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http://www.ghd-net.org

Estimated global mortality associated with the first 12 months of 2009 pandemic influenza A H1N1 virus circulation: a modelling study

18 500 laboratory-confirmed deaths caused by the 2009 pandemic influenza A H1N1 were reported worldwide for the period April, 2009, to August, 2010. This number is likely to be only a fraction of the true number of the deaths associated with 2009 pandemic influenza A H1N1. [The authors] aimed to estimate the global number of deaths during the first 12 months of virus circulation in each country. [...] The authors] estimate that globally there were 201 200 respiratory deaths (range 105 700—395 600) with an additional 83 300 cardiovascular deaths (46 000—179 900) associated with 2009 pandemic influenza A H1N1. 80% of the respiratory and cardiovascular deaths were in people younger than 65 years and 51% occurred in southeast Asia and Africa. [The authors'] estimate of respiratory and cardiovascular mortality associated with the 2009 pandemic influenza A H1N1 was 15 times higher than reported laboratory-confirmed deaths. Although no estimates of symptomatic Case Fatality Ratios (sCFRs) were available from Africa and southeast Asia, a disproportionate number of estimated pandemic deaths might have occurred in these regions. Therefore, efforts to prevent influenza need to effectively target these regions in future pandemics.*

GLOBAL HEALTH NEWS:

New 'SARS-like' coronavirus identified by UK officials
A new respiratory illness similar to the SARS virus that spread globally in 2003 and killed hundreds of people has been identified in a man who is being treated in Britain. The 49-year-old man, who was transferred to a London hospital by air ambulance from Qatar, is the second person confirmed with the coronavirus. The first case was a patient in Saudi Arabia who has since died. Officials are still determining what threat the new virus may pose. The World Health Organization has not recommended any travel restrictions. Prof John Watson, head of the respiratory diseases department at the UK's Health Protection Agency, said: "In the light of the severity of the illness that has been identified in the two confirmed cases, immediate steps have been taken to ensure that people who have been in contact with the UK case have not been infected, and there is no evidence to suggest that they have. [...] Further information about these cases is being developed for healthcare workers in the UK, as well as advice to help maintain increased vigilance for this virus."


GLOBAL HEALTH NEWS:

Flu shot linked to higher incidence of flu in pandemic year
A strange vaccine-related phenomenon spotted at the start of the 2009 flu pandemic may well have been real, a new study suggests. Canadian researchers noticed in the early weeks of the pandemic that people who got a flu shot for the 2008-2009 winter seemed to be more likely to get infected with the pandemic virus than people who hadn't received a flu shot. Five studies done in several provinces showed the same puzzling and unsettling results. But initially, research outside Canada did not, and the effect was dismissed as “the Canadian problem.” News of the unexpected findings broke at a time when countries in North America and parts of Europe were getting ready to start vaccinating their populations against the pandemic virus. Some jurisdictions were also trying to figure out whether to offer the seasonal flu vaccine they had purchased — similar to the 2008-2009 shot — along with the pandemic vaccine, in case the seasonal flu viruses continued to circulate.

Source: The Canadian Press. 2012. Flu shot linked to higher incidence of flu on pandemic year. CBC online (10 September).
**Research on Health & States in Crisis/Conflict:**

**A Congolese community-based health program for survivors of sexual violence**

Many survivors of gender based violence (GBV) in the Democratic Republic of Congo (DRC) report barriers to access health services including, distance, cost, lack of trained providers and fear of stigma. In 2004, Foundation RamaLevina (FORAL), a Congolese health and social non-governmental organization, started a mobile health program for vulnerable women and men to address the barriers to access identified by GBV survivors and their families in rural South Kivu province, Eastern DRC. FORAL conducted a case study of the implementation of this program between July 2010-June 2011 in 6 rural villages. [...] Almost half of the women (45%) reported never receiving health services after the last sexual assault. The majority of survivors reported symptoms consistent with STI. Male partner adherence to STI treatment was low (41%). The case study demonstrated areas of strengths in FORAL’s program, including improved access to health care by survivors and their male partner, enhanced quality of health education and facilitated regular monitoring, follow-up care and referrals. In addition, three critical areas were identified by FORAL that needed further development: provision of health services to young, unmarried women in a way that reduces possibility of future stigma, engaging male partners in health education and clinical care and strengthening linkages for referral of survivors and their partners to psychosocial support and mental health services. *


**Wars and child health: Evidence from the Eritrean-Ethiopian conflict**

Conflict between and within countries can have lasting health and economic consequences, but identifying such effects can be empirically challenging. This paper uses household survey data from Eritrea to estimate the effect of exposure to the 1998–2000 Eritrea–Ethiopia war on children's health. The identification strategy exploits exogenous variation in the conflict’s geographic extent and timing and the exposure of different birth cohorts to the fighting. The unique survey data include details on each household’s migration history, which allows us to measure a child's geographic location during the war and without which war exposure would be incorrectly classified. War-exposed children have lower height-for-age Z-scores, with similar effects for children born before or during the war. Both boys and girls who are born during the war experience negative impacts due to conflict. Effects are robust to including region-specific time trends, alternative conflict exposure measures, and mother fixed effects. *†


**Global Health News:**

**Untold Atrocities: The stories of Syria's children**

Shocking testimony collected from refugees fleeing Syria has revealed that children have been killed, maimed and tortured in the country’s brutal civil war. They have also witnessed the deaths of parents, siblings, other children, and torture. [On 25 September, Save the Children] released Untold Atrocities, a collection of first-hand accounts of the conflict from children and parents receiving help from Save the Children after escaping the violence in Syria. The accounts contain graphic details of how children have been caught up in Syria’s war - witnessing massacres and in some cases, experiencing torture. [Save the Children has] also spoken to refugee children currently in Lebanon about their experiences [... Their] teams are working to help children come to terms with the devastating psychological impact of their experiences, providing specialist support to children showing signs of distress, including self-harm, nightmares and bedwetting. [They are] also calling for the UN to step up its documentation of all violations of children’s rights in Syria and that it should have more resources to do this, so that crimes against children are not committed with impunity. *

GLOBAL HEALTH NEWS:

**MSF assists aid-deprived Sudanese refugees**

More than 2,000 white tents line the green hills near the village of Bambasi, in western Ethiopia. Since July, they have been home to 12,000 Sudanese refugees who fled their homeland and are now taking sanctuary from conflict in a camp established by the Ethiopian authorities and the United Nations High Commissioner for Refugees (UNHCR). [...] The comprehensive peace agreement signed in January 2005 between the Sudan People's Liberation Movement (SPLM) and the Sudanese government was supposed to provide more autonomy for the regions of South Kordofan and Blue Nile. That never happened, and the conflict worsened after South Sudan became independent in July 2011. More than 200,000 Sudanese have since fled to South Sudan or Ethiopia, where they are currently living in refugee camps and are reliant on humanitarian assistance.*

Source: __________. MSF assists aid-deprived Sudanese refugees. MSF online (20 September).

RESEARCH ON HUMAN RIGHTS & GLOBAL HEALTH:

**Bridging international law and rights-based litigation: Mapping health-related rights through the development of the global health and human rights database**

The O'Neill Institute for National and Global Health Law at Georgetown University, the World Health Organization, and the Lawyers Collective have come together to develop a searchable Global Health and Human Rights Database that maps the intersection of health and human rights in judgments, international and regional instruments, and national constitutions. Where states long remained unaccountable for violations of health-related human rights, litigation has arisen as a central mechanism in an expanding movement to create rights-based accountability. Facilitated by the incorporation of international human rights standards in national law, this judicial enforcement has supported the implementation of rights-based claims, giving meaning to states' longstanding obligations to realize the highest attainable standard of health. Yet despite these advancements, there has been insufficient awareness of the international and domestic legal instruments enshrining health-related rights and little understanding of the scope and content of litigation upholding these rights. As this accountability movement evolves, the Global Health and Human Rights Database seeks to chart this burgeoning landscape of international instruments, national constitutions, and judgments for health-related rights. Employing international legal research to document and catalogue these three interconnected aspects of human rights for the public's health, the Database's categorization by human rights, health topics, and regional scope provides a comprehensive means of understanding health and human rights law.*

GLOBAL HEALTH NEWS:

UN: Set plan for women, children with disabilities
Governments meeting at the United Nations about the needs of women and children with disabilities should develop a clear plan of action to promote and uphold their rights, Human Rights Watch said [11 September]. Among others steps, they should make a commitment to address the needs of women and children with disabilities through international development programs. The challenges facing women and children with disabilities [was] the focus of the annual Conference of States Parties for the Convention on the Rights of Persons with Disabilities, scheduled for September 12 to 14, 2012. The convention requires specific protections from discrimination for women and children with disabilities, reflecting their vulnerability to abuses. [...] “Women and children with disabilities are vulnerable to human rights abuses not only because of disability but also because of their age or gender,” said Amanda McRae, disability rights researcher at Human Rights Watch. “Governments at this year’s conference should show that they are not only serious about the rights of women and children with disabilities on paper, but that they intend to put those protections into practice.”*


GLOBAL HEALTH NEWS:

Zainab Bangura starts work at UN: Briefs AU group meeting
The former Minister of Health of Sierra Leone, Mrs. Zainab Hawa Bangura, has started work at her new assignment in New York. It must be recalled that in June this year, the UN Secretary-General, His Excellency Ban-Ki moon, appointed Madam Zainab Hawa Bangura as the UN Special Representative on Sexual Violence in Conflict. According to the UN, the "Special Representative of the Secretary-General on Sexual Violence in Conflict (SRSG) serves as the United Nation’s spokesperson and political advocate on conflict-related sexual violence and is chair of the network UN Action Against Sexual Violence in Conflict. The five priorities for the SRSG’s mandate are: 1) to end impunity for conflict-related sexual violence, 2) to empower women to seek redress, 3) to mobilize political ownership, 4) to increase recognition of rape, and 5) to harmonise the UN’s response.”*

Southeast Asian cooperation in health: A comparative perspective on regional health governance in ASEAN and the EU

Globalization has led to new health challenges for the twenty-first century. These new health challenges have transnational implications and involve a large range of actors and stakeholders. National governments no longer hold the sole responsibility for the health of their people. These changes in health trends have led to the rise of global health governance as a theoretical notion for health policy making. The Southeast Asian region is particularly prone to public health threats such as emerging infectious diseases and faces future health challenges including those of noncommunicable diseases. This study looks at the potential of the Association of Southeast Asian Nations (ASEAN) as a regional organization to lead a regional dynamic for health cooperation in order to overcome these challenges. Through a comparative study with the regional mechanisms of the European Union (EU) for health cooperation, [the authors] look at how ASEAN could maximize its potential as a global health actor. [This] study is based on primary research and semistructured field interviews. To illustrate [its] arguments, [the authors] refer to the extent of regional cooperation for health in ASEAN and the EU for (re)emerging infectious disease control and for tobacco control. [They] argue that regional institutions and a network of civil society organizations are crucial in relaying global initiatives, and ensuring the effective implementation of global guidelines at the national level. ASEAN’s role as a regional body for health governance will depend both on greater horizontal and vertical integration through enhanced regional mechanisms and a wider matrix of cooperation.*

Source: Lamy, Marie & Kai Hong Phua. 2012. Southeast Asian cooperation in health: A comparative perspective on regional health governance in ASEAN and the EU. Asia Europe Journal online (17 August).

GLOBAL HEALTH NEWS:

Accelerating progress on child survival since 2000, UN says

An annual report by the UN Inter-agency Group for Child Mortality Estimation (UN-IGME) shows that in 2011, an estimated 6.9 million children died before their fifth birthday, compared to around 12 million in 1990. Rates of child mortality have fallen in all regions of the world in the last two decades – down by at least 50% in eastern Asia, northern Africa, Latin America and the Caribbean, south-eastern Asia and western Asia. And progress is accelerating: between 2000 and 2011, the annual rate of reduction in the global under-five mortality rate jumped to 3.2%, up from 1.8% in 1990-2000. Sub-Saharan Africa, the region with the greatest challenge in child survival, has doubled its rate of reduction, from 1.5% per year in 1990-2010 to 3.1% in 2000-2011. [...] The gains in child survival, although significant, are still insufficient to achieve Millennium Development Goal 4 of reducing the global under-five mortality rate by two-thirds between 1990 and 2015. Only six of the world’s 10 regions are on track to reach the target. Proven solutions need to be expanded to accelerate progress on child survival faster and farther.*

Factors affecting catastrophic health expenditure and impoverishment from medical expenses in China: Policy implications of universal health insurance

[This paper assesses] the degree to which the Chinese people are protected from catastrophic household expenditure and impoverishment from medical expenses and to explore the health system and structural factors influencing the first of these outcomes. Data were derived from the Fourth National Health Service Survey. [...] The rate of catastrophic health expenditure was 13.0%; that of impoverishment was 7.5%. Rates of catastrophic health expenditure were higher among households having members who were hospitalized, elderly, or chronically ill, as well as in households in rural or poorer regions. A combination of adverse factors increased the risk of catastrophic health expenditure. Families enrolled in the urban employee or resident insurance schemes had lower rates of catastrophic health expenditure than those enrolled in the new rural corporative scheme. The need for and use of health care, demographics, type of benefit package and type of provider payment method were the determinants of catastrophic health expenditure. Although China has greatly expanded health insurance coverage, financial protection remains insufficient. Policy-makers should focus on designing improved insurance plans by expanding the benefit package, redesigning cost sharing arrangements and provider payment methods and developing more effective expenditure control strategies.*


Global Health News:

Achieving universal health coverage in low-income settings

The goal of universal health coverage is deeply embedded in politics, ethics, and international law. [...] There are two related motivations for the commitment to universal health coverage. The first is that every individual has the right to health, and hence to some measure of health care. The second is that poor health has negative spillovers (externalities), from individuals to the community, and from poor countries to rich countries. Society at large therefore has a vested interest in ensuring that poor individuals have access to health coverage. Despite the commitment to universal coverage, in practice effective access to health care and outcomes depends strongly on economic and social conditions. For example, people in the least developed countries have a life expectancy at birth of 59 years and under-5 mortality of 112 per 1000, compared with a life expectancy at birth of 78 years and under-5 mortality of eight per 1000 in the more developed (high-income) countries. In high-income countries with high inequality of income and status, the socially deprived also fare much worse than the rich. Being a member of an ethnic minority or indigenous population can also lead to a lack of access to health care and adverse health outcomes more generally.*

Effect of UK policy on medical migration: a time series analysis of physician registration data

Economically developed countries have recruited large numbers of overseas health workers to fill domestic shortages. Recognition of the negative impact this can have on health care in developing countries led the United Kingdom Department of Health to issue a Code of Practice for National Health Service (NHS) employers in 1999 providing ethical guidance on international recruitment. Case reports suggest this guidance had limited influence in the context of other NHS policy priorities. [This paper describes] the temporal association between trends in new professional registrations from doctors qualifying overseas and relevant United Kingdom government policy [...] New United Kingdom professional registrations by doctors trained in Africa and south Asia more than doubled from 3105 in 2001 to 7343 in 2003, as NHS Trusts sought to achieve recruitment targets specified in the 2000 NHS Plan; this occurred despite ethical guidance to avoid active recruitment of doctors from resource-poor countries. Registration of such doctors declined subsequently, but in response to other government policy initiatives. A fall in registration of South African-trained doctors from 3206 in 2003 to 4 in 2004 followed a Memorandum of Understanding with South Africa signed in 2003. Registrations from India and Pakistan fell from a peak of 4626 in 2004 to 1169 in 2007 following changes in United Kingdom immigration law in 2005 and 2006. Since 2007, registration of new doctors trained outside the European Economic Area has remained relatively stable, but in 2010 the United Kingdom still registered 722 new doctors trained in Africa and 1207 trained in India and Pakistan.*


Trade policy, not moral or health policy: The US Trade Representative, tobacco companies and market liberalization in Thailand

The enforced opening of Thailand’s cigarette market to imports in 1990 has become a cause celebre in debates about the social and health impacts of trade agreements. At the instigation of leading US-based cigarette manufacturers, the US Trade Representative (USTR) threatened trade sanctions against Thailand to compel the government to liberalize its domestic cigarette market. Thailand’s challenge to the USTR led to referral to General Agreement on Tariffs and Trade (GATT) arbitration. While GATT ruled in favour of the USTR on market access, it also found that Thailand could subsequently enact non-discriminatory tobacco control regulation without contravening the GATT agreement. This article contributes to existing literature via its analysis of tobacco industry documents that highlight [...] USTR responsiveness to lobbying from tobacco corporations, raising concerns about the drivers of globalization and the limited protection afforded to public health concerns in trade agreements. Significantly, the documents also indicate that USTR support of the tobacco industry was not unconditional, being subject to wider pressures of global trade negotiations. Such qualification notwithstanding, however, ongoing governmental willingness to advance the international interests of tobacco corporations remains a concern from a public health perspective, particularly given the failure of the US to ratify the World Health Organization’s Framework Convention on Tobacco Control.*

RESEARCH ON ACCESS TO EFFECTIVE MEDICINES:

Advance market commitments for R&D in diseases that disproportionately affect low-income countries

There has been a growing focus on finding ways to increase the availability of beneficial health technologies for the diagnosis, treatment, prevention, elimination and eradication of neglected diseases that disproportionately affect low-income countries. A number of interventions have been suggested but one mechanism that appears to have gained favour is advanced market commitments (AMCs), which has been piloted with the pneumococcal conjugate vaccines. AMCs aim to inflate and reduce the uncertainty around the stream of expected quasi-rents provided by (uninsured) healthcare demands in low-income countries to encourage private pharmaceutical and biotechnology firms to undertake the desired R&D investments. This paper evaluates the potential of AMCs to increase the supply of new molecular entities (NMEs) for neglected diseases and notes that AMCs are the appropriate instruments as long as the global community relies (wholly or in part) on private firms to make systematic rather than piecemeal public service or philanthropic investments. It calls for a review of World Trade Organization’s (WTO) Trade-Related Intellectual Property Rights (TRIPS) agreement to explicitly recognize the inadequacies of intellectual property rights (IPR) and patent protection in stimulating innovation and access to health technologies for neglected diseases.*


GLOBAL HEALTH NEWS:

Trade deal to curb generic-drug use

Besides the United States, ten Pacific countries representing 34% of US trade have so far agreed to join the Trans-Pacific Partnership agreement (TPP) — Australia, New Zealand, Singapore, Malaysia, Brunei, Vietnam, Peru, Chile, Canada and Mexico. The agreement, which could come into effect as early as next year, spans several trade areas, meaning that some countries may be tempted to forgo access to generic drugs in exchange for better access to US markets in other industries. According to previously leaked documents, the TPP looks likely to strengthen patent protection for drugs more than any trade agreement so far. Whereas the current World Trade Organization (WTO) agreement sets a minimum 20-year period for patents around the world, the TPP would follow US practice in extending patents beyond 20 years when the drug-approval process has delayed a drug’s market entrance. Partner countries would also be pressed to award new patents for off-patent drugs that have been formulated in a new way or approved for a new set of patients.*


WIPO drug research project strike first agreements

A World Intellectual Property Organization project aimed at expanding research on diseases occurring predominately in developing countries using IP-protected material has announced its first research agreements. The three first agreements under the WIPO Re:Search project involve London-based pharmaceutical company AstraZeneca, partnering with: iThemba Pharmaceuticals (a research institution in South Africa); the University of California, San Francisco; and the University of Dundee in the United Kingdom. The WIPO Re:Search project aimed at neglected tropical diseases was launched almost a year ago. Since then, its membership has grown from 30 to 50 worldwide, according to WIPO. The project is relatively attractive to industry holding intellectual property rights, and for least-developed countries. The rights holders agree to make their IP assets (such as compounds, drug discovery technologies, regulatory data and know-how) available to anyone royalty-free for research, and any resulting products would be royalty-free in 49 least developed countries (LDCs).*

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

The making of a public health problem: Multi-drug resistant tuberculosis in India

This paper examines how actors construct the public problem of multi-drug resistant tuberculosis (MDR-TB) in India. MDR-TB has been framed by the World Health Organization as a pressing, global public health problem. The responses to MDR-TB are complicated as treatment takes longer and is more expensive than routine TB treatment. This is particularly problematic in countries, such as India, with high patient loads, a large and unregulated private sector, weak health systems and potentially high numbers of MDR-TB cases. This paper analyses how actors struggle for control over ownership, causal theories and political responsibility of the public problem of MDR-TB in India. [...] Two main arguments are put forward. First, the construction of the public problem of MDR-TB in India is a social and political process. The need for representative data, international influence and politics define what is controllable. Second, the government seems to be anxious to control the definition of India’s MDR-TB problem. This impedes an open, critical and transparent discussion on the definition of the public problem of MDR-TB, which is important in responding flexibly to emerging public health challenges.*


GLOBAL HEALTH NEWS:

Treatment of HIV infection: Are we failing children?

Held in the USA for the first time in 22 years, the [19th International AIDS Conference] was an important opportunity to set the tone for the coming years. Huge progress has been made in prevention and treatment of HIV infection worldwide, but important steps are needed to improve care in low-income and middle-income countries. [...] UNICEF Senior Advisor on AIDS scale-up, Chewe Luo, recognises that much has been accomplished in the past decade, but reminded delegates that the “decline in new HIV infections falls short of what we need to achieve to eliminate new HIV infections among children”. To meet global HIV targets, Luo called for transformation of prevention of mother to child transmission (PMTCT) programmes into antiretroviral treatment programmes, which means initiation of lifelong antiretroviral treatment (ART) in pregnant women with HIV infection, irrespective of their CD4 count, in line with the programmatic update to the WHO 2010 guidelines issued in April, 2012 (also known as option B+).*

**RESEARCH ON GLOBAL ACTION ON NON-COMMUNICABLE DISEASES:**

**Diabetes prevention: Global health policy and perspectives from the ground**

Type 2 diabetes and other noncommunicable diseases are a growing public health challenge globally. An estimated 285 million people, corresponding to 6.4% of the world’s adult population, has diabetes, which is expected to reach 552 million by the International Diabetes Federation in 2030. A much larger segment of the world’s population, approximating 79 million individuals in the USA alone, has prediabetes. Globally, a relatively small percentage of those with diabetes or prediabetes are diagnosed with the potential for developing chronic complications. To address this epidemic, governments, in concert with the private sector, need to set policies that promote healthy nutritional and agricultural policies, favor modifications in the environment that encourage greater physical activity and make prevention affordable for all citizens at high risk. The public health sector has the charge of translating evidence-based findings into practical, accessible and cost-effective programs and monitoring the process to continuously improve prevention initiatives. The clinical sector has the formidable challenge of screening and identifying those at high risk and referring them to accredited intervention programs. There is a need to explore additional cost-effective interventions that are customized to meet individual needs that can be offered at the community and clinical levels. Thus, all three sectors, government, public health and clinical, each have a critical role in this process and by working in a partnership, ought to create the necessary synergies essential for making substantial forays in the prevention of Type 2 diabetes.


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**GLOBAL HEALTH NEWS:**

**In first year, global fight against NCDs gathers momentum**

On the first anniversary of the United Nations High-Level Meeting on NCDs where the world formally acknowledged the urgent need for action on these under-recognized diseases, it makes sense to assess how far we’ve come, as well as how much further we need to go. At that meeting, countries unanimously adopted a political declaration that committed them to reduce the toll of NCDs by strengthening national responses and increasing international collaboration. It's been a remarkable year. During the past 12 months, health workers, policymakers and activists rallied around the High-Level Meeting to build a robust civil society movement, which has continued to gather momentum. [...] Despite this progress, much more remains to be done, and it needs to be done urgently. Not only do NCDs account for 36 million deaths a year, their impact is in all countries and is on the rise. Indeed, they take their heaviest toll on the poorest populations in low- and middle-income countries: more than 80 percent of all deaths from NCDs take place in these countries. Fortunately, these diseases are largely preventable. According to the WHO, about 80 percent of heart disease and type 2 diabetes and up to 40 percent of cancers can be prevented by maintaining a healthy lifestyle: by eliminating tobacco, avoiding harmful alcohol, engaging in adequate physical activity and eating a healthy diet.*

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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