RESEARCH ON GLOBAL HEALTH SECURITY:
The challenge of providing the public with actionable information during a pandemic

Analysis of media reporting on the H1N1 vaccine during the 2009 pandemic reveals a dissonance between the nature and content of the reporting, the [United States] government's messages, and the public's perceptions of vaccine safety and desirability. Despite careful attention to history and especially the lessons offered by Richard Neustadt and Harvey Fineberg in their study of the 1976 “Epidemic that Never Was,” government officials failed to escape criticism for decisions made and actions taken in the midst of the unfolding contagion threat. Moreover, public opinion polls show that substantial portions of the population failed to hear, believe, or heed the government's messages. Looking at the enduring narrative of the government's vaccine efforts through the lens of newspaper reports exposes six points of distortion. These points — the pervasive uncertainty inherent in a novel contagion; advances in information technology and electronic communications; the new news environment; the political polarization of American society; the infrastructure of the American public health system; and the oddities of public health emergency and vaccination injury compensation laws — interfered with the public's reception of the government's message and infected the public's perception of government veracity and leadership capability. […] If we are to ensure that the public receives and recognizes accurate and actionable information essential for the prevention or containment of a deadly contagion, we will need to understand and address the impact of these distorting forces.*

Source: Gerwin LE. 2012. The challenge of providing the public with actionable information during a pandemic. The Journal of Law, Medicine & Ethics online (12 October).
RESEARCH ON HEALTH & STATES IN CRISIS/CONFLICT:

The relevance of ‘resilience’?

The concept of resilience is at the centre of current debates in development, climate change adaptation and humanitarian aid. [...] The key critique emanating from the Humanitarian Policy Group’s research is that the most important questions about supporting resilience are too often being left unaddressed. Resilience analysis will become of more practical use to policy and practice if it can become less self-referential and develop two distinct, empirical components. An outward-looking analysis will entail building up a body of empirical studies of collapsed, surviving and recovering livelihoods in and after crises. [...] A second, inward-looking research strand will avoid the pitfalls of being self-referential if it can look empirically at how the bureaucratic requirements of fund disbursement constrain decision-making. A real challenge exists, rarely openly discussed, in accepting the imperfection of bureaucracies, with their need to maintain financial accountability, to manage themselves according to technical specialisation and to work as the implementing arm of political decision-making, while at the same time ensuring that the systems they administer can still provide coherent strategic support to people living with crises.*†


GLOBAL HEALTH NEWS:

Stockpiling oral cholera vaccine

Cholera is re-emerging as a threat on the global public health stage. The number of reported cases worldwide is back at the peak level observed two decades ago, new Vibrio cholerae strains have appeared and antimicrobial resistance has increased. Weak surveillance systems and the possibility of travel and trade sanctions contribute to widespread underreporting of cholera cases, which results in great uncertainty surrounding global disease burden estimates. Such estimates suggest that about 1.4 billion people are at risk of cholera and that the risk is highest among children under five years of age. Annually 2.8 million cases and 91,000 deaths from cholera occur in endemic countries; non-endemic countries contribute another 87,000 cases and 2,500 deaths. Although effective preventive and therapeutic regimens are well established, clearly cholera remains poorly controlled in both outbreak and endemic contexts. [...] Public health interventions, such as case management, enhanced environmental control, improved hygiene and sanitation and social mobilization, should form the backbone of all cholera control programmes. In turn, these interventions depend on effective surveillance and strong health-care systems. This initial, necessarily small, OCV stockpile will not constitute sufficient preparedness for a large or sustained epidemic, its use should complement existing measures as part of a reinvigorated and comprehensive approach to meeting the new challenges involved in global cholera control and prevention.*

Ethics and images of suffering bodies in humanitarian medicine

Media representations of suffering bodies from medical humanitarian organisations raise ethical questions, which deserve critical attention for at least three reasons. Firstly, there is a normative vacuum at the intersection of medical ethics, humanitarian ethics and the ethics of photojournalism. Secondly, the perpetuation of stereotypes of illness, famine or disasters, and their political derivations are a source of moral criticism, to which humanitarian medicine is not immune. Thirdly, accidental encounters between members of the health professions and members of the press in the humanitarian arena can result in misunderstandings and moral tension. From an ethics perspective the problem can be specified and better understood through two successive stages of reasoning. Firstly, by applying criteria of medical ethics to the concrete example of an advertising poster from a medical humanitarian organisation, [the author observes] that media representations of suffering bodies would generally not meet ethical standards commonly applied in medical practice. Secondly, [the author tries] to identify what overriding humanitarian imperatives could outweigh such reservations. [...] While the exact balance between the opposing sets of considerations (medical ethics and humanitarian perspectives) is difficult to appraise, awareness of all values at stake is an important initial standpoint for ethical deliberations of media representations of suffering bodies.*


GLOBAL HEALTH NEWS:

Medical activities to resume in Khost

Médecins Sans Frontières (MSF) will resume medical activities in its maternity hospital in Khost, Afghanistan, which were suspended following an explosion in the hospital in April, 2012. The decision to restart medical services was made after a meeting, or jirga, on Aug. 27 between MSF staff and leading community members, including representatives from all districts of the eastern province of Khost and prominent religious figures and scholars. Those in attendance expressed strong support for MSF’s provision of maternal healthcare in the region.*

Source: ________, 2012. Medical activities to resume in Khost. Médecins Sans Frontières online (17 October).

GLOBAL HEALTH NEWS:

Sahel: Risk is high that humanitarian situation will worsen

"However the armed conflict in northern Mali unfolds, the risk of a further worsening in the humanitarian situation in the region and throughout the Sahel is high," warned the president of the International Committee of the Red Cross (ICRC), Peter Maurer, at the end of a three-day on-site visit. "In particular, in the event of military deployments and renewed hostilities in the north of Mali there would inevitably be consequences for the population, and we have to be ready to respond," said Mr Maurer after going to Niamey and Agadez, in Niger, where the ICRC carries out most of its humanitarian work in the region, and to Bamako and Mopti in Mali. "People in the north of Mali, those who moved southward, and all those who fled the conflict to seek refuge and assistance in neighbouring countries such as Niger, Mauritania, Burkina Faso and Algeria are particularly in need of help," said Mr Maurer. "Their ability to cope with their daily struggles is already greatly diminished. They need food and better access to clean drinking water and health care."*

Source: ________, 2012. Sahel: Risk is high that humanitarian situation will worsen. International Committee of the Red Cross online (24 October).
Integrating interventions on maternal mortality and morbidity and HIV: A human rights-based framework and approach

Maternal mortality and morbidity (MMM) and HIV represent interlinked challenges arising from common causes, magnifying their respective impacts and producing related consequences. Accordingly, an integrated response will lead to the most effective approach for both. Shared structural drivers include gender inequality; gender-based violence (including sexual violence); economic disempowerment; and stigma and discrimination in access to services or opportunities based on gender and HIV. Further, shared system-related drivers also contribute to a lack of effective access to acceptable, high-quality health services and other development resources from birth forward. HIV and MMM are connected in both outcomes and solutions: in sub-Saharan Africa, HIV is the leading cause of maternal death, while the most recent global report on HIV identifies prevention of unintended pregnancy and access to contraception as two of the most important HIV-related prevention efforts. Both are central to reducing unsafe abortion—another leading cause of maternal death globally, and particularly in Africa. A human rights-based framework helps to identify these shared determinants. A human rights-based approach works to establish the health-related human rights standards to which all women are entitled, as well to outline the indivisible and intersecting human rights principles which inform and guide efforts to prevent, protect from, respond to, and provide remedy for human rights violations [...].


Bahrain continues to target doctors

Bahrain's ongoing violations of medical neutrality have been condemned by human rights campaigners, who say that the country's health system is under attack. [...] Human rights groups have called on Bahrain to stop what they called the targeting of doctors who saw their jail sentences upheld last week (Oct 1) by the country's highest court for their role in treating protesters during political unrest last year. [...] The USA, whose Navy's Fifth Fleet is based in the Sunni-ruled Gulf Kingdom, said the court's decision was a setback for reconciliation. "We're also concerned that these convictions serve to further restrict freedom of expression and hurt the atmosphere that's so necessary in Bahrain for national reconciliation", said Victoria Nuland, US State Department spokeswoman. [...] After Bahrain crushed pro-democracy protests early last year, campaigners say that it has failed to fully implement recommendations from an independent inquiry that investigated abuses while clashes between police and protesters, mostly from the Shia majority, continue almost nightly.

Who sets the global health research agenda? The challenge of multi-bi financing

A major challenge in the governance of research funding is agenda-setting, given that the priorities of funding bodies largely dictate what health issues and diseases are studied. The challenge of agenda-setting is a consequence of a larger phenomenon in global health—“multi-bi financing.” Multi-bi financing refers to the practice of donors choosing to route non-core funding—earmarked for specific sectors, themes, countries, or regions—through multilateral agencies such as the World Health Organization (WHO) and the World Bank and to the emergence of new multistakeholder initiatives such as the Global Fund to Fight AIDS, Tuberculosis and Malaria and the GAVI Alliance. These new multistakeholder initiatives have five distinct characteristics: a wider set of stakeholders that include non-state institutions, narrower problem-based mandates, financing based on voluntary contributions, no country presence, and legitimacy based on effectiveness, not process. The shift to multi-bi financing likely reflects a desire by participating governments, and others, to control international agencies more tightly.


GLOBAL HEALTH NEWS:

US global health policy: The US Department of Defense and global health

The Department of Defense (DoD), the largest and oldest agency of the U.S. government, has a long history of supporting health and medical activities around the world. […] DoD possesses and utilizes unique and substantial assets for such activities, such as a tremendous geographic reach, long-standing and influential partnerships with foreign governments and militaries, an ability to rapidly mobilize significant resources, and expertise in scientific and technical areas including research and development. In addition, the recent trend in DoD policy of adopting a more balanced approach to its use of military medical assets […] has made global health-related activities more prominent now than in the past. […] Even so, DoD is not a development agency, and improving global health is not one of its core objectives; rather, its primary mission has always been, and continues to be, providing the military forces necessary to promote and protect the security of the United States. This has led to some ambiguity and tension regarding the role of DoD in this area, with many in the global health community having reservations about DoD’s efforts but lacking a full understanding of its work, and DoD at times failing to give due consideration to the methods and principles that define successful global health programs even as it has increased its attention to such activities.*†

RESEARCH ON HEALTH & DEVELOPMENT, HEALTH SYSTEMS:

Paying for performance and the social relations of health care provision: An anthropological perspective

Over the past decade, the use of financial incentive schemes has become a popular form of intervention to boost performance in the health sector. [...] However, evidence for the impact of these schemes on the wider health system remains limited, and even where evaluations have been positive, unintended effects have been identified. These have included: “gaming” the system; crowding out of “intrinsic motivation”; a drop in morale where schemes are viewed as unfair; and the undermining of social relations and teamwork through competition, envy or ill feeling. Less information is available concerning how these processes occur, and how they vary across social and cultural contexts. While recognizing the potential of P4P, the authors argue for greater care in adapting schemes to particular local contexts. [They] suggest that insights from social science theory coupled with the focused ethnographic methods of anthropology can contribute to the critical assessment of P4P schemes and to their adaptation to particular social environments and reward systems.*


GLOBAL HEALTH NEWS:

Time for innovative dialogue on health systems research

A forthcoming report by the World Health Organization (WHO) on evidence for policy is already fuelling passionate debate, especially among scientists. Opinions are divided: some scientists believe strongly in the systematic assessment of evidence on the effectiveness of health system interventions and reforms; others are skeptical. This is not just another academic debate. Health policy is a noisy field involving many stakeholders. Health reform approaches that seem promising in practice are assessed critically by institutional researchers, whose methodological dictums are sceptically received by field practitioners. [...] A balanced dialogue between different knowledge holders [...] is, in our view, a conditio sine qua non for successful health policies. It concerns us all to consolidate the body of evidence surrounding promising approaches, including data on their possible pitfalls and side-effects. For such a dialogue to take off and become truly global, the following prerequisites should be fulfilled. All contributors should realize that the knowledge agenda for successful reforms extends beyond their own niches. [Second] scientists should always strive for rigour in evaluating reform interventions. [Third] we should be aware that nesting an impact evaluation within a comprehensive health reform effort is not a neutral operation. [...] Finally, we urgently need to think about where to conduct the interactions on the knowledge agenda for better health policies.*

RESEARCH ON HUMAN RESOURCES & MIGRATION OF HEALTH WORKERS:

The impossible dream? Codes of practice and the international migration of skilled health workers

The international migration of skilled health workers has increased significantly from the 1990s. Many source countries have expressed concern over losses of health workers, resulting in regional Codes of Practice and bilateral Memoranda of Understanding being established since 1999 to achieve more effective, equitable and ethical international migration. [...] Codes have three key objectives — protecting rights of migrant workers, adequate workplace support for migrant workers and ensuring that migration flows do not disrupt health services in source countries. There is no agreed definition of ethical international recruitment, and no consensus on the significance and location of harmful recruitment practices. Most codes have covered relatively few regions and exhibit a high degree of generality. Several source countries encourage rather than discourage migration. Migration is a right and occurs in contexts that do not necessarily involve health issues. There are no incentives for recipient countries and agencies to be involved in ethical international recruitment. All codes are voluntary which has restricted their impact. Substantial migration and recruitment have occurred outside their scope, and codes have diverted skilled health workers beyond regulation. The private sector is effectively excluded from codes. Bilateral agreements and memoranda have a greater chance of success, enabling managed migration and return migration, but are more geographically limiting. The most effective constraints to the unregulated flow of skilled health workers are the production of adequate numbers in present recipient countries and provision of improved employment conditions in source countries.*


GLOBAL HEALTH NEWS:

Studying the crisis in human resources for health from the health labour market

The African Development Bank, the Global Health Workforce Alliance and the World Bank have embarked on a synthesis study of a new way of looking at the Human Resources in Health (HRH) crisis in Africa: the health labour market. The joint study will compile current knowledge and evidence, produce a synthesis and identify knowledge gaps on HRH in Africa from the unique perspective of the health worker operating within a competitive labour market. [...] The joint study comes at a time where Africa's health labour market has evolved rapidly into a complex and dynamic market. The old assumption that health workers are passive actors, inherently competent and motivated to serve the public does not hold in most settings. The health labour market approach considers health workers as what they mostly are: economic actors, with clear preferences and making informed tradeoffs. [...] With the review of datasets and literature being carried out in September and October, the synthesis report is expected to be discussed at a regional HRH meeting in December 2012.*

Source: __________. 2012. Studying the crisis in human resources for health from the health labour market. AllAfrica.com online (18 September).
Public health regulation: The impact of intersections between trade & investment treaties in Asia

The conclusion and negotiation of Free Trade Agreements (FTAs) with strengthened IPR protection commitments by Asian states, juxtaposed with the fact that most FTAs also contain ISDS provisions, provide fertile ground for legal complaints arising from health-related measures. Examples troubling many policymakers are the issues relating to pharmaceutical and tobacco control measures. Existing TRIPS flexibilities are important to Asian developing states. FTAs carrying TRIPS-plus obligations expand obligations of States and reduce those flexibilities in various forms. The fact that IPR obligations — including such TRIPS-plus ones — form treaty obligations and that IPRs are likely in most FTAs to be covered “investments” that are eligible for protection and to ISDS, lead to three key implications. First, TRIPS-plus obligations can curtail or significantly reduce a country’s regulatory flexibility with respect to health measures. A direct result can be the significant slowing down of generic products reaching a market, resulting in the maintenance of high prices of patented, prescription medicines. Secondly, health measures may be argued by investors who own affected IPRs — such as pharmaceutical patents — to be a failure by the State to observe its TRIPs-plus obligations. Finally, while such arguments are not guaranteed to succeed, the combination of trade, investment, IPRs, health and dispute settlement issues with availability of investment dispute settlement creates a strong temptation to test such arguments.*†


GLOBAL HEALTH NEWS:

Canada-EU drug patent demand in trade talks costs almost $2B

Confidential federal research on free-trade talks with Europe shows that giving the European Union just one part of what it wants on drug patents would cost Canadians up to $2 billion a year. The Department of Foreign Affairs and International Trade has always insisted it’s a “myth” that the Canada-EU free trade deal would increase health costs. But in September, officials at Industry Canada and Health Canada combined forces to examine the cost of the European demand to implement a patent-term restoration system [...]. They found that based on past history of approval patterns, the EU proposal would add an average life of 2.66 years to a typical drug patent, and increase Canadian drug costs by between $795 million and $1.95 billion annually. The range of projections is large because government analysts have no way of knowing exactly what kind of drugs will be in line for patents in the future, and had to make some broad assumptions.

RESEARCH ON ACCESS TO EFFECTIVE MEDICINES:

Access to medicines, market failure and market intervention: A tale of two regimes

This study explores how an 'Intellectual Property Rights (IPR)/trade regime' has generated a particular set of problems regarding access to medicines despite patents on drugs being presented as economically necessary for reward and future drug innovation. These problems have also inspired and informed activities by so-called new actors in global health. This study argues that a parallel 'pro-access regime' has developed in order to correct some of the most high-profile issues associated with a dysfunctional global pharmaceutical market, especially problems regarding price and innovation that have been exacerbated by stringent global patent rights on new drugs. Therefore, the IPR/trade regime's basic role in global-health governance diverges from how it has been framed and understood, not least of all by its constituent agents and donors. The pro-access regime encompasses new actors in health such as Global Health Partnerships (e.g., GAVI Alliance and the Global Fund to Fight AIDS, Tuberculosis and Malaria), major philanthropic foundations (e.g., the Gates and Clinton Foundations) and new access initiatives (e.g., UNITAID). The study problematises these actors' governance roles with respect to the overarching authority of the IPR/trade regime and makes a case that the two regimes should be understood as being closely connected with respect to the governance of access to medicines and the global political economy of pharmaceuticals.


GLOBAL HEALTH NEWS:

Indonesia in bold move to obtain cheap drugs for HIV

In a move that has surprised and delighted access to medicines campaigners, Indonesia's government has quietly issued an order to override the patents on seven important medicines used to treat people with HIV and hepatitis B and allow cheap versions to be made by local drug companies. The “government use” order was made on 3 September, but with no fanfare and, as yet, no public outcry from the pharmaceutical giants which, in the past, used to defend their patents volubly and aggressively – through the courts as well as diplomatic back-channels. Times have changed somewhat, with much greater public awareness of the toll of treatable diseases and the high price of medicines in developing countries. [...] It appears that the government of President Susilo Bambang Yudhoyono has decided to license the entire slate of medicines its population needs against HIV. [...] The drug patents belong to Merck, GSK, Bristol Myers Squibb, Abbott and Gilead. The drugs include Glaxo's Abacavir and Abbott's Kaletra, which are both useful combinations, as well as Gilead's tenofovir (Viread), which treats hepatitis B as well as being the mainstay of the new prevention treatment for people whose partners are HIV positive. The order says the companies will receive a 0.5% royalty.*

Source: Boseley S. 2012. Indonesia in bold move to obtain cheap drugs for HIV. The Guardian online (11 October).
The impact of new tuberculosis diagnostics on transmission: Why context matters

[This paper estimates] the impact of new tuberculosis diagnostics on tuberculosis transmission given the complex contextual factors that can lead to patient loss before diagnosis or treatment. An epidemic model of tuberculosis specifying discrete steps along the tuberculosis diagnostic pathway was constructed. The model was calibrated to the epidemiology of tuberculosis and human immunodeficiency virus (HIV) infection in the United Republic of Tanzania and was used to assess the impact of a new diagnostic tool with 70% sensitivity for smear-negative pulmonary tuberculosis. The influence of contextual factors on the projected epidemic impact of the new diagnostic tool over the decade following introduction was explored. With the use of smear microscopy, the incidence of tuberculosis will decline by an average of 3.94% per year. If the new tool is added, incidence will decline by an annual 4.25%. This represents an absolute change of 0.31 percentage points (95% confidence interval: 0.04–0.42). However, the annual decline in transmission with use of the new tool is less when existing strategies for the diagnosis of smear-negative cases have high sensitivity and when symptomatic individuals delay in seeking care. Other influential contextual factors include access to tuberculosis care, patient loss before diagnosis, initial patient default after diagnosis and treatment success rate.*


GLOBAL HEALTH NEWS:

Antiretroviral drug resistance in resource-limited settings

More than 90% of the 33 million people living with HIV and 97% of new HIV infections worldwide are in resource-limited settings. The rollout of antiretroviral treatment (ART) to about 7 million people in such settings over the past decade is a remarkable achievement, albeit short of the true need. An inevitable consequence of the widespread availability of ART is treatment failure that selects for strains of drug-resistant virus. A subset of individuals who acquire drug-resistant HIV will transmit their drug-resistant virus to others. This scenario, which is well documented in Europe and North America, has been repeated in resource-limited settings. In The Lancet, Ravindra Gupta and colleagues comprehensively analyse the available data for drug-resistant HIV in untreated individuals in resource-limited settings. Their findings substantiate what would be expected with the rollout of ART to millions of individuals—an increase in the prevalence of drug-resistant HIV strains. […] The authors recommend the continuation and improvement of drug-resistance monitoring in resource-limited settings, which certainly makes sense. Nevertheless, with the documentation of the problem, the greatest challenge is to reduce the frequency of treatment failure and cases of drug resistance, as has been achieved in high-income settings.*

RESEARCH ON GLOBAL ACTION ON NON-COMMUNICABLE DISEASES:

**Political economy analysis for tobacco control in low- and middle-income countries**

Tobacco is already the world’s leading cause of preventable death, claiming over 5 million lives annually, and this toll is rising. Even though effective tobacco control policies are well researched and widely disseminated, they remain largely unimplemented in most low- and middle-income countries (LMICs). For the most part, control attempts by advocates and government regulators have been frustrated by transnational tobacco companies (TTCs) and their supporters. One reason tobacco is so difficult to control is that its political economy has yet to be adequately understood and addressed. [The authors] conducted a review of the literature on tobacco control in LMICs using the databases PubMed, EconLit, PsychInfo and AGRICOLA. Among the over 2500 papers and reports [they] identified, very few explicitly applied political economy analysis to tobacco control in an LMIC setting. [...] To help control advocates better understand and manage the process of policy implementation, [the authors] identify how political economy analysis would differ from the traditional public health approaches that dominate the literature. [They] focus on five important problem areas: information problems and the risks of smoking; the roles of domestic producers; multinational corporations and trade disputes in consumption; smuggling; the barriers to raising taxes and establishing spatial restrictions on smoking; and incentive conflicts between government branches.*


GLOBAL HEALTH NEWS:

**Measuring progress on NCDs: One goal and five targets**

Heads of states and governments made commitments to the prevention and control of non-communicable diseases (NCDs) in the Political Declaration from the UN High-level Meeting on NCDs in September, 2011. A key commitment in the Political Declaration calls upon WHO to develop a comprehensive global monitoring framework to assess progress in the implementation of national strategies and plans for the four main NCDs: cardiovascular diseases (CVD), diabetes, cancer, and chronic respiratory diseases. Central to the monitoring framework is the selection of goals and targets for NCDs. [...] In [the authors’] view, the key criteria for choosing any target should be that it has a strong scientific basis, is sensitive to change, and that achieving it will have a major impact on the global NCD mortality goal. Other criteria include empirical evidence that the target is achievable with cost-effective interventions that are feasible for scaling up, and that baseline data and robust methods for assessing progress are available. Unlike WHO, [the authors] propose that implementation of interventions should initially be limited to only a small number of priority targets to ensure that existing resources are used most efficiently, with additional targets added as country experience and success builds. In proposing targets, [the authors] underline technical considerations over political consensus.*

The Health and Foreign Policy Bulletin is a monthly publication of the Norman Paterson School of International Affairs and the Centre for Trade Policy and Law. Its objective is to promote evidence based policy making by summarizing and disseminating the latest research on the intersection between global health and foreign policy. The Bulletin also identifies key events and developments of importance to policy makers. We are always looking for ways to improve the Health and Foreign Policy Bulletin and to expand its readership. If you have any suggestions or would like to subscribe, please contact us at jacob_hall@carleton.ca. The Bulletin is also available on the website of the Global Health Diplomacy Network (GHD-NET).

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.

ISSN 1923-5739