance”, or simply even “health insurance”, which was used as the basis for a systematic review published in the September issue of the Bulletin of the World Health Organization. Such labels hide more than they illuminate, as shown by emerging evidence on reforms that increase access and financial protection but are funded predominantly from general tax revenues (e.g. Kyrgyzstan, Mexico, Rwanda, Thailand). Deriving meaningful lessons from innovative reform experiences requires a deeper understanding of how countries have altered their funding sources, pooling arrangements, purchasing methods, and policies on benefits and patient cost-sharing.*

Mobility of health professionals pre and post 2004 and 2007 EU enlargements: Evidence from the EU project PROMeTHEUS

European Union (EU) enlargement has facilitated the mobility of EU citizens, including health professionals, from the 2004 and 2007 EU accession states. Fears have been raised about a mass exodus of health professionals and the consequences for the operation of health systems. However, to date a systematic analysis of the EU enlargement's effects on the mobility of health professionals has been lacking. The aim of this article is to shed light on the changes in the scale of movement, trends and directions of flows pre and post 2004 and 2007 EU enlargements. [...] It finds that the stock of health professionals from the new (EU-12) into the old EU Member States (EU-15) have increased following EU accession. The stock of medical doctors from the EU-12 in the EU-15 countries has more than doubled between 2003 and 2007. The available data suggest the same trend for dentists. The extremely limited data for nurses show that the stock of nurses has, in contrast, only slightly increased. However, while no reliable data is available evidence suggests that the number of undocumented or self-employed migrant nurses in the home-care sector has significantly increased. Health professionals trained in the EU-12 are becoming increasingly important in providing sufficient health care in some destination countries and regions facing staff shortages. A mass exodus of health professionals has not taken place after the 2004 and 2007 EU enlargements.*


Global Health News:

Basic hygiene at risk in debt-stricken Greek hospitals

Greek hospitals are in such dire straits that staff are failing to keep up basic disease controls like using gloves and gowns, threatening a rise in multi-drug-resistant infections, according to Europe’s top health official. Greece already has one of the worst problems in Europe with hospital-acquired infections, and disease experts fear this is being made worse by a severe economic crisis that has cut health care staffing levels and hurt standards of care. With fewer doctors and nurses to look after more patients, and hospitals running low on cash for supplies, risks are being taken even with basic hygiene, said Marc Sprenger, director of the European Centre for Disease Prevention and Control (ECDC). [...] Sprenger said the situation means patients with highly-infectious diseases like tuberculosis (TB) may not get the treatment they need, raising the risk that dangerous drug-resistant forms will tighten their grip on Europe.*

Contemporary medical tourism: Conceptualisation, culture and commodification

[In this paper, an] overview is given of the short history and rapid rise of medical tourism, its documentation, and current knowledge and analysis of the industry. Definitions of medical tourism are limited, [therefore] who medical tourists are and how many exist are both indeterminate and inflated. Definitions often conflate medical tourism, health tourism and medical travel, and are further complicated by the variable significance of motivation, procedures and tourism. While media coverage suggests long-distance travel for surgical procedures, and the dominance of middle class European patients, much medical tourism is across nearby borders and from diasporas, and of limited medical gravity, conflicting with popular assumptions. Numbers are usually substantially less than industry and media estimates. Data must remain subject to critical scrutiny. Medical travel may be a better form of overall categorisation with medical tourism a sub-category where ‘patient-tourists’ move through their own volition. Much medical tourism is short distance and diasporic, despite being part of an increasingly global medical industry, linked to and parallel with the tourism industry. Intermediaries (medical tourism companies) are of new significance. Opportunities are diffused by word of mouth with the internet of secondary value. Quality and availability of care are key influences on medical tourism behaviour, alongside economic and cultural factors.*


Strengthening medical product regulation in low- and middle-income countries

Medical product regulatory systems are central to health systems; they ensure high quality and safe interventions like drugs, vaccines, and medical devices for patients who need and count on them. The World Health Organization (WHO) recognizes this fact and includes regulatory system functions as one of the six core building blocks of health systems: access to medical products, vaccines, and technologies of assured quality, safety, and efficacy. Although WHO has recognized their importance, to date, little attention has been focused on regulatory systems in low- and middle-income countries. They have not featured prominently in global health and development assistance programs, and few strategic documents of major global health initiatives, including the United States Global Health Initiative, reference regulatory systems. The global activities that do involve regulatory systems typically involve high-income countries. For example, the International Conference on Harmonization of Technical Requirements for Registration of Pharmaceuticals for Human Use (ICH), which harmonizes regulatory standards and processes for the pharmaceutical industry, includes regulatory authorities from the European Union, Japan, and the United States. [...] The lack of attention to medical product regulatory systems in low- and middle-income countries is a significant gap that needs to be bridged. [The authors thus] propose that strengthening regulatory systems in low- and middle-income countries must become a global health priority [...].*†

RESEARCH ON RESPONSE TO HIV/AIDS, TUBERCULOSIS & MALARIA:

World AIDS Day report: Results
There were more than 700,000 fewer new HIV infections globally in 2011 than in 2001. Africa has cut AIDS-related deaths by one third in the past six years. And as services have been scaled up, uptake has followed. In fact, what had taken a decade before is now being achieved in 24 months. In the past two years there has been a 60% increase in the number of people accessing lifesaving treatment. In most parts of the world we have seen a reduction in new HIV infections among young people. [...] As we enter into the final years of working towards the Millennium Development Goals and the United Nations Political Declaration on HIV/AIDS, much remains to be done to reach our targets. Treatment has not yet reached 7 million people. [...] The people who are most affected by HIV still experience marginalization and exclusion. The results we have seen show us that the momentum of our collective political will and follow through can overcome the biggest of obstacles and challenges—even the shortness of time. It shows us that with our steadfast determination and compassion—that invisible cord that binds us to other human beings regardless of race, gender, personal status, religion or national borders—we can get results for all people.*†


GLOBAL HEALTH NEWS:

WHO members agree on “Strategic Work Plan” on health R&D-But no Convention
After three days and two nights of tough negotiations to address the global gap in research and development for neglected diseases at the World Health Organization, member states agreed to endorse a strategic work plan that includes proposals on the coordination, financing, and monitoring of R&D expenditures separately, but not to advance the idea of an overarching framework. The recommendation for a global R&D convention proved divisive to the very end of the negotiations. [...] Member states agreed on a draft report and resolution, recommending it to be adopted by the next World Health Assembly “without reopening it.” Meeting to consider the expert CEWG report and develop proposals on research coordination, financing, and monitoring of R&D expenditures, member states agreed to establish a Global Health R&D Observatory, explore existing funding and coordinating mechanisms, and to review progress again at the World Health Assembly in May 2016. It is an outcome that has left many member states and public health experts, who were hoping for a more ambitious strategy, disappointed.*


GLOBAL HEALTH NEWS:

Call for global crackdown on fake medicines
A global treaty to crack down on the deadly trade of fake medicines is urgently needed, say experts. Currently, there are more sanctions around the use of illegal tobacco than counterfeit drugs. Writing in the British Medical Journal, experts urge the World Health Organization to set up a framework akin to its one tobacco control to safeguard the public. WHO says more than one in every 10 drug products in poorer nations are fake. [...] In richer countries, medicine safety is better, but substandard and falsified drugs still cause thousands of adverse reactions and some deaths. Recently, in the US, contaminated drug supplies caused an outbreak of meningitis that has so far killed 16 people. [...] In other contexts, global treaties have helped governments strengthen their laws and cooperate internationally to clamp down on havens - for example, on money laundering.*

Source: Roberts M. 2012. Call for global crackdown on fake medicines. BBC online (13 November).
See also: Attaran A. 2012. How to achieve international action on falsified and substandard medicines. BMJ 345:e7381 (13 November).
GLOBAL HEALTH NEWS:

Promises on AIDS are not enough

Experts know how to control the global spread of the AIDS virus. What's missing is enough money and political will to apply proven tactics widely enough to change the course of the epidemic. On [November 29] Secretary of State Hillary Clinton unveiled her promised “blueprint” for reaching an “AIDS-free generation” — meaning a time when virtually no child is born with the virus that causes AIDS and teenagers have much less risk of becoming infected. It lays out ways for containing the epidemic, like expanding the use of the most effective treatments and prevention methods, and focusing on groups most at risk of infection, like sex workers and people who inject drugs. But it failed to set firm goals for the percentage of people to be provided with treatments or the reduction in disease to be achieved. Nor does it offer a pledge of new money to help afflicted nations carry out the tasks. [...] Middle-income countries where AIDS is prevalent have steadily increased their share of the annual total of more than $16 billion spent around the world fighting the disease, but the poorest countries still need help. Governments struggling to revive their economies will be hard pressed to increase money or resources, but this is an investment that the international community cannot put off.*


RESEARCH ON GLOBAL ACTION ON NON-COMMUNICABLE DISEASES:

NCD prevention and control in Latin America and the Caribbean: A regional approach to policy and program development

This article describes efforts from the Pan American Health Organization (PAHO) that have supported progress in country-driven planning and implementing of actions to address noncommunicable diseases (NCD), as well as mechanisms that PAHO has supported for countries in the Americas to share and build on each other’s experiences. The Regional Strategy and Plan of Action for NCD, approved by all member states in 2006, is the major frame for this work. The strategy has 4 lines of action: policy and advocacy; surveillance; health promotion and disease prevention; and integrated management of NCD and risk factors. [...] Almost all member states have made substantial progress in implementing their national chronic disease programs, in most instances reporting exceeding the indicators of the strategic plan related to chronic diseases. From the Caribbean countries, leadership has been provided to achieve the historic UN High-Level Meeting on NCD in September 2011. The region is on track to meet the mortality reduction target set for 2013, though much remains to be done to further increase awareness of and resources for scaling up NCD prevention and control programs, given the huge health and economic burden, increasing costs, and worrying increases of some conditions such as obesity. Major challenges include getting NCD into social protection packages, building the human resource capacity, strengthening surveillance, achieving true intersectoral and multipartner action, given that most determinants of the epidemic lie outside the health sector, and increasing investment in prevention.*

Cancer fight stalls amid push for profits, doctors say

Progress against cancer is stalling, with the latest targeted cancer drugs failing to live up to expectations and priced so high that treatment is becoming unaffordable even in rich countries, according to experts at a meeting of nearly 100 eminent cancer specialists from around the world. At the two-day meeting in Lugano, Switzerland, the doctors agreed a 10-point declaration, to be published early next year, which will chart the way forward for cancer care around the globe. Much needs to be done, they believe, to improve treatment, care and prevention both in the developed world and in poor countries, where cancer rates are rising even faster. They agreed to embark on an ambitious plan to get essential cancer care to those who are dying early in developing countries, in the same way that Aids doctors took on the fight to get HIV treatment into hard-hit Africa. […] Specifically the meeting agreed that while changes are needed in research, regulation and funding to speed progress on new drugs for intractable cancers, a great deal could and must be done now to tackle cancer in less well-off countries where children and women, in particular, are dying of preventable and curable diseases.*

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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†This summary has been prepared using text from the body of the article, in addition to, or in lieu of the original abstract.