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RESEARCH ON GLOBAL HEALTH SECURITY:

Public health preparedness laws and policies: Where do we go after pandemic 2009 H1N1 influenza?

Although the complexity and duration of the 2009 H1N1 pandemic challenged epidemiologists seeking to predict and understand the two waves of infection in the population, from a public health law and policy perspective, the 2009 H1N1 pandemic consisted of at least five phases of policies and policymaking by legislative bodies and public health officials at all levels of government. These policy phases were: 1) pre-event laws and policy, such as the federal Pandemic and All-Hazards Preparedness Act (PAHPA)⁷ that were developed in anticipation of a pandemic or other public health emergencies; 2) a spring phase, during which laws and policies, such as the collection of laboratory samples, social distancing efforts, and the need for funding for the response, were being developed to react to the immediate situation at hand; 3) an interim policymaking phase following the spring epidemiologic wave of infection where policy needs to respond to the second wave were being anticipated, particularly concerning vaccine availability; 4) a fall phase of policymaking responding to operational concerns, such as those related to the distribution and dispensing of vaccine and other countermeasures, and response funding; and 5) an ongoing post-event phase of policymaking responding to perceived successes and challenges of the response. In this article, [the authors] identify the key public health law and policy challenges and barriers associated with these five phases, highlight the policy experiences of state and local officials during the H1N1 response, and suggest opportunities to use public health preparedness policy lessons to address future policy development efforts. *

Source: O'Connor, Jean, et al. 2011. [Public Health Preparedness Laws and Policies: Where Do We Go after Pandemic 2009 H1N1 Influenza?](#) *Journal of Law Medicine & Ethics* (Spring).



Urbanisation and infectious disease in a globalised world

Urbanisation increasingly affects the epidemiological characteristics of infectious diseases. Depending on the pace, dynamics, and environment, urbanisation can either promote or hinder the spread of pathogens. In most developed cities, better living conditions, improvement of domestic hygiene, and targeted public-health interventions contributed to the decline of infectious illnesses. In parallel, chronic diseases have progressed because of changes in lifestyle, population ageing, and improvement in the diagnostic capacities of health services. While some developing countries seem to be on track for this epidemiological transition, uncontrolled urban growth has also resulted in large health inequities and in increases in the transmission of infectious diseases. In cities, numerous resources are present, and political power, money, and knowledge are concentrated. Urban centres offer incredible opportunities for disease surveillance, control, and prevention that are absent in rural areas. Well-planned strategies for vector control have enabled cities to eliminate malaria and dengue, and city-wide sanitation programmes have shown spectacular effects. Additionally, higher levels of social cohesion, the presence of community-based organisations that mobilise populations and advocate for resources, and access to media and modern communication allow urban residents to have increased visibility and a stronger political voice than their rural counterparts. *†

Source: [Alirol, Emilie, et al. 2011. Urbanisation and infectious diseases in a globalised world. *The Lancet Infectious Diseases* Vol. 11, Issue No. 2 \(February\).](#)

GLOBAL HEALTH NEWS:

MEPs criticize WHO over H1N1 pandemic advice

The European parliament has launched a strong attack on the World Health Organization, accusing it of distorting the term “pandemic” during the H1N1 outbreak in 2009-10 and triggering a worldwide false alarm. They argue that this led to inappropriate and disproportionate public health decisions by European Union countries, members of the parliament claim. The criticism comes in a report drafted by the French Green MEP Michèle Rivasi evaluating management of H1N1 flu in 2009-10 in the European Union. The report was overwhelmingly adopted by the parliament’s public health committee on 25 January, with 58 votes in favour of the report, just two against, and one abstention. It calls on WHO to revise the definition of a pandemic to take account not just of the geographical spread of a health threat but also its severity.*

Source: [Watson, Rory. 2011. MEPs criticize WHO over H1N1 pandemic advice. *BMJ* 342:d652 \(1 February\).](#)



RESEARCH ON HEALTH & STATES IN CRISIS/CONFLICT:

Six rapid assessments of alcohol and other substance use in populations displaced by conflict

Substance use among populations displaced by conflict is a neglected area of public health. Alcohol, khat, benzodiazepine, opiate, and other substance use have been documented among a range of displaced populations, with wide-reaching health and social impacts. Changing agendas in humanitarian response - including increased prominence of mental health and chronic illness - have so far failed to be translated into meaningful interventions for substance use. Studies were conducted from 2006 to 2008 in six different settings of protracted displacement, three in Africa (Kenya, Liberia, northern Uganda) and three in Asia (Iran, Pakistan, and Thailand). [The authors] used intervention-oriented qualitative Rapid Assessment and Response methods, adapted from two decades of experience among non-displaced populations. The main sources of data were individual and group interviews conducted with a culturally representative (non-probabilistic) sample of community members and service providers [...] The six studies show the feasibility and value of conducting rapid assessments in displaced populations. One outcome of these studies is the development of a UNHCR/WHO field guide on rapid assessment of alcohol and other substance use among conflict-affected populations. More work is required on gathering population-based epidemiological data, and much more experience is required on delivering effective interventions.*

Source: [Ezard, Nadine, et al. 2011. Six rapid assessments of alcohol and other substance use in populations displaced by conflict. *Conflict and Health* Vol. 5, No. 1 \(11 February\).](#)

GLOBAL HEALTH NEWS:

Cote d'Ivoire: briefing on the humanitarian situation

[The Integrated Regional Information Networks (IRIN)] has produced a series of briefings exploring the crisis in Côte d'Ivoire triggered by contested elections in November 2010. With both Laurent Gbagbo and Alassane Ouattara laying claim to the presidency, the bitter political divisions in the country have led to worsening violence. While regional and international bodies have repeatedly called on Gbagbo to step down, neither sanctions nor mediation initiatives have [broken] the deadlock. Gbagbo and Ouattara head rival administrations, both trying to maximize their resources and isolate the other party. IRIN's series of revised briefings takes a look at the handling of the crisis by the UN, regional bodies the African Union (AU) and Economic Community of West African States (ECOWAS), western governments, and the European Union (EU), while also looking at the economic, human rights and humanitarian consequences of the breakdown.*

Source: [United Nations Office for the Coordination of Humanitarian Affairs – Integrated Regional Information Networks \(IRIN\). 2011. Côte d'Ivoire: Briefing on the humanitarian situation. *ReliefWeb* \(15 February\).](#)



RESEARCH ON HUMAN RIGHTS & GLOBAL HEALTH:

Right to health litigation and HIV/AIDS policy

Domestic litigation has become a principal strategy for realizing international treaty obligations for the human right to health, providing causes of action for the public's health and empowering individuals to raise human rights claims for HIV prevention, treatment, and care. In the past 15 years, advocates have laid the groundwork on which a rapidly expanding enforcement paradigm has arisen at the intersection of human rights litigation and HIV/AIDS policy. As this enforcement develops across multiple countries, human rights are translated from principle to practice in the global response to HIV/AIDS, transforming aspirational declarations into justiciable obligations and implementing human rights through national policies and programs. Yet despite this national progress in creating accountability for health-related rights, there is scarce empirical research on the scope, content, and effect of legal claims pursuant to these human rights standards. As judicial enforcement has increased, rising to the forefront of a budding health and human rights movement, both proponents and opponents of rights-based policy have questioned the limits of this litigation strategy and the impact of litigation on global HIV/AIDS efforts. Reflecting on this growing backlash, there arises an imperative for interdisciplinary analysis — to survey these rights-based claims, compare divergent legal strategies conducive to the realization of human rights, and assess the effects of this litigation on public health outcomes.*

Source: [Meier, Benjamin Mason & Alicia Ely Yamin. 2011 Right to Health Litigation and HIV/AIDS Policy. *The Journal of Law, Medicine & Ethics* Vol. 39, Issue Supplement s1 \(Spring\).](#)

GLOBAL HEALTH NEWS:

Violence against women: An urgent public health priority

Activists have asked the UN human rights chief to pressure Russia to legalise the heroin substitute methadone when she visits next week amid a worsening HIV/AIDS crisis [in that country ...] UN High Commissioner for Human Rights Navi Pillay will meet President Dmitry Medvedev, government officials and around 60 rights campaigners during a five-day visit to Moscow [...] The International Harm Reduction Association (IHRA) and 16 other HIV-focused rights organisations have sent a letter to Pillay asking her to push for HIV/AIDS and drug-fighting measures including the introduction of methadone, during her meetings with Russian government. The UN's World Health Organisation (WHO) says Russia has one of the fastest growing HIV/AIDS epidemics in the world, fueled by up to three million heroin addicts, many of whom use dirty needles, local health organisations say. Unlike most countries, Russia refuses to finance harm reduction programmes such as needle exchanges, or to legalise the replacement drug methadone.*

Source: [Ferris-Rotman, Amie. 2011. Activists push for heroin help in U.N. Russia visit. *Reuters* online \(11 February\)](#)



RESEARCH ON GLOBAL HEALTH GOVERNANCE & INSTITUTIONS:

Applying the principles of AIDS 'exceptionality' to global health: Challenges for global Health Governance

The authors argue that a key feature of the "exceptionality" of the global AIDS response—its reliance on open-ended international solidarity to complement domestic efforts—can only be preserved if it is extended to broader health issues of the poorest countries of the world. This reliance on open-ended international solidarity hinges on three related principles: a new approach to sustainability, a flexible application of fiscal space constraints, and an international financing mechanism that provides long term reliable assistance [...] Our first argument for applying the principles of AIDS exceptionality to health exceptionality is that universal access to AIDS prevention and treatment requires stronger health systems in developing countries [...] Our second argument is that AIDS exceptionality, if left unexpanded to broader health issues, will not resist the pressure from arguments that the global AIDS response is capturing a disproportionate share of international assistance [...] Our third argument is that the practice of providing AIDS treatment to people living in low-income countries requires a more explicit and consistent commitment from the international community (to remain reliable in the long run), and that we find it hard to imagine such an approach that singles out one disease.*†

Source: [Ooms, Gorik, et al. 2011. Applying the principles of AIDS 'exceptionality' to global health: challenges for global health governance. *Global Health Governance* Vol. 4, Issue 1 \(7 February\).](#)

GLOBAL HEALTH NEWS:

Vaccines alliance wants more industry price cuts

Dagfinn Hoybraten, chair of the GAVI Global Alliance for Vaccines and Immunization since January, said he believed drug companies would bow to pressure to cut prices for vaccines that can protect against some of the biggest killers of children in poor countries [...] GAVI is starting vaccination campaigns against pneumococcal disease in several nations. The rollout comes after drug firms Pfizer and GlaxoSmithKline signed a 10-year deal to supply pneumococcal shots at a discounted price of \$7 each for the first 20 percent, and \$3.50 for the rest. The deal was the first under an Advance Market Commitment (AMC) which guarantees a market for vaccines supplied to poor nations and sets a maximum price for drugmakers. But some campaign groups, including the medical charity Medecins Sans Frontieres (MSF), have criticized the AMC for providing just two major companies with a huge new market and paying them subsidies in return for securing lower prices.*

Source:

[Kelland, Kate. 2011. Vaccines alliance wants more industry price cuts. *Reuters online* \(14 February\).](#)



RESEARCH ON HEALTH & DEVELOPMENT, HEALTH SYSTEMS:

The role of institutional design and organizations practice for health financing performance and universal coverage

Many [individuals in] low- and middle income countries heavily rely on out-of-pocket payments to secure health care access. The challenge for these countries is how to modify their health financing system in order to achieve universal coverage. This paper proposes an analytical framework for undertaking a systematic review of a health financing system and its performance on the basis of which to identify adequate changes to enhance the move towards universal coverage. The distinctive characteristic of this framework is the focus on institutional design and organizational practice of health financing, on which health financing performance is contingent. Institutional design is understood as formal rules, namely legal and regulatory provisions relating to health financing; organizational practice refers to the way organizational actors implement and comply with these rules. Health financing performance is operationalized into nine generic health financing performance indicators. Inadequate performance can be caused by six types of bottlenecks in institutional design and organizational practice [rule absence; inadequate rule; conflictive or non-aligned rule; weak rule enforcement; weak organizational capacity; dysfunctional inter-organizational relations]. Accordingly, six types of improvement measures are proposed to address these bottlenecks [rule setting; rule redesign; rule alignment; strengthening rule enforcement; strengthening organizational capacity; improving inter-organizational relationships]. The institutional design and organizational practice of a health financing system can be actively developed, modified or strengthened. By understanding the incentive environment within a health financing system, the potential impacts of the proposed changes can be anticipated.*

Source: [Mathauer, Inke & Guy Carrin. 2011. The role of institutional design and organizational practice for health financing performance and universal coverage. Health Policy Vol. 99, Issue 3 \(March\).](#)

GLOBAL HEALTH NEWS:

Tracking resources for women's and children's health

A newly formed Commission on Information and Accountability for Women's and Children's Health will track resources pledged to actual results. The Commission will provide evidence of which programmes are most effective in saving the lives of women and children and ensure that the money doesn't get swallowed up through inefficiency or corruption. [In this podcast, world leaders – including WHO Director General Margaret Chan and UN Secretary General Ban Ki Moon – provide details on the new Commission and explain its relevance to the development agenda.]*

Source: [_____ . 2011. Tracking resources for women's and children's health. World Health Organization online \(2 February\).](#)



RESEARCH ON HUMAN RESOURCES & MIGRATION OF HEALTH WORKERS:

Human resources for health in southeast Asia: Shortages, distributional challenges, and international trade in health services

The authors address the issues of shortage and maldistribution of health personnel in southeast Asia in the context of the international trade in health services. Although there is no shortage of health workers in the region overall, when analysed separately, five low-income countries have some deficit. All countries in southeast Asia face problems of maldistribution of health workers, and rural areas are often understaffed. Despite a high capacity for medical and nursing training in both public and private facilities, there is weak coordination between production of health workers and capacity for employment. Regional experiences and policy responses to address these challenges can be used to inform future policy in the region and elsewhere. A distinctive feature of southeast Asia is its engagement in international trade in health services. Singapore and Malaysia import health workers to meet domestic demand and to provide services to international patients. Thailand attracts many foreign patients for health services. This situation has resulted in the so-called brain drain of highly specialised staff from public medical schools to the private hospitals [...] Agreements about mutual recognition of professional qualifications for three groups of health workers under the Association of Southeast Asian Nations Framework Agreement on Services could result in increased movement within the region in the future. To ensure that vital human resources for health are available to meet the needs of the populations that they serve, migration management and retention strategies need to be integrated into ongoing efforts to strengthen health systems in southeast Asia. There is also a need for improved dialogue between the health and trade sectors on how to balance economic opportunities associated with trade in health services with domestic health needs and equity issues.*

Source: [Kanchanachitra, Churnrurtai, et al. 2011. Human resources for health in southeast Asia: shortages, distributional challenges, and international trade in health services. *The Lancet* online \(25 January\).](#)

Innovations in cooperation: A guidebook on bilateral agreements to address worker migration

This Guidebook provides an introduction to bilateral agreements, their legal status, and points to the heterogeneity and challenges present in relation to bilateral agreements serving as a solution to the issue of health worker migration. These challenges include the differing approaches to bilateral agreements necessary in relation to differing forms of national immigration policy and the failure in the past of bilateral agreements to fully engage with the concept of migration and development. There have, however, been recent innovations in developing comprehensive bilateral migration agreements that seek to simultaneously facilitate the movement of health workers and respond to the challenges associated with such migration [...] The Guidebook presents two bilateral agreement prototypes. They are relevant both to countries who recruit and facilitate admission through bilateral agreements and to countries who instead rely on 'quality-selective', 'non-discriminatory' immigration, as well as decentralized recruitment, policies. Model Bilateral Agreement I presents a comprehensive approach to managing health worker migration flows. It has been developed through collection and analyses of a significant variety of existing instruments. The model is useful both as a reflection of existing practice and also as a means to implement the recommendations presented in the WHO Global Code of Practice on the International Recruitment of Health Personnel. Model Bilateral Agreement II presents an innovative process of dialogue and cooperation for countries as yet unable to agree upon the precise measures to address the negative effects of health worker migration yet who intend to cooperate in a mutually supportive way.*†

Source: [Dhillon, Ibadat S, et al. 2010. Innovations in cooperation: A guidebook on bilateral agreements to address health worker migration. *Realizing Rights/Global Health & Development at the Aspen Institute* online \(May\).](#)



RESEARCH ON TRADE POLICY & HEALTH:

India-EU relations in health services: Prospects and challenges

India and the EU are currently negotiating a Trade and Investment Agreement which also covers services. This paper examines the opportunities for and constraints to India-EU relations in health services in the context of this agreement, focusing on the EU as a market for India's health services exports and collaboration [...] Twenty six semi-structured, in-person, and telephonic interviews were conducted in 2007-2008 in four Indian cities. The respondents included management and practitioners in a variety of healthcare establishments, health sector representatives in Indian industry associations, health sector officials in the Indian government, and official representatives of selected EU countries and the European Commission based in New Delhi. Secondary sources were used to supplement and corroborate these findings. The interviews revealed that India-EU relations in health services are currently very limited. However, several opportunity segments exist, namely: i) Telemedicine; ii) Clinical trials and research in India for EU-based pharmaceutical companies; iii) Medical transcriptions and back office support; iv) Medical value travel; and v) Collaborative ventures in medical education, research, training, staff deployment, and product development. However, various factors constrain India's exports to the EU. These include data protection regulations; recognition requirements; insurance portability restrictions; discriminatory conditions; and cultural, social, and perception-related barriers.*

Source: [Chanda, Rupa. 2011. India-EU Relations in Health Services: Prospects and Challenges. *Globalization and Health* Vol.7, No. 1 \(10 February\).](#)

GLOBAL HEALTH NEWS:

Globalisation and antibiotic resistance

The global spread of bacteria carrying the New Delhi metallo- β -lactamase-1 (NDM-1) enzyme through India, Pakistan, and the United Kingdom—and now half a dozen other countries—has sparked much media coverage. The outbreak's importance stems from the broad resistance to all antibiotics except tigecycline and colistin seen in bacterial strains carrying the gene for NDM-1 and from the ready transmission across borders [...] Modern advances in health care, from organ transplants to cancer chemotherapy, are reliant on effective antibiotics and vulnerable to resistance. Multidrug resistant strains are no longer an isolated phenomenon, nor confined by political borders [...] With a dearth of novel antibiotics in the pipeline, the conservation of existing ones is imperative. Infection control and rational antibiotic use are central to such efforts, but it is also susceptible to the failure of collective action. No hospital can remain an island if other community institutions are not doing their part in infection control. The spread of NDM-1 also suggests that globalisation has redefined the bounds of community. To tackle antibiotic resistance, all involved must “think globally, act locally.”*

Source:

[So, Anthony, et al. 2010. Globalisation and antibiotic resistance. *BMJ* Vol. 341:c5116 \(21 September\).](#)



RESEARCH ON INTELLECTUAL PROPERTY & HEALTH

The dog that barked but didn't bite: 15 years of intellectual property disputes at the WTO

Hope as well as fear was running wild when in 1995 the multilateral trading system incorporated the protection of intellectual property (IP) rights. As one author put it, 'the [IP] component of the World Trade Organization (WTO) Agreement represented a revolution in international intellectual property law'. This article provides a reality check 15 years after the fact with a particular focus on how the WTO performed in terms of settling IP disputes under the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS). It compares conventional expectations associated with the creation of TRIPS and WTO dispute settlement to: i) the number and types of TRIPS disputes actually filed and decided, ii) institutional and substantive decisions and interpretations reached by WTO Panels and the Appellate Body in their application of the TRIPS agreement and, finally, iii) the status of implementation of adverse WTO rulings under TRIPS. The article offers a number of hypotheses that may explain these descriptive results centred on: i) the rather unique features of WTO dispute settlement, ii) the TRIPS Agreement itself as compared to other trade agreements, and iii) an escalating cycle of IP-scepticism, due in no small part to the hard-line position taken by many IP industries themselves, and culminating in the 2001 Doha Declaration on TRIPS and Public Health which confirmed and slightly expanded TRIPS flexibilities in the context of the access to essential medicines debate.*

Source: [Pauwelyn, Joost. 2010. The Dog That barked But didn't Bite: 15 years of Intellectual Property Disputes at the WTO. *Journal of International Dispute Settlement* Vol. 1, Issue 2 \(August\).](#)

GLOBAL HEALTH NEWS:

Pharma backs calls for extension of TRIPS deadline for least-developed countries

Developed country pharmaceutical companies [on 10 February] announced their support for an extension of the deadline for poor countries to comply with a global trade agreement on intellectual property rights that would significantly raise their obligations to protect IP. The extension idea has been proposed by the United Kingdom government in a new trade strategy document. The Geneva-based International Federation of Pharmaceutical Manufacturers & Associations (IFPMA) said in a release that the research-based pharmaceutical industry supports calls to extend the deadline for least-developed countries to comply with the provisions of the World Trade Organization Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) [...] Least-developed countries had a transition period of 10 years, until 2005, to comply. Despite resistance from some developed countries, in 2005 least-developed countries were extended to 2013. [...] Now there is discussion about giving the poorest countries even more time to adopt TRIPS. A number of least-developed countries have requested technical assistance in adopting laws to match TRIPS, but it is questionable whether many would meet the 2013 target.*

Source: [New, William. 2011. Pharma Backs Calls For Extension Of TRIPS Deadline For Least-Developed Countries. *Intellectual Property Watch* online \(10 February\).](#)



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

Protecting HIV information in countries scaling up HIV services: a baseline study

Individual-level data are needed to optimize clinical care and monitor and evaluate HIV services. Confidentiality and security of such data must be safeguarded to avoid the stigmatization and discrimination of people living with HIV. [The authors] set out to assess the extent that countries scaling up HIV services have developed and implemented guidelines to protect the confidentiality and security of HIV information. Questionnaires were sent to UNAIDS field staff in 98 middle- and lower-income countries, some reportedly with guidelines (G-countries) and others intending to develop them (NG-countries). Responses were scored, aggregated and weighted to produce standard scores for six categories: *information governance*, *country policies*, *data collection*, *data storage*, *data transfer* and *data access*. Responses were analyzed using regression analyses for associations with national HIV prevalence, gross national income per capita, OECD income, receiving US PEPFAR funding, and being a G- or NG-country. Differences between G- and NG-countries were investigated using non-parametric methods. Higher *information governance* scores were observed for G-countries compared with NG-countries; no differences were observed between *country policies* or *data collection* categories. However, for *data storage*, *data transfer* and *data access*, G-countries had lower scores compared with NG-countries. No significant associations were observed between country score and HIV prevalence, per capita gross national income, OECD economic category, and whether countries had received PEPFAR funding. Few countries, including G-countries, had developed comprehensive guidelines on protecting the confidentiality and security of HIV information. Countries must develop their own guidelines, using established frameworks to guide their efforts, and may require assistance in adapting, adopting and implementing them.

Source: [Beck, Eduard J, et al. 2011. Protecting HIV information in countries scaling up HIV services: a baseline study. *Journal of the International AIDS Society* Vol. 14, No. 6 \(6 February\).](#)

GLOBAL HEALTH NEWS:

Supporting the Global Fund to fight fraud

[On 26 January] Germany's Development Minister, Dirk Niebel, announced that the country will suspend its payments to the Global Fund to Fight AIDS, Tuberculosis and Malaria until it gets answers about corruption allegations recently reported by the *Associated Press* (AP). AP had, in fact, re-reported last year's findings from the Global Fund's Inspector General's office—its own independent unit that was set up in 2005 to fight fraud—which found that Fund grants had been misused in Djibouti, Mali, Mauritania, and Zambia. The [Inspector General's] report was published online in October, 2010, with a response from the Fund. In total, the Fund is demanding the recovery of a relatively small amount of its disbursements—US\$34 million from these and other countries, out of a total of \$13 billion disbursed. It has also stopped, suspended, or safeguarded the relevant grants, and is assisting national authorities with criminal investigations and proceedings to ensure those responsible for the fraud are brought to justice. [In light of this robust response, Germany's move seems heavy handed, especially because the Fund, the world's main financier of AIDS, tuberculosis, and malaria programmes, is already facing a \$7—8 billion funding shortfall. Even more baffling is the timing of the announcement, which followed the AP report rather than the official release of the Inspector General's findings last year, which the Fund says Germany was informed about. Corruption occurs in all countries, rich and poor, but thrives in environments where checks on those entrusted with power are loose, civil society is poorly represented, poverty is entrenched, and inequalities are vast. Germany should engage in debates about how to tackle these problems rather than taking measures that seem tough on corruption but will ultimately cost lives].*

Source: [The Lancet. 2011. Supporting the Global Fund to fight fraud. *The Lancet* Vol. 377, Issue 9764 \(5 February\).](#)



RESEARCH ON GLOBAL ACTION ON NON-COMMUNICABLE DISEASES:

Getting the politics right for the September 2011 UN High-level Meeting on Noncommunicable Diseases

The UN General Assembly's decision to convene a "high-level meeting on the prevention and control of noncommunicable diseases (NCDs) worldwide" in September 2011 creates a major, timely opportunity to elevate chronic diseases onto the global stage. Just as the 2011 UN General Assembly Special Session on HIV/AIDS was a pivotal moment in the global response to AIDS, there is hope that the September session on NCDs can become a historic rallying point. But we need to be realistic. Time to prepare adequately is short. NCDs do not enjoy many of the advantages that helped propel AIDS to become a global priority. High-level leadership is thus far missing, and the odds are long that the September meeting will have a transformative impact. Important gains are indeed possible in September but only with disciplined pragmatism and urgent, focused action to seize the moment. First, there is the urgent need to focus advocacy efforts on four disease areas – cancer, cardiovascular disease, chronic respiratory disease, and diabetes. At the same time, attention needs to be concentrated on common risk factors for the four diseases – tobacco use, unhealthy diet, physical inactivity, harmful use of alcohol, environmental carcinogens, and indoor and outdoor pollution. Global tobacco control can and should be a lead engine. Second, there is an urgent need to improve the packaging and delivery of key data to reach a nontechnical audience. Third, there is the need for tough-minded realism and quick action to generate far more robust political leadership. It is critical both to take account of the special challenges facing the NCD sector and leverage strategically the special political assets that are at hand: notably the UN secretary general, the WHO director general, and the NCD alliance. Fourth, there is the need for clear, feasible, and measurable goals that governments and their citizens can work toward achieving in coming years.*†

Source: [Sridhar, Devi, et al. 2011. Getting the politics right for the September 2011 UN High-Level Meeting on Noncommunicable Diseases. CSIS online \(15 February\).](#)

GLOBAL HEALTH NEWS:

Moscow Conference puts global focus in NCDs

[From 28-29 April 2011, Moscow will host the *First global ministerial conference on healthy lifestyles and noncommunicable disease control.*] The conference is jointly organized by the Russian Federation and WHO and takes place 28-29 April 2011. Its aim is to support Member States develop and strengthen policies and programmes on healthy lifestyles and NCD prevention. These efforts are based on the *Global strategy for the prevention and control of NCDs and its action plan*, which include multisectoral and innovative approaches in prevention and care [...] The conference is also being held in the lead up to the United Nations General Assembly High-level Meeting on the Prevention and Control of Noncommunicable Diseases on 19-20 September 2011.*

Source: [_____ . 2011. Moscow conference puts global focus on NCDs. World Health Organization online \(February\).](#)



HEALTH & FOREIGN POLICY BULLETIN

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

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