

# HEALTH DIPLOMACY MONITOR

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## Health Diplomacy Monitor

The Health Diplomacy Monitor aims to report and inform readers about key international negotiations currently underway which have a significant impact on global health. The objective is to "level the playing field" by increasing transparency and making information about the issues and proposals being discussed more readily available.

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## A WORD FROM THE EDITOR

The current issue of the Health Diplomacy Monitor highlights again the diversity of global and regional fora where health diplomacy is taking place, including in fora for which health is not a primary mandate or where it has not been often discussed in the past. By covering these issues, we seek to underscore that collective actions at the global level that have an impact on health can take multiple forms and use multiple instruments. Our health diplomacy "radar" has to scan a wide territory in order to provide an accurate picture of the landscape.

Two articles review recent efforts to use the human rights framework to improve global health by improving access to clean water and sanitation. Mark Pearcey presents the content and context of two new UN resolutions on the right to water and sanitation that were

adopted at the General Assembly and at the Human Rights Council. The challenge now, as it is often the case, is to translate these texts into concrete actions and measures. Lucilla Spini and Francesca Bernardini focus on one attempt to putting the right to water into practice, which is taking place at the UN Economic Commission for Europe, using the Protocol on Water and Health adopted in 2005.

Jenilee Guebert and Robin Lennox examine the outcomes of the recent G20 Leaders' summit in Korea. Health is not explicitly on their agenda given the focus on economic matters of this forum, but the leaders of these richest nations have discussed many health-related issues such as food security and the MDGs. Their final declaration refers to non-communicable diseases as a key challenge

to be addressed. We will continue to monitor the G8 and the G20 and their approach to global health challenges in the coming years. Another article by Adam Karamdt-Scott reviews the recent work that ASEAN has been taking on health-related matters, focusing on recent meetings for regional cooperation on pharmaceutical products. Cooperation on this topic has been on-going in the region since 1979 but, since the SARS epidemic in 2003, health matters have received much more attention from this organisation.

Other contributions to this issue look at recent developments taking place in actual health fora and mechanisms such as the Global Fund and the Framework Convention on Tobacco Control. Bente Molenaar reports that donors pledged 11.69 billion USD to the Global Fund to fight HIV/AIDS, TB and malaria for the years 2011-2013. She highlights that this represents the highest level of funding in the history of the Global Fund, with an increase of 20% from the previous replenishment meeting held in Berlin in 2007. She also reports on the latest meeting of the parties to the Framework convention on Tobacco control, where members agreed to regulate the flavoring of cigarettes (with menthol, sugar, or cinnamon for example). Rene Loewenson writes about the ongoing global discussions around universal health coverage, focusing on the first Global Symposium on health systems research. This symposium aimed to address a key knowledge gap: while a substantial body of biomedical research has informed evidence based medicine and patient care, the same is not true for decisions on how to finance, organise, or manage health systems, despite their wider population impact. Finally, AsherLev Santos summarises for us some of the key outcomes of the PAHO Directing council meeting.

The editorial team welcomes your comments and suggestions on the current and future issues of the Health Diplomacy Monitor.

- Chantal Blouin

## DONORS PLEDGE RECORD LEVEL OF FUNDING FOR GLOBAL FUND



Photo: The Global Fund

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### BACKGROUND

#### THE ISSUE:

The Global Fund to Fight AIDS, Tuberculosis, and Malaria (GF) is a global public/private partnership that since its creation in 2002 has become the main source of funding for programs to fight AIDS, tuberculosis (TB), and malaria. Funding for the Global Fund comes from a wide range of donors at replenishment meetings. Donors recently met for the third replenishment round for the Global Fund.

#### GLOBAL HEALTH IMPACT:

AIDS, tuberculosis, and malaria are significant obstacles to reaching the Millenium Development Goals (MDGs). In 2008, there were an estimated 243 million cases of malaria causing 863,000 deaths, mostly of children under five years of age [1]. Similarly, TB continues to be deadly. According to WHO estimates, 9.4 million people were infected by TB in 2008 and caused the death of 1.8 million [2]. HIV/AIDS has killed more than 25 million people worldwide. Statistics show that 2.7 million people contracted HIV in 2008. Since 2002, the Global Fund has spent US\$ 19.3 billion, funding more than 572 programs in 144 countries [3].

#### THE ROLE OF DIPLOMACY:

The board of the Global Fund consists of 20 voting members, representing donor and recipient countries, as well as representatives from non-governmental organizations, the private sector (including businesses

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and foundations), and affected communities. A number of partner organizations are also represented as non-voting members of the board. Key decisions are debated at board meetings held at least twice a year.

#### PLEDGES TO THE GLOBAL FUND FOR THE YEARS 2011-2013

Donors came together in New York, October 4-5, 2010, for the third replenishment meeting of the Global Fund. Donors pledged US\$ 11.69 billion for continued work for the years 2011-2013. The contributions represent the highest level of funding in the history of the Global Fund, with an increase of 20 percent from the previous replenishment meeting held in Berlin in 2007 [4]. At a press conference, Richard Manning, the vice-chair of the replenishment meeting, emphasised the good news. Noting that despite difficult financial times, many donors had demonstrated their continued commitment to the Global Fund. For example, the United States increased its contribution by 38 percent [5]. A board member commented that the Global Fund has more funding than ever, but that it will be necessary to look for more innovative and sustainable sources of funding in the future.

#### SHORTFALL

In the months leading up to the replenishment meeting in New York, Michel Kazatchkine, the Executive Director of the Global Fund, had actively been lobbying donors for a significantly larger increase in the level of funding. The US\$ 11.7 billion pledged does not meet even the low end of the three different funding scenarios outlined by the Global Fund. According to the three funding scenarios, at the low end, US\$ 13 billion would ensure continued support for program implementation, and at the high end US\$ 20 billion would have made it possible to reach the health-related Millennium Development Goals (MDGs) [6].

In a press release dated October 5, Michel Kazatchkine noted: "We need to recognize that this amount is not enough to meet expected demand. It will lead to difficult decisions in the next three years that could slow down the efforts to beat the three diseases." Speaking at a press conference following the pledging conference, the Executive Director clarified that while the pledges do not meet the original funding scenarios, there will not be any cutbacks. He noted that the pledges made would secure existing programming as well as programming commitments made for phase II. He added that their "effort of scaling up will slow down as compared to what we were hoping for, and that would have taken us to [meet] the MDGs." The lower level of funding might affect the number of funding rounds in the coming years.

There have been suggestions that maternal and child

health (MCH) be explicitly included in the Fund's mandate. At the October 5 press conference, Michel Kazatchkine dismissed this option, saying that there is "no way we could do more on another topic without increased resources."

#### NEXT STEPS:

The Global Fund's next board meeting is in Bulgaria, December 13-15. There is no doubt that this will be an opportunity for reflection on the scale of work in light of the level of funding for the years 2011-2013. Important issues on the agenda will include consideration of the prioritization criteria. These criteria are especially critical in a context of insufficient funds for scaling up work. Other items on the agenda include a consideration of options for enhancing the Global Fund's contribution to MCH and a revision of guidelines and requirements for Country Coordinating Mechanisms (CCMs).

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## THE RIGHT TO WATER AND SANITATION: TWO NEW RESOLUTIONS AT THE UN



Photo: Rights to Water and Sanitation

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### BACKGROUND

#### THE ISSUE:

In 2000, the international community committed itself to the Millennium Development Goals (MDGs). Amongst them, MDG 7(c) commits states to reducing the proportion of people without sustainable access to safe drinking water and basic sanitation by half. [1] Recent diplomatic efforts have sought to address this issue by defining a legal basis for making access to safe drinking water and sanitation a human right. Within the UN system, this has included passage of the resolution The human right to water and sanitation (A/RES/64/292) by the General Assembly on 28 July 2010, [2] and passage of the resolution Human rights and access to safe drinking water and sanitation (A/HRC/15/L.14) by the Human Rights Council on 30 September 2010. [3] By framing safe drinking water and sanitation as a human right, these resolutions seek to promote “national and international justifiable approaches that promote accountability and transparency and provide mechanisms to progressively realise increasing peoples access to water and sanitation.” [4]

#### GLOBAL HEALTH IMPACT:

According to recent estimates, “1.7 billion people have gained access to safe drinking water since 1990. Yet 884 million people worldwide still do not have access to safe drinking water and 2.6 billion people lack access to basic sanitation services, such as toilets or latrines.” [5] Indeed, recent data shows that nearly 80% of the world’s population experiences a high threat level to their water security. [6] In the coming decades, this situation is likely to worsen because of the impacts of climate change, pollution and a rapidly growing human population. [7] For example, between 2008 and 2015, it is estimated that the number of people lacking access to improved sanitation will jump from 2.6 billion, to 2.7 billion – a difference of 100 million people. [5]

This situation is most acute in sub-Saharan Africa and South Asia; in these regions it is estimated that 69% and 64% of the population respectively lacks access to basic

sanitation. [5] Lack of access to safe drinking water and sanitation affects states in both social and economic terms. According to one estimate, in “areas poorly served with water and sanitation, the child mortality rate is multiplied by 10 or 20 compared to areas with adequate water and sanitation services.” [8] Meanwhile, in 2003 it was estimated that the “overall economic loss in Africa alone due to lack of access to safe water and basic sanitation [was] \$28.4 billion a year, or around 5% of GDP.” [9]

### THE ROLE OF DIPLOMACY

Resolutions on access to safe drinking water and sanitation passed by the Assembly and Council will help establish a rights-based framework for advancing progress on MDG 7(c). This framework is deemed to offer four key benefits: 1) it establishes a legal basis for people to hold governments to account; 2) it obliges governments to engage in genuine consultation with local communities and provide full access to information; 3) it ensures that governments prioritize access to essential safe water supplies; and 4) it prohibits discrimination by ensuring laws/policies place a focus on vulnerable populations. [4]

### INTRODUCTION

In July 2010, the General Assembly took a step in recognizing the right to safe drinking water and sanitation by passing The human right to water and sanitation, tabled by Bolivia. Through it, the Assembly recognizes “the right to safe and clean drinking water and sanitation as a human right that is essential for the full enjoyment of life and all human rights.” [2] However, critics point out that the legal basis for recognizing this right is not adequately established by the resolution.

In September, the Human Rights Council adopted the resolution Human rights and access to safe drinking water and sanitation, tabled by Germany and Spain. Through it, the Council affirms “that the human right to safe drinking water and sanitation is derived from the right to an adequate standard of living and inextricably related to the right to the highest attainable standard of physical and mental health, as well as the right to life and human dignity.” [3] By establishing this basis, the resolution affirms the right as legally binding and re-affirms that states bear the primary responsibility for its realization. [3] Indeed, Catarina de Albuquerque, UN Independent Expert on the right to water and sanitation, explains that it establishes that the “right to water and sanitation is a human right, equal to all other human rights, which implies that it is justiciable and enforceable.” [10]

## POSITIONS

Introducing the draft resolution – The human right to water and sanitation – to the Assembly in July, Bolivia noted that a right to safe drinking water and sanitation had not yet been fully recognized despite references to it in various texts (e.g. Convention on the Elimination of All Forms of Racial Discrimination, and the Convention on the Elimination of All Forms of Discrimination against Women). [11] In fact, General Comment no. 15 of the Committee on Economic and Social and Cultural Rights confirmed the right to water as existing in international law, suggesting that it could be interpreted within Articles 11 and 12 of the Convention on Economic, Social and Cultural Rights (the Covenant); specifically, the right to an adequate standard of living and the right to health, respectively. [12]

Despite passing by a vote of 122 in favour to 0 against, 41 states decided to abstain from voting on the Assembly's resolution. Amongst those that abstained, the United States (US) and Canada expressed substantive and procedural concerns about the text. On a substantive level, the US questioned the legal basis of the right, indicating that there is "no 'right to water and sanitation' in an international legal sense." [11] Echoing similar concerns, Canada detailed procedural deficiencies in the drafting of the text. It claimed that the Assembly's resolution pre-empted the work of the Council, and limited the opportunity for international consensus. Specifically, Canada pointed out that the resolution prevented full consideration of de Albuquerque's annual report to the Human Rights Council [11] – the UN Independent Expert on the right to water and sanitation is mandated by Human Rights Council resolution 7/22, to submit an annual report to the Council on the issue of human rights obligations related to access to safe drinking water and sanitation.\* [13] For Canada,

*The work of the Independent Expert was expected to serve as a basis for member states to consider, debate and delineate the basis, scope and content of any right to water and sanitation. It is premature to recognize such a right without allowing states the benefit of full deliberation based on the Independent Expert's findings, their own internal processes and the agreement of states. [11]*

Building on momentum generated by the Assembly, the Council passed Human rights and access to safe drinking water and sanitation by consensus in September. Reason for consensus within the Council was largely based on the resolution's role in establishing a legal foundation for the right. Having previously abstained from voting on the Assembly's text, the United States was 'proud' to join consensus by voting in favour of the Council's resolution. In its explanation of vote, the US agreed with the Council's assessment that a right to safe drinking water and

sanitation is derived from the economic, social and cultural rights of the Covenant. [14] On this basis, it further claimed that signatories to the Covenant must undertake steps to achieve its full realization. [14]

Although choosing not to call for a vote on the Council's resolution, the United Kingdom (UK) chose to disassociate itself from consensus. Its representative, Peter Gooderham, indicated that while the UK supported the view that a right to safe drinking water was derived from the right to an adequate standard of living, no legal basis existed to identify sanitation as a human right. [15] Specifically, since no internationally agreed to definition existed for the term 'sanitation,' the Council's resolution risked ambiguity; both in terms of what an individual could claim from the state, and what a state must afford its population. [15] The UK's position was later met by strong criticism from civil society, which has for the most part received the Assembly and Council resolutions warmly. Danielle Morley, Executive Secretary of Freshwater Action Network, suggested inconsistency in the UK position, pointing to the fact that the UK reaffirmed its commitment to MDG 7 at the High Level UN Summit on the MDGs in early September. [16] Likewise, Amnesty International also criticized the UK government for its stance, requesting that it rectify its position at the earliest possible date. [17]

## NEXT STEPS

Moving forward, the primary issue confronting the international community will be translating the right to safe drinking water and sanitation into concrete reality. Of the measures proposed by the Council's resolution, this will involve: 1) developing tools/mechanisms to achieve the right to safe water and sanitation; 2) ensuring full transparency in the implementation process of delivering safe drinking water and sanitation; 3) focusing on marginalized groups; 4) integrating human rights impact assessments; 5) adopting/implementing effective regulatory frameworks; and 6) putting in place accountability mechanisms to remedy human rights violations. [3]

\*The UN Independent Expert on the right to water and sanitation also presents an annual report to the General Assembly, as mandated by Human Rights Council Resolution 12/8.

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## PUTTING THE RIGHT TO WATER INTO PRACTICE: THE PAN-EUROPEAN PROTOCOL ON WATER AND HEALTH



Photo: UNICEF Dushanbe and Waterwiki.net

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### BACKGROUND

#### THE ISSUE:

The Protocol on Water and Health to the 1992 UNECE Convention on the Protection and Use of Transboundary Watercourses and International Lakes (the Water Convention), adopted at the WHO-Europe Third Ministerial Conference on Environment and Health (London, UK, 16–18 June 1999) is the first legally binding agreement linking the sustainable management of water resources and the reduction of water-related diseases. As per its Article 22, the Protocol is open for accession by States members of the UN Economic Commission for Europe (UNECE) and by States members of the Regional Committee for Europe of the WHO. So far, 24 countries within the pan-European region – a region ranging from North America to Central Asia – have ratified the Protocol.

One of the main objectives of the Protocol is to ensure access to safe water and adequate sanitation to everyone, thus representing a useful tool to translate the human right to water and sanitation into practice. On 23-25 November 2010, the Second Session of the Meeting of the Parties to the Protocol took place in Bucharest (Romania). The meeting focused on reporting requirements and how to support Parties in setting targets, establishing surveillance and early-warning systems, as well as response plans.

#### GLOBAL HEALTH IMPACT:

Access to drinking water and to sanitation is substantially lower in the Eastern part of the pan-European region, in particular in rural area. Eastern Europe, the Caucasus and Central Asia is the only region in the world not progressing towards the related Millennium Development Goals (MDGs) to access to water and sanitation; many countries are stagnating if not regressing with obvious consequences in hygiene and water-related disease. [2] Lack of sanitation, improper waste treatment, unsafe disposal methods for chemicals, overuse of fertilizers

and unsustainable water management pose tremendous health threats, exacerbated also by new emerging issues such as climate change. According to the World Health Organization (WHO), more than 13,000 children under the age of 14 die every year from water-related diarrhoea, mostly in Eastern Europe and Central Asia.

#### THE ROLE OF DIPLOMACY:

In 1999, the ministers and representatives of European Member States of WHO, recognizing “the continuing lack of reliable access to sufficient safe water and sanitation for many communities” in the region, adopted the Protocol on Water and Health, at the occasion of the Third Ministerial Conference on Environment and Health in London (UK). The Protocol, within the framework of the WHO European environment and health process, entered into force in 2005 and has to date 24 Parties within the pan-European region.

The Protocol’s objectives encompass the protection of human health through the improvement of water management, the prevention, control and reduction of water-related diseases, as well as the protection of ecosystems. It operates through two core provisions, namely the setting of national targets addressing the entire water cycle and the establishment of surveillance and systems for early warning and response to water-related disease. Quite uniquely for multilateral environmental agreements, the Protocol is jointly serviced by the World Health Organization Regional Office for Europe (WHO/EURO) and the United Nations Economic Commission for Europe (UNECE), which facilitate and coordinate the implementation of activities.

#### INTRODUCTION

The First Session of the Meeting of the Parties (MOP) to the Protocol was held in Geneva (Switzerland), on 17-19 January 2007.[1] This was the opportunity to define the functioning and architecture of the Protocol, including the terms of reference of the bodies under the Protocol: the Compliance Committee, the Task Force on Indicators and Reporting, the Task Force on Surveillance, and the Task Force on Extreme Weather Events.

Co-chaired by Norway and Romania, the Second Meeting, which took place in Bucharest, was attended by 33 countries, several UN organizations (e.g. UNESCO, UN-HABITAT, and UNU-INWEH), intergovernmental, and non-governmental organizations. This article summarises the key outcomes of that meeting.

#### NEW CONTRACTING PARTIES

At the meeting, several countries announced that they had started the process of ratification or accession to

the Protocol. Some were very advanced, like Bosnia and Herzegovina which had completed the national procedure. Armenia, Kyrgyzstan, Serbia, Slovenia, Sweden, the former Yugoslav Republic of Macedonia announced that they were planning to become Parties by the end of 2011. Extending the geographical coverage of the Protocol to the East and South of the region is crucial, given that this is where the needs are the greatest.

#### FIRST REPORTING EXERCISE

The MOP reviewed the first pilot reporting exercise under the Protocol and noted with appreciation that national reports had been submitted by more than three-quarters of the Parties to the Protocol, as well as by three States not Party to the Protocol. A varied quality of reports was received, as highlighted in the regional report on the status of implementation of the Protocol, prepared by the Joint Secretariat, summarizing information from 23 national summary reports. Inter alia, differences were identified amongst reports depending on the countries’ progress on setting targets, and vague information was provided with respect to emerging issues such as climate change. Furthermore, particular differences were found between reports which were consulted between ministries and those who were not. Taking into account these issues, the MOP adopted the guidelines and template for summary reports in accordance with Article 7.

#### GUIDANCE, GUIDELINES AND TOOLS

Several new products, tools and publications developed under the Protocol were presented and adopted to provide guidance on different water-related topic areas and advance the implementation of the Protocol.

**“Guidelines on the Setting of Targets, Evaluation of Progress and Reporting”[3]**, developed by the Task Force on Indicators and Reporting, under the leadership of the Government of Switzerland, to address the challenges highlighted by the Parties with respect to setting targets and reviewing and assessing progress, in accordance with the provisions in Articles 6 and 7. As Parties are required to set measurable targets in areas covering the entire water cycle (e.g. quality of drinking, bathing and waste water), set dates by which these targets will be achieved, and report on progress towards achievement of these targets, the document is a key tool towards advancing the implementation of the Protocol. It provides a logical framework as well as strategic and practical recommendations, and build on existing good practices and experiences of the Protocol’s Parties.

**“Policy Guidance on Water-Related Disease Surveillance”[4] and the “Technical Guidance for Setting Up, Implementing and Assessing Surveillance Systems of Water-Related Disease” [5]**, developed through the Task Force on Surveillance, under the leadership of the Government of Italy. These documents are intended to assist countries in establishing surveillance and early-warning systems, as well as contingency and outbreak response plan in accordance with Article 8 of the Protocol.

**“Guidance on Water Supply and Sanitation in Extreme Weather Events”**[6] (publication) developed through the Task Force on Extreme Weather Events under the leadership of the Government of Italy, also with the support of the Government of the Netherlands. The Guidance is intended to assist policy-makers and managers of water supply and sanitation services in making water supply and sanitation services resilient under changing weather patterns and extreme weather events (e.g. floods).

**“Small scale water supplies in the pan-European Region: Background – Challenges – Improvement”** [7] (publication), developed under the leadership of the Government of Germany. The publication is intended to support decision-makers in addressing the specific challenges of small-scale water supply and sanitation systems that are the backbone of water supply in rural areas in the pan-European region.

#### TECHNICAL ASSISTANCE AND PROJECT IMPLEMENTATION

Under the Protocol, Parties are required to assist each other towards implementation. At its first session, the MOP established the Ad Hoc Project Facilitation Mechanism (AHPFM), chaired by Norway, to foster coordination of international aid and to enhance the capacity of recipient countries in Eastern Europe, the Caucasus, Central Asia and South-Eastern Europe, to facilitate access to the funds required to implement the Protocol. At this second MOP, the Parties have recognised the potential of the Mechanism for promoting action on the ground and triggering partnerships between donor and recipient countries. In Ukraine and in the Republic of Moldova, the Mechanism has supported projects allowing the two countries to set targets and target dates in accordance with the Protocol, in accordance with Articles 6 and 7. The project in the Republic of Moldova on setting national targets and target dates was presented, including the process of national expert meetings and broader consultations with civil society culminating in the approval of the List of National Targets and Target dates by a joint order of Ministers of Environment and Health. The growing number of additional requests for assistance showed the need for continuation and further development of this initiative.

#### PUBLIC PARTICIPATION

The Protocol invites public participation and involvement in the pursuit of the basic human right to water and sanitation. As also highlighted at the Workshop on Information and Public Participation in Water and Health-related Issues (Bucharest, 15-16 June 2010), under the leadership of the Government of Romania and Women in Europe for a Common Future (WECF), the involvement of the public in the implementation of the Protocol is of crucial importance. A concept note on access to information and public participation under the Protocol (ECE/MP.WH/2010/4-EUDHP/1003944/4.2/1/10), submitted by the WECF, in

cooperation with the Ministry of Environment and Forests of Romania, highlighted the relevant provisions under the Protocol, as well as examples of best practices, including the Atlas on Water and Health (WHO Collaborating Centre for Health Promoting Water Management and Risk Communication), the Aarhus Centres and initiatives by Non-Governmental Organizations (NGOs). However, it was also noted that public participation still remains a common challenge. To tackle this difficulty, Parties agreed on an innovative cooperation with the UNECE Convention on Access to Information, Public Participation in Decision-making and Access to Justice in Environmental Matters (Aarhus Convention), which will also address the development of guidelines/manuals for involving the public in consultations and decision-making processes under the Protocol.

#### THE WAY FORWARD

The Third Session of the MOP to the Protocol on Water and Health will be hosted by the Government of Norway in 2013. In the intersessional period, the Working Group on Water and Health will monitor progress in the implementation of the Protocol and of its programme of work. Thematic workshops and capacity-building activities are envisaged for the new triennium.

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# HEALTH AT THE G20: A SMALL BUT SIGNIFICANT STEP IN SEOUL



Photo: The Korea Herald

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## BACKGROUND

### THE ISSUE:

The Group of Twenty (G20) met for their fifth summit on November 11-12, 2010, in Seoul, Korea. On par with previous summits, the leaders' primary focus was on economic and financial issues. While the leaders did not discuss health in a major way, it was specifically referenced in their final summit documents. Most notably, non-communicable diseases and the importance of health issues were highlighted in both the Seoul Development Consensus and the Multi-Year Action Plan for Shared Growth. The related issue of development was a prominent theme, culminating in the Seoul Development Consensus for Shared Growth. Other health-related issues, including climate change, food security, and poverty reduction, were also discussed.

### GLOBAL HEALTH IMPACT:

Many have advocated for the G20 leaders to take up global health issues since they started meeting in November 2008. Members such as Indonesia have also pushed for the group to take up the issue. At the Seoul Summit, while still very limited, the G20 referenced health – directly and indirectly – more than it had at any previous meeting. Health is likely to continually increase in importance on the G20 agenda. If so, the G20 could have a major impact on global health.

### THE ROLE OF DIPLOMACY:

The G20 is a leaders level group, where the most systemically significant countries compromise to address global issues in a coordinated manner. The G20 members have also met at the finance minister and central bankers governors' level since 1999. It is an informal, flexible group, where members can address any issue; shift their agenda as necessary; and invite additional countries and multilateral organizations if they want.

## THE SEOUL SUMMIT

On November 11-12, the G20 met for its fifth summit in Seoul, Korea. In keeping with its self-declared role as the world's premier economic forum, the G20 agenda focused primarily on economic and financial issues. At the end of their meeting, the leaders released two documents related to global health: the Seoul Development Consensus for Shared Growth and the Multi-Year Action Plan on Development [1]. By including development as a core item on their agenda, the Korean chair sought to ensure that the benefits of development would be shared among all countries, including Low Income Countries (LICs) that lack representation in the G20 [2]. While health was not a priority on the agenda, non-communicable diseases and several health-related issues, including climate change, food security, poverty reduction and development, were discussed.

The topic of health was also raised informally by some of the G20 representatives in describing the broader implications of their development plans. During a pre-summit press conference, Korean president Lee Myung-bak spoke of the need to share technology and best practices with developing countries in order to improve progress on issues such as health and agricultural productivity [3]. Indonesia also insisted that non-communicable diseases be mentioned in the Multi-Year Action Plan.

## THE G20 AND NON-COMMUNICABLE DISEASES

In its Multi-Year Action Plan, the G20 discussed the critical need to further develop human capital in developing countries, particularly LICs. To do so, the Action Plan emphasized the need to "identify the links between education, health problems, gender gaps and life-long skills development." In reference to health problems, the impact of non-communicable diseases was specifically mentioned [4]. This was the first mention of non-communicable diseases ever made in either the G8 or G20 declarations. Non-communicable diseases such as diabetes, cancer, cardiovascular disease, cardiopulmonary disease and obesity are critical health issues. Cardiovascular diseases alone are the world's largest killers and cause over 17 million deaths per year [5]. In relation to economic development, non-communicable diseases are a barrier to skills development and productivity [4].

This connection between health and economic growth and development is increasingly being made. A recent report released by analysts from the Organisation for Economic Co-operation and Development (OECD) emphasized the vital role that safeguarding and improving healthcare, particularly in prevention of chronic disease, will have in ensuring long-term economic growth [6]. The IMF has also

indicated the impact that growing healthcare costs will have in diminishing the ability of G20 countries to reach their goal of halving their debts by 2013 [7].

By specifying the need to address non-communicable diseases while pursuing economic development, the G20 is directly addressing this issue. Such an acknowledgment is a significant and positive step towards integrating health into the G20's larger economic agenda.

#### CLIMATE CHANGE, FOOD SECURITY, AND THE MDGs AT THE SEOUL SUMMIT

The Seoul Consensus emphasized the G20's commitment to work in partnership with developing countries, particularly LICs, to further their economic growth and development [8]. In its Multi-Year Action Plan, the G20 identified infrastructure and food security as two of the key areas for improvement [4]. The development of infrastructure, a key tenet of the partnership, will likely contribute to the improvement of healthcare systems and delivery.

The leaders also pledged to find ways to: increase agricultural productivity and increase access to food and nutrition [4]; reduce volatility in food markets in order to increase food security[1]; and to improve agricultural infrastructure in LICs in order to bolster food production [4].

The leaders also re-emphasized the importance of achieving the Millennium Development Goals (MDGs) by their 2015 deadline. They described the Seoul Consensus as complementary to the G20's commitment to achieve the MDGs, and they set out concrete measures to do so in their Multi-Year Action Plan [1]. Of the eight MDGs, MDGs 4, 5, and 6 – to reduce child mortality, improve maternal health, and combat HIV/AIDS, malaria and other diseases respectively – are health targets [9]. The achievement of all of the MDGs will have a positive impact on global health. Also, the Development Consensus emphasized the importance of making improvements in areas of poverty reduction, food security, human rights and gender equality [8]. Each of these issues relate directly to the achievement of the MDGs.

On the issue of climate change the G20 stated that they would “spare no effort” to reach a resolution at the United Nations Framework Convention for Climate Change (UNFCCC) meeting in Cancun in November-December 2010 [1]. Tackling climate change would have a substantial positive impact on global health. A growing body of scientific research has shown that the effects of climate change on human health constitute a major global health threat [10]. An agreement by the G20 to reduce greenhouse gas emissions would significantly help to

mitigate these effects.

#### HEALTH AT THE NEXT G8/G20 SUMMITS

In June 2011, both the G8 and G20 summits will be hosted in France. Development is likely to be a core issue on both agendas. It is possible that global health issues will be discussed at the next G20 summit in Cannes. However, it is more likely that the G20 will continue to expand on health-related issues rather than discuss health in a more substantial way. President Sarkozy has already affirmed his desire to include African development and food security on the next G20 agenda [11]. Continued commitment on both of these issues will likely have a positive impact on global health.

President Sarkozy has also advocated for the establishment of a permanent G20 secretariat that would be responsible for general issues, such as climate change and development [12]. Any health issues discussed by the leaders in the future would be monitored by such a body.

Following the summit in Cannes, Mexico will host the G20 in November 2012. President Calderón has already asserted his support for an expanded agenda, emphasizing the importance of development and climate change in particular [13]. The agenda has yet to be finalized and it is unknown whether health will be included. Building on the momentum of the Seoul Summit, leaders are likely to continue to recognize the importance of health as a cross-cutting issue. To what extent and in what form this recognition will appear remains uncertain.

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NEW GLOBAL MOMENTUM FOR UNIVERSAL  
 COVERAGE AND FOR BRINGING EVIDENCE  
 ON HEALTH SYSTEMS INTO POLICYMAKING



Photo: First Global Symposium on Health Systems Research

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BACKGROUND

THE ISSUE:

In November 2010, the first Global Symposium on Health Systems Research (HSR) on "Science to Accelerate Universal Health Coverage" shared evidence and identified priorities for strengthening HSR to achieve universal health coverage (UHC).

The focus and alliance that emerged from the conference and the high-level support from many global and national agencies suggest the potential for greater visibility and inclusion of evidence on health systems in future global health policy debates. While the many global forums advocating UHC indicate that there is a consistent focus on policy on universality, this doesn't necessarily imply a consistent policy view. The different perspectives on UHC indicate that the term "universal" cannot simply be assumed to mean the same interests, meanings, and values for all who use it.

GLOBAL HEALTH IMPACT:

There are currently wide gaps in coverage. For example the 2010 World Health Report indicates that the proportion of births attended by a skilled health worker in countries ranges from 10 percent to close to 100 percent, and is

highest in high-income countries and communities that already have the lowest rates of maternal mortality. Closing the coverage gap between rich and poor communities in 49 low-income countries alone would, for example, save the lives of more than 700,000 women between now and 2015 [1].

THE ROLE OF DIPLOMACY:

UHC as a goal, and the health systems strengthening it, should inform policy dialogue on specific global agendas, including the recently agreed United Nations Secretary General strategy on maternal, neo-natal, and child health; and the upcoming UNGASS strategy on non-communicable diseases. In global policy advocacy for UHC, it will be important to make clear and discuss the different positions on UHC, their policy options and consequences, and the political views and values that lie behind them.

RAISING THE GLOBAL PROFILE OF KNOWLEDGE ON HEALTH SYSTEMS

In 2008, the World Health Report called on health leaders to understand the value of investment in health systems research. In the report, the World Health Organization (WHO) pointed to a deficit in investment in research on health systems and in the understanding of the political context, performance, or perceptions of the health system, commenting that, "No other \$5 trillion economic sector would be happy with so little investment in research related to its core agenda.... [2, p. 110]. This suggests that while a substantial body of biomedical research has informed evidence-based medicine and patient care, the same is not true for decisions on how to finance, organize, or manage health systems, despite their wider population impact.

As one response to this, the WHO and other partners held the First Global Symposium on Health Systems Research (HSR) in November 2010 in Montreux, Switzerland. The conference gathered 1,200 participants from over 100 countries and from diverse constituencies – researchers, health officials, policy makers, funders – to share and debate current HSR and explore how to strengthen the production and use of HSR in policy and practice, particularly in low and middle-income countries. While there have been many disease and issue specific global forums that include health systems issues, this was the first global symposium to make the system itself a focus.

This reflects a growing understanding that while globalization has challenged the performance of health systems in many countries, there has been a relative neglect of the investments and steps needed to make

health systems equitable, inclusive, and able to deliver programmes that respond to specific public health challenges. The 2008 World Health Report points to a need to refocus on the system as a whole, calling for reforms relating to universal coverage, service delivery, public policy, and leadership [2]. The Global Symposium thus took as its theme “Science to Accelerate Universal Health Coverage,” to share evidence, identify significant knowledge gaps, and to identify priorities for strengthening HSR to achieve universal coverage.

#### THE GLOBAL SYMPOSIUM ON HSR

Research was presented on the financing, organization, and leadership of health systems; health worker issues; the role of relationships, trust, and social power in organizing systems towards universal coverage. There were debates on methods, capacities, and incentives for implementing HSR, and options for stimulating the use of research knowledge in policy and practice (see <http://www.hsr-symposium.org> for plenary session webcasts and the background papers).

The final statement to the conference from the Steering Committee recognized that “there is an enormous energy to move forward with a further agenda of action...” [3]. The steering committee, consisting of thirty academics, UN agencies, national health institutions, development agencies, foundations, global funds, and international research organizations (see <http://www.hsr-symposium.org/index.php/steering-committee>) initiated a new alliance of actors globally with an agenda of work to:

- electronically archive and disseminate the papers and debates at the conference;
- create an international society for health systems research, knowledge, and innovation, to build greater constituency, credibility, and capacity for improved and interdisciplinary HSR globally, and to provide visibility and support to regional, national, and collaborative efforts on HSR; and
- focus on the United Nations SG strategy on maternal, neo-natal, and child health and the upcoming UNGASS on non-communicable diseases to strengthen health systems in order to accelerate universal health coverage. As Lincoln Chen of the China Board and Harvard University noted at the closing of the conference, this does not imply building dogmatic prescriptions for identical actions. Instead, it shifts the policy dialogue to agreeing on principles for action, to exchanging evidence on the effectiveness of action, and to ensuring accountability for achieving citizens’ entitlements to UHC.

The focus and alliance that emerged from the conference and the support of the high-level organisations in the steering committee suggests the potential for pursuit of these approaches, and for raising the visibility, production, and inclusion of evidence on health systems in future

global health policy debates.

The symposium sessions also raised many challenges to be overcome. Health systems are complex, and the interdisciplinary approaches needed to understand them may yield evidence that appears to be less compelling or “scientific” than that from experimental approaches. HSR is not isolated from the demands of politics, policy, and practice, calling for approaches that build participation of affected communities, learning by doing, and links to policy actors, while still maintaining scientific rigour. Moreover, competitive funding models undermine the collaborative relations needed to build research capacities in low and middle-income countries. Finally, African countries, in particular, have limited Internet user penetration (reaching only 9.6 percent in 2010 compared to 67 percent in Europe) excluding many from participating in the increasingly electronic processes for communicating and sharing knowledge globally [4].

#### DIFFERENT UNDERSTANDINGS OF UNIVERSAL HEALTH COVERAGE

A fundamental challenge is building clarity on what is meant by universal health coverage (UHC). Within two weeks of the Global Symposium, a series of events related to universal health coverage took place: an international ministerial conference was held in November 2010 by the WHO on “Health Systems Financing: Key to Universal Coverage” hosted by the German government; the WHO launched its 2010 World Health Report entitled “Health Systems Financing: The Path to Universal Coverage”; and in December 2010, the Government of Brazil and the World Social Forum on Health held the First World Conference on the Development of Universal Social Security Systems. Clearly, there is a consistent focus on policy on universality, but this doesn’t necessarily imply a consistent policy view.

The World Health Assembly in 2005 endorsed a resolution defining UHC as access for all to appropriate health services at an affordable cost. In its 2010 annual report, the WHO sets the principle that universal coverage demands that countries work to set up pooled funds that cover three dimensions: expanding the number of people covered, expanding the scope of services and reducing cost sharing (direct payment such as user fees). There is consensus that imposing large fees for health care is unacceptable, since it would impoverish poor communities. However, from that point on the policy differences emerge.

These principles set a policy focus that is primarily on the financing and benefits options, to incrementally widen access to health care. The Rockefeller Foundation has launched a Joint Learning Network of countries

implementing Universal Health Coverage, and Dr. Ariel Pablos-Mendez of the Rockefeller Foundation has argued that UHC is a goal that can be achieved through a mix of public and private funding options, including through private insurance arrangements for different social groups [5].

At the World Conference on the Development of Universal Social Security Systems, the Government of Brazil and the World Social Forum focused on rights based guarantees and entitlements for all citizens to achieve universal access to health care. To achieve this, measures are required to overcome segmentation in the health system and eliminate inequalities in access to health systems. Progressive taxes and mandatory public insurance systems are the means to facilitate the risk pooling and solidarity to achieve this; but, as this is contested by wealthy groups, it also demands social power and action for people to demand and use these services. As researchers from Africa, Asia, and the Americas said in a statement at the final plenary of the symposium: "Equity is the central goal. Universal health coverage is the means of achieving equity."

A further debate has been raised within all the forums above, whether UHC is a matter for each state to secure on its own, with ad hoc international assistance for low-income countries, or whether there is a national and global obligation to guarantee a basic health entitlement for all people and to finance this through more predictable global health funding than at present.

Even more deeply, as Ilcheong Yi of the UN Research Institute for Social Development argued in the World Conference on the Development of Universal Social Security Systems, universalism can be viewed not simply as a matter of the funding, allocation, and expansion of social benefits and services, but a principle for organising social and economic reform across all spheres of production, redistribution, and protection, to address poverty and inequality [6].

Within global forums, the debates indicate that the term "universal" cannot simply be assumed to mean the same for all users. The Second Global Symposium on HSR is planned for 2012 or 2013 to evaluate progress, share insights, and recalibrate the agenda of science to accelerate universal health coverage, hosted by China. It will be an opportunity to review the extent to which knowledge and evidence on approaches to UHC are informing existing UN and national strategies, such as those on maternal, neo-natal, and child health and non-communicable diseases. Within the context of the strengthening global policy advocacy for UHC, as the Peoples Health Movement commented in a statement at

the Global Symposium on HSR, it will be equally important for the research community to give voice to and discuss these different positions, the policy options they imply, and the political and ideological views and values that lie behind them.

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# IMPLEMENTING THE FRAMEWORK CONVENTION ON TOBACCO CONTROL: NEW REGULATION ON TOBACCO FLAVOURING



Photo: Framework Convention Alliance

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## BACKGROUND

### THE ISSUE:

The Conference of the Parties to the WHO Framework Convention on Tobacco Control (COP4) met November 15-20, 2010, in Uruguay. It was a regularly scheduled meeting of the COP, and the purpose was to review progress and make decisions to improve implementation.

### GLOBAL HEALTH IMPACT:

It has been estimated that tobacco use kills more than five million people a year. Up to half of current users are expected to die of a tobacco-related disease. Second-hand smoking also represents a significant health risk, causing some 600,000 premature deaths annually [1].

### THE ROLE OF DIPLOMACY:

In February 2005 the WHO Framework Convention on Tobacco Control (FCTC) entered into force. It has 172 Parties and represents WHO's most important tobacco control tool. The Conference of the Parties (COP) is the governing framework of the FCTC. They meet regularly to review the implementation of the FCTC. They adopt annexes, protocols, and amendments to the Convention, and make decisions to improve its efficiency. The COP can also establish subsidiary bodies to carry out work. One such example is the Intergovernmental Negotiating Body for the elaboration of a Protocol on Illicit Trade in Tobacco Products.

## INTRODUCTION

The fourth session of the Conference of the Parties to the WHO Framework Convention on Tobacco Control (COP4) took place November 15-20, 2010, in Uruguay. The meeting was described by the Framework Convention Alliance (FCA) as an achievement for global health. They view the guidelines dealing with the issue of adding flavours to tobacco as a major step forward [2].

## THE FRAMEWORK CONVENTION ON TOBACCO CONTROL (FCTC)

The FCTC was developed in response to rapidly expanding tobacco use globally. Increasingly, smokers live in low or middle-income countries, placing significant strain on health systems, which, in many cases, are already stretched. Global marketing of tobacco products, along with sponsorships and advertising, have contributed to making tobacco use an international problem. The FCTC aims to help Parties reduce the demand for tobacco products, as well as finding strategies to tackle supply issues. Articles 6-14 contain measures to reduce demand:

- price and tax measures;
- protection from exposure to tobacco smoke;
- regulation of contents of tobacco products;
- regulation of packaging and labelling;
- training and education; and
- regulation of advertising, promotion, and sponsorship.

Provisions 15-17 deal specifically with the supply side of tobacco use. The articles consider:

- the illicit trade in tobacco products;
- sales to and by minors; and
- provision of support for economically viable alternative activities [3].

The tobacco industry is strong in many countries. According to the Food and Agriculture Organization (FAO) of the United Nations, in countries such as Brazil and China, for example, unmanufactured tobacco is among the top 20 food and agricultural commodities. In a country like Malawi, unmanufactured tobacco is the second most important food and agricultural commodity [4]. Finding alternative crops for those currently reliant on tobacco is therefore important. The industry leads active lobbying efforts on several fronts. On the legal front, the tobacco company Philip Morris International recently filed a case with the World Bank's International Centre for Settlement of Investment Disputes (ICSID) against Uruguay over anti-tobacco control measures, including graphic warnings on packaging. Philip Morris International denies that the Bilateral Investment Treaty claim is aimed at tobacco control measures. Instead, they maintain, they are challenging regulations that go far beyond public health measures. Regulations forcing companies to sell only one pack variation per cigarette brand, an increase in health warnings on tobacco packaging to 80 percent, and the requirement to print images on tobacco packaging that include shocking pictures will harm the company's investments in Uruguay, argues PMI. The case is still pending [5]. Meanwhile, COP4 passed a declaration in support of Uruguay, "reaffirming their strong commitment to prioritize health measures and to exchange information on the industry's activities which attempt to interfere with

the implementation of public health policies” [6].

#### THE FOURTH MEETING OF THE CONFERENCE OF THE PARTIES

The Conference of the Parties adopted partial guidelines on the implementation of Articles 9 and 10. Article 9 deals with the testing and measuring of contents and emissions of tobacco and their regulation, while Article 10 deals with the disclosure of information on content and emissions to government authorities, as well as the public [6]. The draft guidelines were developed by a working group of Parties for consideration at the Uruguay meeting.

The guidelines deal with the use of flavouring ingredients used in tobacco, such as sugars, menthol, or spices, such as cinnamon and mint, for example. The use of flavouring masks the “harsh and irritating character of tobacco smoke” [7], and by regulating the use of these, it is believed that fewer people would start using tobacco products.

The adoption of the guidelines was viewed by the FCA as a major step forward, and such regulation will help reduce the number of new, often young, smokers. The tobacco industry weighed in heavily against this, leading up to the COP4, arguing that such measures would discriminate against certain types of tobacco, such as burley tobacco. China argued against the regulation of additives and flavouring, but late in the negotiations joined the majority. Guidelines on Article 12, which deals with education, communication, training, and public awareness, were also adopted. These hold that Parties should establish further infrastructure and support training and education to raise awareness about the risks associated with smoking. Further guidelines for implementation of Article 14 (Demand reduction measures concerning tobacco dependence and cessation) outline how Parties should integrate services aimed at helping people stop smoking into national health care systems in order to make them more accessible. The hope is that this would contribute to an increase in the number of smokers who manage to quit. There was a decision to continue work in the area of options for viable alternative livelihoods for tobacco growers. The working group’s mandate was extended. The delegates also decided to create a new working group to draft guidelines on price and tax measures (Article 6) if funding can be secured to carry out the work [7].

The International Negotiating Body (INB) will continue work on a protocol to combat illicit trade in tobacco products, with the goal of concluding work in 2012.

#### NEXT STEPS

Although a number of new guidelines were adopted, effective implementation will continue to be a challenge

in the efforts to curb tobacco use. Funding will remain a challenge for the FCTC, and Parties were called upon to comply with their obligations to pay dues in a timely fashion. The Conference of the Parties is expected to meet again in the Republic of Korea in the last quarter of 2012.

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## ASEAN AND REGIONAL COOPERATION ON PHARMACEUTICALS



Photo: The Global Fund

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### BACKGROUND

#### THE ISSUE:

The 26th meeting of the ASEAN Working Group on Pharmaceuticals Development (AWGPD) was held in Bangkok, Thailand, from December 7-9, 2010. The purpose of the meeting was to develop a work plan to inform regional cooperation on pharmaceutical development, aiming at:

- better integrating and using traditional, complementary and alternative medicine in national healthcare systems
- developing a regional Pharmacovigilance systems to monitor safety of drugs
- sharing information about drug prices among members.

#### GLOBAL HEALTH IMPACT:

The Association of South East Asian Nations (ASEAN) comprises ten member states that collectively represent a total population of 600 million people. Although the organization was originally established in 1967 to promote greater economic, social, and cultural integration and ease political tensions throughout the region, particularly since the 2003 SARS outbreak ASEAN has taken a much greater role and interest in health affairs.

#### THE ROLE OF DIPLOMACY:

The region's health ministers agreed to the ASEAN Strategic Framework on Health Development (2010-2015) in July 2010 as part of their overall commitment to realizing the ASEAN One Community by 2015. Although political agreement had already been reached on the principles broadly informing pharmaceutical sector cooperation in South-East Asia, the AWGPD was tasked with developing a detailed work plan to implement the strategic framework by identifying key priorities and targets to pursue. The AWGPD is one of the longest-running health-related ASEAN working groups. It meets on an annual basis and is comprised of technical experts drawn from governments.

### ASEAN REGIONAL HEALTH DEVELOPMENT WORK

ASEAN was founded on August 8, 1967, to promote greater integration and cooperation in a region that was undergoing a period of profound post-colonial readjustment. At the

time, ASEAN's membership comprised five countries – Thailand, Indonesia, Singapore, Malaysia and the Philippines – but it soon expanded to include Brunei Darussalam, Cambodia, Laos, Viet Nam and Myanmar (formerly Burma) bringing the total membership to ten member states [1].

From its creation, the organization has operated under a decision making-by-consensus model (often referred to as “the ASEAN Way”) [3]. Yet, even though decisions were made by consensus at the highest political level, prior to the signing of the ASEAN Charter in December 2008 participation in and adherence to ASEAN agreements was voluntary. Countries could, and therefore often did, opt out if it was later determined the agreement was not in their national interest [4].

In 2003, ASEAN Leaders agreed to form the ASEAN Community. Under this agreement, a new ASEAN Charter was developed to facilitate the creation of the “One Community” by 2015 [5]. The organization's portfolio of responsibilities has been divided into three “pillars” or streams that include political-security, economic, and socio-cultural. The Charter, which was signed in December 2008, also established a new legal framework, provided ASEAN with a new legal identity, and allowed for the creation of a number of new organs, such as working groups, to boost its community-building process [6, 7]. Under the terms of the Charter, decisions made by consensus are now also legally binding on ASEAN member states.

Health and health-related matters were not a core focus of ASEAN when the organization was established. Rather, other agencies such as the World Health Organization's regional offices in South-East Asia (SEARO) and the Western Pacific Region (WPRO) were viewed as more technically competent to address these issues. One of the exceptions to this general rule was the ASEAN Technical Cooperation Project on Pharmaceuticals that was initiated in 1979 [8].

The primary purpose of this project when it was launched in 1979 was to strengthen the pharmaceutical sector industry throughout all ASEAN countries to “ensure the sufficient and regular supplies of effective and safe essential drugs of acceptable quality.” [8]

Beyond the pharmaceutical sector, in 2000, ASEAN Health Ministers met in Indonesia for only the fifth time since the organization's creation to endorse a new initiative “Healthy ASEAN 2020” that maintained “health shall be at the centre of development [10]. The importance of health to ASEAN was then further reinforced following the 2003 SARS outbreak. ASEAN played a key role in coordinating

the response of its member states to this crisis [11], and particularly since 2003 the organization has assumed an ever-increasing interest in health matters. Indeed, it is only over the past decade that health ministers from ASEAN countries have met regularly on a biannual basis. Extraordinary meetings have also been called to coordinate governments' responses to humanitarian crises such as the 2003 SARS outbreak, the spread of H5N1 influenza, and the 2009 H1N1 Swine Flu pandemic [12].

The AWGPD exists as the longest-running health-related working group within ASEAN, having been established in 1979 to advance the ASEAN Technical Cooperation Project on Pharmaceuticals. The name and function of the working group has changed over time to include new areas of responsibility such as improving regulation of traditional, alternative, and complementary medicine [15, 16]. Although the working group initially worked very closely with other health bodies such as the World Health Organization, relying on the technical expertise they provided, in later years the working group has become increasingly self-reliant as the technical expertise within ASEAN countries has continued to grow and develop. The contemporary core focus of the group is on modern pharmaceutical development, procurement and regulation, as well as overseeing the development, quality improvement, and standardisation of both conventional and traditional medicine and practices. Due to the highly specialized nature of the subjects discussed by the AWGPD, delegates attending the working group meetings are primarily drawn from government with a professional background, training and qualifications in pharmaceuticals [9].

#### THE 26TH ASEAN WORKING GROUP ON PHARMACEUTICALS DEVELOPMENT MEETING

The 26th AWGPD meeting was held over three days in Bangkok, Thailand, between December 7-9, 2010. Delegates from eight of the ten ASEAN member states attended the meeting. (Myanmar and Cambodia did not send a delegation). The core purpose of the meeting was to develop and endorse a detailed work plan to ensure the successful implementation of the ASEAN Strategic Framework on Health Development (2010-2015) that had been agreed to by health ministers at the tenth ASEAN Health Ministers Meeting earlier that year in July. Under this framework, the AWGPD has been tasked with initiating, facilitating, and coordinating several core areas of pharmaceutical-related work, including:

- developing a regional roadmap for the integration of traditional, complementary, and alternative medicine into national healthcare systems;

- developing recommendations and strategies to better utilize traditional medicine as alternative healthcare;
- development of an ASEAN Pharmacovigilance System that will monitor the safety of medicines to reduce harm and assist decision-making in the allocation of resources [17]; and,
- promote the sharing of information among ASEAN member states on drug prices to improve access to essential medicines [16].

The majority of the three-day meeting was officially closed to the public; however, representatives from United States Pharmacopeia – a US non-governmental organization/public standard-setting authority for over-the-counter and prescription medicines – and the US-based Centre on Global Development think tank were invited to present. The meeting concluded with the development and full endorsement of a new work plan that will guide member states' activities. The new work plan includes a series of measureable criteria to evaluate member states' performance [9]. In this regard, the ASEAN Secretariat charged with facilitating and coordinating member states' efforts, hailed the meeting as a "great success" observing that, "we now have a viable and detailed action plan for achieving very significant reforms ahead of 2015 that will have very positive and widespread benefits for the people of the South East Asian region." [18]

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## PAHO DIRECTING COUNCIL MEETING: TOBACCO CONTROL, IHR, VACCINES, MALNUTRITION, CHAGAS DISEASE



Photo: <http://new.paho.org>

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### BACKGROUND

#### THE ISSUE:

The meeting of the Directing Council of PAHO (Pan American Health Organisation) was held on 27 September to 1 October in Washington, D.C. Commitment to key issues were made to ensure continued multilateral cooperation for health in the region, focusing on strengthening regional public health institutions and delivery mechanisms, the Framework Convention on Tobacco Control, and the IHR and epidemic preparedness.

#### GLOBAL HEALTH IMPACT:

Strengthening regional governance and coordination will help continue progress toward improved health outcomes. This includes specific health outcomes related to vaccine preventable diseases or vector born diseases such as Chagas. This also includes normative declarations

regarding the importance of health as a key issue for security and for collective, multinational action as seen in the support of regional centers.

#### THE ROLE OF DIPLOMACY:

The Directing Council is one of the four PAHO governing bodies. The others are The Pan American Sanitary Conference (the Conference), The PAHO Executive Committee and The Pan American Sanitary Bureau (the Bureau). The Conference is the main governing entity, which meets every five years. In the years that the Conference does not meet, the Council convenes and acts in its place. Each member state is represented and has voting privileges during Council proceedings with The Executive Committee shaping the Council agendas.

Countries in the Americas are not new to using diplomacy and foreign relations to achieve health goals. In fact given the difference among member states in their capacity to support health initiatives, several countries in the region is dependent on cooperative action to accomplish health outcomes.

### INTRODUCTION

The 50th Directing Council of the Pan American Health Organization (PAHO) met from 27 September 2010 to 1 October 2010. The key issues considered included the implementation of agreements such as the Framework Convention on Tobacco Control (FCTC) and the International Health Regulations (IHR) in the region; the continued support for regional institutions such as the Revolving Fund for Vaccines; and the interruption of malnutrition and diseases such as Chagas disease.

### FCTC IMPLEMENTATION IN THE REGION

The Framework Convention on Tobacco Control (FCTC) is the first international treaty that focused on health and was negotiated under the auspices of the World Health Organization.<sup>1</sup> Major components of the FCTC are prohibition of tobacco advertisements, explicit labeling requirements and stricter regulations on the use and distribution of tobacco products. In the region of the Americas, 27 member countries (77%) are a party to the convention.<sup>2</sup> Noting the efforts of the tobacco industry to undermine tobacco control legislation in member countries, the Council resolved to help improve member countries' capacity to shape appropriate legislation to meet FCTC requirements.<sup>3</sup> However, tobacco companies argue that such restrictions and labeling requirements pose a restriction to free trade. Provisions in the FCTC to address

to address trade were not included in the negotiated treaty.<sup>4</sup> Whether or not there will be amendments to the FCTC to address the tension between trade and health priorities is unclear. What is also unclear is whether regional agreements can be used to address this.

#### IHR IMPLEMENTATION

The International Health Regulations proved critical in shaping the surveillance methods and the global response during the 2009 H1N1 influenza pandemic. The IHRs are not binding, hard-law treaties, but rather consensus based agreements that provided a framework for communication and mobilization of resources and personnel. Labs in Canada and the United States identified and confirmed this novel strain of the H1N1 virus. The origin of these cases were identified and reported to the WHO, which mobilized resources to contain the spread of the H1N1 virus, and to mobilize treatment for those infected. Member states lauded the action and cooperation during the H1N1 pandemic, but also called for continued vigilance, particularly in strengthening surveillance systems and the vaccination processes for vulnerable groups such as pregnant women. However, just how such strengthening will come about was not specified. Surveillance under the IHRs depends on the capacity of individual nations to conduct surveillance activities. Regional cooperation and data sharing may compensate for countries with less developed infrastructure. During this Council meeting, member states resolved to continue supporting regional centers such as the Latin American and Caribbean Center on Health Sciences Information (BIREME) in Brazil and to have closer ties with national public health institutions in the region.<sup>5</sup>

#### REVOLVING FUND FOR VACCINES

2010 marked the 30th Anniversary of the Revolving Fund for Vaccines. The Revolving Fund has effectively provided member states with a collective bargaining mechanism for lower cost vaccines. To date 300 million doses of vaccines have been procured through the fund. The Hon. Dr. Esperanza Martinez, Minister of Health from Paraguay, spoke to the benefits of the Revolving Fund for Vaccines crediting the fund for helping eliminate polio and measles from the region with the potential to eliminate rubella as well.<sup>6</sup> However, the increased use of these bargaining mechanisms has taxed the fund's financial resources. In order to continue supporting this effort, the Directing Council resolved to increase the amount charged to member countries to access the mechanisms from three percent to three and a half percent.<sup>7</sup>

#### MALNUTRITION

The Directing Council approved a strategy to improve the rates of malnutrition in the region. Almost 32 million children under five years of age suffer effects from malnutrition in the Americas, the effects of which are unevenly dispersed between countries or ethnic groups within countries. For example, Costa Rica has an estimated malnutrition prevalence rate of 5.6% while Guatemala is almost 55%.<sup>8</sup> The strategy approved by the Council urges member states to develop nutrition related policies. The strategy also recognizes the role other United Nations agencies, non-governmental organizations, and private entities can play, and encourages cooperation between these groups to accomplish these goals. The report to the Council highlighted the potential positive effect that addressing malnutrition would have on the Millennium Development Goals.<sup>9</sup>

#### CHAGAS DISEASE

The Council resolved to continue efforts to combat Chagas disease. Chagas disease is the most prevalent tropical disease in the region. By the end of 2001 Chagas disease burden was greater than that of malaria, leishmaniasis, leprosy or schistosomiasis combined.<sup>10</sup> Previous declarations by the World Health Assembly and PAHO set goals to interrupt Chagas disease by 2010.<sup>11</sup> However, many countries in the region failed to reach this goal given the low priority of Chagas disease on health agendas, limited resource allocation, and problems with how national and local health systems interact.<sup>12</sup> New goals for 2015 were outlined in the strategy to interrupt Chagas disease transmission. This new strategy called for the reduction of vector born transmission of *T.cruzi* and increased services for those infected.<sup>12</sup>

#### Next Steps

Member states voted to approve resolutions that encourage member states to support PAHO initiatives and strategies. However with many of the resolutions and decisions made, little tangible resources were dedicated to accomplishing these goals. Increasing financial resources to support acquisition of public health materials and the revolving fund for vaccines is an exception. Another exception is the support for regional centers like the BIREME to aid in data sharing. However, many of the recommendations leave it up to the member nations to increase their capacity to accomplish various goals. Whether other cooperative mechanisms will find the same success as the Revolving Fund for Vaccines has yet to be determined.

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