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### RESEARCH ON GLOBAL HEALTH SECURITY:

## Global health security: Closing the gaps in responding to infectious disease emergencies

Rising concerns about the human, political, and economic costs of emerging infectious disease threats and deliberate epidemics have highlighted the important connection between global public health and security. This realization has led security communities, particularly in the U.S., to seek ways to bolster the international health response to public health emergencies as a means of protecting national security. While there have been important recent efforts to strengthen international response to infectious disease threats, there are areas that deserve more attention from both the health and security communities. In this article, [the authors] describe two important gaps in international frameworks that govern the response to global public health threats which can negatively affect the security of states: 1) despite attempts to strengthen international rules for responding to public health emergencies, there continues to be strong disincentives for states to report disease outbreaks; and 2) systems for detecting and responding to outbreaks of infectious diseases are hindered by a lack of standards of practice for sharing biological samples and specimens. To address these gaps in global governance of infectious disease threats, additional incentives are needed for states to report disease outbreaks to the international community; there should be greater enforcement of countries' international health obligations; and both political and scientific communities should develop workable practice standards for sharing biological samples of all types.\*

Source: [Nuzzo, Jennifer B & Gigi Kwik Gronvall. 2011. Global Health Security: Closing the Gaps in Responding to Infectious Disease Emergencies. Global Health Governance Vol. IV, No. 2 \(Spring\).](#)



### GLOBAL HEALTH NEWS:

#### **Future perfect? Improving preparedness through the experiences of the influenza A (H1N1) 2009 pandemic**

Last year, WHO requested a review of the functioning of the International Health Regulations (IHR) to include the global response to the 2009 influenza pandemic. [...] The specific circumstances and characteristics of the 2009 pandemic (time, place, virus) had not been predicted. However, concerted preparedness activities had been underway for several years motivated by: scientific and historical awareness of the recurrent nature of influenza pandemics; the emergence and persistence of an avian H5N1 influenza virus capable of causing relatively rare, but severe and often fatal, human infections; and the 2003 experience with severe acute respiratory syndrome (SARS) coronavirus. Such events convincingly demonstrated to the modern world that, in addition to severe illness, the spread of new infections can cause significant societal disruption and anxiety. [...] More recently, the IHR Review Committee has concluded that the world still remains ill-prepared to respond to a severe influenza pandemic or to any similar global public health event. This conclusion is consistent with the experience of many countries which discovered gaps in several areas in their response to the 2009 pandemic. These included gaps in their ability to react briskly and to communicate effectively in the face of a rapidly developing emergency, gaps in compiling accurate information swiftly to monitor fast-moving events, and, among many developing and even middle-income countries, inability to access certain critical supplies, such as pandemic vaccines, in time.\*

Source: [Penn, Charles R. 2011. Future perfect? Improving preparedness through the experiences of the influenza A \(H1N1\) 2009 pandemic. \*Bulletin of the World Health Organization\* Vol. 89, No. 7 \(July\).](#)

### RESEARCH ON HEALTH & STATES IN CRISIS/CONFLICT:

#### **Targets of retribution: Attacks against medics, injured protesters, and health facilities**

In February and March 2011 thousands of Bahrainis, most of them from the country's Shi'a majority, took to the streets to demand political reform. [...] The Bahraini government reacted to the protests with a mixture of violent repression, offers of limited concessions, and, for a time, political dialogue. Since the start of the protests on February 14, more than 30 people have died in protest-related violence, mostly at the hands of the Bahraini security forces. Hundreds more have been wounded, some seriously. [...] This report documents the key elements of what appears to be a systematic campaign by the Bahraini government aimed at punishing and intimidating medical professionals suspected of sympathies with protesters and hindering access to health care facilities for persons wounded by security forces. The first element of this campaign consisted of attacks on offsite medical facilities and providers at protest sites and the denial of access to medical treatment to the injured. [...] The second element of the government's campaign against the medical community was the siege of several hospitals and medical centers, including the Salmaniya Medical Complex (SMC), Bahrain's largest public hospital, where many of the most severely injured protesters were taken for treatment. [...] The third element of the government's campaign has been the arrest, detention, and torture or ill-treatment of patients with protest-related injuries. [...] The fourth element of the government's campaign against the medical community in Bahrain has been the arbitrary arrest, interrogation, mistreatment, detention, and prosecution of doctors and medical staff.\*†

Source: [\\_\\_\\_\\_\\_ . 2011. Targets of Retribution: Attacks against Medics, Injured Protesters, and Health Facilities. \*Human Rights Watch\* online \(18 July\).](#)



**GLOBAL HEALTH NEWS:**

**UN sets donors conference for Somalia famine**

Efforts to save starving Somalis and others suffering from drought in East Africa were ratcheted up Monday [25 July], with U.N. agencies pitching for \$1.6 billion from donor countries and private companies being urged to provide trucks, ships and other logistical aid to speed food to the malnourished. Rome-based U.N. Food and Agriculture Organization chief Jacques Diouf told an emergency meeting on the Horn of Africa crisis that a pledging conference would be held in Nairobi, Kenya, on Wednesday to seek \$1.6 billion in aid over the next 12 months, with \$300 million of that aid coming in the next three months. Monday's emergency session was held at the request of France, which is making development of agriculture in poorer countries a priority in international policies. The speed of the stepped-up efforts appeared to take some by surprise. The U.S. ambassador to the U.N. food agencies, Ertharin Cousin, told reporters she didn't immediately know if her country would be boosting its contribution on top of what it has already given. U.S. Secretary of State Hillary Rodham Clinton announced last week that the U.S. will provide an additional \$28 million in aid for Somalis suffering from hunger, on top of more than \$431 million in emergency assistance to the eastern Horn of Africa this year. The United Nations' top humanitarian and relief official, Valerie Amos, told reporters that so far just under \$1 billion has been received from donors so far, but that "we need another billion." More than 11 million people are estimated to need help in East Africa's worst drought in 60 years, in Kenya, Ethiopia, Somalia, Eritrea and South Sudan.\*

Source: [D'Emilio, Frances. 2011. UN sets donors conference for Somalia famine. Forbes.com online \(25 July\).](#)

**GLOBAL HEALTH NEWS:**

**UN to expose school, hospital attackers**

Countries and groups that attack schools and hospitals will be named and shamed by the United Nations and could be liable to sanctions under a resolution passed by the Security Council on [12 July]. Perpetrators will be added to a list the U.N. Secretary General Ban Ki-moon [already] publishes as an annex to an annual report on children and armed conflict. The [current] list identifies those who kill, maim or rape children in armed conflicts, or recruit and use them as child soldiers. The resolution [to expand this list], unanimously passed [...] by the 15-member Security Council, asks Ban to also include in the report's annexes those who engage in recurrent attacks on schools and hospitals. "Persistent perpetrators need to face credible consequences," Germany's Foreign Minister Guido Westerwelle told the Council. "If they do not change their behavior, they should face measures through sanctions regimes." [...] Security Council sanctions typically include asset freezes and travel bans. The resolution adopted on Tuesday was did not specifically address what sanctions might be applied.\*

Source: [Reuters. 2011. UN to expose school, hospital attackers. AlertNet online \(12 July\).](#)



*RESEARCH ON HUMAN RIGHTS & GLOBAL HEALTH:*

## **Health and human rights: Epistemological status and perspectives of development**

The health and human rights movement (HHR) shows obvious signs of maturation both internally and externally. Yet there are still many questions to be addressed. These issues include the movement's epistemological status and its perspectives of development. This paper discusses critically the conditions of emergence of HHR, its identity, its dominant schools of thought, its epistemological postures and its methodological issues. [The authors'] analysis shows that: a) the epistemological status of HHR is ambiguous; b) its identity is uncertain in the absence of a validated definition: is it an action movement, an interdisciplinary field, a domain, an approach, a setting or a scientific discipline? c) its main schools of thoughts are defined as "advocacists", "ethicists", "interventionists", "normativists"; d) the movement is in the maturation process as a discipline in which "interface", "distance", "interference" and "fusion" epistemological postures represent the fundamental steps; e) parent disciplines (health sciences and law) competences, logics and cultures introduce duality and difficulties in knowledge production, validation and diffusion; f) there is need to re-write the history of the HHR movement by inscribing it not only into the humanitarian or public health perspectives but also into the evolution of sciences and its social, political and economical conditions of emergence.\*

*Source:* [Mpinga, Emmanuel Kabengele, et al. 2011. Health and human rights: epistemological status and perspectives of development. \*Medicine, Health Care and Philosophy\* Vol. 14, No. 3 \(August\).](#)

*GLOBAL HEALTH NEWS:*

## **The assault on reproductive rights**

[Twenty-five] years of progress in strengthening the rights of women to equitable access to health services are now under threat. At the UN High-Level Meeting on AIDS, held in New York last month, those determined to stop progress for women achieved notable victories. In a recent newsletter forwarded to members of Family Watch International, a network dedicated to conservative causes (such as fighting abortion), lobbyists proclaimed success in "removing many harmful provisions" and replacing these with stigmatising propaganda. [...] Thankfully, some countries are fighting to challenge this thinking. The US Government, for example, issued guidance last month on requirements for women, girls, and gender equality in their Global Health Initiative programmes. Ten key elements are set out, including participation of women and girls in health programmes, targeting of gender-based violence, empowering girls through education, promoting policies and laws that improve gender equality and health status, and addressing the economic, social, legal, and cultural barriers to progress for women.\*

*Source:* [The Lancet. The assault on reproductive rights. \*The Lancet\* Vol. 378, Issue 9786 \(9 July\).](#)



*GLOBAL HEALTH GOVERNANCE*

## **Global public-private health partnerships: Lessons from ten years of experience**

Global Health Partnerships (GHPs) have contributed significantly to improved global health outcomes as well as the manner in which global health is governed. Yet in a context of an increasingly complex global health landscape, resource scarcity and a shift from disease-specific to systems strengthening approaches, it is important to continually enhance and apply our understanding of how to improve GHP performance. The authors reviewed and synthesised findings from eight independent evaluations of GHPs as well as research projects conducted by the authors over the past several years, the most recent of which involved semi-structured discussions with 20 'partnership pioneers'. This paper presents the major drivers of the GHP trend, briefly reviews the significant contributions of GHPs to global health and sets out common findings from evaluations of these global health governance instruments. The paper answers the question of how to improve GHP performance with reference to a series of lessons emerging from the past ten years of experience. These lessons cover the following areas: 1) value-added and niche orientation; 2) adequate resourcing of secretariats; 3) management practices; 4) governance practices; 5) ensuring divergent interests are met; 6) systems strengthening; 7) continuous self-improvement.\*

*Source:* [Buse, Kent & Sonja Tanaka. 2011. Global Public-Private Health Partnerships: lessons learned from ten years of experience. \*International Dental Journal\* Vol. 61, Suppl. 2 \(August\).](#)

*GLOBAL HEALTH NEWS:*

### **The vaccine paradox**

The next decade will likely bring astonishing successes in vaccine biology, discovery, and delivery. Justifiable confidence in this proposition led the Bill & Melinda Gates Foundation last year to pledge US\$10 billion to a new Decade of Vaccines. For the world's largest and most influential health foundation, vaccines are the number one priority. The foundation estimates that if vaccine coverage could be scaled up to 90%, the lives of 7.6 million children younger than 5 years could be saved between 2010 and 2019. If a malaria vaccine became available by 2014, this figure could rise by a further 1.1 million. To address the opportunity the Gates Foundation has identified, [the Lancet] brought together some of the leading scientists working in vaccines today to set out the hopes and possibilities for the coming decade. As [they] gathered for [their] first meeting, broad optimism was tempered with caution. One contributor argued that "the present way we work will not sustain the next decade of vaccines". Another said that despite the manifest successes of today's vaccines, we had to face up to "a relative failure". We have not created a sustainable environment for new vaccines to thrive. This [Lancet] Series on the new decade of vaccines explores why there is an unprecedented opportunity for vaccines, but also why we must choose a different trajectory for this future decade if those opportunities are to be fully realised.\*

*Source:* [Horton, Richard & Pamela Das. 2011. The vaccine paradox. \*The Lancet\* Vol. 378, Issue 9788 \(23 July\).](#)



*RESEARCH ON HEALTH & DEVELOPMENT, HEALTH SYSTEMS:*

## **Strengthening systems for communicable disease surveillance: Creating a laboratory network in Rwanda**

The recent emergence of a novel strain of influenza virus with pandemic potential underscores the need for quality surveillance and laboratory services to contribute to the timely detection and confirmation of public health threats. To provide a framework for strengthening disease surveillance and response capacities in African countries, the World Health Organization Regional Headquarters for Africa (AFRO) developed an Integrated Disease Surveillance and Response (IDSR) [strategy] aimed at improving national surveillance and laboratory systems. IDSR emphasizes the linkage of information provided by public health laboratories to the selection of relevant, appropriate and effective public health responses to disease outbreaks. [The authors] reviewed the development of Rwanda's National Reference Laboratory (NRL) to understand essential structures involved in creating a national public health laboratory network. [The authors also] reviewed documents describing the NRL's organization and record of test results, conducted site visits, and interviewed health staff in the Ministry of Health and in partner agencies. [...] Among the identified success factors were: a structured governing framework for public health surveillance; political commitment to promote leadership for stronger laboratory capacities in Rwanda; defined roles and responsibilities for each level; coordinated approaches between technical and funding partners; collaboration with external laboratories; and use of performance results in advocacy with national stakeholders. Major challenges involved general infrastructure, human resources, and budgetary constraints.\*

Source: [Kebede, Senait, et al. 2011. Strengthening systems for communicable disease surveillance: creating a laboratory network in Rwanda. \*Health Research Policy and Systems\* Vol. 9, No. 27 \(24 June\).](#)

*GLOBAL HEALTH NEWS:*

## **The Millennium Development Goals Report: 2011**

More than 10 years have passed since world leaders established goals and targets to free humanity from extreme poverty, hunger, illiteracy and disease. The Millennium Declaration and the MDG framework for accountability derived from it have inspired development efforts and helped set global and national priorities and focus subsequent actions. While more work lies ahead, the world has cause to celebrate, in part due to the continued economic growth of some developing countries and targeted interventions in critical areas. Increased funding from many sources has translated into the expansion of programmes to deliver services and resources to those most in need. [Some of the health-related highlights of this report show that: 1) targeted interventions have succeeded in reducing child mortality; 2) increased funding and control efforts have cut deaths from malaria; 3) investments in preventing and treating HIV are yielding results; 4) effective strategies against tuberculosis are saving millions of lives; 5) every region has made progress in improving access to clean drinking water. However, the report also highlights significant health challenges: 1) advances in sanitation often bypass the poor and those living in rural areas; and 2) progress has been uneven in improving access to safe drinking water]\*

Source: [United Nations. 2011. The Millennium Development Goals Report: 2011. United Nations online \(June\).](#)



*RESEARCH ON HUMAN RESOURCES & MIGRATION OF HEALTH WORKERS:*

## **Continuity and Change in human resources policies for health: Lessons from Brazil**

This paper reports on progress in implementing human resources for health (HRH) policies in Brazil, in the context of the implementation and expansion of the Unified Health System (Sistema Unico de Saude - SUS). [...] There are two key features of HRH change which are related to the implementation of SUS which merit attention: the achievement of staffing growth, and the improvement in HRH policy making and management. Staff growth rates across the period have been high enough to exceed population growth rates. As a consequence, the ratio of staff to population has improved. In 1990, the physician ratio per 1000 inhabitants was 1.12. In 2007, it was 1.74. Another critical factor in achieving staffing growth has been HRH policy making capacity and influence within the political establishment. Policies have had to adapt to changing circumstances, whilst focusing on sequential improvements aimed at achieving long term goals. The end objectives, of improving care and access to care, have been kept in view. No one Ministry could secure all the resources and impetus for change that has been required, hence the need for inter-ministry, inter-governmental and inter-agency collaboration, and the development of alliances of shared interest. Across the period of thirty years or more, not all initiatives have been equally successful, but a momentum has been maintained. There was no single long term plan or strategy, but in Brazil this has enabled the progress to be adapted and re-oriented as the broader context changed over the years.\*

*Source:* [Buchan, James, et al. 2011. Continuity and change in human resources policies for health: lessons from Brazil. \*Human Resources for Health\* Vol. 9, No. 17 \(5 July\).](#)

*GLOBAL HEALTH NEWS:*

## **Health workforce support opportunities in the Global Fund's Round 11**

In the lead up to the launch of the Round 11 of the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund), the Alliance calls on its members, partners and potential applicants to pay due attention to the funding window open for health system strengthening (HSS) interventions. The Global Fund's primary objective is to respond to countries' needs related to the three target diseases, which also involves addressing critical health system bottlenecks such as the shortage of health personnel. Round 11 will be launched on 15 August. For the first time, Round 11 will offer opportunities for eligible countries to request cross-cutting HSS funds independently from a disease specific proposal, as long as the proposed interventions directly contribute to improving the countries responses to more than one of the diseases. In many occasions the correlation between the disease specific control strategy and the availability of skilled, motivated and supported health workforce has been acknowledged. One recent example is the bold message that emerged from the side session "Can MDG 6 be achieved with the Health Workforce we have?" at the High Level Meeting on AIDS in New York, where human resources for health (HRH) was clearly recognized as one of most critical pillars of the national AIDS response.\*

*Source:* [Global Health Workforce Alliance. 2011. Health workforce support opportunities in the Global Fund's Round 11. \*World Health Organization\* online \(7 Jul\).](#)



*RESEARCH ON TRADE POLICY & HEALTH:*

## **Framing international trade and chronic diseases**

There is an emerging evidence base that global trade is linked with the rise of chronic disease in many low and middle-income countries (LMICs). This linkage is associated, in part, with the global diffusion of unhealthy lifestyles and health damaging products posing a particular challenge to countries still facing high burdens of communicable disease. [The authors] developed a generic framework which depicts the determinants and pathways connecting global trade with chronic disease. [They] then applied this framework to three key risk factors for chronic disease: unhealthy diets, alcohol, and tobacco. This led to specific 'product pathways', which can be further refined and used by health policy-makers to engage with their country's trade policy-makers around health impacts of ongoing trade treaty negotiations, and by researchers to continue refining an evidence base on how global trade is affecting patterns of chronic disease. [...] The findings summarized in this article imply the need for a more concerted approach to regulate trade-related risk factors and thus more engagement between health and trade policy sectors within and between nations. An explicit recognition of the role of trade policies in the spread of non-communicable disease risk factors should be a minimum outcome of the September 2011 Summit, with a commitment to ensure that future trade treaties do not increase such risks.\*

Source: [Labonte, Ronald, et al. 2011. Framing International Trade and Chronic Diseases. \*Globalization and Health\* Vol. 7, No. 21 \(4 July\).](#)

*GLOBAL HEALTH NEWS:*

## **Horn of Africa drought, food crisis: Agricultural trade policies questioned**

Severe drought has left some ten million people in the Horn of Africa short of food and water, the UN has warned. As the crisis grows, some experts are questioning the role of agricultural trade and investment policies in the region. A joint statement from two intergovernmental agencies and a humanitarian aid group [UN's Food and Agriculture Organization and the World Food Programme, along with aid agency Oxfam], has said that the "slow-onset" humanitarian crisis leaves millions of women, men, and children vulnerable to "devastating hunger and malnutrition." Full funding of emergency assistance, support to poor farmers, and policies to address challenges such as climate change are needed "to ensure that complacency does not drive destiny in this region," claims the [July 8<sup>th</sup>] communiqué [...]. The groups say that Djibouti, Ethiopia, Kenya, Somalia, and parts of Uganda are affected by the crisis; the majority of the newly affected people - 1.2 million, by the groups' estimates - are reportedly in Kenya. The number of Somali refugees in Kenyan and Ethiopian camps has also grown to a record of over half a million people.\*

Source: [International Centre for Trade and Sustainable Development. 2011. Horn of Africa Drought, Food Crisis: Agricultural Trade Policies Questioned. \*Bridges Weekly Trade News Digest\*. Vol. 15, No. 26 \(13 July\).](#)



*RESEARCH ON ACCESS TO EFFECTIVE MEDICINES:*

### **The need for better data about counterfeit drugs in developing countries: a proposed standard research methodology tested in Chennai, India**

There is still surprisingly little basic research data to support widely repeated claims about the prevalence of drug counterfeiting. To meet the need for more reliable drug quality data, [the authors] designed a study framework that includes clear definitions of measured end points, sampling methods and assay technique. [The] objective was to test this research design in Chennai (formerly Madras), India, using a joint Indian and Canadian team. The city was divided into ten areas along municipal lines. From each area, ten stores and pharmacies selling drugs were selected. At each of these 100 outlets, three study drugs (artesunate, ciprofloxacin and rifampicin) were purchased. The 300 samples were tested by Liquid Chromatography–Mass Spectrometry. Assay content was expressed as a percentage of stated tablet content. Based on assay results and their distribution, [the authors] developed drug quality definitions for normal manufacturing standards, counterfeiting, decomposition, poor quality control and adulteration. The group mean for ciprofloxacin was close to normal manufacturing limits ( $99.2 \pm 7.1\%$ ) but rifampicin ( $91.6 \pm 5.7\%$ ), and artesunate ( $80.1 \pm 9.1\%$ ), were both below normal pharmaceutical standards. Overall, 43% of all samples fell below the widely accepted manufacturing range of 90–110% of stated content. No tablet from any sample contained less than 50% of the stated dose. The quality of at least some anti-infective drugs in Chennai is below commonly accepted standards but we found no evidence of criminal counterfeiting. Poor drug quality was most likely due to decomposition during storage or poor manufacturing standards.\*

Source: [Seear, M, et al. 2011. The need for better data about counterfeit drugs in developing countries: a proposed standard research methodology tested in Chennai, India. \*Journal of Clinical Pharmacy and Therapeutics\*. Vol. 36, Issue 4 \(August\).](#)

*GLOBAL HEALTH NEWS:*

### **Gilead license expands access, but several countries left out**

An agreement announced [on 12 July] by pharmaceutical company Gilead to licence several HIV/AIDS drugs to the Medicines Patent Pool could improve access to medicines for patients, but excludes several countries with large numbers of people living with HIV, the international medical humanitarian organisation Médecins Sans Frontières (MSF) said. [...] On the positive side, the licence covers two promising drugs in the pipeline, cobicistat and elvitegravir, one pipeline combination and the crucial drug tenofovir. [...] The licence also allows for new fixed-dose combinations and child-friendly medicines to be developed. Critically, the licence is the first of its kind to explicitly incorporate the potential use of public health safeguards: it allows medicines to be exported to countries excluded from the agreement when their governments choose to override the patent with a compulsory licence, and also allows producers to exit the agreement for any one of the drugs if Gilead loses a patent because of a legal challenge. [...] On the negative side, the agreement falls significantly short of what is needed to fully meet the public health needs for HIV/AIDS: it limits price-busting competition by confining manufacturing to one country (India) and includes narrow supply options for active pharmaceutical ingredients needed to make the drugs. Most critically, people living with HIV in certain middle-income countries are excluded. [...] If voluntary measures like the Patent Pool are unable to ensure people access to the medicines they need, countries that are left out will need to aggressively pursue non-voluntary paths like compulsory licences.\*

Source: [\\_\\_\\_\\_\\_ 2011. Gilead license expands access, but several countries left out. \*Médecins Sans Frontières\* online \(12 July\).](#)



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

### **Life expectancy of persons receiving combination antiretroviral therapy in low-income countries [cART]: A cohort analysis from Uganda**

[This paper estimates] life expectancy of patients once they initiate cART in Uganda [using a] prospective cohort study. After adjustment for loss to follow-up, crude mortality rates (deaths per 1000 person-years) ranged from 26.9 (95% CI, 25.4 to 28.5) in women to 43.9 (CI, 40.7 to 47.0) in men. For patients with a baseline CD4 cell count less than  $0.050 \times 10^9$  cells/L, the mortality rate was 67.3 (CI, 62.1 to 72.9) deaths per 1000 person-years, whereas among persons with a baseline CD4 cell count of  $0.250 \times 10^9$  cells/L or more, the mortality rate was 19.1 (CI, 16.0 to 22.7) deaths per 1000 person-years. Life expectancy at age 20 years for the overall cohort was 26.7 (CI, 25.0 to 28.4) additional years and at age 35 years was 27.9 (CI, 26.7 to 29.1) additional years. Life expectancy increased substantially with increasing baseline CD4 cell count. Similar trends are observed for older age groups. A small (6.4%) proportion of patients were lost to follow-up, and it was imputed that 30% of these patients had died. Few patients with a CD4 cell count greater than  $0.250 \times 10^9$  cells/L initiated cART. Ugandan patients receiving cART can expect an almost normal life expectancy, although there is considerable variability among subgroups of patients.\*

Source: [Mills, Edward J, et al. 2011. Life Expectancy of Persons Receiving Combination Antiretroviral Therapy in Low-Income Countries: A Cohort Analysis From Uganda. \*Annals of Internal Medicine\* online \(18 July\).](#)

#### GLOBAL HEALTH NEWS:

### **Treatments as prevention—a double hat-trick**

Plasma HIV-1 RNA concentration is now accepted as a key driver of HIV transmission, and appropriate use of HAART [Highly Active Anti-Retroviral Treatment] is highly effective in reducing plasma HIV-1 RNA to undetectable levels, consequently decreasing HIV transmission. [...] HPTN 052—a randomised trial of HIV serodiscordant couples—was halted by the data and safety monitoring board after a planned interim analysis. [...] The investigators reported an impressive 96% decrease in the risk of HIV transmission with immediate HAART. Of note, immediate HAART was also associated with a 30% decrease in the combined endpoint of disease progression and death, and an 83% reduction in the incidence of extra-pulmonary tuberculosis. For the past decade, we have struggled with the substantial tension between those advocating for the need to rigorously pursue every question before implementing treatment as prevention initiatives and those advocating for the research to be done as part of an implementation strategy. Nowadays, particularly in the wake of the compelling—although yet to be reported in detail—HPTN 052 results, we are no longer in equipoise. The evidence is clear: treatment conclusively prevents morbidity, mortality, and transmission. From this point on, these three endpoints should be considered together. Further, we urgently need new normative guidelines that fully incorporate treatment as prevention, without caveats. It would be unethical not to offer immediate HAART to serodiscordant couples.\*

Source: [Montaner, Julio SG. 2011. Treatment as prevention—a double hat-trick. \*The Lancet\* Vol. 378, Issue 9787 \(16 July\).](#)



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

### **Non-communicable diseases-neglected diseases in global health work?**

During the last few years we have seen a move from 'international health' to 'global health'. This is a consequence of understanding how global trends and determinants increasingly influence public health everywhere in the world. There is a mushrooming of meetings, initiatives, programmes and centres on global health. Consequently, also financial aid to global health activities has much increased. Much of this goes to programmes on infectious diseases or other traditional health issues—many of them in [the] form of vertical disease specific actions. Very little, i.e. less than 3% of the global development assistance for health, goes to prevention and control of chronic non-communicable diseases (NCDs). This is in sharp contrast to the observations on how global health is rapidly changing. Although many infectious diseases and other traditional health issues, like child and maternal mortality, remain serious problems and should be vigorously addressed, NCDs have started to dominate global public health. Already now some 2/3 of all deaths in the world, i.e. approximately 36 million annual deaths, are due to NCDs. Gone are the times when NCDs were 'diseases of affluence' and only of industrialized countries. Nearly 80% of NCD deaths occur in the developing world, where much of the mortality occurs in the working aged population hampering social and economic development. And in most countries these diseases and their risk factors have moved to lower socio-economic segments of the population, being a major cause of health inequalities and adding to poverty.\*†

*Source:* [Puska, Pekka. 2011. Non-communicable disease-neglected diseases in global health work? \*European Journal of Public Health\*. Vol. 21, Issue 3 \(June\).](#)

*GLOBAL HEALTH NEWS:*

### **Expectations for the United Nations high-level meeting on noncommunicable diseases**

The United Nations General Assembly's decision to convene a high-level meeting on the prevention and control of noncommunicable diseases (NCDs) worldwide in September 2011 is a major, timely opportunity to elevate chronic diseases onto the global stage and to encourage action by individual governments. Just as the 2001 United Nations General Assembly Special Session on HIV/AIDS was a pivotal moment in the global response to AIDS, there is hope that the September session on NCDs will become an historic rallying point. How shall we judge the success of the meeting? If Member States can address the following five critical elements, then new measurable goals and means of building accountability may be within reach. First, the meeting should put a spotlight on the true scale of morbidity and mortality caused by NCDs and the economic consequences for households, health systems and national economies. [...] Second, governments should commit to developing national NCD plans by convening, for example, a multisectoral national task force or commission to elaborate country-specific strategies and targets. [...] The third key element of success is financing. [...] A fourth requirement is the commitment of governments to strengthening national regulation of NCD risk factors, including pushing for change in the food and beverage industry. [...] Finally, incentives and mechanisms to encourage cross-sectoral action and coordination are central to sustained progress.\*

*Source:* [Sridhar, Devi, et al. 2011. Expectations for the United Nations high-level meeting on noncommunicable diseases. \*Bulletin of the World Health Organization\*. Vol. 89, No. 7 \(July\).](#)

*See Also:* [United Nations. 2011. Zero Draft: Draft outcome document of the High-level Meeting on the prevention and control of non-communicable diseases. \*The NCD Alliance\* \(23 June\).](#)



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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 [hfp\\_bulletin@carleton.ca](mailto:hfp_bulletin@carleton.ca). The Bulletin is also available on the website of the Global Health Diplomacy Network (GHD-NET).

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## Health and Foreign Policy Bulletin

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