



IN THIS ISSUE

RESEARCH ON GLOBAL HEALTH SECURITY:

[Non-prescription antimicrobial use worldwide: A systematic review p. 1](#)

RESEARCH ON HEALTH & STATES IN CRISIS/CONFLICT:

[Improved response to disasters and outbreaks by tracking population movements with mobile phone network data: A post-earthquake geospatial study in Haiti. p. 2](#)

RESEARCH ON HUMAN RIGHTS & GLOBAL HEALTH:

[Imprisonment and women's health: Concerns about gender sensitivity. p. 3](#)

RESEARCH ON GLOBAL HEALTH GOVERNANCE & INSTITUTIONS:

[GAVI's future: Steps to build strategic leadership, financial sustainability, and better partnerships. p. 4](#)

RESEARCH ON HEALTH & DEVELOPMENT, HEALTH SYSTEMS:

[Progress towards Millenium Development goals 4 and 5 on maternal and child mortality: An updated systematic analysis. p. 5](#)

RESEARCH ON HUMAN RESOURCES & MIGRATION OF HEALTH WORKERS:

[Care drain: The Political making of health worker migration . p. 6](#)

[The Experience of Chinese physicians in the national health diplomacy programme deployed to Sudan p. 6](#)

RESEARCH ON TRADE POLICY & HEALTH:

[Opportunities and risks of the proposed FCTC protocol on illicit trade p. 7](#)

RESEARCH ON ACCESS TO EFFECTIVE MEDICINES:

[Pharmacogenomic technologies: A necessary "luxury" for better global public health? p. 8](#)

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

[Are HIV epidemics among men who have sex with men emerging in the Middle East and North Africa?. p. 9](#)

RESEARCH ON GLOBAL ACTION ON NON-COMMUNICABLE DISEASES:

[From burden to "best buys": Reducing the economic impact of NCDs in low- and middle income countries p. 10](#)

RESEARCH ON GLOBAL HEALTH SECURITY:

Non-prescription antimicrobial use worldwide: A systematic review

In much of the world antimicrobial drugs are sold without prescription or oversight by health-care professionals. The scale and effect of this practice is unknown. [The authors] systematically reviewed published works about non-prescription antimicrobials from 1970–2009, identifying 117 relevant articles. [Thirty-five] community surveys from five continents showed that non-prescription use occurred worldwide and accounted for 19–100% of antimicrobial use outside of northern Europe and North America. Safety issues associated with non-prescription use included adverse drug reactions and masking of underlying infectious processes. Non-prescription use was common for non-bacterial disease, and antituberculosis drugs were available in many areas. Antimicrobial-resistant bacteria are common in communities with frequent non-prescription use. In a few settings, control efforts that included regulation decreased antimicrobial use and resistance. Non-prescription antimicrobial and antituberculosis use is common outside of North America and northern Europe and must be accounted for in public health efforts to reduce antimicrobial resistance.*

Source [Morgan, Daniel J, et al. 2011. Non-prescription antimicrobial use worldwide: a systematic review. *The Lancet Infectious Diseases* Vol. 11, Issue 9 \(September\).](#)



GLOBAL HEALTH NEWS:

As avian influenza cases drop, government told to remain vigilant

Improving surveillance and scientific research will enable Indonesia to cope with the threat of the avian influenza virus (H5N1), the Health Ministry says. Health Minister Edang Rahayu Sedyaningsih said on Tuesday [20 September] that as of Sept. 1, there had been seven confirmed cases of H5N1 infections in humans this year in Indonesia, adding that there had been more cases in birds. [...] Despite the low rate of human infection, she said the disease was still a threat because the virus frequently mutated. [...] To cope with the virus threats, the government is improving the BSL-3 Laboratory at the Ministry's Research and Development Unit. The BSL-3 Laboratory has the capacity to contain agents that may cause serious or lethal diseases as a result of contact or inhalation. The laboratory is able to sequence viruses both from animals and humans.*

Source: [Faizal, Ely Burhaini. 2011. As avian influenza cases drop, govt told to remain vigilant. *The Jakarta Post* online \(21 September\).](#)

RESEARCH ON HEALTH & STATES IN CRISIS/CONFLICT:

Improved response to disasters and outbreaks by tracking population movements with mobile phone network data: A post-earthquake geospatial study in Haiti

Population movements following disasters can cause important increases in morbidity and mortality. Without knowledge of the locations of affected people, relief assistance is compromised. No rapid and accurate method exists to track population movements after disasters. [The authors] used position data of subscriber identity module (SIM) cards from the largest mobile phone company in Haiti (Digicel) to estimate the magnitude and trends of population movements following the Haiti 2010 earthquake and cholera outbreak. [...] The authors found that routinely collected data on the movements of all active SIM cards in a disaster-affected nation could, with potentially high validity, be used to provide estimates of the magnitude, distribution, and trends in population displacement. With pre-earthquake census data, the method could also provide estimates on area-specific population sizes, which could lead to important improvements in the allocation of relief supplies and the quality of needs assessment surveys. Further, [the authors] found that the method was feasible to use for close to real-time monitoring of population movements during an infectious disease outbreak. [They] recommend establishing relations with mobile phone operators prior to emergencies as well as implementing and further evaluating the method during future disasters.*†

Source: [Bengtsson, Linus, et al. 2011. Improved Response to Disasters and Outbreaks by Tracking Population Movements with Mobile Phone Network Data: A Post-Earthquake Geospatial Study in Haiti. *PLoS Medicine* Vol. 8, No. 8 \(August\).](#)

GLOBAL HEALTH NEWS:

The final push for polio eradication

According to the latest report from the Independent Monitoring Board (IMB) of the Global Polio Eradication Initiative (GPEI), continued transmission of polio is a "global health emergency", and plans to interrupt transmission by the end of 2012 are "at risk". With a US\$590 million funding gap and weak political leadership in some countries, the engagement of communities to plan and implement local approaches is paramount. [...] However, the issues in Pakistan and other areas where transmission continues are enormous, says Zulfiqar Bhutta (Aga Khan University, Karachi, Pakistan). Vaccine refusal can be widespread, and in Pakistan, affects some communities numbering 20 000—30 000 people. An emerging difficulty is that even repeated doses of oral polio vaccine (OPV) are failing to protect some children in very deprived areas. Although not fully elucidated, the factors involved include malnutrition and micronutrient deficiencies, diarrhea, and failure to receive other vaccinations in the expanded programme on immunisation (EPI).*

Source: [Morris, Kelly. 2011. The final push for polio eradication. *The Lancet Infectious Diseases* Vol. 11, No. 9 \(September\).](#)



GLOBAL HEALTH NEWS:

Polio strain spreads to China from Pakistan

Polio has been found in China for the first time since 1999 after spreading from Pakistan, the World Health Organization (WHO) has confirmed. It said a strain of polio (WPV1) found in China was genetically linked with the type now circulating in Pakistan. At least seven cases have now been confirmed in China's western Xinjiang province, which borders Pakistan. The WHO warned there was a high risk of the crippling virus spreading further during Muslim pilgrimages to Mecca. On Tuesday, the WHO said the polio cases in Xinjiang had been detected in the past two months. The Chinese authorities are now investigating the cases, and a mass vaccination campaign has been launched in the region.*

Source: [_____](#). 2011. Polio strain spreads to China from Pakistan. *BBC online* (20 September).

RESEARCH ON HUMAN RIGHTS & GLOBAL HEALTH:

Imprisonment and women's health: Concerns about gender sensitivity

The health of prisoners is among the poorest of any population group and the apparent inequalities pose both a challenge and an opportunity for country health systems. The high rates of imprisonment in many countries, the resulting overcrowding, characteristics of prison populations and the disproportionate prevalence of health problems in prison should make prison health a matter of public health importance. Women prisoners constitute a minority within all prison systems and their special health needs are frequently neglected. The urgent need to review current services is clear from research, expert opinion and experience from countries worldwide. Current provision of health care to imprisoned women fails to meet their needs and is, in too many cases, far short of what is required by human rights and international recommendations. The evidence includes a lack of gender sensitivity in policies and practices in prisons, violations of women's human rights and failure to accept that imprisoned women have more and different health-care needs compared with male prisoners, often related to reproductive health issues, mental health problems, drug dependencies and histories of violence and abuse. Additional needs stem from their frequent status as a mother and usually the primary carer for her children.*

Source: [van den Bergh, Brenda, et al. 2011. Imprisonment and women's health: concerns about gender sensitivity, human rights and public health. *Bulletin of the World Health Organization*. Vol. 89, No. 9 \(September\).](#)

GLOBAL HEALTH NEWS:

FMG: Kenya acts against unkindest cut

Kenya has become the latest African country to ban female genital mutilation [FGM], with the passing of a law making it illegal to practice or procure it or take somebody abroad for cutting. The law even prohibits derogatory remarks about women who have not undergone FGM. Offenders may be jailed or fined or both. Members of the Kenyan Women Parliamentary Association said it was a historic day. [...] Nobody imagines this means FGM will never take place again in Kenya, but making it illegal is a massive step towards changing attitudes and giving strength to those who oppose the practice. Kenya follows a number of African governments in outlawing the practice. According to the Pan African news agency, at the time of the African Union summit in June, which proposed prohibition of FGM, Benin, Ivory Coast, Djibouti, Egypt, Eritrea, Ethiopia, Ghana, Guinea, Niger, Nigeria, Kenya, Central African Republic, Senegal, Chad, Tanzania, Togo and Uganda already had legislation against it.*

Source: [Boseley, Sarah. 2011. FGM: Kenya acts against unkindest cut. *The Guardian online* \(8 September 2011\).](#)



GLOBAL HEALTH GOVERNANCE

GAVI's future: Steps to build strategic leadership, financial sustainability, and better partnerships

In the relatively short period that the GAVI Alliance has been operating, millions of deaths have been averted, and new vaccines in the pipeline hold the promise of considerable future impacts. Governments can independently introduce vaccines, but many low-income countries choose to partner with GAVI out of their own sovereign self-interest. The partnership increases buying power, leverages new resources and political support, helps shape markets to be more favourable, compensates for irregular funding flows, brings valuable technical assistance, and advances country planning over the long term for the financing and sustainment of new, underutilized, and basic vaccines. [...] Its many achievements notwithstanding, GAVI will need a strengthened, strategic approach to meet future demands. In the midst of a global recession and constrained donor and national budgets, and as the vaccine landscape expands and becomes more complex, GAVI will need to concentrate on its core mission, extend coverage to the underserved in low-income countries, plan strategically for the future, better tie health systems investments to vaccine gains, and test whether GAVI can contribute to assisting lower-middle-income countries accelerate their immunizations. It is essential that GAVI's financing efforts shape markets to reduce vaccine pricing, at the same time that GAVI aggressively leverages traditional donors, wins over emerging economies, and increases partner government commitments.

Source: [Carty, Lisa, et al. 2011. GAVI's FUTRUE: Steps to Build Strategic Leadership, Financial Sustainability, and Better Partnerships. Centre for Strategic & International Studies online \(June\).](#)

GLOBAL HEALTH NEWS:

WHO reform for a healthy future: An overview

WHO plays a critical role as the world's leading technical authority on health. Addressing the increasingly complex challenges of the health of populations in the twenty-first century – from persisting problems to new and emerging public health threats – requires the Organization to make changes. Continuous process improvement is a vital component of organizational excellence. In taking on more and more of these challenges, WHO has, like many other organizations, become overcommitted. At a time of financial crisis, it is underfunded and overstretched. Priority setting has not been sufficiently strategic. The Organization's financing does not always match well with its priorities and plans. Further, despite several innovations put in place over the past few years, some of the Organization's ways of working are outdated. The kind of comprehensive reform that is now proposed is critical to a renewed Organization that works efficiently, effectively, and transparently. A transformed WHO will also be more flexible, responsive, and accountable. Finally, the global health community has greatly expanded, such that there are now a large number of players with overlapping roles and responsibilities. In 1948 WHO was the only global health organization; now it is one of many. This proliferation of initiatives has led to a lack of coherence in global health. Expected outcomes of the reform [are threefold: 1) refocusing core business to address the twenty-first century health challenges facing countries and the world; 2) reforming the financing and management of WHO to address health challenges more effectively; 3) transforming governance to strengthen public health.

*†

Source: [_____ . 2011. WHO reform for a health future: an overview. World Health Organization online \(20 July\).](#)

See Also: ["WHO reform for a healthy future" website](#)



RESEARCH ON HEALTH & DEVELOPMENT, HEALTH SYSTEMS:

Progress towards Millennium Development Goals 4 and 5 on maternal and child mortality: An updated systematic analysis

With 4 years until 2015, it is essential to monitor progress towards Millennium Development Goals (MDGs) 4 and 5. Although estimates of maternal and child mortality were published in 2010, an update of estimates is timely in view of additional data sources that have become available and new methods developed. [...] The authors] update the analyses of the progress towards MDGs 4 and 5 from 2010 with additional surveys, censuses, vital registration, and verbal autopsy data. [...] Under-5 deaths have continued to decline, reaching 7.2 million in 2011 of which 2.2 million were early neonatal, 0.7 million late neonatal, 2.1 million postneonatal, and 2.2 million during childhood (ages 1–4 years). Comparing rates of decline from 1990 to 2000 with 2000 to 2011 shows that 106 countries have accelerated declines in the child mortality rate in the past decade. Maternal mortality has also continued to decline from 409 100 (uncertainty interval 382 900–437 900) in 1990 to 273 500 (256 300–291 700) deaths in 2011. [The authors] estimate that 56 100 maternal deaths in 2011 were HIV-related deaths during pregnancy. Based on recent trends in developing countries, 31 countries will achieve MDG 4, 13 countries MDG 5, and nine countries will achieve both. Even though progress on reducing maternal and child mortality in most countries is accelerating, most developing countries will take many years past 2015 to achieve the targets of the MDGs 4 and 5. Similarly, although there continues to be progress on maternal mortality the pace is slow, without any overall evidence of acceleration.*

Source: [Lozano, Rafael, et al. 2011. Progress towards Millennium Development Goals 4 and 5 on maternal and child mortality: an updated systematic analysis. *The Lancet online* \(20 September\).](#)

GLOBAL HEALTH NEWS:

Can performance-based financing [PBF] be used to reform health systems in developing countries?

By nature, PBF is economically driven and focuses principally on public finance. Indeed it is assumed that PBF is equally applicable to other sectors but as such it overlooks the human dimension to development. The World Health Report 2008: Primary Health Care (Now More Than Ever) reminds us that better health outcomes are best achieved when service delivery is organized around people's needs and expectations and that "putting people first" should be the focus of reforms. But the setting of service delivery targets actually risks creating a conflict of interest between patients and providers and can act as a disincentive to patient-centred care. [...] PBF has international support because it fits neatly into the Millennium Development Goals aid paradigm for rapid progress on a few key indicators. But [the authors] think it is misplaced to focus on outcomes and results without a thorough understanding and development of the processes and relationships that are necessary to obtain sustained improvements and quality of care. While quantitative targets can encourage creativity to increasing access, [they] wonder if quality of health care can ever really be improved when the system and its providers focus on targets linked to financial gain instead of on patient-centred care and the needs of the populations they serve.*†

Source: [Ireland, Megan, et al. Can performance-based financing be used to reform health systems in developing countries. *Bulletin of the World Health Organization* Vol. 89, No. 9 \(September\).](#)



RESEARCH ON HUMAN RESOURCES & MIGRATION OF HEALTH WORKERS:

Care drain: The political making of health worker migration

Increased migration of health-care workers has become the topic of academic and political discussions. Questions have been raised on the ethical level as to whether recruitment of health-care workers should be considered a crime, 'a case of poaching', or whether it can be considered 'just' in any given philosophical framework of justice. The shortage of health-care workers, especially in sub-Saharan countries, and the more or less systematic recruitment by developed countries, tells us that the care imbalance is becoming more acute. Policy measures to contain this care drain either in countries of origin (for example, increase of salary) or in destination countries (for example, non-recruitment) did not have a lasting impact. The question on the ethical level is: How to evaluate this social practice? On the level of policymaking: How to find regulatory means to contain the migration of health workers? This article provides a novel analysis of contemporary health-care workers' migration by identifying the responsible political framework and underlying reasons neglected elsewhere. Care drain is of crucial importance for population health in developing countries, especially in Africa, where health care is deteriorating for lack of personnel. National policies, especially in Europe and the United States, adversely influence population health in many developing countries. This situation could be improved through adequate compensation and training, appropriate policies, hospital-to-hospital partnerships, and ceasing recruitment from developing countries.*†

Source: [Kaelin, Lukas. 2011. Care drain: The political making of health worker migration. *Journal of Public Health Policy* online \(25 August\)](#)

The experience of Chinese physicians in the national health diplomacy programme deployed to Sudan

Chinese Medical Teams have been working in developing countries since 1963 as a health diplomacy strategy. In 2010, 1252 Chinese medical personnel were assigned to 48 countries. [The authors] conducted a review of Chinese literature and governmental websites to describe the history and current distribution of Chinese Medical Teams around the world. In addition, [they] interviewed members of a 36-member Chinese Medical Team deployed to Sudan primarily about their motivations to join the programme and the challenges and benefits they face, along with their Sudanese hosts. The most significant challenge health workers described was homesickness. Most members said they were able to maintain motivation through their curiosity and the doctor-friendly environment. All but two rated their own working performance as 'good' or 'very good', while their Sudanese colleagues consistently rated them even higher. Participants reported conflicting beliefs regarding the perceived responsibilities of the team and challenges around communication. Three pillars support the Chinese Medical Team programme in Sudan: bilateral government commitment, the professionalism of the Medical Teams, and the welcoming medical environment.*

Source: [Wang, Kai, et al. 2011. The experience of Chinese physicians in the national health diplomacy programme deployed to Sudan. *Global Public Health* online \(5 July\).](#)

GLOBAL HEALTH NEWS:

A south-south cooperation

Haja Zainab Bangura, Sierra Leone's Health and Sanitation Minister, [...] has traveled to several countries or talked to counterparts in other ministries of health to find more doctors and nurses. Her ports of call are not what you'd expect: Cuba. South Africa. Nigeria. [...] South Africa has given Sierra Leone \$3 million to pay for 32 Cuban doctor specialists to work in the West African country. Nigeria has sent 50 doctors, nurses, and midwives. Sudan is thinking about sending doctors. Kuwait contributed \$15 million to help upgrade three hospitals – improvements that will assist doctors and nurses do their jobs. [...] Rosann Wisman, director of the Ministerial Leadership Initiative for Global Health, [...] said Bangura's mission reflects both the increased cooperation among developing countries but also the complexities of dealing with health worker migration. "Developing countries are helping one another because they understand the needs of one another," Wisman said. "On health workers, part of the issue is that major donor countries are the destination for a lot of the health workers. Sierra Leone health workers are going to the UK, or going to the US, so it's a very complicated relationship. You have donor countries on the one hand providing support to help train their health workers and at the same time they are making it very attractive for those very same health workers to migrate to that donor country."*

Source: [Okafor, Judd-Leonard. 2011. Nigeria: Health Minister Calls for Diaspora Help. *allAfrica.com* online \(25 July\).](#)



RESEARCH ON TRADE POLICY & HEALTH:

Opportunities and risks of the proposed FCTC protocol on illicit trade

Parties to the WHO Framework Convention on Tobacco Control (FCTC) are in the final stages of negotiating a protocol aimed at strengthening international cooperation in the fight against illicit tobacco trade. While an effective multilateral response to illicit tobacco trade would make a significant contribution to global tobacco control, achieving this through the FCTC forum is challenging. First, while illicit tobacco trade is a health problem, the expertise, experience and capacity needed to combat illicit trade are not traditionally found in health agencies. [Nationally, expertise is located in customs, revenue, law enforcements and justice agencies. Internationally, expertise is found in bodies like the United Nations Office on Drugs and Crime and the World Customs Organization.] The development of links with other agencies, both domestic and international, is critical to ensure both an effective response and an efficient use of limited governmental and non-governmental resources. Second, in many parts of the world, the tobacco industry cooperates closely with governments in the combating of illicit trade. This cooperation poses risks for tobacco control, particularly if relationships and norms of cooperation spill over into other areas of FCTC implementation. An examination of the industry's positioning suggests that it sees an opportunity to portray itself as 'legitimate' and 'responsible', a friend of governments, and a way to integrate itself into FCTC processes.*†

Source: [Lieberman, Jonathan, et al. 2011. Opportunities and risks of the proposed FCTC protocol on illicit trade. *Tobacco Control* online \(5 August\).](#)

GLOBAL HEALTH NEWS:

Tobacco product regulation and the WTO: US-Clove cigarettes

On 2 September 2011, the World Trade Organization (WTO) released the report of a panel tasked with considering a complaint brought by Indonesia concerning prohibitions on certain flavoured tobacco products implemented by the United States (US). The panel concluded that the US violated WTO law and recommended that the US be asked to bring its laws into conformity with WTO law. [...] There are three obvious approaches available to the US. One approach is to appeal the decision. Given the conclusions of the [Tobacco Products Scientific Advisory Committee]TPSAC on menthol, it would appear that any appeal would turn on how the less favorable treatment standard in Article 2.1 of the [Agreement on Technical Barriers to Trade] TBT Agreement was applied, rather than on questions of likeness. Another approach is for the US to bring its laws into conformity with WTO law. The US could do this in one of two ways. First, the US could lift the prohibition on clove cigarettes, an approach that is regressive in terms of public health. Second, the US could prohibit menthol-flavored cigarettes. [...] The third approach available to the US is to refuse to bring its laws into conformity with WTO law (an unlikely approach in the absence of an appeal). If the US chooses this approach, the WTO Dispute Settlement Body will most likely authorize the suspension of concessions at a level equivalent to the extent that Indonesia's benefits under the agreement are nullified or impaired as a consequence of the initial violation.*†

Source: [O'Neill Institute for National and Global Health Law. 2011. Briefing Paper – 12 September 2011: Tobacco Product Regulation and the WTO: US-Clove Cigarettes. *O'Neill Institute for National and Global Health Law* online \(12 September\).](#)

See Also: [International Centre for Trade and Sustainable Development. 2011. WTO Disputes Roundup: Rulings Issued on Spirits, Tobacco. *Bridges Weekly Trade News Digest* Vol. 15, No. 29 \(7 September\).](#)



RESEARCH ON ACCESS TO EFFECTIVE MEDICINES:

Pharmacogenomic technologies: A necessary “luxury” for better global public health?

Pharmacogenomic technologies aim to redirect drug development to increase safety and efficacy of individual care. [...] This paper evaluates the capacity of pharmacogenomic technologies to meet six criteria described by the University of Toronto Joint Centre for Bioethics group: 1) impact of the technology; 2) technology appropriateness; 3) capacity to address local burdens; 4) feasibility to be implemented in reasonable time; 5) capacity to reduce the knowledge gap; and 6) capacity for indirect benefits. [The authors find that the] implementation of pharmacogenomic technologies may lead to the development of drugs that appear to be a “luxury” for populations in need of numerous interventions that are known to have a demonstrable impact on population health (e.g., secure access to potable water, reduction of social inequities, health education). However, [their] analysis shows that pharmacogenomic technologies do have the potential to redirect drug development and distribution so as to improve the health of vulnerable populations.*

Source: [Olivier, Catherine & Bryn Williams-Jones. 2011. Pharmacogenomic technologies: a necessary “luxury” for better global public health? *Globalization and Health* Vol. 7, No.30 \(24 August\).](#)

GLOBAL HEALTH NEWS:

Still a long way to go for anti-counterfeiting trade agreement

The Anti-Counterfeiting Trade Agreement negotiated last year will be open for signature for two years, until the first of May 2013. But while this looks like a long time, it may be needed by the 37 negotiating governments (including the United States, Japan, South Korea and the 27 European Union members) to iron out problems on their way to implementing what some rights owners welcomed as a possible new “gold standard” for the enforcement of intellectual property rights. In the European Parliament, the Committee on International Trade (INTA) has filed a request to its Legal Services regarding potential discrepancies between the much-debated agreement and existing EU legislation (the so-called EU *acquis*). INTA raised questions about the European Commission’s choice of the legal basis for the agreement and also potential violations of existing international obligations [ex. the European Convention on Human Rights and the EU Charter of Fundamental Freedoms]. [...] In addition] the fact that the Parliament’s Legal Service will have to answer two sets of legal questions on ACTA and the ACTA negotiation process, skirmishes between the different EP party groups in both committees about what should be asked are showing the sensitivity of the ACTA dossier. Conservative INTA member Daniel Caspary (EPP) said broad and open question would allow for a thorough check. Green Party members and advisers propose to ask more detailed questions and include a check on the compatibility of ACTS with European fundamental rights and the EU’s obligation to promote the rule of law in developing countries.*

Source: [Ermer, Monika. 2011. Still A Long Way To Go For Anti-Counterfeiting Trade Agreement. *Intellectual Property Watch* online \(8 September\).](#)



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

Are HIV epidemics among men who have sex with men emerging in the Middle East and North Africa?

Men who have sex with men (MSM) bear a disproportionately higher burden of HIV infection than the general population. MSM in the Middle East and North Africa (MENA) are a largely hidden population because of a prevailing stigma towards this type of sexual behaviour, thereby limiting the ability to assess infection transmission patterns among them. It is widely perceived that data are virtually nonexistent on MSM and HIV in this region. The objective of this review was to delineate, for the first time, the evidence on the epidemiology of HIV among MSM in MENA. This was a systematic review of all biological, behavioural, and other related data on HIV and MSM in MENA. [...] This review showed that considerable data are available on MSM and HIV in MENA. While HIV prevalence continues at low levels among different MSM groups, HIV epidemics appear to be emerging in at least a few countries, with a prevalence reaching up to 28% among certain MSM groups. By 2008, the contribution of MSM transmission to the total HIV notified cases increased and exceeded 25% in several countries. The high levels of risk behaviour (4–14 partners on average in the last six months among different MSM populations) and of biomarkers of risks (such as herpes simplex virus type 2 at 3%–54%), the overall low rate of consistent condom use (generally below 25%), the relative frequency of male sex work (20%–76%), and the substantial overlap with heterosexual risk behaviour and injecting drug use suggest potential for further spread.*

Source: [Mumtaz, Ghina, et al. 2011. Are HIV Epidemics Among Men Who Have Sex with Men Emerging in the Middle East and North Africa?: A Systematic Review and Data Synthesis. *PLoS Medicine* Vol. 8, No. 8 \(August\).](#)

GLOBAL HEALTH NEWS:

Researchers announce first correlates of protection for HIV vaccine

Researchers have identified the first correlates of protection (measurable signs of immunity) of a vaccine intended to protect against HIV infection. This gives further direction to how a useful vaccine might be developed. The announcement came on 13 September at the AIDS Vaccine Conference in Bangkok, Thailand. HIV vaccine research began in 1984 when the virus was first identified as the cause of the new AIDS epidemic. After 25 years and continuously dashed hopes, many scientists were surprised to learn in 2009 that the RV144 clinical trial conducted in Thailand showed a modest 31% protection. “What we now have is clues to why it might have worked. That is something we haven’t had over the past 30 years,” said Barton Haynes, the Duke University researcher who led the two year effort to uncover those clues. The collaborative international research team conducted 30 additional tests on stored blood samples drawn from 16000 participants in the RV144 trial in its search for answers. One key scientific finding is that “antibodies specific to the V2 region (of the outer coating of the virus) correlated with the lowest infection rates among those who were vaccinated,” he said.*

Source: [Roehr, Bob. 2011. Researchers announce first correlates of protection for HIV vaccine. *BMJ* 343: d5880 \(15 September\).](#)



RESEARCH ON GLOBAL ACTION ON NON-COMMUNICABLE DISEASES:

From burden to “best buys”: Reducing the economic impact of NCDs in low- and middle income countries

[This report] brings together findings from two new studies aimed at equipping decision-makers in government, civil society and the private sector with key economic insights needed to help reduce the growing burden of NCDs: 1) A global analysis of the economic impact of NCDs by the World Economic Forum and the Harvard School of Public Health; 2) An analysis of the costs of scaling up a core intervention package in low- and middle-income countries by the World Health Organization. The economic consequences of NCDs are staggering. Under a “business as usual” scenario where intervention efforts remain static and rates of NCDs continue to increase as populations grow and age, cumulative economic losses to low- and middle-income countries (LMICs) from the four diseases are estimated to surpass US\$ 7 trillion over the period 2011-2025 (an average of nearly US\$ 500 billion per year). [...] By contrast, findings from the second study by the WHO indicate that the price tag for scaled-up implementation of a core set of NCD “best buy” intervention strategies is comparatively low. Population-based measures for reducing tobacco and harmful alcohol use, as well as unhealthy diet and physical inactivity, are estimated to cost US\$ 2 billion per year for all LMICs – less than US\$ 0.40 per person. Individual-based NCD “best buy” interventions – which range from counselling and drug therapy for cardiovascular disease to measures to prevent cervical cancer – bring the total annual cost to US\$ 11.4 billion. [...] In economic terms, the return will be many billions of dollars of additional output.*

Source: [Bollyky, Thomas. 2011. From burden to “best buys”: Reducing the economic impact of NCDs in low- and middle-income countries. World Health Organization and World Economic Forum online \(18 September\).](#)

GLOBAL HEALTH NEWS:

The path forward on NCDs

Making international progress on NCDs is hardly hopeless, but this week's UN meetings inspire three observations regarding the path forward. First, the future progress on international NCD control and prevention is unlikely to occur in the UN General Assembly or be led by traditional global health donors. Even when limited to their four major risk factors--tobacco, alcohol, unhealthy diet, and inactivity--NCDs implicate such a wide array of industries and vested interests that achieving consensus among the more than 190 countries of the UN General Assembly is difficult, except in broad and voluntary terms. [...] Second, progress on NCDs is more likely to occur at the national level, especially in the middle-income countries where these diseases will soon be most prevalent. According to the WHO, the most effective interventions for preventing and controlling NCDs are relatively low-cost and can be implemented at the national and local level. [...] These interventions require political will, however, and will only occur when governments become accountable to their citizens for their control, prevention, and treatment costs. [...] Third, there remain important roles for international cooperation, donors, and trading partners on NCDs. International consensus on risk-reduction measures and the challenges presented by NCDs provide important cover for countries seeking to implement public health interventions in the face of industry lobbying. The UN declaration tasks WHO, which is reeling from a 20 percent budget cut and the loss of hundreds of jobs, with developing these consensus targets, but donors must first provide the resources for that expanded new role.*

Source: [Bollyky, Thomas. 2011. The path forward on NCDs. Council on Foreign Relations online \(22 September\).](#)

See Also: [The Lancet. 2011. Urgently needed: a framework for obesity control. The Lancet Vol. 378, Issue 9793 \(27 August\).](#)

[Cohen, Deborah. 2011. Commitment to tackling alcohol misuse is missing from UN summit declaration, experts say. BMJ 343:d5836 \(13 September\).](#)



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Editors

Chantal Blouin
Valerie Percival

Assistant Editor

Mark Pearcey

Layout Editor

Julian Barbieri

Dunton Tower, Room 2116
Carleton University
1125 Colonel By Drive
Ottawa, Ontario K1S 5B6

Tel: 613.520.6696
Fax: 613.520.3981
Email: hfp_bulletin@carleton.ca



Carleton
UNIVERSITY

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