Ethical reasoning in pandemic preparedness plans – Southeast Asia and the Western Pacific

The emergence of H1N1 in 2009 shows that it is a mistake to regard the scenario of having to implement pandemic plans as merely hypothetical. This recent experience provides an opportunity to inquire into the current state of pandemic preparedness plans with regard to their ethical adequacy. One aspect that deserves consideration in this context is the disclosure of ethical reasoning. Accordingly, the following [paper] is an analysis of examples of pandemic plans and drafts of plans from Southeast Asia and the Western Pacific. [...] In the analysis, different fields of ethical consideration concerning equity, personal rights and accountability are distinguished. [It indicates that] there are both pragmatic and genuinely ethical reasons to explicitly address issues of these types in pandemic plans. [However] the extent to which ethical language appears in the national plans in South East Asia and the Western Pacific suggests that there is limited awareness of ethical considerations, or at least insufficient ethical substantiation of pandemic action. [The authors conclude ...] that further inclusion of ethical considerations into pandemic plans is ethically demanded. It is of particular significance that these considerations are formulated and remain discernible as instances of ethical deliberation.*

GLOBAL HEALTH NEWS:

Fact Sheet: Global Health Security
This week [18-24 September] President Obama addressed the United Nations General Assembly and urged the global community come together to prevent, detect, and fight every kind of biological danger, whether it is a pandemic, terrorist threat, or treatable disease. The United States is taking a multi-faceted approach to the full spectrum of challenges posed by infectious diseases, whether naturally occurring, accidental, or the result of a deliberate attack. Through fora such as the UN Security Resolution 1540, the Biological Weapons Convention (BWC), and the World Health Organization (WHO), the United States is pursuing this common vision to ensure that disease no longer threatens the security and prosperity of nations. The “Global Health Security” policy framework is derived from the common approaches that shape key U.S. strategies and initiative: the National Strategy for Counterfeiting Biological Threats, the National Security Strategy, Department of Health and Human Services National Health Security Strategy, and the Global Health Initiative. Improving capacities to detect, report and respond to infectious disease threats, as reflected in the WHO’s International Health regulations (IHR). The United States is committed to assisting countries in developing core capacities to assess, notify, and respond to infectious disease threats and to meet the WHO milestone of having these capacities in place by 2010. Coordinating across its diverse international health programs, the United States is focused on assisting host countries in meeting their IHR obligations.*


RESEARCH ON HEALTH & STATES IN CRISIS/CONFLICT:

Utilization of outpatient services in refugee settlement health facilities: A comparison by age, gender, and refugee versus host national status
Comparisons between refugees receiving health care in settlement-based facilities and persons living in host communities have found that refugees have better health outcomes. However, data that compares utilization of health services between refugees and the host population, and across refugee settlements, countries and regions is limited. [The authors] address this information gap. The analysis in this paper uses data from the United Nations High Commissioner of Refugees (UNHCR) Health Information System (HIS). [...] There was no statistically significant difference between the size of the male and female populations across refugee settlements. Across all settlements reporting to the UNHCR database, the percent of the refugee population that was less than five years of age is 16% on average. The availability of a centralized database of health information across UNHCR-supported refugee settlements is a rich resource. The SPHERE standard for emergencies of 1-4 visits per person per year appears to be relevant for Asia in the post-emergency phase, but not for Africa. In Africa, a post-emergency standard of 1-2 visits per person per year should be considered. Although it is often assumed that the size of the female population in refugee settlements is higher than males, we found no statistically significant difference between the size of the male and female populations in refugee settlements overall. Another assumption – that the under-fives make up 20% of the settlement population during the emergency phase—does not appear to hold for the post-emergency phase; under-fives made up about 16% of refugee settlement populations.*

Denial of flood aid to the Ahmadiyya Muslim community in Pakistan

During the catastrophic floods of 2010 in Pakistan, approximately 500 internally displaced families belonging to the Ahmadiyya sect of Islam were denied humanitarian relief. The failure of international agencies and Pakistan’s government to protect basic human rights in the context of disaster relief raises profound questions. If all humanitarian work associated with natural disasters must be governed by canons of human rights, how should international agencies deal with legally empowered official discrimination? A review of the history of the Ahmadiyya community in Pakistan reveals decades of state-sanctioned persecution, particularly through its anti-blasphemy laws, and poses a serious challenge to the international community. When effective intervention is predicated on cooperation with state institutions, how can international relief agencies avoid becoming implicated in official discrimination? The denial of flood aid to Pakistan’s Ahmadiyya community highlights the need for concerted action in disaster settings to prevent discrimination against vulnerable groups. Discriminatory legislation is not only a violation of basic norms enshrined in international compacts, it is a key problem for disaster relief.

**Global Health News:**

**Medical community urged to defend Bahraini doctors**

Human rights groups are hoping Bahrain will set aside the prison sentence of up to 15 years imposed on 20 doctors after a military court convicted them of links to anti-government protests on Sept. 29. [...] Groups ranging from WHO to the World Medical Association expressed their concern over the doctors' prosecution by Bahrain, a tiny Gulf kingdom of about 525,000 people of whom 70% are Shia and are ruled by the Al-Khakifs royal family of the Sunni minority. Mostly Shia protesters took to the streets demanding greater equality and political reform earlier this year after uprisings in Tunisia and Egypt but the Bahraini authorities, with backing from fellow Gulf monarchies Saudi Arabia and the United Arab Emirates, crushed the uprising.[...] The doctors were found guilty of charges including occupying a hospital, stockpiling weapons, spreading lies and false news, inciting hatred of Bahrain’s rulers and calling for their overthrow, and withholding treatment of Sunnis. Bahraini officials said ambulances were used to carry weapons and that hospital blood supplies were used to fake or embellish injuries among protesters. The doctors vigorously denied the charges, saying some of them were tortured and forced to make false confessions.*


**Global Health Governance**

**The role of non-governmental organizations in global health diplomacy: negotiating the Framework Convention on Tobacco Control**

The Framework Convention on Tobacco Control (FCTC) is an exemplar result of global health diplomacy, based on its global reach (binding on all World Health Organization member nations) and its negotiation process. The FCTC negotiations are one of the first examples of various states and non-state entities coming together to create a legally binding tool to govern global health. They have demonstrated that diplomacy, once consigned to interactions among state officials, has witnessed the dilution of its state-centric origins with the inclusion of non-governmental organizations (NGOs) in the diplomacy process. To engage in the discourse of global health diplomacy, NGO diplomats are immediately presented with two challenges: to convey the interests of larger publics and to contribute to inter-state negotiations in a predominantly state-centric system of governance that are often diluted by pressures from private interests or mercantilist self-interest on the part of the state itself. How do NGOs manage these challenges within the process of global health diplomacy itself? What roles do, and can, they play in achieving new forms of global health diplomacy? This paper addresses these questions through presentation of findings from a study of the roles assumed by one group of non-governmental actors (the Canadian NGOs) in the FCTC negotiations. The findings presented are drawn from a larger grounded theory study. Qualitative data were collected from 34 public documents and 18 in-depth interviews with participants from the Canadian government and Canadian NGOs. This analysis yielded five key activities or roles of the Canadian NGOs during the negotiation of the FCTC: monitoring, lobbying, brokering knowledge, offering technical expertise and fostering inclusion. This discussion begins to address one of the key goals of global health diplomacy, namely ‘the challenges facing health diplomacy and how they have been addressed by different groups and at different levels of governance’.

**Global Health News:**

**Turning the page from emergency to sustainability: The final report of the High Level Independent Review Panel on Fiduciary Controls and Oversight Mechanisms of the Global Fund to Fight AIDS, Tuberculosis and Malaria**

The High-Level Independent Review Panel on Fiduciary Controls and Oversight Mechanism was established in March [2011] after the Global Fund's Office of the Inspector General reported misappropriation of Global Fund grant funds in some countries. The panel has assessed the Global Fund's current practices in financial oversight and implementation. To perform the assessment, the members of the panel examined a representative sample of grants in 40 countries in different risk categories, drawing conclusions and making recommendations. The panel visited 12 countries and closely reviewed Global Fund policies and documents. The panel has submitted its recommendations to the Global Fund's Board and finds that the organization needs to focus much more on its core business of managing grants to save and protect lives. [In particular, it recommends: 1) moving from an emergency to sustainable response; 2) declaring a doctrine of risk and management; 3) strengthening internal governance; 4) streamlining the grant proposal process; 5) empowering middle management's decision making; and 5) focusing on results.]


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**Research on Health & Development, Health Systems:**

**An analysis of Liberia’s 2007 National Health Policy: Lessons for health systems strengthening and chronic disease care in poor, post-conflict countries**

Globally, chronic diseases are responsible for an enormous burden of deaths, disability, and economic loss, yet little is known about the optimal health sector response to chronic diseases in poor, post-conflict countries. Liberia’s experience in strengthening health systems and health financing overall, and addressing HIV/AIDS and mental health in particular, provides a relevant case study for international stakeholders and policymakers in other poor, post-conflict countries seeking to understand and prioritize the global response to chronic diseases. In this case study, [the authors] examine the early reconstruction of Liberia’s health care system from the end of conflict in 2003 to the present time, highlight challenges and lessons learned from this initial experience, and describe future directions for health systems strengthening and chronic disease care and treatment in Liberia. Six key lessons emerge from this analysis: (i) the 2007 National Health Policy’s 'one size fits all' approach met aggregate planning targets but resulted in significant gaps and inefficiencies throughout the system; (ii) the innovative Health Sector Pool Fund proved to be an effective financing mechanism to recruit and align health actors with the 2007 National Health Policy; (iii) a substantial rural health delivery gap remains, but it could be bridged with a robust cadre of community health workers integrated into the primary health care system; (iv) effective strategies for HIV/AIDS care in other settings should be validated in Liberia and adapted for use in other chronic diseases; (v) mental health disorders are extremely prevalent in Liberia and should remain a top chronic disease priority; and (vi) better information systems and data management are needed at all levels of the health system.*

RESEARCH ON HUMAN RESOURCES & MIGRATION OF HEALTH WORKERS:

No child out of reach: Time to end the health worker crisis

Every day, 22,000 children around the world die before they have reached their fifth birthday. With the right treatment and prevention, the overwhelming majority of these deaths are avoidable. But millions of children die because of a global health worker crisis that means they miss out on life-saving care. [...] This crisis is two-fold. Firstly, there are too few health workers to meet the needs of children in the poorest countries. [...] Secondly, the health workers that do exist are often not working in the places where they are most needed, and many lack the skills, resources and authority they need to save children’s lives. [...] This challenge will not be met overnight: recruiting, training and deploying health workers in the numbers needed will take years, and requires both global political action and far-reaching changes in policy and practice at the national level. At the global level, political leaders and international institutions must place health workers at the top of their agenda for achieving the health-focused Millennium Development Goals (MDGs) on child and maternal mortality. [Five actions are particularly needed: 1) garner global political action at the highest level; 2) ensure more health workers with appropriate skills; 3) tackle unequal access to care by reaching the most vulnerable children; 4) ensure a fair wage for all health workers; 5) generate more and better funding for healthcare.]*


GLOBAL HEALTH NEWS:

Health effects of financial crisis: Omens of a Greek tragedy

Here, [the authors] describe changes in health and health care in Greece on the basis of [their] analysis of data from the EU Statistics on Income and Living Condition, which provide comparable cross-sectional and longitudinal information on social and economic characteristics and living conditions throughout the EU. [...] There are signs that health outcomes have worsened, especially in vulnerable groups. [The authors] noted a significant rise in the prevalence of peoples reporting that their health was “bad” or “very bad” [...] Suicides rose by 17% in 2009 from 2007 and unofficial 2010 data quoted in parliament mention a 25% rise compared with 2009. [...] Violence has also risen, and homicide and theft rates nearly doubled between 2007 and 2009. [...] A significant increase in HIV infections occurred in late 2010. The latest data suggest that new infections will rise by 52% in 2011 compared with 2010 (922 new cases versus 65), with half of the currently observed increases attributable to infections among intravenous drug users. [...] Another indicator of the effects of the crisis on vulnerable groups is increased use of street clinics run by NGOs. Until recently, these clinics mainly catered to immigrants, but the Greek chapter of Médecins du Monde estimates that the proportion of Greeks seeking medical attention from their street clinics rose from 3-4% before the crisis to about 30%.*

**Medical tourism: Treatments, markets and health system implications: A scoping review**

This review identifies the key emerging policy issues relating to the rise of medical tourism’. The review details what is currently known about the flow of medical tourists between countries and discusses the interaction of the demand for, and supply of, medical tourism services. It highlights the different organisations and groups involved in the industry, including the range of intermediaries and ancillary services that have grown up to service the industry. Treatment processes (including consideration of quality, safety and risk) and system-level implications for countries of origin and destination (financial issues; equity; and the impact on providers and professionals of medical tourism) are highlighted. The review examines harm, liability and redress in medical tourism services with a particular focus on the legal, ethical and quality-of-care considerations. 

*…+ The central conclusion from this review is that there is a lack of systematic data concerning health services trade, both overall and at a disaggregated level in terms of individual modes of delivery, and of specific countries. This is both in terms of the trade itself, as well as its implications. Mechanisms are needed that help us track the balance of trade around medical tourism on a regular basis.*†


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**Global Health News:**

**Europe: Will European health services in 2020 include medical tourism?**

Through the new EU Cross-Border health Directive [a policy aimed at developing a framework that removes obstacles European patients face when travelling to another European country for treatment], the EU has taken on the responsibility to co-ordinate the interoperability of health systems in Europe. The EU believes that member states have much to gain from greater co-operation on eHealth and the increasing use of telemedicine and telemonitoring solutions to reduce hospitalisation of chronic heart disease patients and to cut the use of healthcare resources. On a daily basis, hugely improved and much more expensive cures are emerging. The directive on cross-border healthcare will benefit patients across Europe by clarifying their rights to get access to safe and high-quality treatment across EU borders and be reimbursed for it. In addition to providing a clear and coherent set of rules on cross-border healthcare, the new directive will help patients who need specialized treatment, who are seeking a diagnosis or treatment for a rare disease.*

**Source:** _________. 2011. Europe: Will European health services in 2020 include medical tourism? International Medical Travel Journal online (28 September).
A win-win solution?: A critical analysis of tiered pricing to improve access to medicines in developing countries

Tiered pricing - the concept of selling drugs and vaccines in developing countries at prices systematically lower than in industrialized countries - has received widespread support from industry, policymakers, civil society, and academics as a way to improve access to medicines for the poor. [...] In this paper, the authors find several critical shortcomings to tiered pricing: it is inferior to competition for achieving the lowest sustainable prices; it often involves arbitrary divisions between markets and/or countries, which can lead to very high prices for middle-income markets; and it leaves a disproportionate amount of decision-making power in the hands of sellers vis-a-vis consumers. In many developing countries, resources are often stretched so tight that affordability can only be approached by selling medicines at or near the cost of production. Policies that "de-link" the financing of R&D from the price of medicines merit further attention, since they can reward innovation while exploiting robust competition in production to generate the lowest sustainable prices. However, in special cases - such as when market volumes are very small or multi-source production capacity is lacking - tiered pricing may offer the only practical option to meet short-term needs for access to a product. In such cases, steps should be taken to ensure affordability and availability in the longer-term.*


GLOBAL HEALTH NEWS:

Why drug safety should not take a back seat to efficacy

Historically, the evaluation of harmful effects resulting from prescription drug use has been considered less important than demonstrating drug efficacy, yet the harms caused by specific adverse drug reactions are a major, and avoidable, contributor to hospitalizations and deaths. There are many reasons (both scientific and social) why reliable data on harmful effects may only emerge well after drug approval and marketing. Some evidence suggests that drugs approved under a rapid regulatory review process may be more likely to show problems with safety post-marketing than drugs that go through a slower evaluation process. And debates continue about the best ways to meaningfully synthesize and interpret data on the possible harmful effects of drugs—for example, how passive surveillance systems (spontaneous reports of suspected adverse reactions) should be improved, whether new drugs should go through a phased launch process with enhanced safety evaluations, and whether risk mitigation strategies are appropriate for drugs with safety concerns. [...] Clearly, for post-approval safety studies, one size will not fit all. Conduct and reporting are unlikely to be standardizable in the same way as has been possible for randomized trials, in which there is agreement on what information needs to be registered about the study and when, and specific standards for the reporting of studies [...] are widely accepted. [...] However, these challenges should not discourage investigators, regulators, and patients from demanding a higher safety standard for approved drugs.*

Assessment of population-level effect of Avahan, an HIV-prevention initiative in India

The aim of Avahan, the India AIDS Initiative, was to reduce HIV transmission in the general population through large-scale prevention interventions focused on high-risk groups. It was launched in 2003 in six states with a total population of 300 million and a high HIV burden. [The authors] assessed the population-level effect of the first phase of Avahan (2003–08). Population prevalence was estimated by use of adjustment factors from the national HIV sentinel surveillance data obtained annually from antenatal clinics. A mixed-effects multilevel regression model was developed to estimate the association between intervention intensity and population HIV prevalence trends, taking into account differences in the underlying epidemic trends in states and other potential confounders, and to estimate the number of HIV infections averted with Avahan. Eighty (61%) of 131 districts in the six Avahan states received funding from Avahan for HIV prevention, as the only or shared source. Greater intensity of Avahan, measured as amount of grant per HIV population (medians US$24—432 in the six states), was significantly associated with lower HIV prevalence in Andhra Pradesh (p=0·004), Karnataka (p=0·004), and Maharashtra (p=0·008) states; this association was not significant in Tamil Nadu (p=0·06), Manipur (p=0·62), and Nagaland (p=0·67). Overall, [the authors] estimated that 100 178 HIV infections (95% CI 25 897—207 713) were averted at the population level from 2003 up to 2008 as a result of Avahan. The results of [the] analysis suggest that Avahan had a beneficial effect in reducing HIV prevalence at the population level over 5 years of programme implementation in some of the states.*


GLOBAL HEALTH NEWS:

Global funding for infectious diseases: TB or not TB?

WHO’s sixteenth annual report on global tuberculosis control, released on Oct 11, present detailed and encouraging statistics, carefully interwoven with words of caution about the peril of failing to maintain disease-specific funding. Taking a global view, the numbers are undoubtedly sobering, with 8.8 million new cases of tuberculosis estimated in 2010, and about 1.45 million deaths from tuberculosis across populations with and without HIV. In 2009, 9.7 million children are thought to have been orphaned by parental deaths caused by tuberculosis (whether or not accompanied by HIV). The good news is that incidence of tuberculosis seems to have been falling worldwide since 2002. Impressive falls in tuberculosis mortality have been achieved in various countries and regions, including Uganda, Tanzania, Cambodia, and the Americas. But the most striking achievements are in China, where in the period 1990-2010 prevalence of tuberculosis infection is reported to have halved and mortality reduced by 78%. Underpinning confidence in the new finding, mortality estimates in the WHO report have been based on greatly improved methods compared with previous iterations, including vital registration data from 91 countries and direct measurements from India and China.*

GLOBAL HEALTH NEWS:

Two cheers for the malaria vaccine
A vaccine to protect children against malaria has been shown moderately effective in a large clinical trial – an achievement that could save millions of lives. The vaccine, known as RTS,S and made by GloxoSmithKline, is the first ever to be shown effective against a human disease caused by parasites. When tested in 6,000 infants ages 5 to 17 months in seven sub-Saharan nations, it reduced the risk of infection with severe malaria by 47 percent during the year after the shots, far less than the 90 percent efficacy rate typically sought for other vaccines. And there are other big hurdles still to surmount. There are hints that the protection may wane over time and results from administering a booster shot won’t be known until 2014. Side effects could pose a problem; seizures and fevers were higher among children given the vaccine. If final results of this ongoing study, which involves more than 15,000 children in all, show that the vaccine is safe and effective, the goal is to deploy it in 2015.*


RESEARCH ON GLOBAL ACTION ON NON-COMMUNICABLE DISEASES:

Informing the 2011 UN session on noncommunicable diseases: Applying lessons from the AIDS response
The September 2011 UN High-Level Meeting on Noncommunicable Diseases provides an opportunity for the international community and national stakeholders to raise awareness and launch an effective global response to noncommunicable diseases (NCDs). Valuable policy lessons have been learned in the control of AIDS that can help inform the global dialogue when designing a NCD response in developing countries. The AIDS response demonstrates success in advocacy and resource mobilization, priority setting, coalition building, strong national and community leadership, strengthening of community health infrastructures, and health system strengthening. Weaknesses of the AIDS response to avoid when building a NCD response include creation of stove-pipe vertical programs, ineffectiveness of prevention efforts, and inefficient and uncoordinated use of resources. The lessons learned in the global response to AIDS are relevant to the likely outcomes of the UN High-Level Meeting on NCDs: 1) improvement in advocacy and recognition of the NCD burden, 2) greater attention in national planning and resource allocation, 3) a longer-term investment of donors, and 4) greater emphasis on strengthening health systems.

GLOBAL HEALTH NEWS:

**Tobacco control measures under industry assault**

Tobacco industry bids to undermine tobacco prevention and control measures by mounting legal challenges based on international trade treaties appear to have become all the rage, to the dismay of public health advocates. Australia, Norway and Uruguay now face such trade-related lawsuits. Two similar suits against Thailand and the United States were recently settled in the industry’s favour. And as Margaret Chan indicated, legal skirmishing underway at the World Trade Organization suggests that many more countries will soon join the list of industry targets. The Framework Convention on Tobacco Control (FCTC), a 2005 initiative to which roughly 170 countries have become signatories, has been effectively used to introduce such tobacco control measures as plain packaging and expanded health warnings on cigarette packages. But the industry is combing the fine print of trade treaties with an eye toward gutting tobacco control initiatives, says Ellen Shaffer, codirector of the San Francisco, California-based Center for Policy Analysis on Trade and Health. […] A spate of recently-negotiated trade agreements around the world (there are now more than 2000 such agreements), often signed without consideration of public health consequences, has fuelled the trend, she adds. “It’s a real test of the often arcane and complex architecture of these trade agreements.”


GLOBAL HEALTH NEWS:

**France targets tobacco industry to raise cash for global health**

France is considering introducing an innovative new additional tax on the tobacco industry, in an effort to reduce the number of deaths from tobacco related illnesses. [...] The proposed new tax, which would raise money to be used in France and in the developing world, is inspired by Unitaid, the international facility to buy drugs for developing countries. Unitaid’s main source of funding is a levy on airplane tickets. France’s minister of health, Xavier Bertrand, has commissioned a report on new ways of implementing all measures recommended in the World Health Organization’s Framework Convention on Tobacco Control, which France ratified in 2004.


GLOBAL HEALTH NEWS:

**Note from the Editors**

The May 2011 issue of the Health and Foreign Policy Bulletin highlighted the following research article:


A comment on the piece has recently been published that we would like to bring to your attention:

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. The Bulletin is also available on the website of the Global Health Diplomacy Network (GHD-NET).

Summaries presented in the Bulletin are modified from original content.

*This summary has been adapted from original text, modifications may have included the addition and/or subtraction of text.

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