HEALTH & FOREIGN POLICY

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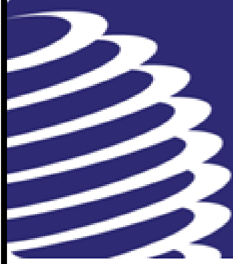
Research on Global Health Security:

The United States Department of Defence and the International Health Regulations (2005): Perceptions, pitfalls, and progress towards implementation

Shortly after the onset of the [H1N1] pandemic, the Armed Forces Health Surveillance Center began coordinating public health centres and laboratories of the United States' Navy, Army and Air Force to aggressively respond to this new threat among beneficiaries and active duty service members worldwide. An initial area of concern quickly became identifying the responsible party and appropriate mechanism for reporting laboratory-confirmed cases of novel influenza A/H1N1 among United States military personnel stationed in foreign countries, in compliance with the International Health Regulations (2005) (IH). Interactions between medical units of the United States military and the corresponding host countries' Ministries of Health varied widely based on established formal and informal arrangements, the nature of current missions and the host country's requirements for reporting routine medical events during outbreaks of disease and other public health emergencies. Where a collaborative relationship was established with host country counterparts, reporting of pandemic influenza A/H1N1 cases to the host country Ministry of Health was rather seamless. In cases where a relationship did not exist, and for all individuals overseas who were diagnosed through Department of Defense reference laboratories, cases were reported through the different Department of Defense service public health hubs to the Armed Forces Health Surveillance Center. Detailed case lists were then compiled and submitted to the United States Department of Health and Human Services, the designated national focal point for IHR reporting. Reports were then sent by this Department through the WHO regional offices and to the national focal points in the corresponding host country per Articles 6 and 9 of the IHR.*†

Source:
Johns, Matthew, et al. 2011. The United States Department of Defense and the International Health Regulations (2005). *Bulletin of the World Health Organization*. Vol. 89, No. 3 (March).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GLOBAL HEALTH NEWS:

Draft Report of the Review Committee on the Functioning of the International Health Regulations (2005) and on Pandemic Influenza A (H1N1) 2009

In January 2010, at its 126th session, WHO's Executive Board welcomed the Director-General's proposal to convene a Review Committee provided for in Chapter III of Part IX of the International Health Regulations 2005 (IHR). The Director-General's proposal included a request for the Committee to review the experience gained in the global response to the influenza A (H1N1) 2009 pandemic, in order to inform the review of the functioning of the Regulations; to help assess and, where appropriate, to modify the ongoing response; and to strengthen preparedness for future pandemics. [...] The Review Committee offers three overarching conclusions: 1) The IHR helped make the world better prepared to cope with public health emergencies. The core national and local capacities called for in the IHR are not yet fully operational and are not now on a path to timely implementation worldwide. 2) WHO performed well in many ways during the pandemic, confronted systemic difficulties and demonstrated some shortcomings. The Committee found no evidence of malfeasance. 3) The world is ill-prepared to respond to a severe influenza pandemic or to any similarly global, sustained and threatening public health emergency. Beyond implementation of core public health capacities called for in the IHR, global preparedness can be advanced through research, strengthened health-care delivery systems, economic development in low- and middle-income countries and improved health status.*

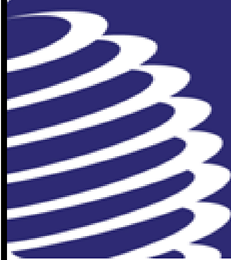
Source: Review Committee on the Functioning of the International Health Regulations (2005) and on Pandemic Influenza A (H1N1) 2009. 2011. Draft Report of the Review Committee on the Functioning of the International Health Regulations (2005) and on Pandemic Influenza A (H1N1) 2009. Draft Report. *World Health Organization* online (7 March).

RESEARCH ON HEALTH & STATES IN CRISIS/CONFLICT:

Transmission dynamics and control of cholera in Haiti: An epidemic model

Official projections of the cholera epidemic in Haiti have not incorporated existing disease trends or patterns of transmission, and proposed interventions have been debated without comparative estimates of their effect. [The authors] used a mathematical model of the epidemic to provide projections of future morbidity and mortality, and to produce comparative estimates of the effects of proposed interventions. [They] project 779 000 cases of cholera in Haiti (95% CI 599 000—914 000) and 11 100 deaths (7300—17 400) between March 1 and November 30, 2011 [and] expect that a 1% per week reduction in consumption of contaminated water would avert 105 000 cases (88 000—116 000) and 1500 deaths (1100—2300). [The authors also] predict that the vaccination of 10% of the population, from March 1, will avert 63 000 cases (48 000—78 000) and 900 deaths (600—1500). The proposed extension of the use of antibiotics to all patients with severe dehydration and half of patients with moderate dehydration is expected to avert 9000 cases (8000—10 000) and 1300 deaths (900—2000). A decline in cholera prevalence in early 2011 is part of the natural course of the epidemic, and should not be interpreted as indicative of successful intervention. Substantially more cases of cholera are expected than official estimates used for resource allocation. Combined, clean water provision, vaccination, and expanded access to antibiotics might avert thousands of deaths.*

Source: Andrews, Jason R. & Sanjay Basu. 2011. Transmission dynamics and control of cholera in Haiti: an epidemic model. *The Lancet* online (16 March).



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GLOBAL HEALTH NEWS:

Japan: The aftermath

In the immediate aftermath, the aid and medical response to the earthquake and tsunami that struck Japan on March 11 has been complicated by the sheer scale of the devastation, widespread damage to supply routes, and concerns about radiation leaks from the stricken [Fukushima Daiichi] nuclear power plant. As emergency supplies of fuel, water, food, blankets, and other essentials finally began to get through to the estimated 350 000 people living in 2500 evacuation centres in the northeast of the island, officials were issuing reassurances about food, milk, and tap water found to have been contaminated with radioactive iodine-133. Just over 1 week after the magnitude 9.0 earthquake unleashed a powerful tsunami that washed away entire communities on the coasts of Iwate, Miyagi, and Fukushima prefectures, Japan is only just beginning to comprehend the scale of the humanitarian crisis in its midst. Japan's police agency says that the death toll has reached 8649, with 12 877 people still missing. But with authorities in Miyagi reporting more than 15 000 people missing in their jurisdiction alone, the final total is expected to be much higher.*

Source: ________. 2011. Japan: the aftermath. *The Lancet* online (22 March).

RESEARCH ON HUMAN RIGHTS & GLOBAL HEALTH:

Human rights consequences of mandatory HIV screening policy of newcomers to Canada

This paper focuses on the key human rights consequences of the HIV screening policy that applies to all permanent and some temporary resident applicants to Canada. This mandatory policy was introduced in early 2002 by Citizenship and Immigration Canada after consultation with Health Canada. The policy has yet to be evaluated and, until recently, the actualities of the medical encounters where testing occurs in domestic and international settings have not been researched. There is no systematic documentation of the policy's implications on either the lives of persons who submit to mandatory testing or on health systems. This article argues that there are sound options for responding to the human rights challenges posed by the screening policy [and concludes by proposing four recommendations: 1) clarify objectives and goals of the HIV testing policy; 2) evaluate the functioning of the mandatory screening policy; 3) monitor the policy using public health, ethics, and human rights approaches; 4) provide stable funding for domestic social science research on HIV/AIDS and immigration].*†

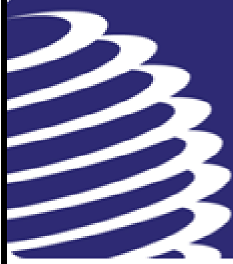
Source: Meier, Benjamin Mason & Alicia Ely Yamin. 2011 Right to Health Litigation and HIV/AIDS Policy. *The Journal of Law, Medicine & Ethics* Vol. 39, Issue Supplement s1 (Spring).

GLOBAL HEALTH NEWS:

Withholding medical care from detainees is widespread, says UN

Denying medical treatment to detainees, especially victims of torture and prisoners with serious illnesses, can constitute cruel and inhumane treatment, says a United Nations independent expert on torture. A report presented to the UN's Human Rights Council documents individual cases of detainees who were not given urgent medical care in many countries, including China, Italy, Iraq, Iran, Libya, Kazakhstan, Moldova, Burma (Myanmar), Russia, Saudi Arabia, and Ukraine. Some of the detainees died in custody, it says. Juan Méndez, the UN's special rapporteur on torture, said that he is also "deeply concerned" by the large number of places of detention that do not meet minimum international standards, including conditions relating to food, healthcare, minimum space, and hygiene. […] Mr Méndez said he was aware that some states don't have the facilities to provide the necessary care and that in those circumstances provision should be made to treat people in regular hospitals and medical facilities.*

Source: Zarcostas, John. 2011. Withholding medical care from detainees is widespread, says UN. *BMJ* 342: d1626 (14 march).



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RESEARCH ON GLOBAL HEALTH GOVERNANCE & INSTITUTIONS:

Global food safety: Exploring key elements for an international regulatory strategy

The two most striking examples of global foodborne illnesses — the case of BSE-vCJD [Mad Cow disease] and the case of melamine-contaminated products from China — show how food safety crises permeate national boundaries and demonstrate the lack of current institutional capacity to handle future crises. […] National legislation and regulation alone are insufficient to address global food safety problems. Furthermore, the sole reliance on private forms of governance to regulate cross-border food-supply chains is similarly an unsatisfactory answer to the complex problem. Instead, effective regulatory strategy must go beyond the use of such unilateral measures. Scrutinizing the mandates, efforts, and influences of relevant international institutions, this Article argues that current international institutions fail to provide a comprehensive and effective regulatory strategy to ensure global food safety. It further proposes […] the essential regulatory elements for future reform in global food safety strategies. Emphasizing the importance attributable to the WHO's use of law in global food safety governance, this article concludes by pointing out a possible way to incorporate these key regulatory elements into an effective international regulatory strategy — a framework convention protocol approach. This incremental approach to international rulemaking is a practical channel for developing a political and scientific consensus, for synergizing the strengths of states and nonstate actors, and for producing effective and efficient global food safety regulation. *†

Source: Lin, ching-Fu. 2011. Global Food Safety: Exploring Key Elements for an International Regulatory Strategy. *Virginia Journal of International Law*. Vol. 51, Issue 3 (29 January).

GLOBAL HEALTH NEWS:

Global Fund names co-chairs to lead review

The Global Fund to Fight AIDS, Tuberculosis and Malaria has named a former senior U.S. government official and Botswana's former president to co-chair an external review of its financial systems, amid heightened scrutiny from donors over misuse of some grants and a potential funding reduction from the U.S. On Tuesday [15 March], the Global Fund named Michael Leavitt and Festus Mogae to co-chair a panel that will review its mechanisms for disbursements of grant money, potentially recommending improvements. The panel is meant to provide reassurance to donors and will report its findings within a few months, said its executive director, Michel Kazatchkine. […] The large international financier of drugs and programs to combat the three killer diseases suspended grants or implemented new safeguards in four countries—Zambia, Mali, Djibouti, and Mauritania—after uncovering evidence last year of fraudulent invoices for training, payments to suspicious vendors, and other incidents of misuse. […] The appointment of Mr. Leavitt, a former Republican governor of Utah who held two cabinet positions under George W. Bush, puts a seasoned U.S. expert in politics, management, and global health on the panel.*

Source:
McKay, Betsy. 2011. Global Health Fund Names Co-Chairs to Lead Review. *Wall Street Journal* online (15 March).

RESEARCH ON HEALTH & DEVELOPMENT, HEALTH SYSTEMS:

Health policy and systems research: Defining the terrain; identifying the methods

The much greater attention now being given to health systems is helping to highlight knowledge gaps and encourage greater emphasis on Health Policy and Systems Research (HSPR). Funding has increased in recent years, and a number of areas within HPSR are receiving increased attention, notably systematic reviews and impact evaluation. Beyond the immediate methodological development needs of HPSR, three main challenges stand out. Firstly, based on personal interactions with traditional research funders, it is clear that they fear that HPSR does not produce generalizable findings, and hence may not be worthy of support. [...] Greater methodological development of comparative studies [...] would help address the concern of generalizability, but it is also important to build up an advocacy case, based on examples of high quality comparative research such as comparative case studies of particular issues. Secondly, the generally poor quality of HPSR [...] highlights the need to invest in capacity development of researchers and their institutions, as well as in the knowledge base of research methods. Part of this will involve training, but as important is likely to be experience and learning by doing. Finally, given the policy-orientation of HPSR, and the common criticism that HPSR knowledge is not well orientated to the needs of policy makers or well communicated to them, structures and mechanisms are needed which link the policy-making and research communities to agree research priorities and identify research questions.*†

Source: Mills, Anne. 2011. Health policy and systems research: defining the terrain; identifying the methods. *Health Policy and Planning* Vol. 26, No. 2 (March).

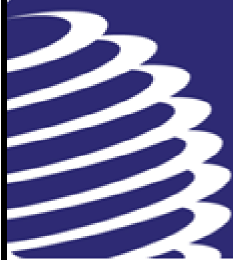
GLOBAL HEALTH NEWS:

Oxfam warns countries not to copy Ghana's "flawed" health insurance

Ghana's new health insurance scheme benefits far fewer people than is claimed and should not be held up by the World Bank as a model for expanding free universal healthcare in other low and middle income countries, says a new report by Oxfam [titled 'Achieving a Shared Goal']. Rather than two thirds of the population being covered by the scheme, as Ghana's National Health Insurance Authority and the World Bank have claimed, less than a fifth of Ghanaians could be benefiting, the charity says. Its report claims that most people have to continue to pay out of their own pockets for their healthcare. An Oxfam health policy adviser, Anna Marriott, told the BMJ that despite every citizen contributing towards the health insurance scheme through value added tax (VAT), only 18% of the population are currently valid members.*

Source: Moszynski, Peter. 2011. Oxfam warns not to copy Ghana's "flawed" health insurance scheme." *BMJ* 342: d1630 (11 March).

See Also: Apoya, Patrick & Anna Marriott. 2011. Achieving a Shared Goal: Free universal health care in Ghana. *Oxfam International* online (9 March).



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RESEARCH ON HUMAN RESOURCES & MIGRATION OF HEALTH WORKERS:

Cross-border mobility of health professionals: Contesting patients' right to health

Cross-border labour mobility in the health sector is portrayed as both an opportunity for health professionals immigrating to developed countries, and as a challenge for patients remaining in low-income countries with restricted access to health care provision. In policy debates, this problem is articulated as the opposition between, 'the right to freedom of movement' and 'the right to health'. The underlying layers of this dilemma expose competing institutional interests for source and destination countries, international organisations, private recruitment agencies, trade unions and professional organisations. To resolve some of these tensions, a 'soft law' regulation (ethical recruitment policy) was adopted in the UK in the early 2000s. This article argues that this ethical recruitment policy produces an ambivalent effect. Ethical recruitment on the one hand proposes a practical mechanism to the realisation of the right to health in source countries, through encouraging employers' behaviour in accordance with ethical principles in international recruitment. On the other hand, this policy protects the reputation of institutional stakeholders, changing the rhetoric around international recruitment rather than the practice.*

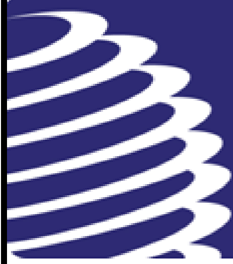
Source: Plotnikova, Evgeniya Vadimvna. 2011. Cross-border mobility of health professionals: Contesting patients' right to health. *Social Science & Medicine* online (3 March).

GLOBAL HEALTH NEWS:

US funding to train 140,000 African health workers

The United States will fund training for 140,000 African health care workers in an initiative to "transform and dramatically increase" medical education on the continent, the top US AIDS official announced Tuesday [8 March 2011]. Ambassador Eric Goosby said the plan will bring partnerships between African and U.S. medical schools by "really fostering and strengthening a collegial network" to empower medical professionals on the continent that shoulders the worst of the world's HIV-AIDS epidemic and its heaviest load of other chronic diseases. He said he hoped it also would help stem, and even reverse, the brain drain of doctors and nurses who receive expensive, subsidized training in Africa, only to be recruited to work overseas amid a worldwide shortage of health professionals. […] Some $130 million from the U.S. President's Emergency Plan for AIDS Relief and the National Institutes of Health will be awarded as grants over five years to medical schools across sub-Saharan Africa to work with partner schools in the United States.*

Source: Faul, Michelle. 2011. US funding to train 140,000 African health workers. *Bloomberg Businessweek* online (8 March).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RESEARCH ON TRADE POLICY & HEALTH:

The North American Free Trade Agreement (NAFTA) and Mexican nursing

In the context of nurse migration, experts view trade agreements as either vehicles for facilitating migration or as contributing to brain-drain phenomena. Using a case study design, this study explored the effects of the North American Free Trade Agreement (NAFTA) on the development of Mexican nursing. Drawing results from a general thematic analysis of 48 interviews with Mexican nurses and 410 primary and secondary sources, findings show that NAFTA changed the relationship between the state and Mexican nursing. The changed relationship improved the infrastructure capable of producing and monitoring nursing human resources in Mexico. It did not lead to the mass migration of Mexican nurses to the United States and Canada. At the same time, the economic instability provoked by the peso crisis of 1995 slowed the implementation of planned advances. Subsequent neoliberal reforms decreased nurses' security as workers by minimizing access to full-time positions with benefits, and decreased wages.*

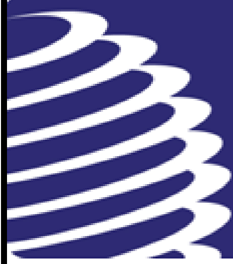
Source: Squires, Allison. 2011. The North American Free Trade Agreement (NAFTA) and Mexican Nursing. *Health Policy and Planning*. Vol. 26, No. 2 (March).

GLOBAL HEALTH NEWS:

US officials pushed products deemed unsafe by China

In 2007, two U.S. Congressmen privately admonished a Chinese official about the sudden spike in potentially harmful made-in-China products being shipped around the world, according to a cable from the U.S. embassy in Beijing obtained by WikiLeaks. [...] Two years later, the cables show, the same U.S. Congressmen – Mark Kirk, then a House Republican from Illinois, and Rick Larsen, a Democrat from Washington – returned to Beijing, only this time they had an entirely different message. Kirk and Larsen asked Chinese officials to look the other way as an American company failed to meet regulations restricting the use of a toxic chemical in medical equipment sold to Chinese hospitals. The company, Baxter Healthcare, was making blood bags for intravenous delivery using polyvinyl chloride (PVC), a plastic softener that has been banned in some other parts of the world. A chemical found in PVC has been shown to build up in humans, causing developmental defects in children, among other things.*

Source: Flitter, Emily. 2011. U.S. officials pushed products deemed unsafe by China. *Reuters* online (9 March).



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Research on Intellectual Property & Health

An elementary consideration of humanity? Linking trade-related intellectual property rights to the human right to health in international law

This paper explores methods of achieving linkage in international law between the human right to health and the World Trade Organization (WTO) Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS). It explores the relevance to this question of international law's accepted hierarchies, namely *jus cogens* (peremptory norms), *ergo omnes* duties (duties "owed to all") and section 103 of the United Nations (UN) Charter. It argues that these rules collectively prohibit gross violations of any rights including health, and place reasonable limits on all human conduct (including trade) to protect human health and life. It turns to historical support for these assertions, including recent *de facto* recognition that access to AIDS medicines in Sub-Saharan Africa presents a legitimate exception to TRIPS rights. The paper further explores interpretive methods in international law for recognizing the prioritized value of human life and health within existing WTO law and dispute settlement processes […] It concludes that raising health's priority requires a substantive reordering of the normative priorities that drive trade rules. It suggests that a practical strategy for raising the priority of health within decision making by WTO dispute settlement panels and domestic governments is to advance legal argument about health's appropriate location within international law's existing hierarchies.

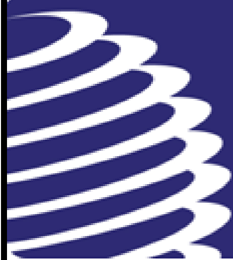
Source: Forman, Lisa. 2011. An elementary consideration of humanity? Linking trade-related intellectual property rigts to the human right to health in international law. *The Journal of World Intellectual Property* online (4 March).

Global Health News:

MSF questions GAVI vaccine deal

Médecins Sans Frontières (Doctors without Borders) has questioned why two drugs companies are to receive millions of dollars in a vaccine deal being branded as a huge breakthrough for poor countries. The Global Alliance for Vaccines and Immunisation (GAVI) announced last month that thousands of infants in Kenya would receive their first shots against pneumococcal diseases as part of a global roll-out of vaccines targeting the world's biggest child killer - pneumonia. GAVI revealed at the time that 19 developing countries (excluding South Africa) would have access to the vaccine within a year and if the alliance secures further funding, to more than 40 countries by 2015. However, MSF revealed that GlaxoSmithKline (GSK) and Pfizer/Wyeth were receiving a significant subsidy, funded by donor governments, in order to secure their participation in the scheme. The companies have each agreed to sell 30 million doses annually for 10 years in exchange for US$3.50 per dose, plus a total subsidy of US$225-million for each company. However, MSF said the deal was shortchanging emerging country suppliers who have said they could sell similar pneumococcal vaccine products at U$2 per dose, more than 40% less than the price currently paid by GAVI.*

Source: Thom, Anso. 2011. MSF Questions Gavi Vaccine Deal. *allAfrica.com* online (3 March).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RESEARCH ON RESPONSE TO HIV/AIDS, TUBERCULOSIS & MALARIA:

The social determinants of tuberculosis: From evidence to action

Growing consensus indicates that progress in tuberculosis control in the low- and middle-income world will require not only investment in strengthening tuberculosis control programs, diagnostics, and treatment but also action on the social determinants of tuberculosis. However, practical ideas for action are scarcer than is notional support for this idea. [The authours] developed a framework based on the recent World Health Organization Commission on Social Determinants of Health and on current understanding of the social determinants of tuberculosis. Interventions from outside the health sector—specifically, in social protection and urban planning—have the potential to strengthen tuberculosis control. […] Gaps still exist in our understanding of the extent to which socioeconomic determinants drive the current TB epidemic, the underlying processes linking socioeconomic determinants to TB, and how to best address these determinants. However, [they] believe that taking TB control forward is both desirable and possible and that current recognition of the importance of addressing the social determinants of health provides a real opportunity to expand the current paradigm for TB control. Key to success will be the capacity to design research in which different disciplines can develop a shared approach and common conceptual framework. A great deal will be learned as partnerships involving actors from within and beyond the health sector conduct rigorous evaluations of the impact of economic and development aid programs on TB control.*†

Source: Hargreaves, James R., et al. The social determinants of tuberculosis: From evidence to action. American *Journal of Public Health*. Vol. 101, No. 4 (April).

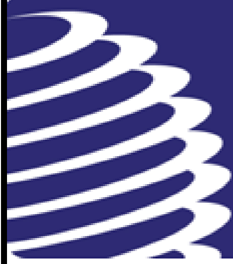
GLOBAL HEALTH NEWS:

UN fears for long-term AIDS treatment

[The] Aids treatment programmes that have been so painstakingly and devotedly put in place and are saving the lives of millions of people with HIV in poor countries are under threat. [According to] Paul De Lay, deputy executive director of UNAIDS, "We are seriously concerned about the future of HIV treatment programmes. Only about one-third of people in need have access to treatment. In the current economic climate even sustaining that over the long term will be a challenge. There are 5.2 million people in developing countries on antiretroviral medication that keeps HIV under control and allows them to live a normal life, working and looking after their family. They make up only a third of those who need the drugs – 15 million are estimated to need medication now and more will need it in due course." But instead of the planned expansion, the treatment programmes are even now beginning to shrink. [...] There are real worries now that people already on the drugs, who need to take them for life unless a cure is found, may not be able to get the supply they need. If that happens and they stop for a while, the virus in their body will develop resistance to the drugs they were on and they will need a different combination of drugs, known as second line. And these are more expensive.*

Source: Boseley, Sarah. 2011. UN fears long-term Aids treatment. *Guardian.co.uk* online (15 March).

See Also: __________. 2011. 2011 United Nations High-Level Meeting on AIDS (8-10 June). *World Health Organization*.



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RESEARCH ON GLOBAL ACTION ON NON-COMMUNICABLE DISEASES:

Global health governance and the challenges of chronic, non-communicable diseases

David Stuckler, Corinna Hawkes, and Derek Yach argue that the governance of chronic disease should be understood as "the dynamic relationship between the burden of disease and the complete set of civil society, private sector, non-governmental organization, nation-state and other national and transnational institutional responses." […] This paper [attempts] to demonstrate why global responses are required and to outline a simple framework for mapping and understanding the role of specific initiatives. [Four primary reasons are provided as to why Non-Communicable Diseases merit a collective, global response: 1) governments around the world are facing similar national challenges in respect to NCDs; 2) the determinants that contribute to rates of NCDs in society are transnational in scope; 3) developing countries face resource constraints in financial, material, technical, and human terms for coping with NCDs; and 4) the emergence of new initiatives focused on the goals of NCD prevention/treatment point to the urgent need for an over-arching global response to signal priorities, identify gaps, and evaluate progress.] By seeking to identify global public health functions, [the paper emphasizes] that global leadership and governance is required and that national responses, by themselves, cannot ensure an efficient or effective response. At the same time, without downplaying the central role that WHO must play, it is important that NCD prevention should become, as far as possible, a shared project of the international community rather than another branch of WHO's activities.*†

Source: Magnusson, Roger S. 2010. Global Health Governance and the Challenge of Chronic, Non-Communicable Disease. *Law, Medicine & Ethics*. Vol. 38, Issue 3 (Fall).

GLOBAL HEALTH NEWS:

NCD Alliance proposes draft outcome document for successful UN Summit on Non-Communicable Diseases

Practical, achievable actions to turn the tide of a global epidemic of non-communicable diseases are today [22 March 2011] published by the NCD Alliance. The actions are set out in a Proposed outcome document that represents the NCD Alliance's proposals for a successful UN High-Level Summit on NCDs to be held in New York this September. Expert thinking and extensive experience in dealing with cancer, cardiovascular disease, chronic respiratory disease and diabetes have been brought together to develop 34 recommendations with the overall aim of reducing deaths by NCDs by two per cent a year. The Summit is only the second in the UN's history to be held on a health-related issue. The first one, held in 2001 on HIV/AIDS, is largely credited with garnering the political will and resources to turn around the AIDS crisis.*

Source: ________. 2011. NCD Alliance unveils ground-breaking document for successful UN Summit on Non-communicable Diseases. *The NCD Alliance* online (22 March).

See Also: ________. 2011. The NCD Alliance: Putting non-communicable diseases on the global agenda. *NCD Alliance* online (22 March).

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