Global public health legal responses to H1N1

The H1N1 pandemic prompted the first significant application of a number of international legal and policy mechanisms that have been developed in the last decade to respond to this kind of event. Furthermore, it presented a considerable test for public health systems at all levels, from global to local. Although initial predictions forecasting high morbidity and mortality from this virus overestimated its eventual impact, the human toll of the pandemic was nevertheless significant. [... Several explanations may be offered, in hindsight, to explain the lower-than-expected morbidity and mortality rates. The rates might represent a momentous success for public health, validating the strategies – including legal strategies – employed to stem the spread of diseases. The result might also be attributed to epidemiological fortuity, since this strain of influenza A (H1N1) virus proved less virulent than initially feared. [However, the authors suggest] that the 2009 influenza A (H1N1) virus prompted a number of legal responses that were integral to the resulting public health outcomes. Legal frameworks supported a complex global response, requiring the combined efforts of governments, inter-governmental and non-profit institutions, and private entities. The application of these frameworks demanded international cooperation among these actors on activities including disease surveillance and sharing of information and resources. In addition, laws impacted access to pharmaceutical countermeasures such as vaccines and antiviral medication. Governments also employed public health powers to institute a variety of non-pharmaceutical countermeasures in an attempt to control the spread of the virus, including quarantine, school closures, and other social distancing measures.*†
**RESEARCH ON HEALTH & STATES IN CRISIS/CONFLICT:**

**Post-conflict health reconstruction: Search for a policy**

Despite increasing experience in health reconstruction in societies emerging from conflict, the policy basis for investing in the development of equitable and effective health systems in the wake of war remains unsettled. Consideration of post-conflict health reconstruction is almost entirely absent in donor policies on global health. Practically by default, health programmes are seen increasingly as an element of stabilisation and security interventions in the aftermath of armed conflict. That perspective, however, lacks an evidence base and can skew health programmes towards short-term security and stabilisation goals that have a marginal impact and violate the principles of equity, non-discrimination, and quality, which are central to sound health systems and public acceptance of them. A better approach is to ground policy in legitimacy, viewing health both as a core social institution and one that, if developed according to human rights principles, including equity, non-discrimination, participation and accountability, can advance the effectiveness and the quality of governance in the emerging state.


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**GLOBAL HEALTH NEWS:**

**Smallpox-Destruction gets delayed**

Global health officials Tuesday [24 May] delayed setting a deadline for the destruction of the last known stocks of smallpox for at least three more years, a compromise that will enable scientists in the U.S. and Russia to continue researching medicines to counter a potential bioterror attack using smallpox. The consensus at the World Health Assembly, the decision-making body of the World Health Organization, came after a contentious debate over two days. The U.S., Russia and more than two dozen other countries in the developed and developing world had supported a resolution to keep the stocks of the deadly virus for at least an additional five years. It also required countries aside from the U.S. and Russia to declare to the WHO that they didn't hold stocks of live smallpox virus. Iran, China, Thailand and other countries objected to the resolution and wanted an earlier timetable.


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**Final report of the independent panel of experts on the cholera outbreak in Haiti**

Ten months after the devastating earthquake of January 12, 2010, cholera appeared in Haiti for the first time in nearly a century. The outbreak subsequently claimed over 4,500 lives, sickened almost 300,000 people, and continues to cause infections and deaths in Haiti. […] Several independent researchers studying genetic material from the bacteria responsible for the outbreak of cholera in Haiti graciously provided their results to [the authors of this report]. They used a variety of molecular analysis techniques to examine multiple samples of the bacteria. Their results uniformly indicate that: 1) the outbreak strains in Haiti are genetically identical, indicating a single source for the Haiti outbreak; and, 2) the bacteria is very similar, but not identical, to the South Asian strains of cholera currently circulating in Asia, confirming that the Haitian cholera bacteria did not originate from the native environs of Haiti. The hydrological data, combined with the epidemiological timeline, and supported by the molecular analysis information verifies that contaminated river water was the likely route of spread of *Vibrio cholerae* from the mountains of Mirebalais to the coastal areas around the Artibonite River Delta. These research findings indicate that the 2010 Haiti cholera outbreak was caused by bacteria introduced into Haiti as a result of human activity; more specifically by the contamination of the Meye Tributary System of the Artibonite River with a pathogenic strain of the current South Asian type *Vibrio cholerae*.


India's 2011 census revealed a growing imbalance between the numbers of girls and boys aged 0—6 years, which [the authors] postulate is due to increased prenatal sex determination with subsequent selective abortion of female fetuses. [The authors] aimed to establish the trends in sex ratio by birth order from 1990 to 2005 with three nationally representative surveys and to quantify the totals of selective abortions of girls with census cohort data. [...] After adjusting for excess mortality rates in girls, estimates of number of selective abortions of girls rose from 0—2.0 million in the 1980s, to 1.2—4.1 million in the 1990s, and to 3.1—6.0 million in the 2000s. Each 1% decline in child sex ratio at ages 0—6 years implied 1.2—3.6 million more selective abortions of girls. Selective abortions of girls totaled about 4.2—12.1 million from 1980—2010, with a greater rate of increase in the 1990s than in the 2000s. Selective abortion of girls, especially for pregnancies after a firstborn girl, has increased substantially in India. Most of India's population now live in states where selective abortion of girls is common.*


A rite of torture for girls

People usually torture those whom they fear or despise. But one of the most common forms of torture in the modern world, incomparably more widespread than waterboarding or electric shocks, is inflicted by mothers on daughters they love. It's female genital mutilation — sometimes called female circumcision — and it is prevalent across a broad swath of Africa and chunks of Asia as well. Mothers take their daughters at about age 10 to cutters like Maryan Hirsi Ibrahim, a middle-aged Somali woman who says she wields her razor blade on up to a dozen girls a day. "This tradition is for keeping our girls chaste, for lowering the sex drive of our daughters," Ms. Ibrahim said. "This is our culture." [...] This is one of the most pervasive human rights abuses worldwide, with three million girls mutilated each year in Africa alone, according to United Nations estimates. [...] For four decades, Westerners have campaigned against genital cutting, without much effect. Indeed, the Western term "female genital mutilation" has antagonized some African women because it assumes that they have been "mutilated." Aid groups are now moving to add the more neutral term "female genital cutting" to their lexicon. [...] But it is clear that the most effective efforts against genital mutilation are grass-roots initiatives by local women working for change from within a culture.*


RESEARCH ON GLOBAL HEALTH GOVERNANCE & INSTITUTIONS:

A report of the CSIS Global Health Policy Centre: Health Diplomacy of Foreign governments

In the fall of 2010, the CSIS Global Health Policy Centre hosted three seminars featuring experts on regional politics, global health policy, and diplomacy to facilitate discussion, information exchange and analysis regarding the linkages between health and foreign policy in key countries. The seminars focused on the following topics: “Health Diplomacy of Rival Powers: China and Russia,” “Health Diplomacy of Middle-Income Countries: Brazil and Cuba,” and OECD Health Diplomacy: France, Japan and Norway.” [...] Several trends became apparent within the context of the discussions. Broadly speaking each country’s engagement is driven by its history and political outlook and by the image it seeks to project regionally and internationally. At the same time, some countries engage in global health outreach because they reap economic benefits, including access to raw materials or trade relations, thanks to their health-related assistance. For other governments, providing health assistance builds alliances, or “symbolic capital,” which can be cashed in at critical political junctures. Many governments active in the global health arena support efforts to strengthen disease surveillance in countries where health systems are weak, in large part to prevent infectious diseases from spreading and threatening their own populations. Yet for some of the emerging actors and would-be donors in the global health field, the lack of a cohort of trained development professionals will reduce the efficacy of health-related assistance in the short to medium term.*

Source: Bliss, Katherine E. 2011. A report of the CSIS Global Health Policy Centre: Health Diplomacy of Foreign Governments. CSIS Global Health Policy Centre online (May).

GLOBAL HEALTH NEWS:

The G-8’s self-serving math

The final communiqués haven’t been written. But the word on the street is that when leaders of the Group of 8 industrialized countries meet in France this week, they will claim that wealthy countries have come close to fulfilling their 2005 promise to boost annual development aid by $50 billion by 2010. They are not even in the ballpark. The Organization for Economic Cooperation and Development, which keeps track of aid flows, said aid from rich nations in 2010 was $19 billion short of the promises made at the G-8 summit meeting in Gleneagles, Scotland, six years ago. Aid to Africa came in $14.5 billion short. Yet the G-8 seems determined to fudge the numbers rather than admit to a broken promise. The accountability report published on the G-8 Web site last week inflates the aid figure by not accounting for the fact that a dollar today is worth much less than it was when the promise was made. By this accounting, annual aid from wealthy countries came about $1 billion short.*


Revamp for WHO

The top decision-making body at the World Health Organization (WHO) — the World Health Assembly — last week [16 May-23 May] backed reforms that might bring the biggest changes to the agency in its 63-year history. Concerns about the WHO's performance stretch back decades, but the current harsh financial climate and an altered global-health landscape have brought the need for reform to a head. The WHO's member states now want the over-extended agency to focus its activities on a far smaller number of core areas. But some experts think the reforms are unlikely to go far enough, and are calling for an overhaul of the agency's structure and governance. [...]The reform proposal approved by the assembly last week lacks specifics, and is most significant as a green light for what will be complex negotiations. But its appraisal of the WHO is not glowing — it depicts the agency as archaic, overextended and lacking adequate assessment of its programmes and staff.*

RESEARCH ON HEALTH & DEVELOPMENT, HEALTH SYSTEMS:

10 best resources on...the current effects of global health initiatives on country health systems

The last decade has seen momentous shifts in the global development assistance architecture for health. Actors at the global level are changing. In addition to the WHO, UNICEF, the World Bank and donor governments, new actors including philanthropic trusts and other civil society organizations, private-for-profit organizations, global health initiatives (GHIs) and partnerships are becoming increasingly significant. GHIs are mobilizing substantial new resources for disease control programmes in low- and middle-income countries (LMICs) leading to dramatic scaling up of services, especially for HIV and AIDS. […] Among the concerns expressed about GHIs are the unintended negative effects of disease-specific programmes (often perceived as ‘vertical’ programmes) including whether they undermine efforts to improve donor harmonization (co-ordination between donors) and alignment (co-ordination between donors and recipient government policies and programmes), place increased burdens on already weak health systems and unintentionally weaken the delivery of services for non-focal diseases.*†

Source: Spicer, Neil & Aisling Walsh. 2011. 10 best resources on … the current effects of global health initiatives on country health systems. Health Policy and Planning online (5 May).

GLOBAL HEALTH NEWS:

The costs of performance-based financing

Paying people based on their performance has been under discussion throughout the history of work contracts. […] Various institutions including Roman society, the churches, trade unions and modern governments concerned with certain bankers’ performance have tried to emphasize the “true value of labour” and have made a stand against performance contracts. […] Looking at the broader evidence, one finds the following arguments against performance-based financing based on three main issues. First, there is the issue of its effect on worker motivation in the health sector. It is argued that the introduction of financial incentives into a working environment characterized by a high degree of idealism might actually erode workers’ intrinsic motivation […] Second, performance-based financing focuses on a certain range of indicators. This can often lead to “gaming”, i.e. the neglect of non-remunerated aspects of work and the focus on remunerated ones […] Third, the hidden costs of performance-based financing are not limited to emotional costs (concerning the self-esteem of health workers) and technical costs (due to misdirected focus on indicators). There are considerable costs (both financially and in working hours invested) in establishing a performance-based financing system that continuously monitors the quantity and perceived quality of health-sector performance.*

Research on Human Resources & Migration of Health Workers:

Key factors leading to reduced recruitment and retention of health professionals in remote areas of Ghana: A qualitative study and proposed policy solutions

The ability of many countries to achieve national health goals such as the Millennium Development Goals remains hindered by inadequate and poorly distributed health personnel, including doctors. The distribution of doctors in Ghana is highly skewed, with a majority serving in two major metropolitan areas (Accra and Kumasi), and inadequate numbers in remote and rural districts. Recent policies increasing health worker salaries have reduced migration of doctors out of Ghana, but made little difference to distribution within the country. This qualitative study was undertaken to understand how practicing doctors and medical leaders in Ghana describe the key factors reducing recruitment and retention of health professionals into remote areas, and to document their proposed policy solutions. [...] All participants felt that rural postings must have special career or monetary incentives given the loss of locum (i.e. moonlighting income), the higher workload, and professional isolation of remote assignments. Career 'death' and prolonged rural appointments were a common fear, and proposed policy solutions focused considerably on career incentives, such as guaranteed promotion or a study opportunity after some fixed term of service in a remote or hardship area. There was considerable stress on the need for rural doctors to have periodic contact with mentors through rural rotation of specialists, or remote learning centres, and reliable terms of appointment with fixed endpoints. Also raised, but given less emphasis, were concerns about the adequacy of clinical equipment in remote facilities, and remote accommodations.*


Global Health News:

Médecins sans Frontières pleads for more Canadian Physicians

Medical relief projects are facing a "human resources crisis," as Canadian doctors become increasingly difficult to recruit to humanitarian work, says Leslie Shanks, medical director for Médecins Sans Frontières (MSF). Whether it's the time commitment, "disaster fatigue" or a lack of infrastructure to support doctors leaving the country for relief work stints, Shanks says it's becoming tougher to attract Canadian doctors to humanitarian projects in far-flung parts of the world. "It's always been a challenge and we've always worked hard to find Canadian doctors that meet our criteria, but this last year has been particularly difficult and it's absolutely clear that our major limitation in terms of being able to respond to disasters is our shortage in human resources. [...] MSF exceeded its recruitment goals this year, sending 39 Canadian doctors to the field by August. But that success belies the fact that demands at the field level were much higher than expected, in part because of ongoing emergencies in Haiti, says Simona Powell, director of human resources. With MSF's existing physician pool spread thin, she says the organization needs 45 new applications from Canadian doctors in order to meet operational needs for 2011.*

Source: Vogel, Lauren. 2010. Médecins sans Frontières pleads for more Canadian physicians. CMAJ online (29 November).
RESEARCH ON TRADE POLICY & HEALTH:

The effects of medical tourism: Thailand’s experience
[This paper explores] the positive and negative effects of medical tourism on the economy, health staff and medical costs in Thailand. The financial repercussions of medical tourism were estimated from commerce ministry data, with modifications and extrapolations. [...] Medical tourism generates the equivalent of 0.4% of Thailand’s gross domestic product but has exacerbated the shortage of medical staff by luring more workers away from the private and public sectors towards hospitals catering to foreigners. This has raised costs in private hospitals substantially and is likely to raise them in public hospitals and in the universal health-care insurance covering most Thais as well. The “brain drain” may also undermine medical training in the future. Medical tourism in Thailand, despite some benefits, has negative effects that could be mitigated by lifting the restrictions on the importation of qualified foreign physicians and by taxing tourists who visit the country solely for the purpose of seeking medical treatment. The revenue thus generated could then be used to train physicians and retain medical school professors.*


RESEARCH ON ACCESS TO EFFECTIVE MEDICINES:

Access to care and medicines, burden of healthcare expenditures, and risk protection: Results from the World Health Survey
[This paper assesses] the contribution of health insurance and a functioning public sector to access to care and medicines and household economic burden. [The authors] used descriptive and logistic regression analyses on 2002/3 World Health Survey data in 70 countries. Across countries, 286,803 households and 276,362 respondents contributed data. More than 90% of households had access to acute care. However, less than half of respondents with a chronic condition reported access. In 51 low and middle income countries (LMIC), health care expenditures accounted for 13–32% of total 4-week household expenditures. One in four poor households in low income countries incurred potentially catastrophic health care expenses and more than 40% used savings, borrowed money, or sold assets to pay for care. Between 41% and 56% of households in LMIC spent 100% of health care expenditures on medicines. Health insurance and a functioning public sector were both associated with better access to care and lower risk of economic burden. To improve access, policy makers should improve public sector provision of care, increase health insurance coverage, and expand medicines benefit policies in health insurance systems.*

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

Cost-effectiveness of new WHO recommendations for prevention of mother-to-child transmission of HIV resource-limited setting

[This paper seeks] to determine whether new WHO recommendations for long-course antiretroviral therapy (ART) prophylaxis are cost-effective for prevention of mother-to-child transmission (PMTCT) of HIV compared to short-course strategies in Nigeria. [The authors] conducted a cost-effectiveness analysis from a health-system perspective, with a target population consisting of HIV-infected pregnant women in Nigeria. [...] If implemented at the level of antenatal coverage in Nigeria (58%), mother-to-child HIV transmission could be reduced to 16.1% with minimal standard of care [MSOC] and 12.8% with the intervention. At current pregnancy rates, the intervention would prevent 7680 infant HIV cases and avert 230 400 DALYs annually, compared to MSOC. The average health-system cost of the intervention was US$ 401 per pregnancy compared to $293 per pregnancy with MSOC. The intervention was associated with an ICER of $113 per DALY averted compared to MSOC, and was highly cost-effective using a willingness-to-pay threshold of per-capita Nigerian GDP. Implementation of new WHO recommendations for extended maternal and infant prophylaxis is highly cost-effective compared to short-course regimens for PMTCT of HIV in Nigeria.*


GLOBAL HEALTH NEWS:

HIV treatment as prevention – it works

Last week [16-22 May] any doubts around treatment as an approach to halt the spread of the HIV epidemic were allayed. An international study showed that antiretroviral treatment can prevent the sexual transmission of HIV among heterosexual couples in whom one partner is HIV-infected and the other is not. UNAIDS described the result as a “serious game changer” for HIV prevention. The phase 3 clinical trial, HPTN 052, was done by the HIV Prevention Trials Network and funded by the US National Institutes of Health. It was due to run until 2015, but compelling interim results led the international data and safety monitoring board to recommend the results be publicly released as soon as possible. Although the results are unsurprising given the extensive ecological data supporting the prevention benefits of treatment, this is the first large randomised trial to provide a true impact evaluation. The study showed a 96% reduction in risk of HIV transmission—the primary outcome.*


GLOBAL HEALTH NEWS:

Safe injection advocates await top court ruling

The Supreme Court of Canada is set to decide whether Insite, a health-care facility in Vancouver's downtown eastside, falls under provincial or federal jurisdiction, and whether closing it would violate the rights of drug addicts who use the facility. If the high court rules in favour of provincial jurisdiction, facilities comparable to Insite could quickly pop-up in cities across the country including Montreal, advocates say. [...] Insite opened in 2003 after an epidemic rise in overdose deaths in Vancouver's downtown eastside, allowing drug addicts to inject their own heroin under the supervision of a nurse. [...] The Conservative government has indicated it wants to end the exemption and see the supervised injection site closed. In May 2008, following a B.C. court ruling in favour of the facility, then-health minister Tony Clement said the Conservative government wanted the facility shut down. Supporters of Insite, including the B.C. government, which funds the facility, point to peer-reviewed studies that conclude Insite prevents overdose deaths, reduces the spread of HIV and hepatits, and curbs crime and open drug use. The federal government has rejected that evidence, arguing the facility fosters addiction, misuses resources, and runs counter to its tough-on-crime agenda.*

RESEARCH ON GLOBAL ACTION ON NON-COMMUNICABLE DISEASES:

The power of the process: Evaluating the impact of the Framework Convention on Tobacco Control negotiations

[This paper evaluates] the impact of the FCTC negotiations on the diffusion of tobacco control policies. [The authors analyzed] country characteristics to determine their effects on the frequency, type and strength of tobacco control policies adopted among WHO Member States. Bivariate analyses were conducted for each characteristic to compare the frequency and strength of control policies adopted between pre-negotiation and negotiation periods. Multivariate regression analyses were performed to determine the predictive nature of these variables. The frequency of policy adoption intensified during the years the FCTC negotiations were most intense. The strength of policies adopted also shifted significantly towards policies promoted by WHO. The average strength of policies adopted varied significantly according to country characteristics. All characteristics, with the exception of total and male smoking prevalence, were significantly associated with the number of policy types adopted. This study suggests that investments in international legal processes can be effective, even when the outcomes are unclear from the start. The FCTC negotiation process coincided with a rise in domestic policy adoption in the direction advocated by WHO. However, there remains a need to improve outreach and diffusion to lower-income countries in tobacco control, as well as other areas of chronic disease control.*


GLOBAL HEALTH NEWS:

Health ministers pledge to tackle non-communicable diseases with global action

Ninety health ministers and health officials from 167 countries committed themselves to taking “whole of government” and international actions to combat non-communicable disease (NCDs) at a meeting in Moscow. They gathered at the First Global Ministerial Conference on Healthy Lifestyles and Non-communicable Disease Control [28-29 April], which is part of the build up to the United Nations High Level Meeting on NCDs to be held in New York in September. […] The ministers in the Moscow Declaration “note that policies that address the behavioural, social, economic, and environmental factors associated with NCDs should be rapidly and fully implemented” and “emphasise that prevention and control of NCDs requires leadership at all levels, and a wide range of multilevel, multisectorial measures.” One of the major themes of the conference was the recognition that health ministers and health services alone can make only a small impact on NCDs. “A paradigm shift is imperative in dealing with NCD challenges,” says the declaration. There is a need to “shift from disease centred to people centred approaches and population health measures.”*


GLOBAL HEALTH NEWS:

Food makers resist US lawmakers’ proposal for guidelines in marketing to children

The food and advertising industries are pushing back against an Obama administration proposal that calls for food makers to voluntarily limit the way they market sugary cereals, salty snacks and other foods to children and teens. From yogurt makers to candy manufacturers, they lined up Tuesday [24 May] to tell regulators that the first-ever proposed guidelines for marketing to children would not stop the childhood obesity problem but would certainly hurt their businesses and abridge their right to free speech. The guidelines, ordered by Congress and written by a team from the Federal Trade Commission, the Food and Drug Administration, the Centers for Disease Control and Prevention, and the Agriculture Department, ignited a debate about the role of marketing in soaring obesity rates among children. [...] The regulators held Tuesday’s meeting to gather input from the public. They are accepting written comments until July 14 before finalizing the recommendations and submitting them in a report to Congress.*