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RESEARCH ON GLOBAL HEALTH SECURITY:

Emerging infectious diseases in Southeast Asia

Southeast Asia is a hotspot for emerging infectious diseases, including those with pandemic potential. Emerging infectious diseases have exacted heavy public health and economic tolls. Severe acute respiratory syndrome rapidly decimated the region's tourist industry. Influenza A H5N1 has had a profound effect on the poultry industry. The reasons why southeast Asia is at risk from emerging infectious diseases are complex. The region is home to dynamic systems in which biological, social, ecological, and technological processes interconnect in ways that enable microbes to exploit new ecological niches. These processes include population growth and movement, urbanisation, changes in food production, agriculture and land use, water and sanitation, and the effect of health systems through generation of drug resistance. Southeast Asia is home to about 600 million people residing in countries as diverse as Singapore, a city state with a gross domestic product (GDP) of US\$37 500 per head; and Laos, until recently an overwhelmingly rural economy, with a GDP of US\$890 per head. The regional challenges in control of emerging infectious diseases are formidable and range from influencing the factors that drive disease emergence, to making surveillance systems fit for purpose, and ensuring that regional governance mechanisms work effectively to improve control interventions.

Source:

[Coker, Richard, et al. 2011. Emerging infectious disease in southeast Asia: regional challenges to control. *The Lancet* online \(25 January\).](#)



GLOBAL HEALTH NEWS:

NDM-1 – A cause for worldwide concern

The most recent reports of superbugs in the professional and lay literature discuss NDM-1, which stands for New Delhi metallo-beta-lactamase 1 and actually refers not to a single bacterial species but to a transmissible genetic element encoding multiple resistance genes that was initially isolated from a strain of klebsiella obtained from a patient who acquired the organism in New Delhi, India. [...] What makes this enzyme so frightening is not only its intrinsic ability to destroy most known beta-lactam antibiotics but also the company it keeps. [...] The original organism was found to be resistant to all antimicrobial agents tested except colistin. Molecular examination of the isolate revealed that it contained a novel metallo-beta-lactamase that readily hydrolyzed penicillins, cephalosporins, and carbapenems (with the exception of aztreonam). The gene encoding this novel beta-lactamase (which had not been known previously) was found on a large 180-kb resistance-conferring genetic element that was easily transferred to other Enterobacteriaceae and that contained a variety of other resistance determinants, including a gene encoding another broad-spectrum beta-lactamase (CMY-4) and genes inactivating erythromycin, ciprofloxacin, rifampicin, and chloramphenicol.

Sources:

[Moellering, Robert C. 2010. NDM-1 – A Cause for Worldwide Concern. *NEJM*. Vol. 363, No. 25 \(16 December\).](#)

RESEARCH ON HEALTH & STATES IN CRISIS/CONFLICT:

Five complementary interventions to slow cholera: Haiti

[In 2003] cholera was among the diseases mentioned in warnings about the politicisation of water and health projects. Although cholera had not been documented in Haiti for many decades, it has long been the most feared waterborne disease [...] Case-fatality rates of untreated severe cholera can reach 50%, although most agree that aggressive case management can drop this figure to under 1%. What, then, are the key steps to slow the spread of cholera and to reduce case-fatality rates to under 1%? Five are worth mentioning, all of them drawing on a model of intervention that links prevention to care [...] First, we must identify and treat all those with symptomatic cholera. This effort requires both the capacity to identify and refer those with symptoms, and the existence of centres equipped and trained to treat them. In less than a month, dozens of cholera treatment centres have been erected, often in tents [...] Second, a concerted effort should be made to make oral cholera vaccines available in Haiti and elsewhere. This would require a global stockpile of cholera vaccine [...] Third, prevention in this context means doing everything we can to remedy Haiti's water insecurity and improve sanitation [...] Fourth, all vertical health projects, whether focused on AIDS, cholera, nutrition, women's health, or any other endeavour, must be dedicated at least in part to strengthening Haiti's health system [...] Fifth, cholera demands not simply a harmonisation of global health policy, but also raising the bar on our goals.

Source:

[Ivers, Louise, et al. 2010. Five complementary interventions to slow cholera: Haiti. *The Lancet*. Vol. 376, Issue 9758 \(18 December\).](#)



GLOBAL HEALTH NEWS:

Kala-azar outbreak is symptomatic of humanitarian crisis facing southern Sudan

An outbreak of kala-azar demonstrates the “dire humanitarian crisis” facing southern Sudan, according to the medical charity Médecins Sans Frontières (MSF). The agency says the outbreak is “just one symptom” of the wider medical humanitarian crisis in southern Sudan, which includes an “abysmal lack of healthcare, chronic malnutrition, regular outbreaks of preventable diseases, and insecurity that displaces communities and destroys lives.” Kala-azar, or visceral leishmaniasis, is a neglected tropical disease carried by sandflies and is endemic in the region. Symptoms include an enlarged spleen, fever, weakness, and wasting. It thrives in poor, remote, and unstable areas with extremely limited healthcare. Elin Jones, medical coordinator at MSF, says, “With kala-azar, it’s always a race against time to save lives. Yet the race is too often lost before it ever begins, as three quarters of people are unable to access even basic medical care and the weak health system cannot cope with such emergencies. This epidemic then further compounds the already dire medical humanitarian situation facing the population.”

Source:

[Moszynski, Peter. 2010. Kala-azar outbreak is symptomatic of humanitarian crisis facing southern Sudan. *BMJ* Vol. 341, Issue c7276 \(17 December\).](#)

RESEARCH ON HUMAN RIGHTS & GLOBAL HEALTH:

Worldwide violence against women legislation: An equity approach

[This article] describes the recommendations and interventions addressing violence against women (VAW) in vulnerable women (disabled, pregnant, ethnic minority, immigrant and older women) in key documents and laws enacted in different countries. [Methodologically, it performs] content analysis of key documents for the development of VAW policies and laws: The United Nations Handbook for Legislation on Violence Against Women Advance Version, the Model of Laws and Policies on Intrafamilial Violence Against Women of the Pan-American Health Organization and Recommendation No. R(2002)5 of the Committee of Ministers of the European Council. The content of the 62 VAW laws was also analyzed. Key documents demonstrate the importance of eliminating any obstacle facing disabled, pregnant, immigrant, ethnic minority or older women when accessing VAW services. Only 12 laws mention one or more of these groups of vulnerable women. Pregnant, disabled and ethnic minority women are the groups most often mentioned. In these laws, references to punitive measures, action plans and specific strategies to guarantee access to VAW resources are the most common interventions [...] This study has [identified] the need to raise the profile of vulnerable women in the legislation on VAW. Higher priority should be given to these groups of women in the international recommendations made in key documents in order to overcome VAW using an equity approach. The different barriers that vulnerable women must face in order to gain access to VAW services should lead policy makers to consider the special needs of these women.

Source:

[Ortiz-Barreda, Gaby, et al. 2010. Worldwide violence against women legislation: An equity approach. *Health Policy online* \(30 Deember\).](#)



GLOBAL HEALTH NEWS:

Violence against women: An urgent public health priority

Violence against women has been described as “perhaps the most shameful human rights violation, and the most pervasive.” Addressing violence against women is central to the achievement of Millennium Development Goal (MDG) 3 on women’s empowerment and gender equality, as well as MDGs 4, 5 and 6. It is also a peace and security issue. In spite of this recognition, investment in prevention and in services for survivors remains woefully inadequate [...] WHO has recently published *Preventing intimate partner and sexual violence against women: taking action and generating evidence*. This publication summarizes the existing evidence on strategies for primary prevention, identifying those that have been shown to be effective and those that seem promising or theoretically feasible. The review highlights the urgent need for more evidence on effective prevention interventions and for integrating sound evaluation into new initiatives, both to monitor and improve their impact and to expand the global evidence base in this area. It recognizes how infant and early childhood experiences influence the likelihood of people later becoming perpetrators or victims of intimate partner and sexual violence, as well as the need for early childhood interventions, especially for children growing up in families where there is abuse. It also recognizes the importance of strategies to empower women, financially and personally, and of challenging social norms that perpetuate this violence.

Source:

[Garcia-Moreno, Claudia & Charlotte Watts. 2011. Violence against women: an urgent public health priority. *Bulletin of the World Health Organization \(BLT\)*. Vol. 89, No. 1 \(January\).](#)

GLOBAL HEALTH NEWS:

India: Drop charges against maternal death protesters

About 1,000 people gathered peacefully on December 28 in the Barwani district to protest the high numbers of maternal deaths, and the lack of accountability for these deaths, at the district hospital. Law enforcement officials arrested one protester, threatened to arrest others, and issued a warrant for another participant on charges of rioting, being part of an unlawful assembly, and obstructing public servants from performing their duties [...] The authorities should drop all charges against the protesters and tell the police to stop threatening peaceful protesters going forward, Human Rights Watch said. In November 2010, activists recorded nine maternal deaths at the Barwani district hospital, even though the hospital is designated a comprehensive emergency obstetric care unit, which should be equipped to deal with childbirth complications around-the-clock. Despite a 2010 national policy mandating states to investigate maternal deaths and take corrective action, the state did not review the circumstances that led to any of the deaths. Tribal communities in this region face daunting challenges in getting life-saving maternal health care [...] Health rights activists also recorded a number of cases in which pregnant women who sought emergency obstetric care had been turned away from the Barwani district hospital and referred to a larger hospital in Indore city, five hours away.

Source:

[. 2011. Indian: Drop Charges Against Maternal Death Protesters. *Human Rights Watch* online \(10 January\).](#)



RESEARCH ON GLOBAL HEALTH GOVERNANCE & INSTITUTIONS:

A new approach to global health institutions? A case study of new vaccine introduction and the formation of the GAVI Alliance

There is an emerging research agenda to analyse empirically the forces driving changes in global health governance. This study applies analytical tools from international relations research to explain the formation of international health regimes. The study utilizes two explanatory perspectives: individual leadership, and the interests of key non-state actors in the formation process, using the case of the formation of the Global Alliance for Vaccines and Immunization (GAVI) from 1995 to 1999. The case study is based on material from interviews with key actors, an archival review of documents from the Children's Vaccine Initiative (CVI), and published literature. Findings show that the regime formation process was initiated by individuals who were primarily affiliated to scientific communities and led to the World Bank and the Gates Foundation becoming champions of a new coordinating mechanism for new vaccine introduction. Negotiations in the regime formation process were between a small group of founding agencies with divergent interests regarding immunization priorities. The case also sheds light on the authority of the WHO and the resources of the Gates Foundation in driving the process towards the final structure of the alliance.

Source:

[Sandberg, Kristin Ingstad, et al. 2010. A new approach to global health institutions? A case study of new vaccine introduction and the formation of the GAVI Alliance. *Social Science & Medicine*. Vol. 71, No. 7 \(October\).](#)

Brazil's Ascendance: The soft power role of global health diplomacy

Brazil's steady ascendance on the world stage over the past decade has been led, in large part, by the country's growing economic might. A much lauded BRIC (Brazil, Russia, India and China) country blessed by vast resources, Brazil is predicted to emerge this century as a regional and global economic powerhouse. However, the country's rising influence must also be understood as the product of an effective foreign policy and, in particular, the assumption of high-profile diplomatic roles in negotiating to address key global issues such as climate change, nuclear non-proliferation and trade liberalisation. Among emerging economies, Brazil has been particularly adept at leveraging what is described as "soft power", defined as the capacity to persuade or attract others to do what one wants through the force of ideas, knowledge and values. Coined by Joseph Nye, the concept of soft power contrasts with "hard power" whereby coercion (underpinned by military and economic might) is used to influence others to act in ways in which they would not otherwise do. He argues that, in a more interconnected world of accelerating globalisation and resultant collective action problems, the currency of global leadership favours soft over hard power. In recent years, world leaders have begun to talk about "smart power" whereby soft and hard power is combined in ways that are mutually reinforcing. Brazil's prominence in global health diplomacy can be understood in this context. Its effective combination of economic might and diplomatic acumen in addressing global health issues offers lessons for other countries seeking to play a more prominent leadership role in the emerging world order.

Source:

[Lee, Kelley & Eduardo J Gómez. 2011. Brazil's Ascendance: The soft power role of global health diplomacy. *The European Business Review online* \(January-February\).](#)



GLOBAL HEALTH NEWS:

Weighing an ambitious QDDR

The Quadrennial Diplomacy and Development Review (QDDR), two years in the making, was presented by United States' Secretary of State Hillary Clinton as a foreign-policy roadmap that sees "leading through civilian power" as a way to save lives and money. Among other elements, the review seeks to reorganize State Department bureaucracies, hand over the Obama administration's health and agriculture programs to U.S. Agency for International Development (USAID), and hire more staff. [In this article] four Council on Foreign Relations (CFR) fellows weigh in on the effectiveness of the review's provisions. Laurie Garrett sees the QDDR as "spectacularly important" for public health and clinical medicine at a time when U.S. funding is crucial. Yanzhong Huang cautions that while QDDR could be a powerful contribution to U.S. projections of "soft power," the report hasn't outlined enough concrete measures to be convincing about real change. Isobel Coleman notes that while the report could presage real improvement in USAID, it is difficult to reform bureaucracies. Paul Stares applauds the effort to improve U.S. conflict prevention and response but points out that effectiveness will depend in part on careful attention to organizational structure.

Source:

[Garrett, Laurie, et al. 2010. Weighing an Ambitious QDDR. Council on Foreign Relations online \(16 December\).](#)

See Also:

[State Department and USAID. 2010. The First Quadrennial Diplomacy and Development Review: Leading Through Civilian Power. US Department of State online \(15 december\).](#)

RESEARCH ON HEALTH & DEVELOPMENT, HEALTH SYSTEMS:

Health and health-care systems in southeast Asia: Diversity and Transitions

Southeast Asia is a region characterised by much diversity, including public health challenges. Social, political, and economic development during the past few decades has facilitated substantial health gains in some countries, and smaller changes in others. The geology of the region, making it highly susceptible to earthquakes and resultant tsunamis, along with seasonal typhoons and floods, further increases health risks to the population from natural disasters and long-term effects of climate change. Public policy in these countries cannot ignore such risks to health, which could have important social and economic consequences. Regional cooperation around disaster preparedness and in the surveillance of and health systems response to disease outbreaks has obvious advantages as a public health strategy. Concomitantly, all countries in the region are faced with large or looming chronic disease epidemics. Even in the poorest populations of the region, non-communicable diseases already kill more people than do communicable, maternal, and perinatal conditions combined, with many of these deaths occurring before old age. Greatly strengthened health promotion and disease prevention strategies are an urgent priority if the impressive health gains of the past few decades in most countries of the region are to be replicated. Further growth and integration of the ASEAN region should include as a priority enhanced regional cooperation in the health sector to share knowledge and rationalise health systems operations, leading to further public health gains for the region's diverse populations.

Source:

[Chongsuivatwon, Viraskdi, et al. 2011. Health and health-care systems in southeast Asia: diversity and transitions. The Lancet online \(25 January\).](#)



GLOBAL HEALTH NEWS:

Now it's free, how to pay for it? Sierra Leone's dilemma

In April 2010, Sierra Leone launched its first free health-care initiative aimed at improving abysmal maternal and child mortality rates [...] The Ministry of Health and Sanitation's first monitoring bulletin on the initiative shows steady positive trends in access of services by women and children, even after adjusting for the spike in numbers due to initial euphoria and curiosity about the initiative [...] But providing such life-saving services is costly. Maintaining free health care at the point of service will depend on the government's ability to finance two critical elements: essential drugs and health workers' salaries. The Ministry of Health estimates that the free health-care initiative will cost the government an extra US\$ 34 million on top of its usual health expenditure in its first year. [...] Donors, including the United Kingdom's Department for International Development (DfID), The World Bank, the African Development Bank and the Global Fund to Fight AIDS, Tuberculosis and Malaria, will pick up more than half the tab for the first year of the initiative (i.e. until March 2011). [However] A recent World Bank report predicts it will cost an additional US\$ 15–25 million per year for the next five years. The report, which considers three scenarios, says even the most optimistic scenario will still not see additional costs met until three or four years into the initiative.

Source:

[Thompson, Felicity. 2010. Now it's free, how to pay for it? Sierra Leone's dilemma. *Bulletin of the World Health Organization \(BLT\)*. Vol. 88, No. 12 \(December\).](#)

RESEARCH ON HUMAN RESOURCES & MIGRATION OF HEALTH WORKERS:

Reflections on the ethics of recruiting foreign-trained human resources for health

Developed countries' gains in health human resources (HHR) from developing countries with significantly lower ratios of health workers have raised questions about the ethics or fairness of recruitment from such countries. By attracting and/or facilitating migration for foreign-trained HHR, notably those from poorer, less well-resourced nations, recruitment practices and policies may be compromising the ability of developing countries to meet the health care needs of their own population. Little is known, however, about actual recruitment practices. In this study we focus on Canada (a country with a long reliance on internationally trained HHR) and recruiters working for Canadian health authorities [...] HHR recruiters' reflections on the global flow of health workers from poorer to richer countries mirror much of the content of global-level discourse with regard to HHR recruitment. A predominant market discourse related to shortages of HHR outweighed discussions of human rights and ethical approaches to recruitment policy and action that consider global health impacts. We suggest that the concept of corporate social responsibility may provide a useful approach at the local organizational level for developing policies on ethical recruitment. Such local policies and subsequent practices may influence public debate on the health equity implications of the HHR flows from poorer to richer countries inherent in the global health worker labour market, which in turn could influence political choices at all government and health system levels.

Source:

[Runnels, Vivien, et al. 2011. Reflections on the ethics of recruiting foreign-trained human resources for health. *Human Resources for Health*. Vol. 9, No. 2 \(20 January\).](#)



RESEARCH ON TRADE POLICY & HEALTH:

Why is medical travel of concern to global social policy?

An analysis of the implications of the trade in health services for global social policy requires a multilevel understanding of policy issues and debates, politics and the political economy of the countries involved, and the intermediaries, companies, medical travellers, providers, organ donors and others involved in the trade. This special issue of *Global Social Policy* seeks to contribute to such an analysis from the perspectives of different social science disciplines. [Following an ethnographic study of medical travelers by Beth Kangas and an exploratory study of medical travelers by Alsharif, Labonté and Lu,] Chee Heng Leng's article then focuses on the role of the state in advancing medical tourism in two countries. She argues for the need to situate policy making in the context of the political economy of a country. The political economic forces that shape national health care systems also shape policy making and create the conditions/spaces for the possibilities of equitable social policies. The next article by Sallie Yea uses an ethnographic study of commercial kidney providers in the Philippines to illustrate how using an anti-trafficking discourse that universalizes their experiences as one form of human trafficking can be misleading. She argues that casting transplant tourism as a form of human trafficking without understanding the motivations of people who are living a marginalized existence for wanting to sell their kidneys locks policy makers into a counter-productive approach. Dominique Martin complements Yea's article by discussing the policy issues and debates surrounding the trade in human biological materials, and suggests a way forward. To achieve social justice at the international level, it will be necessary for countries to be self-sufficient in their supply and demand/need for human biological materials. Finally, Andrea Whittaker reviews the regulatory challenges that are presented by medical travel [...] and investigates the possibilities of a global response by international health organizations.

Source:

[Heng Leng, Chee & Andrea Whittaker. 2010. Guest editors' introduction to the special issue : Why is medical travel of concern to global social policy?. *Global Social Policy*. Vol. 10, No. 3 \(December 13\).](#)

See Also:

[. 2010. Special Issue: Why is medical travel of concern to global social policy?. *Global Social Policy*. Vol. 10, No. 3 \(December 13\).](#)

GLOBAL HEALTH NEWS:

Canada accused of hypocrisy over asbestos exports

Although Canada will not expose its own citizens to asbestos, its plans to continue exporting the deadly substance to developing countries has drawn widespread condemnation [...] Asbestos is a lethal and naturally occurring group of minerals that has brought death and misery to people worldwide. Due to its good tensile strength and resistance to damage, asbestos became extremely popular throughout the early 20th century, and, in many less wealthy nations, remains so today, where it has several uses including strengthening cement and prolonging the life of road surfaces. Once the link between asbestos and lung disease and cancer was proven beyond doubt, high-income countries began phasing out its use and removing it from buildings. Despite this, WHO estimates that about 125 million people worldwide remain exposed to asbestos in the workplace [...] Canada is actively removing asbestos from its buildings, and has a de-facto ban on using the substance in any form in all but exceptional circumstances. But unlike other rich nations, Canada has been a major exporter of chrysotile, or white asbestos. It was the world's fourth biggest exporter (behind Russia, Kazakhstan, and Brazil) shipping about 150 000 tonnes per year to developing countries such as India, Indonesia, and the Philippines, where little or no protection exists for workers or exposed populations.

Source:

[Kirby, Tony. 2010. Canada accused of hypocrisy over asbestos exports. *The Lancet*. Vol. 376, No. 9757 \(11 December\).](#)



RESEARCH ON INTELLECTUAL PROPERTY & HEALTH

Common health policy and the shaping of global pharmaceutical policies

The global focus on pharmaceutical policies and, in particular, on intellectual property rights (IPR) and medicines has been dominated by debates over access to medicines in developing countries and the lack of resources for research and development (R&D) to address tropical and neglected diseases [...] However, while the provision of additional resources for tackling HIV/AIDS, tuberculosis, and malaria and the investment in research and development in neglected diseases are certainly important, such resources alone are not sufficient to tackle global health challenges. Access to medicines and inadequate research and development are usually framed as problems that prevail only with regard to specific diseases and only in the poorest developing countries, and which can be remedied through an increased allocation of aid without further changes to innovation, trade, or industrial policies globally [...] In order to achieve more ethical global health outcomes, health policies must be driven by health priorities and should take into account broader health policy requirements, including the needs of specific national health systems. It is thus important to recognize that the division of interests in key policy areas are not necessarily between the priorities of rich and poor countries, but between (1) pharmaceutical industry interests and health policy interests, and (2) national industrial and trade policy interests and public health policies.

Source:

[Koivusalo, Meri. 2010. Common Health Policy Interests and the Shaping of Global Pharmaceutical Policies. *Ethics & International Affairs*. Vol. 24, No. 4 \(Winter\).](#)

GLOBAL HEALTH NEWS:

Views differ on WTO's generics solution, IPR enforcement

A rarely-used system intended to help poor countries import generic versions of patent-protected drugs was the main focus of discussions at the October session of the TRIPS Council. [...] WTO Members reviewed how well the so-called 'paragraph 6 solution' was working [...] The solution, adopted by WTO Members in 2003, allows generics makers to export drugs under compulsory licence to developing countries without manufacturing capacity, but also imposes a complex web of requirements on both exporters and importers, mostly designed to ensure that the drugs are not re-exported to other countries, where they could threaten brand-name manufacturers' markets. The procedure has been used only once, for a shipment of HIV/AIDS drugs from Canada to Rwanda in 2008. India, Brazil, China, South Africa and other developing countries argued that this infrequency implied that the system must be too complicated to use. Canada, backed by other developed countries such as the US, Australia, Japan and Switzerland, suggested that the system was fine, and that governments had not used it because they were able to negotiate better drug prices with patent-holders, or import cheap generics from countries where the drugs were not under patent.

Source:

[. 2010. Views Differ on WTO's Generics Solution, IPR Enforcement. *International Centre for Trade and Sustainable Development*. Vol. 14, No. 4 \(December\).](#)



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

Universal antiretroviral treatment: The challenge of human resources

The World Health Organization's (WHO) 2009 report *Towards universal access: scaling up priority HIV/AIDS interventions in the health sector* documents a remarkable increase in the number of people receiving antiretroviral treatment (ART) worldwide – from 3 million in 2007 to 4 million in 2008 – creating hope that, with sustained energy, universal ART coverage might be achievable. At the same time, the report emphasizes many challenges in delivering ART on such a massive scale. [...] There are four possibilities for how past increases in ART coverage could have been achieved: (i) increased inflow of human resources for health into a country's health system, (ii) decreased outflow of human resources, (iii) task-shifting from highly-skilled to less-skilled health workers, or (iv) internal shifting of human resources from the general health systems to ART programme [...] Regardless of how the jump in ART coverage from 33% to 42% [...] was achieved, future increases in ART coverage will become increasingly difficult: All else being equal, the larger the number of people receiving ART now, the lower their average mortality, and so the larger the total number of people who will need treatment in the future. In other words, ART programmes will fall victim to their own success – the more successful they are at reducing HIV-related mortality, the more difficult they will find it to scale up.

Source:

[Bärnighausen, Till, et al. 2010. Universal antiretroviral treatment: the challenge of human resources. *Bulletin of the World Health Organization \(BLT\)*. Vol. 88, No. 12 \(December\).](#)

GLOBAL HEALTH NEWS:

Global health fund freezes some Ivory Coast aid

The Global Fund to fight AIDS, Tuberculosis and Malaria said on [11 January] it was freezing disbursement of grants to the Ivory Coast and taking measures to safeguard its stocks and funds due to political instability. The West African country, the world's largest cocoa producer, is mired in a tense political stand-off. The United Nations say more than 200 people have been killed in violence. The World Bank and International Monetary Fund (IMF) have cut off incumbent leader Laurent Gbagbo for refusing to step down after a November 28 election that his presidential rival Alassane Ouattara is widely recognised to have won [...] However, the Geneva-based fund would allow procurement and distribution of life-saving drugs against the HIV virus and malaria, to continue, provided partner agencies, including the charity CARE, seek its prior authorisation.

Source:

[. 2011. Global health fund freezes some Ivory Coast aid. *Reuters online* \(11 January\).](#)



RESEARCH ON GLOBAL ACTION ON NON-COMMUNICABLE DISEASES:

Enabling access to new WHO essential medicines: The case for nicotine replacement therapies

Tobacco use kills 5.4 million people annually [...] Unless tobacco cessation and control vastly improves, the death toll from tobacco this century will easily reach an estimated 1 billion deaths. In this paper, we discuss the benefits and challenges of enabling access to pharmacotherapies (nicotine replacement therapies (NRTs)) to treat nicotine dependence and bolster tobacco cessation in low and middle income countries (LMIC). In March 2009, NRTs (specifically, nicotine gums and patches) were added to the Model List of Essential Medicines by the World Health Organization (WHO). Essential medicines are defined as those that satisfy the priority health care needs of the population, and the Essential Medicines List (EML) is used by over 160 governments as a guide for determining which medicines should be made available to their citizens at low cost. The addition of a medicine to the international EML directly encourages individual nations to add the drug to their national EML and to internal drug registries [...] In this context, we argue that in light of the increasing global burden of tobacco dependence and the clinical utility of NRT, these new WHO essential medicines can and should be available more widely.

Source:

[Kishore, Sandeep, et al. 2010. Enabling access to new WHO essential medicines: the case for nicotine replacement therapies. *Globalization and Health*. Vol. 6, No. 22 \(19 November\).](#)

GLOBAL HEALTH NEWS:

Critics say UNICEF-Cadbury partnership is mere sugarwashing

The United Nations Children's Fund, is a global advocate for children and one of the most recognized charities in the world. It is also a partner with candy maker Cadbury Adams Canada Inc., which has given UNICEF \$500 000 over three years to build schools in Africa. In exchange, Cadbury is allowed to put the widely recognized UNICEF logo on packaging for its products. [...] Critics of partnerships between industry and charity claim it is unlikely that businesses have altruistic intentions; rather, they are looking to associate themselves with good causes to create a "halo effect" in the hopes of improving sales [...] But corporate sponsorship by the food industry — unlike say, the tobacco industry — is not subject to much scrutiny. This may explain how such partnerships as the much-criticized 2005 deal between the American Diabetes Association and Cadbury Schweppes, a major producer of soft drinks, come to exist.

Source:

[Collier, Roger. 2010. Critics say UNICEF-Cadbury partnership is mere sugarwashing. *Canadian Medical Association Journal*. Vo. 182, No. 19 \(8 November\).](#)



HEALTH & FOREIGN POLICY BULLETIN

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