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IN THIS ISSUE

RESEARCH ON GLOBAL HEALTH SECURITY:
The latest threat in the war on antimicrobial resistance. p.1

RESEARCH ON HEALTH & STATES IN CRISIS/CONFLICT:
The mental health of populations directly and indirectly exposed to violent conflict in Indonesia. . . . . p. 2

RESEARCH ON HUMAN RIGHTS & GLOBAL HEALTH:
Making health an imperative of foreign policy: The value of a human rights approach. . . . . p. 4

RESEARCH ON GLOBAL HEALTH GOVERNANCE & INSTITUTIONS:
Framing health and foreign policy: Lessons for global health diplomacy . . . . p. 5

RESEARCH ON HEALTH & DEVELOPMENT, HEALTH SYSTEMS:
The Millennium Development Goals: a cross-sectoral analysis and principles for goal setting after 2015 . . . . .p. 6

Access to care and medicines, burden of health care expenditures, and risk protection: Results from the World Health Survey. . . . . p. 6

RESEARCH ON HUMAN RESOURCES & MIGRATION OF HEALTH WORKERS:
'Circular migration' and the potential to improve health outcomes. . . . . p. 7

RESEARCH ON TRADE POLICY & HEALTH:
FCTC guidelines on tobacco industry foreign investment would strengthen controls on tobacco supply and close loopholes in the tobacco treaty . . . . p. 8

RESEARCH ON INTELLECTUAL PROPERTY & HEALTH:
A one-time-only combination: Emergency medicine exports under Canada's access to medicines regime . . . . p. 9

RESEARCH ON RESPONSE TO HIV/AIDS, TUBERCULOSIS & MALARIA:
Inadequate pre-antiretroviral care, stock-out of antiretroviral drugs and stigma: Policy challenges/bottlenecks to the new WHO recommendations for earlier initiation of antiretroviral therapy (CD<350 cells/µL) in eastern Uganda. . . . . p. 10

RESEARCH ON GLOBAL ACTION ON NON-COMMUNICABLE DISEASES:
Follow the money: How billions of dollars that flow from smokers in poor nations to companies in rich nations greatly exceed funding for global tobacco control and what might be done about it. . . . . p. 11

RESEARCH ON GLOBAL HEALTH SECURITY:

The latest threat in the war on antimicrobial resistance

Enterobacteriaceae are among the most important causes of serious nosocomial and community-associated bacterial infections in people. Resistance is developing to drugs (carbapenems) which are the last line of effective treatment available for infections. Kumarasamy and colleagues provide evidence that NDM-producing Enterobacteriaceae (mostly *K pneumoniae* and *E coli*) are widespread in India and Pakistan. They also identify patients in the UK, who had recently travelled to India for several types of medical procedures, whose infections were multiresistant to many groups of antibiotics. The spread of these multiresistant bacteria merits very close monitoring and worldwide, internationally funded, multicentre surveillance studies, especially in countries that actively promote medical tourism.

Source:
Pitout, Johann DD. 2010. The latest threat in the war on antimicrobial resistance. *The Lancet Infectious Diseases* Vol. 10, Issue 9 (September).

See also:
Kumarasamy, Karthikeyan, et al. 2010. Emergence of a new antibiotic resistance mechanism in India, Pakistan, and the UK: A Molecular, biological, and epidemiological study. *The Lancet Infectious Diseases* Vol. 10, Issue 9 (September).

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GLOBAL HEALTH NEWS:

Pandemic influenza – (some) reasons to be cheerful?

There was no fanfare to accompany WHO's declaration on 10 August that the world was entering a "post-pandemic period". However, this announcement should herald the start of a period of reflection; now is the time to ask: how can we do better? Three suggestions are tabled. First, we need to be better prepared; there needs to be global investment in responsive vaccine production systems, which allow production to track demand. This will require the development of a political framework to ensure adequate funding, procurement agreements, and worldwide distribution strategies well before the next outbreak. Second, we need systems in place to maximize learning. Protocols and approvals should be ready for randomized trials of treatment strategies; these could then begin recruiting as soon as an outbreak occurs. Finally, a relationship of trust needs to be rebuilt between experts and the general public. The disparity between predicted and actual severity of this pandemic has severely dented experts' credibility, experts now need to use all methods at their disposal to engage the public.

Sources:

The Lancet. 2010. Pandemic influenza – (some) reasons to be cheerful? *The Lancet* Vol. 376, Issue 9741 (21 August).

The Lancet Infectious Diseases. 2010. WHO failing in duty of transparency. *The Lancet Infectious Diseases* Vol. 10, Issue 8 (August).

RESEARCH ON HEALTH & STATES IN CRISIS/CONFLICT:

The mental health of populations directly and indirectly exposed to violent conflict in Indonesia

The mental health impact of disasters can be expected to be similar to that of a ripple effect – where the risk of mental health consequences generally decreases with increasing distance from the disaster centre. This paper examines the 'ripple effect' hypothesis on the mental health consequences in populations exposed to man-made disasters in a developing country context, through a comparison of two different populations living in different proximities from the centre of disaster in Moluccas. Cross-sectional longitudinal data were collected from 510 Internally Displaced Persons (IDPs) living in Ambon, who were directly exposed to the violence, and non-IDPs living in remote villages in Moluccas, who had never been directly exposed to violence. It finds that there was significantly more psychological distress "caseness" in IDPs than non-IDPs. The mental health consequences of the violent conflict in Ambon supported the ripple effect hypothesis as displacement status appears to be a strong risk factor for distress, both as a main effect and interaction effect.

Source: Turnip, Sherly S, et al. 2010. The mental health of populations directly and indirectly exposed to violent conflict in Indonesia. *Conflict and Health* Vol. 4, Issue 14 (30 July).

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GLOBAL HEALTH NEWS:

Health-care dynamics in Haiti

The emergency medical response in Haiti was one of the few success stories of the earthquake relief effort, but the influx of foreign doctors has had unintended consequences. For example, before the earthquake, only two obgyns permanently resided in the city of Leogane (population 30 000). In the weeks that followed, foreign doctors flooded into Leogane and for the first time in its troubled history the city had a surplus of skilled care. Seven months later the foreign doctors are still there, helping to rehabilitate Haiti's thousands of new amputees, and providing basic care. However, the influx of foreign doctors caused many local private clinics to lose business, displacing Haitian medical professionals who soon found themselves competing for patients in a marketplace dominated by volunteers. But, if aid agencies' enduring presence has forced medical professionals out of a paying job, it has also been a lifeline for many others. For example, nearly 1000 Haitian doctors and nurses are employed in health facilities run by Médecins Sans Frontières (MSF). The question of how long free foreign doctors should stay in Haiti, and what may happen when they leave will remain critical to the evolving humanitarian response.

Source: Adams, Patrick. 2010. Health –care dynamics in Haiti. *The Lancet* Vol. 376, Issue 9744 (11 September).

GLOBAL HEALTH NEWS:

The unfolding human tragedy in Pakistan: fighting alone

In a fortnight that saw incessant flooding of all the major rivers across the length of Pakistan, almost 1800 people died and more than 20 million were displaced. An estimated fifth of the entire landmass and most of the fertile agricultural land on either side of the major rivers was submerged and much of the infrastructure for communication, transport, education, and public health in the affected districts was destroyed. However, a particularly distressing observation is the slow global response to the disaster. Less than a third of the immediate call for US$460 million has been pledged and little received. Indeed, many of the displaced people are not in governmental shelters but have been housed and clothed by communities and non-governmental organizations. In view of the scale of the disaster and estimated losses exceeding $10 billion, indigenous assistance will hardly suffice, and urgent global aid and support is needed.

Source: Bhutta, Zulfiqar & Shereen Zulfiqar Bhutta. 2010. The unfolding human tragedy in Pakistan: Fighting alone. *The Lancet* Vol. 376, Issue 9742 (28 August).

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RESEARCH ON HUMAN RIGHTS & GLOBAL HEALTH:

Making health an imperative of foreign policy: The value of a human rights approach

Health is increasingly seen as relevant to foreign policy; nevertheless, it remains subordinate to other interests such as security and economics. This subordination is inconsistent with the Human Rights Approach to Health (HRAH) which is based upon normative obligations of states relating to health, the duty of states to cooperate with each other, obligations involving the provision of adequate resources, and need to ensure broad participation in decision making. The HRAH can make an important contribution to building the "will" that is needed to make health a more important part of foreign policymaking. The HRAH does this by classifying health as an imperative that must be taken into account in foreign policymaking. The HRAH also provides individuals and civil society with the tools to hold foreign policy makers accountable for legally binding obligations they have undertaken in treaties and the morally and politically important commitments they have made in non-binding aspirational statements.

Source: Bustreo, Flavia, et al. 2010. Making health and imperative of foreign policy: The value of a human rights approach. *Health and Human Rights* Vol. 12, Issue 1.

GLOBAL HEALTH NEWS:

Health law, human rights, and public health

Two volumes of previously published articles on the relationship between law, human rights and public health, entitled "The Ethics of Public Health" has recently been released (Ashgate 2010). The two volumes provide an opportunity to review the evolution of the relationship between health, ethics and law. These articles contained in the volumes highlight that public health covers poverty and warfare to genetics and climate change through governmental actions taken to prevent disease and improve people's quality of life. Both bioethics and public health ethics are products of World War II: bioethics grew out of the 1945–46 Nazi Doctors' Trial and public health ethics grew out of the 1948 Universal Declaration of Human Rights. Jonathan Mann, the former head of the WHO's global AIDS programme, remarked that the language of bioethics was well suited to the practice of medicine, whereas the language of human rights was needed for public health. Public health is, of course, based on the actions of governments—it is empowered (and constrained) by human rights laws globally, and constrained by domestic laws nationally (ex. the Constitution of the USA). Sofia Gruskin's article describes the use of a human rights framework to assess public health policy issues placing emphasis on several foundational human right precepts: equality, which prohibits any form of discrimination, and the special status of women and children, which requires governments to prioritize their needs and provide not only basic medical care, but also food, clean water, housing, and education.

Source: Annas, Ge2010. Health law, human rights, and public health. *The Lancet Infectious Diseases* Vol. 10, Issue 9 (24 August).

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RESEARCH ON GLOBAL HEALTH GOVERNANCE & INSTITUTIONS:

Framing health and foreign policy: Lessons for global health diplomacy

Several governments have issued specific foreign policy statements on global health and a new term, global health diplomacy, has been coined to describe the processes by which state and non-state actors engage to position health issues in foreign policy decision-making. This paper reviews the arguments for health in foreign policy that inform global health diplomacy. These are organized into six policy frames: security, development, global public goods, trade, human rights and ethical/moral reasoning. Differing arguments within and between these policy frames, while overlapping, can also be contradictory. This raises an important question about which arguments prevail in actual state decision-making. Initial findings support conventional international relations theory that most states, even when committed to health as a foreign policy goal, still make decisions primarily on the basis of the 'high politics' of national security and economic material interests. Development, human rights and ethical/moral arguments for global health assistance, the traditional 'low politics' of foreign policy, are present in discourse but do not appear to dominate practice. While political momentum for health as a foreign policy goal persists, the framing of this goal remains a contested issue.

Source : Labonté, Ronald and Michelle L Gagnon. (2010) Framing health and foreign policy: Lessons for global health diplomacy. *Globalization and Health* Vol. 6, Issue 14 (22 August).

GLOBAL HEALTH NEWS:

Norwegian WHO strategy

Norway has a seat on the Executive Board of the World Health Organization (WHO) from May 2010 to May 2013; the Norwegian board member is Director General of Health Bjørn Inge Larsen. In connection with this, the Public Health Administration and the Foreign Service have joined forces on a Norwegian strategy that will apply for the duration of the Norwegian term of office. Norway's WHO strategy is based on an interest and value-oriented approach. Norway will seek to strengthen WHO as a leading, normative organization for promoting global health. Through WHO, Norway will seek to promote universal access to health services based on the fundamental right to health services for all by promoting healthy living conditions and strengthening health systems. Well developed and transparent international health cooperation is important for safeguarding Norwegian public health in relation both to its neighbouring areas and in the face of global challenges. This is an important security priority and thus an integral part of Norway's foreign policy and international development policy.

Source: Norwegian Ministry of Health and Care Services and Norwegian Ministry of Foreign Affairs. 2010. Norwegian WHO Strategy: Norway as a member of WHO's Executive Board 2010-2013. *Government of Norway* (September).

RESEARCH ON HEALTH & DEVELOPMENT, HEALTH SYSTEMS:

The Millennium Development Goals: A cross-sectoral analysis and principles for goal setting after 2015

The Millennium Development Goals (MDGs) represent an unprecedented global consensus about measures to reduce poverty. Although impressive progress has been made towards some goals, global targets will not be met in some regions, particularly sub-Saharan Africa and south Asia. This Commission brings together sectoral experts on different MDGs from the London International Development Centre to identify cross-cutting challenges that have emerged from MDG implementation so far. The authors used this analysis as the basis to identify a set of principles for future goal development, after 2015. They conclude that future goals should be built on a shared vision of development, and not on the bundling together of a set of independent development targets. A holistic approach is needed to avoid gaps in the development agenda and ensure synergy between its interlinked components, each of which should address elements of human, social, and environmental development. While a broad development agenda arising from this process should be agreed on internationally, the development of this framework must occur locally, to ensure community and national ownership of goals and their monitoring.

Source: Waage, Jeff, et al. 2010. The Millennium Development Goals: A cross-sectoral analysis and principles for goal setting after 2015. *The Lancet* Vol. 376, Issue 9745 (18 September).

Access to care and medicines, burden of health care expenditures, and risk protection: Results from the World Health Survey

This paper assesses the contribution of health insurance and a functioning public sector to access to care and medicines and household economic burden. This was achieved using descriptive and logistic regression analyses on 2002/2003 World Health Survey data in 70 countries. Across countries, 286 803 households and 276 362 respondents contributed data. More than 90% of households had access to acute care. However, less than half of respondents with a chronic condition reported access. In 51 low and middle income countries (LMIC), health care expenditures accounted for 13–32% of total 4-week household expenditures. One in four poor households in low income countries incurred potentially catastrophic health care expenses and more than 40% used savings, borrowed money, or sold assets to pay for care. Between 41% and 56% of households in LMIC spent 100% of health care expenditures on medicines. Health insurance and a functioning public sector were both associated with better access to care and lower risk of economic burden. To improve access, policy makers should improve public sector provision of care, increase health insurance coverage, and expand policies to support affordable access to medicines in health systems.

Source: Wagner, Anita K, et al. 2010. Access to care and medicines, burden of health care expenditures, and risk protection: Results from the World Health Survey. *Health Policy* online (9 September).

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GLOBAL HEALTH NEWS:

Brazil's march towards universal health coverage

In 1988, half of Brazil's population had no health coverage. Two decades after establishing its Unified Health System (*Sistema Único de Saúde*), more than 75% of the country's estimated 190 million people rely exclusively on it for their health care coverage, and significant health improvements have ensued. For example, life expectancy at birth, for both sexes, has risen from 67 years in 1990 to around 73 years in 2008. Decentralization has played a fundamental part in Brazilian health-financing reform. In 1996, legislation transferred part of the responsibility for the management and financing of health care to the country's 26 states and more than 5000 municipal governments. States are required to allocate a minimum of 12% of the total budget to health while municipal governments must spend 15% of their budget on health. The federal government also contributes money raised from taxes. At the municipal level this system seems to work well: 98% of the municipalities meet the 15% budgetary requirement. However, this kind of commitment is less evident at the state level, with more than half of the 26 states failing to meet the required 12% funding target. Inadequate funds are linked to problems in the basic health infrastructure and shortages of hospital staff. According to Dr Francisco de Campos, national secretary of the Secretariat of Human Resources for Health at the Ministry of Health, "We need a combination of managerial expertise and money. If we just put more money in the system without monitoring expenditure, this won't necessarily improve services."

Source: ________. 2010. Brazil's march towards universal coverage. *Bulletin of the World Health Organization*. Vol. 88, Issue 9 (September).

RESEARCH ON HUMAN RESOURCES & MIGRATION OF HEALTH WORKERS:

'Circular Migration' and the potential to improve health outcomes

Tim Finch and Sarah Mulley recently argued in *Public Policy Research* that the public debate on migration to the UK has lacked 'a strong articulation of a progressive centre ground which recognises the benefits of migration, but which does not ignore the costs … understand[ing] that the rights of migrants need to be respected, but also that government needs to be able to enforce the UK's right to determine who comes into the country – and who remains here'. This article agrees with each of these points and seeks to push them further, in the context of the migration of highly skilled African health workers. The NHS and British citizens more generally need to recognize their established dependence on health workers from these poor sending countries, which looks likely to continue for the foreseeable future. They should further recognize that for many if not most of these sending countries, the addition or subtraction of a single doctor or nurse can have a much greater impact on home country health outcomes than on UK health outcomes. The European Commission (2007: 4) describes the advantages of 'migration that is managed in a way allowing some degree of legal mobility back and forth between two countries' as including the formalization of a migration relationship, improving data collection for sending and receiving countries, expanding capacity for and streamlining legal migration opportunities, and adopting measures that address and reverse brain drain. Policymakers should thus also explore the possibility that well planned 'circular migration' can shift recruitment from being a 'zero-sum' to a 'positive-sum' relationship between sending and recruiting countries.

Source: Lawrence, Andrew. 2010. 'Circular migration' and the potential to improve health outcomes. *Public Policy Research* Vol. 17, Issue 1(March-May).

GLOBAL HEALTH NEWS:

Increasing access to health workers in remote and rural areas through improved retention: Global policy recommendations

The World Health Organization (WHO) has produced recommendations in response to requests from global leaders, civil society and Member States to address the movements of health workers within the boundaries of a country and to focus on strategies to increase the availability of health workers in remote and rural areas through improved attraction, recruitment and retention. A number of interconnected principles should underpin all efforts to improve the recruitment and retention of health workers in remote and rural areas. Adhering to the principle of health equity will help in allocating available resources in a way that contributes to the reduction of avoidable inequalities in health. And grounding rural retention policies in the national health plan will provide a framework for holding all partners accountable for producing tangible and measurable results. The recommendations are clustered according to four themes: 1) education; 2) regulatory; 3) financial incentives; and 4) personal and professional support.

Source: World Health Organization. 2010. Increasing access to health workers in remote and rural areas through improved retention: Global policy recommendations. *World Health Organization (July).*

RESEARCH ON TRADE POLICY & HEALTH:

FCTC guidelines on tobacco industry foreign investment would strengthen controls on tobacco supply and close loopholes in the Tobacco Treaty

The Framework Convention on Tobacco Control (FCTC) contains no provisions covering tobacco industry investments. This creates the potential for tobacco companies to benefit from investment liberalization by using foreign investments to avoid tobacco tariffs, increase tobacco consumption and otherwise impair the implementation of FCTC-style measures. Reducing and ultimately eliminating foreign investment activities by tobacco companies can be justified on health grounds, even though it runs counter to current investment liberalization trends. Through the FCTC process, non-binding guidelines can be elaborated to assist parties in recognizing and responding to foreign investment strategies of tobacco companies, to support efforts to exclude the tobacco sector from investment liberalization and otherwise would improve all countries' awareness of the threat from foreign investment strategies of tobacco companies and provide them with approaches to handle the problems

Source: Lo, Chang-fa. 2010. FCTC guidelines on tobacco industry foreign investment would strengthen controls on tobacco supply and close loopholes in the tobacco treaty. *Tobacco Control* Vol. 19, Issue 4 (August).

GLOBAL HEALTH NEWS:

WTO panel established on clove cigarettes

A WTO panel was established on 20 July 2010 at Indonesia's second-time request (WT/DS406/2) which challenged the US measure (Section 907 (a)(1) of the Family Smoking Prevention and Tobacco Control Act 2009) prohibiting the production or sale of clove cigarettes. Indonesia said that following the implementation of this law, clove cigarettes produced in Indonesia may no longer be imported into the US. Indonesia stated that it had been extremely patient and tried to avoid this day since 2004, working with the US at every opportunity. It added that clove cigarettes have been prohibited from the US market since 22 September 2009, while menthol cigarettes continued to be sold. The US said it had worked over a long period of time to engage constructively with Indonesia on this issue. The US said that the prohibition on sales of flavoured cigarettes contained in the Family Smoking Prevention and Tobacco Control Act was fully justified. The US said that the use of tobacco products by young Americans was a paediatric disease and that there was a scientific and medical consensus on the fact that tobacco products caused cancer, heart disease and other serious adverse health effects.

Source: WTO. 2010. Panel established on clove cigarettes. *World Trade Organization* online (20 July).

RESEARCH ON INTELLECTUAL PROPERTY & HEALTH

A one-time-only combination: Emergency medicine exports under Canada's access to medicines regime

In 2008, a Canadian generic pharmaceutical firm, Apotex Inc., shipped 7 million doses of antiretroviral drugs to Rwanda for the treatment of HIV/AIDS. While this event may be seen as a positive outcome of international patent changes that facilitate the fulfilment of health as a human right, the fact that there has been only one shipment of medication in response to these changes highlights the difficulties with both the Canadian legislation and with the international decisions that it implements. The shipment was authorized under Canada's Access to Medicines Regime, which implements the World Trade Organization (WTO) General Council Decision (the Decision), made in 2003, to permit someone other than the patent holder to manufacture a lower-cost version of a patented drug or medical device for export to developing countries that do not have the capacity to manufacture such products. The Decision requires that the developing country announce its intention to use this mechanism, to specify the expected quantity of drugs to be supplied, and to issue a compulsory license for the drugs. The requirement of notification in particular may render developing countries vulnerable to pressure from pharmaceutical firms. Neither the mechanism created by the Decision nor Canadian legislation implementing it have facilitated the export of generic medicines to developing countries.

Source: Weber, Ashley and Lisa Mills. 2010. A one-time-only combination: Emergency medicine exports under Canada's access to medecines regime. *Health and Human Rights*. Vol. 12, No. 1 (July).

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GLOBAL HEALTH NEWS:

Disease now resistant as fake medicines flood market in Kenya

There are more than 11,000 drugs registered to sell in Kenya, the highest in the eastern Africa region. One antibiotic, for instance, the combination of *Amoxicillin* and *Clavulanic* acid 625mg, has over 26 types of generic drugs in the market. This explosion of drugs in the market has swamped regulatory agencies leading to an increase in counterfeit and sub-standard medicines. Statistics from the National Quality Control Laboratory (NQCL) on drugs presented for registration show that about 40 per cent of the pre-registration drug samples analyzed in 2008 failed to meet the quality test. It is estimated that between 20 and 30 per cent of drugs in the local market are counterfeits. They have either too much or too little of the active ingredient, which is critical in successful treatment of diseases. In East Africa, Kenya leads as the most expensive destination when it comes to medicines, making it a fertile ground for counterfeits. Drugs experts say the culprits of this business usually present their best samples to the NQCL for registration, and then manufacture or import counterfeited or substandard drugs in the subsequent batches knowing the country rarely does post-market surveillance.

Source: Okwemba, Arthur. 2010. Disease now resistant as fake medicines flood market. *Daily Nation* online (9 September).

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

Inadequate pre-Antiretroviral Care, stock-out of antiretroviral drugs and stigma: Policy challenges/bottlenecks to the new WHO recommendations for earlier initiation of antiretroviral therapy (CD<350 cells/µL) in Eastern Uganda

This study explores reasons for late antiretroviral treatment (ART) initiation among known HIV-positive persons in care, from a client/caretaker perspective, in eastern Ugandan. In this country, ART awareness is presumably high but AIDS related mortality is a common function of late initiation of antiretroviral medications (ARVs). In-depth interviews were conducted in Iganga, Uganda with clients who started ART at 50–200 CD4 cells/µL and those initiated very late at CD4 < 50 cells/µL. Focus-group discussions were also conducted with caretakers of clients on ART. Content analysis was performed to identify recurrent themes. ARV stock-outs, inadequate pre-antiretroviral care and lack of staff confidentiality were system barriers to timely ART initiation. Weak social support and prevailing stigma and misconceptions about ARVs as drugs designed to kill, cause cancer, infertility or impotence were other important factors. If the new WHO recommendations (start ART at CD4 350 cells/µL) should be feasible, people living with HIV (PLHIV)/communities need sensitization about the importance of regular pre-ARV care through the local media and authorities. The ARV supply chain and staff attitudes towards client confidentiality must also be improved in order to encourage timely ART initiation. Stronger social support structures must be created through public messages that fight stigma, enhance acceptance of PLHIV and encourage timely ART initiation.

Source: Muhamadi, Lubega, et al. 2010. Inadequate pre-antiretroviral care, stock-out of antiretroviral drugs and stigma: Policy challenges/bottlenecks to the new WHO recommendations for earlier initiation of antiretroviral therapy (CD<350 cells/µL) in eastern Uganda. *Health Policy*. Vol. 97, Issues 2-3 (October).

GLOBAL HEALTH NEWS:

AIDS doctors, activists call for more health funds

On the 10th of September, doctors and AIDS activists urged African governments to fulfil a decade-old pledge to spend more of their own money on health if they want international help in fighting AIDS. Graca Machel, a longtime advocate for children in her homeland of Mozambique and around the world, told reporters that African governments need to honour pledges made at an African Union summit in 2001 to devote at least 15 percent of national budgets to health; to date, only a half dozen countries have done so. Dr. Avertino Barreto, Mozambique's deputy director of health, said foreigners cannot be expected to help if Africans do not help themselves. "I believe that donors will come […] But African governments [...] must take the first decision."

Source: Bryson, Donna. 2010. AIDS doctors, activists call for more health funds. *Associated Press* online (10 September).

RESEARCH ON GLOBAL ACTION ON NON-COMMUNICABLE DISEASES:

Follow the Money: How billions of dollars that flow from smokers in poor nations to companies in rich nations greatly exceed funding for global tobacco control and what might be done about it.

The business of selling cigarettes is increasingly concentrated in the hands of five tobacco companies that collectively control almost 90% of the world's cigarette market, four of which are publicly traded corporations. The economic activities of these cigarette manufacturers can be monitored through their reports to shareholders and other public documents. Reports for 2008 show that the revenues of these five companies exceeded $300 billion, of which more than $160 billion was provided to governments as taxes, and that corporate earnings of the four publicly traded companies were over $25 billion, of which $14 billion was retained after corporate income taxes were paid. By contrast, funding for domestic and international tobacco control is not reliably reported. Estimated funding for global tobacco control in 2008, at $240 million, is significantly lower than resources provided to address other high-mortality global health challenges. Tobacco control has not yet benefited from the innovative finance mechanisms that are in place for HIV/AIDS, tuberculosis and malaria. The Framework Convention on Tobacco Control (FCTC) process could be used to redirect some of the earnings from transnational tobacco sales to fund FCTC implementation or other global health efforts.

Source: Callard, Cynthia. 2010. Follow the money: How billions of dollars that flow from smokers in poor nations to companies in rich nations greatly exceed funding for global tobacco control and what might be done about it. *Tobacco Control* Vol. 19, Issue 4 (August).

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GLOBAL HEALTH NEWS:

The hope and the promise of non-communicable diseases

On May 13, 2010, the United Nations General Assembly passed resolution 265, 'Prevention and control of non-communicable diseases', a major political statement calling for Heads of State to address NCDs in a 'High Level' plenary meeting scheduled for September 2011. Out of this meeting, and its associated "outcome document", will come a series of programmatic steps by all UN members. We cannot understate the potential of this UN resolution to make chronic non-communicable diseases (NCDs) a global priority among international leaders. While in the past there have been numerous resolutions at the World Health Assembly for greater action on NCDs, this UN resolution has special significance, as it comes with the hope to achieve multisectoral commitment and promise to deliver change. However, its overall effectiveness will depend on the ability of the international community to take advantage of this political opportunity to institutionalize NCD prevention and control into policies and programs within the broader development agenda.

Source: Alleyene. George, et al. 2010. The hope and the promise of the UN Resolution on non-communicable diseases. *Globalization and Health* Vol. 6, Issue 15 (9 September).

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.

Health and Foreign Policy Bulletin

Editors
Chantal Blouin
Valerie Percival

Assistant Editor
Mark Pearcey

Layout Editor
Julian Barbieri

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

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

ISSN 1923-5739