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*RESEARCH ON GLOBAL HEALTH SECURITY:*

### The Public's Response to the 2009 H1N1 Influenza Pandemic

In April 2009, a novel influenza A (H1N1) virus emerged in the United States (US) and within weeks it had spread to every region in the country. Given the crucial role the public plays in containing and spreading an illness, the authors examined the US public's reaction to the pandemic and the public health response. This was achieved through a comprehensive review of available data from national public opinion polls conducted by telephone between April 2009 and January 2010. The authors find two key factors that deterred individuals from being vaccinated. First, safety concerns; although 87% of the public believed the H1N1 influenza vaccine was either "very safe" or "somewhat safe," only 33% believed it was "very safe." Second, concern about getting sick with H1N1 declined over time: the proportion of people who were concerned about getting sick dropped from a peak between 51% and 59% in October and November, to 40% by mid-December. Throughout the H1N1 pandemic, more than half the population appeared to have a positive impression of the US government's response. However, the public did express two concerns. First, some people noted displeasure with the national vaccine shortage. Second, concerns were raised about public health officials' efforts to make sure the H1N1 vaccine was safe early in the distribution process.

Source: SteelFisher, Gillian K, et al. 2010. The Public's Response to the 2009 H1N1 Influenza Pandemic. *NEJM* online (19 May).

<http://content.nejm.org/cgi/content/full/NEJMp1005102>



**GLOBAL HEALTH NEWS:**

## **Report of the First Meeting of the Review Committee on the Functioning of the International Health Regulations (2005) in Relation to Pandemic (H1N1) 2009**

In January 2010, the WHO Executive Board requested a proposal from the Director-General to assess the international response to pandemic influenza A(H1N1), and later approved her suggestion to convene the International Health Regulation (IHR) Review Committee to review both the pandemic response and the functioning of the IHR. The Committee has three key objectives: 1) assess the functioning of the International Health Regulations (2005); 2) assess the ongoing global response to the pandemic H1N1; and 3) identify lessons for strengthening preparedness and response for future pandemics/public health emergencies. The Committee held its first meeting 12-14 April 2010. At the meeting, the Chair proposed a tentative schedule for the Committee's work; this involves holding a second meeting in late June 2010 and a third meeting in late September 2010. A final report will be presented by the Review Committee to the Sixty-fourth World Health Assembly in May 2011.

Sources:

First Meeting of the Review Committee on the Functioning of the International Health Regulations (2005) in Relation to Pandemic (H1N1) 2009. 2010. Report of the First Meeting of the Review Committee on the Functioning of the International Health Regulations (2005) in Relation to Pandemic (H1N1) 2009. *World Health Organization* (14 April).

[http://www.who.int/ihr/r\\_c\\_meeting\\_report\\_1\\_en.pdf](http://www.who.int/ihr/r_c_meeting_report_1_en.pdf)

\_\_\_\_\_. 2010. How will the global response to the pandemic H1N1 be reviewed? *World Health Organization* online (12 April)

[http://www.who.int/csr/disease/swineflu/frequently\\_asked\\_questions/review\\_committee/en/index.html](http://www.who.int/csr/disease/swineflu/frequently_asked_questions/review_committee/en/index.html)

**RESEARCH ON HEALTH & STATES IN CRISIS/CONFLICT:**

## **A case study of health sector reform in Kosovo**

The impact of conflict on population health and health infrastructure has been well documented; however the efforts of the international community to rebuild health systems in post-conflict periods have not been systematically examined. Based on a review of relevant literature, this paper develops a framework for analyzing health reform in post-conflict settings, and applies this framework to the case study of health system reform in post-conflict Kosovo. The paper examines two questions: first, the selection of health reform measures; and second, the outcome of the reform process. It measures the success of reforms by the extent to which reform achieved its objectives. Through an examination of primary documents and interviews with key stakeholders, the paper demonstrates that the external nature of the reform process, the compressed time period for reform, and weak state capacity undermined the ability of the success of the reform program.

Source: Percival, Valerie, and Egbert Sondorp. A case study of health sector reform in Kosovo. *Conflict and Health* Vol. 4, No. 7 (16 April).

<http://www.conflictandhealth.com/content/4/1/7/abstract>



**GLOBAL HEALTH NEWS:**

**More than 60 States Endorse the Oslo Commitments on Armed Violence**

To galvanize movement on the Oslo Commitments on Armed Violence, and call for more countries to join, the Norwegian Ministry of Foreign Affairs and the United Nations Development Programme (UNDP) co-hosted a global meeting on armed violence in Geneva (12 May 2010), aimed at making the reduction of armed violence a top issue on the global development agenda. More than 60 countries agreed to concrete measures to address armed violence. Systematic monitoring and measurement of armed violence, integration of efforts to combat armed violence into development plans at all levels of government and recognition of victims' rights are key elements.

*Sources*

The Oslo Commitments on Armed Violence, 2010. (12 May)

<http://www.osloconferencearmedviolence.no/pop.cfm?FuseAction=Doc&pAction=View&pDocumentId=24790>

United Nations Development Programme. 2010. Armed Violence Threatens Progress on Millennium Development Goals. *ReliefWeb* online (12 May).

<http://ocha-gwapps1.unog.ch/rw/rwb.nsf/db900SID/MUMA-85E4GL?OpenDocument>

**GLOBAL HEALTH NEWS:**

**Aid groups urge Haiti reconstruction body to adopt light touch**

International aid groups responding to Haiti's January earthquake fear that a commission being set up to manage the reconstruction process may create a bottleneck that will hamper their work. Haiti's parliament approved the creation of the body in mid-April, but it is not expected to be up and running for at least another two or three months. The joint commission – to be co-chaired by the UN special envoy for Haiti, former US President Bill Clinton, and Haitian Prime Minister Jean-Max Bellerive – will decide which reconstruction projects will receive funding from donor pledges of more than \$5 billion for the next two years. One of the commissions' key aims is to improve the transparency and governance of aid spending. But international NGOs have argued that if the commission is required to approve every reconstruction project it could delay urgent work to rebuild the shattered country. They are lobbying instead for the body to approve aid groups' broader strategies and programmes – on health or shelter – which would allow them the flexibility to move money around and respond to changing circumstances.

*Source:* Rowling, Megan. 2010. Aid groups urge Haiti reconstruction body to adopt light touch. *ReliefWeb* online (7 May).

<http://www.reliefweb.int/rw/rwb.nsf/db900sid/VDUX-858RRW?OpenDocument&rc=2&emid=EQ-2010-000009-HTI>



**RESEARCH ON HUMAN RIGHTS & GLOBAL HEALTH:**

### **Uganda: Protect, Don't Punish People with HIV**

Uganda has long received praise for its successful handling of the HIV/AIDS pandemic in the 1990s, when it engaged civil society in its prevention efforts and worked to reduce the stigma of the disease. Prevalence rates declined as a result of government policies that promoted the empowerment of civil society, frank discussions of HIV transmission, pragmatic emphasis on comprehensive HIV prevention strategies, and improved access to treatment. However, recent evidence suggests that HIV incidence and prevalence have increased in Uganda. The HIV/AIDS Prevention and Control Bill, introduced 19 May 2010, threatens to worsen this trend. In violation of fundamental principles of consent, the bill would discourage voluntary HIV testing while making testing mandatory for pregnant women. Mandatory testing undermines the rights of women and girls to security of their person, does not meet the consent requirement set out in medical ethics and international human rights law, and is discriminatory. Combined with the bill's grant of discretion to medical practitioners to disclose an individual's status to other parties, the law exposes women to intimate partner violence and abandonment.

Source: Human Rights Watch. 2010. Uganda: Protect, Don't Punish, People With HIV. *Human Rights Watch* online (19 May).  
<http://www.hrw.org/en/news/2010/05/13/uganda-protect-don-t-punish-people-hiv>

**GLOBAL HEALTH NEWS:**

### **The unconscionable health gap: A global plan for justice**

According to the Marmot Commission, "the social conditions in which people are born, live, and work are the single most important determinant of good or ill health." To help close this gap, the author proposes a global plan for justice—a voluntary compact between states and their partners. Such a global plan for justice—a soft norm—could be achieved through the passage of a World Health Assembly resolution that authorizes the Director-General to negotiate funding, priorities, and implementation. Such a plan would set achievable funding targets for a global health fund to be distributed according to need, and guarantee a universal package of essential services, comprised of three core components: 1) essential vaccines and medicines; 2) basic survival needs; and 3) adaption to climate change. The international community must do more than lament ongoing, unconscionable health inequalities. It must act boldly and with a shared voice. If the world does not act, the avoidable suffering and early death among the world's least healthy people will continue unabated—a breach of social justice that is no longer ethically acceptable.

Source: Gostin, Lawrence. 2010. The unconscionable health gap: a global plan for justice. *The Lancet* Vol. 375, Issue 9725 (1 May).  
[http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(10\)60065-7/fulltext](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(10)60065-7/fulltext)



*RESEARCH ON GLOBAL HEALTH GOVERNANCE & INSTITUTIONS:*

### **Global Health and Foreign Policy**

In recent years global health issues have risen to the highest levels of international politics. This elevated political priority has resulted in increased funding for, and attention to, select global health issues. However, there has been limited examination of the tensions that characterize the relationship between global health and foreign policy and of the potential effects of linking global health efforts with the foreign-policy interests of states. This paper reviews the relationship between global health and foreign policy by examining the roles of health across 4 major components of foreign policy: 1) aid; 2) trade; 3) diplomacy; and 4) national security. It finds that state action on health is often motivated by foreign-policy interests. These interests can be economic (protecting trade), diplomatic (preventing epidemics), strategic (preventing bioterrorism), or a combination of interests. While foreign-policy interests are likely to continue to determine state engagement on global health issues, self-serving motives for state action on health do not have to lead to poor outcomes. Whether further successes are achieved, or be undermined by the pursuit of interests, will depend upon the ability of public health practitioners to understand foreign-policy perspectives on health and promote global health interests in the world of high politics.

*Source:* Feldbaum, Harley, et al. 2010. Global Health and Foreign Policy. *Epidemiologic Reviews* online (27 April).

<http://epirev.oxfordjournals.org/cgi/content/abstract/mxq006>

*GLOBAL HEALTH NEWS:*

### **Lancet's Editorial on Canada's Health Leadership**

At a meeting in Halifax, Nova Scotia (April 27–28), the G8 development ministers agreed to back Canada's provisional set of principles to improve the health of women and children in developing nations. Canada should be praised for making maternal and child health a priority issue for the G8. Around 350 000 women die during childbirth every year. Nine million children younger than 5 years also die every year. Most of these deaths are preventable. However, the plan is missing some key elements. First, there is no talk of emergency obstetric care. This omission is likely to be an oversight and should be rectified. Second, improving access to safe abortion services is also absent. This omission is no accident, but a conscious decision by Canada's Conservative Government. This stance must change; 70 000 women die from unsafe abortions worldwide every year. The Canadian Government does not deprive women living in Canada from access to safe abortions; it is therefore hypocritical and unjust that it tries to do so abroad. Although the country's decision only affects a small number of developing countries where abortion is legal, bans on the procedure, which are detrimental to public health, should be challenged by the G8, not tacitly supported. Canada and the other G8 nations could show real leadership with a final maternal health plan that is based on sound scientific evidence and not prejudice.

*Source:* The Lancet. 2010. Canada's G8 health Leadership. *The Lancet* Vol. 375, Issue 9726 (8 May).

[http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(10\)60685-X/fulltext](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(10)60685-X/fulltext)



*RESEARCH ON HEALTH & DEVELOPMENT, HEALTH SYSTEMS:*

### **An approach to health system strengthening in the Union of Myanmar**

In 2007 and 2008, Myanmar developed a health system strengthening (HSS) strategy and proposal through funding support from the Global Alliance for Vaccines and Immunization (GAVI). Critical success factors in the development of the HSS strategy included: 1) evidence-based development of the strategy through a sector analysis; and 2) a long-term approach to strategy development with wide stakeholder participation. In the coming years, implementation of the HSS strategy should position the Ministry of Health and its partners to implement system reforms in the areas of health planning, financing and human resource management. These innovations in Myanmar, with evidence of similar breakthroughs in other countries of the Asian region (ex. North Korea, Cambodia, Nepal and Sri Lanka), provides promising evidence of the potential for the HSS approach to respond to the issue of “within country” inequities in access to health care.

Source: Tin, Nilar, et al. 2010. An approach to health system strengthening in the Union of Myanmar. *Health Policy* Vol. 95, Issue 2-3 (May).

[http://www.sciencedirect.com/science?\\_ob=ArticleURL&\\_udi=B6V8X-4XY3K6V-2&\\_user=10&\\_coverDate=05%2F31%2F2010&\\_rdoc=1&\\_fmt=high&\\_orig=browse&\\_srch=doc-info\(%23toc%235882%232010%23999049997%231849686%23FLA%23display%23Volume\)&\\_cdi=5882&\\_sort=d&\\_docanchor=&\\_ct=23&\\_acct=C00050221&\\_version=1&\\_urlVersion=0&\\_userid=10&md5=79665d6fa3c879dc6e898f463b96e98e](http://www.sciencedirect.com/science?_ob=ArticleURL&_udi=B6V8X-4XY3K6V-2&_user=10&_coverDate=05%2F31%2F2010&_rdoc=1&_fmt=high&_orig=browse&_srch=doc-info(%23toc%235882%232010%23999049997%231849686%23FLA%23display%23Volume)&_cdi=5882&_sort=d&_docanchor=&_ct=23&_acct=C00050221&_version=1&_urlVersion=0&_userid=10&md5=79665d6fa3c879dc6e898f463b96e98e)

*GLOBAL HEALTH NEWS:*

### **Five years to go and counting: Progress towards the Millennium Development Goals**

Despite notable achievements in the health-related Millennium Development Goals (MDGs), progress continues to be poorly distributed across interventions and populations. For example, strategies to address the multidimensional nature of deprivation and exclusion are urgently needed if the world is to reach the MDG goal on maternal health. Globally, less than half of pregnant women have the minimum of four antenatal visits as recommended by the World Health Organization. In sub-Saharan Africa and south-eastern Asia, in 2008 less than half of all births were assisted by a skilled health worker; in sub-Saharan Africa, there has been virtually no progress at all since the 1990s. A reflection of the failure to prioritize maternal health is the limited availability and poor quality of data on maternal mortality. A decade after the Millennium Declaration, few low-income and middle-income countries have health information systems able to generate reliable mortality data. With only five years remaining until the 2015 deadline, it is time for a call to action for countries and development partners to seriously invest in counting births, deaths and causes of death

Source: AbouZahr, Carla and Ties Boerma. 2010. Five years to go and counting: progress towards the Millennium Development Goals. *Bulletin of the World Health Organization* Vol. 88, No. 5 (May).

<http://www.who.int/bulletin/volumes/88/5/10-078451/en/index.html>

**GLOBAL HEALTH NEWS:**

**Preparation for a Joint Action Plan and Accountability Framework for MDGs 4, 5, & 6**

The Norwegian government has joined with the United Nations Secretary General to lead a campaign for the health-related Millennium Development Goals. Their objective is to launch a *Joint Action Plan and Accountability Framework* at the United Nations High-Level Meeting on the Millennium Development Goals, which will be held from September 20-22, 2010.

The Joint Action Plan will build on the Global Consensus on Maternal, Newborn and Child Health endorsed by the G8 last year and launched at the United Nations in September 2009. While consultations on this Plan are ongoing, the objectives are the following: 1) identify the financing gap for the health and fill that gap through more efficient use of existing and mobilization of new resources; 2) build on existing health commitments while securing new ones, 3) increase political commitment and accountability for the health related MDGs, and, 4) promote an integrated approach amongst various global and local health initiatives.

To achieve this integrated approach, the Plan will focus on national health plans to ensure country ownership and coordination; the strengthening of local health systems; and the development of joint goals across all health related MDGs. In addition, the Plan will encourage innovation and facilitate research to develop new interventions and new ways of delivering care.

Securing new resources will be a critical component of this Action Plan. By 2015, the funding shortfall is an estimated USD 31 billion per year. The Joint Action Plan will propose mechanisms to meet this shortfall, including securing additional financial commitments by local and international actors and promoting the harmonization of international financial mechanisms, through mechanisms like the Health Systems Funding Platform.

Specific working groups have been established to develop the Joint Action Plan. The working group on financing will be led by the World Bank; Canada, Rwanda and the WHO will lead the accountability framework; the Advocacy and social mobilization group will be led by the United Nations Foundation, the Partnership for Mother, Newborn and Child Health, and ONE; while Norway and Johnson and Johnson will lead the role of innovation.

*Sources:*

<http://www.regjeringen.no/en/dep/smk/Selected-topics/the-millennium-development-goals.html?id=87050>

[http://www.who.int/pmnch/media/press\\_materials/pr/2009/20090922\\_worldleadersconsensus/en/index.html](http://www.who.int/pmnch/media/press_materials/pr/2009/20090922_worldleadersconsensus/en/index.html)

[http://www.who.int/pmnch/media/press\\_materials/pr/2009/20090923\\_pmnch\\_mediaadvisory\\_unevent.pdf](http://www.who.int/pmnch/media/press_materials/pr/2009/20090923_pmnch_mediaadvisory_unevent.pdf)



*RESEARCH ON HUMAN RESOURCES & MIGRATION OF HEALTH WORKERS:*

### **Compulsory service programmes for recruiting health workers in remote and rural areas: do they work?**

Compulsory service programmes have been used worldwide as a way to deploy and retain a professional health workforce within countries. This study identifies three different types of compulsory service programmes in 70 countries. These programmes are all governed by some type of regulation, ranging from a parliamentary law to a policy within the Ministry of Health. Depending on the country, doctors, nurses, midwives and all types of professional allied health workers are required to participate in the programme. Some of the compliance-enforcement measures include withholding full registration until obligations are completed, withholding degree and salary, or imposing large fines. As governments consider the cost of investment in health professionals' education, the loss of health professionals to emigration and the lack of health workers in many geographic areas, they are using compulsory service requirements as a way to deploy and retain the health workforce.

*Source:* Frehywot, Seble, et al. 2010. Compulsory service programmes for recruiting health workers in remote and rural areas: do they work? *Bulletin of the World Health Organization* Vol. 88, No. 5 (May).

<http://www.who.int/bulletin/volumes/88/5/09-071605-ab/en/index.html>

*GLOBAL HEALTH NEWS:*

### **WHA agrees new code on ethical recruitment of international health personnel**

On 21 May, the World Health Assembly adopted a new voluntary global code of practice on the ethical recruitment of international health personnel which discourages countries from actively recruiting from poor nations facing critical staff shortages. The code, adopted during the annual World Health Assembly, also calls for countries which recruit staff from poorer countries to fund the training of health professionals in those countries. The new code, hammered out after intense negotiations on the sidelines of the assembly, included strong inputs from Norway, the United Kingdom, the European Union, Brazil, the Philippines, Zambia, Kenya, South Africa, and Botswana.

*Source:* Zarcostas, John. 2010. WHO agrees new code on ethical recruitment of international health personnel. *BMJ* 340:c2784 (25 May).

[http://www.bmj.com/cgi/content/extract/340/may25\\_2/c2784](http://www.bmj.com/cgi/content/extract/340/may25_2/c2784)



**RESEARCH ON TRADE POLICY & HEALTH:**

### **Purchasing health services abroad: Practices of cross-border contracting and patient mobility in six European countries**

Contracting health services outside the public, statutory health system entails purchasing capacity from domestic non-public providers or from providers abroad. Over the last decade, these practices have made their way into European health systems, brought about by performance-oriented reforms and EU principles of free movement. This article explains the development, functioning, purposes and possible implications of cross-border contracting. Primary and secondary sources on purchasing from providers abroad have been collected in a systematic way and analysed in a structured frame. The findings suggest that purchasers from benefit-in-kind systems develop capacity when this mechanism responds to unmet demand; pressures domestic providers; and/or offers financial advantages, especially where statutory purchasers compete. Providers which receive patients tend to be located in countries where treatment costs are lower and/or where providers compete. The modalities of purchasing and delivering care abroad vary considerably depending on contracts being centralized or direct, the involvement of middlemen, funding and pricing mechanisms, cross-border pathways and volumes of patient flows. The arrangements and concepts which cross-border contracting relies on suggest that statutory health purchasers, under pressure to deliver value for money and striving for cost-efficiency, experiment with new ways of organizing health services for their populations.

Source: Glinos, Irene A, et al. 2010. Purchasing health services abroad: Practices of cross-border contracting and patient mobility in six European countries. *Health Policy* Vol. 95, Issue 2-3 (May).

[http://www.sciencedirect.com/science?\\_ob=ArticleURL&\\_udi=B6V8X-4Y0K9HN-1&\\_user=10&\\_coverDate=05%2F31%2F2010&\\_rdoc=2&\\_fmt=high&\\_orig=browse&\\_srch=doc-info\(%23toc%235882%232010%23999049997%231849686%23FLA%23display%23Volume\)&\\_cdi=5882&\\_sort=d&\\_docanchor=&\\_ct=23&\\_acct=C00050221&\\_version=1&\\_urlVersion=0&\\_userid=10&md5=5de14322b01dbd39682f1abd30056206](http://www.sciencedirect.com/science?_ob=ArticleURL&_udi=B6V8X-4Y0K9HN-1&_user=10&_coverDate=05%2F31%2F2010&_rdoc=2&_fmt=high&_orig=browse&_srch=doc-info(%23toc%235882%232010%23999049997%231849686%23FLA%23display%23Volume)&_cdi=5882&_sort=d&_docanchor=&_ct=23&_acct=C00050221&_version=1&_urlVersion=0&_userid=10&md5=5de14322b01dbd39682f1abd30056206)

**GLOBAL HEALTH NEWS:**

### **India, Brazil challenge EU at WTO over drugs**

India and Brazil launched a trade dispute against the European Union and the Netherlands on 12 May 2010, saying their seizures of generic drugs were hurting healthcare in poor countries and disrupting international trade. The debate turns on one of the most sensitive issues dividing rich and poor nations: the intellectual property rights of corporations such as makers of pharmaceuticals versus access to affordable medicine for people in developing countries. India said the repeated seizures were based on allegations of the infringement of intellectual property rights in the country of transit, even though the generic drugs in question were legal in their countries of origin and destination. EU officials argue that their checks aim to identify counterfeit medicine rather than stopping people in developing countries from getting treatment. Both India and Brazil have requested consultations with the EU and Netherlands on the issue, the first formal step in a WTO dispute. They now have 60 days to try and resolve it, otherwise Brazil and India can ask the WTO to set up a panel of experts to rule whether the European actions breach international trade rules.

Source: Lynn, Jonathan. 2010. India, Brazil challenge EU at WTO over drugs. *AlertNet* online (12 May).

<http://www.alertnet.org/thenews/newsdesk/LDE64B1O6.htm>



### RESEARCH ON INTELLECTUAL PROPERTY & HEALTH

#### **NEGOTIATING EQUITABLE ACCESS TO INFLUENZA VACCINES: GLOBAL HEALTH DIPLOMACY AND THE CONTROVERSIES SURROUNDING AVIAN INFLUENZA H5N1 AND PANDEMIC INFLUENZA H1N1**

One of the most controversial areas of global health diplomacy are negotiations to increase equitable access to vaccines for highly pathogenic avian influenza A (H5N1) (HPAI-H5N1) and pandemic 2009 influenza A (H1N1) (2009-H1N1). The limited results produced by these negotiations have stimulated calls for a new global framework to improve equitable access to influenza vaccines. The prospects for such a framework are not however promising, because the national interests of most developed states vis-à-vis dangerous influenza strains favour retaining the existing imbalanced, reactive, and ad hoc approach to vaccine access. Developing countries want obligatory benefit sharing in return for virus sharing, with binding terms spelled out in a Standard Material Transfer Agreement (SMTA). In contrast, developed countries want to avoid binding obligations to provide benefits in exchange for access to virus samples provided by developing countries. The negotiating path that could lead to a new global access framework for influenza vaccines is not apparent, especially in a context in which aggregate global production capacity is woefully inadequate, the geographic location of production facilities is concentrated in developed countries, timelines for developing new vaccines create problems for rapid prevention strategies, and existing manufacturing technologies and distribution systems require improvements.

SOURCE: Fidler, David. 2010. Negotiating Equitable Access to Influenza Vaccines: Global Health Diplomacy and the Controversies Surrounding Avian Influenza H5N1 and Pandemic Influenza H1N1. *PLoS Medicine* Vol. 7, Issue 5 (4 May).

<http://www.plosmedicine.org/article/info:doi/10.1371/journal.pmed.1000247>

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

#### **Heterosexual HIV-1 transmission after initiation of antiretroviral therapy: a prospective cohort analysis**

The authors assessed the effect of ART use by patients infected with HIV-1 on risk of transmission to their uninfected partners. Participants in the prospective cohort analysis were from a randomized placebo-controlled trial that enrolled heterosexual African adults who were seropositive for both HIV-1 and herpes simplex virus type 2, and their HIV-1 seronegative partners. At enrolment, HIV-1 infected participants had CD4 counts of 250 cells per  $\mu\text{L}$  or greater and did not meet national guidelines for ART initiation; during 24 months of follow-up, CD4 counts were measured every 6 months and ART was initiated in accordance with national guidelines. The primary outcome was genetically-linked HIV-1 transmission within the study partnership. The authors also assessed rates of HIV-1 transmission by ART status of infected participants. Only one of 103 genetically-linked HIV-1 transmissions was from an infected participant who had started ART. In participants not on ART, the highest HIV-1 transmission rate was from those with CD4 cell counts lower than 200 cells per  $\mu\text{L}$ . In couples in whom the untreated HIV-1 infected partner had a CD4 cell count greater than 200 cells per  $\mu\text{L}$ , 66 of 94 transmissions occurred when plasma HIV-1 concentrations exceeded 50 000 copies per mL. Low CD4 cell counts and high plasma HIV-1 concentrations might guide use of ART to achieve an HIV-1 prevention benefit. Provision of ART to HIV-1 infected patients could be an effective strategy to achieve population-level reductions in HIV-1 transmission.

Donnell, Debra, et al. 2010. Heterosexual HIV-1 transmission after initiation of antiretroviral therapy: a prospective cohort analysis. *The Lancet*. online (27 May).

[http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(10\)60705-2/fulltext#article\\_upsell](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(10)60705-2/fulltext#article_upsell)



### GLOBAL HEALTH NEWS:

#### **Tuberculosis control and elimination 2010-50: cure, care, and social development**

Rapid expansion of the standardised approach to tuberculosis (TB) diagnosis and treatment recommended by WHO allowed more than 36 million people to be cured of TB between 1995 and 2008. Yet tuberculosis remains a severe global public health threat with more than 9 million new cases every year worldwide. Indeed, the important long-term elimination target set for 2050 will not be reached with present strategies and instruments. Several key challenges persist. Many vulnerable people do not have access to affordable services of sufficient quality. Technologies for diagnosis, treatment, and prevention are old and inadequate. Multidrug-resistant tuberculosis is a serious threat in many settings. HIV/AIDS continues to fuel the tuberculosis epidemic, especially in Africa. Furthermore, other risk factors and underlying social determinants help to maintain tuberculosis in the community. Acceleration of the decline towards elimination of this disease will need invigorated actions in four broad areas: 1) continued scale-up of early diagnosis and proper treatment for all forms of tuberculosis in line with the Stop TB Strategy; 2) development and enforcement of bold health-system policies; 3) establishment of links with the broader development agenda; and 4) promotion and intensification of research towards innovations.

Source: Lönnroth, Knut, et al. 2010. Tuberculosis control and elimination 2010-50: cure, care, and social development. *The Lancet* Vol. 375, Issue 9728 (22 May).

<http://www.thelancet.com/journals/lancet/article/PIIS0140-6736%2810%2960483-7/fulltext?&elsca1=TL-210510&elsca2=email&elsca3=segment>

### RESEARCH ON GLOBAL ACTION ON NON-COMMUNICABLE DISEASES:

#### **Tackling Africa's chronic disease burden: from the local to the global**

Africa faces a double burden of infectious and chronic diseases. While infectious diseases still account for at least 69% of deaths on the continent, age specific mortality rates from chronic diseases as a whole are actually higher in sub Saharan Africa than in virtually all other regions of the world. Over the next ten years the continent is projected to experience the largest increase in death rates from cardiovascular disease, cancer, respiratory disease and diabetes. African health systems are weak and national investments in healthcare training and service delivery continue to prioritise infectious and parasitic diseases. There is a strong consensus that Africa faces significant challenges in chronic disease research, practice and policy. This editorial reviews eight original papers submitted to a Globalization and Health special issue themed: "Africa's chronic disease burden: local and global perspectives". The review finds that there is an urgent need for primary and secondary interventions and for African health policymakers and governments to prioritise the development and implementation of chronic disease policies. Two gaps need critical attention: 1) the need for multidisciplinary models of research to properly inform the design of interventions; 2) the need to improve understanding of the processes and political economies of policymaking in sub Saharan Africa.

Source: De-Graft Aikins, Ama, et al. 2010. Tackling Africa's chronic disease burden: from the local to the global. *Globalization and Health* Vol. 6, No. 5 (19 April).

<http://www.globalizationandhealth.com/content/6/1/5/abstract>



# HEALTH & FOREIGN POLICY

## BULLETIN

A publication of the Norman Paterson School of International Affairs

[research.policy-net.org/blogs/healthandforeignpolicy](http://research.policy-net.org/blogs/healthandforeignpolicy)

### GLOBAL HEALTH NEWS:

#### UN agency lauds Assembly resolution on non-communicable diseases

The World Health Organization (WHO) welcomed a General Assembly resolution – adopted 13 May – calling for the curbing of premature deaths from non-communicable diseases (NCDs), the leading cause of death in the world. The resolution highlights the importance of supporting countries to enhance access to essential medicines and affordable medical technology. It also called for a high-level Assembly meeting, with the participation of heads of State and government, to take place in New York in September 2011 on the issue. Many of the deaths caused by NCDs in developing countries, could be prevented by reducing exposure to tobacco use, unhealthy diets, physical inactivity and harmful use of alcohol, as well as improving early detection of breast and cervical cancers, diabetes and high blood pressure. In spite of signs that death rates from non-communicable diseases have stabilized or even declined in many high-income countries in recent decades, research points to deaths from these diseases increasing in all regions of the world. Continuing on the current trajectory, more than 40 million people will die from them annually by 2015

Source: \_\_\_\_\_, 2010. UN agency lauds Assembly resolution on non-communicable diseases. *UN News Centre* online (14 May).  
<http://www.un.org/apps/news/story.asp?NewsID=34698&Cr1+diseases>

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](mailto:hfp_bulletin@carleton.ca).

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