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PRINCE MAHIDOL AWARD CONFERENCE

GLOBAL HEALTH POST 2015

ACCELERATING EQUITY

PRINCE MAHIDOL AWARD CONFERENCE | 2015 |

26-31 JANUARY 2015 BANGKOK, THAILAND

MESSAGE FROM THE CHAIRS

OF THE INTERNATIONAL ORGANIZING COMMITTEE

In the year 2000, leaders of the world community set forth a shared vision for development based on the fundamental values of freedom, equality, solidarity, tolerance, respect for nature and shared responsibility, in the form of the Millennium Declaration adopted by the UN General Assembly. The Millennium Development Goals (MDGs) which followed have since provided milestones for global and national development efforts, with the overall target date of 2015. The MDG framework helped to galvanize development efforts and set global and national priorities. While important progress has been made much more work remains to be done in the future.

We know that the circumstances in which we now discuss the post-2015 development framework are very different from those in the late 1990s when the MDGs were being framed. We are no longer thinking in terms of what one set of countries commits to doing with financial or technical support from others. Rather, we are looking for ways of structuring new global goals so that they reflect global challenges of concern to us all.

The vision for global development contained in the Millennium Declaration was intended to unify pursuance of economic, social and environmental objectives along with ensuring peace, security and respect for democratic values. Priority was given to protecting the destitute and vulnerable with recognition that reduction of inequalities in all societies is essential to inclusive, sustainable development. The adoption of explicitly inclusive approaches to ensure equity at all levels is merited not only on ethical grounds, but also from the perspectives of development and peace and security. This vision is as relevant today as in 2000, notwithstanding the major changes that have occurred since then.

The world is now faced with the task of building a new vision. In moving forward, it will be essential for the post-2015 development framework to seek to achieve inclusive, people-centered, sustainable development as well as a resilient society with an approach that is based on social justice, equity, structural transformation, economic diversification and growth.

Health is important as an end in itself and is an essential component of the post-2015 development framework. Health enables people to reach their full potential. Health is also at the center of sustainable development as health is a beneficiary of development, a contributor to development, and a key indicator of what people-centered, rights-based, inclusive, and

equitable development seeks to achieve. Healthy children learn better and become healthy adults. Healthy adults work more effectively, earning higher and more regular wages. Benefits of investing in health are immediate and obvious, both for specific interventions and for strengthening health systems more broadly. Ensuring people's right to health, including through universal health coverage with quality healthcare, is vital for inclusive social development and has been identified as a critical element for the post-2015 world.

In recognizing the world's unique opportunity today to ensure that all of our voices are reflected in the post-2015 development framework to build a better and more prosperous tomorrow, the Prince Mahidol Award Conference has joined forces with international partners to host the Prince Mahidol Award Conference 2015 with the theme "Global Health Post 2015 – Accelerating Equity."

Within the post-2015 development framework, health is an integral part of human wellbeing, which also includes material, psychological, social, education, work, environment, political, and security dimensions. These dimensions of wellbeing are interrelated and interdependent. The new development framework should clearly articulate and support the synergies between health and the other goals; the goals should be framed in a way that their attainment requires policy coherence and shared solutions across multiple sectors – a whole-of-government approach, with equity for all at the core.

As Chairs of the International Organizing Committee, we are delighted to contribute to this ongoing global discussion and to welcome you to Bangkok, Thailand to join more than 600 fellow leaders and educators from around the world. We strongly encourage your active participation and ideas to contribute to developing a better world for future generations. This is an awesome responsibility which rests upon all of us. We must aspire to eradicate poverty, protect the environment and promote economic opportunity for all. Failure is not an option so we must work together to create a just world where all people live with dignity and fulfil their potential. What a truly exciting opportunity we have!

Dr. Vicharn PANICH
Chair
Prince Mahidol
Award Conference

Dr. Marie-Paule KIENY
Co-Chair
World Health Organization

Dr. Timothy EVANS
Co-Chair
The World Bank

Dr. Luiz LOURES
Co-Chair
Joint United Nations
Programme on HIV/AIDS

Dr. Ariel PABLOS-MENDEZ
Co-Chair
U.S. Agency for
International Development

Mr. Kiyoshi KODERA
Co-Chair
Japan International
Cooperation Agency

Mr. Michael MYERS
Co-Chair
The Rockefeller
Foundation

Dr. Lincoln C. CHEN
Co-Chair
China Medical Board

Prof. David HEYMANN
Co-Chair
Chatham House

KEYNOTE ADDRESS

GLOBAL HEALTH POST 2015: ACCELERATING EQUITY

Donald AINSLIE HENDERSON

Prince Mahidol Award
Laureate 2014
In the Field of Public Health

Distinguished Scholar
Center for Health Security

Dean Emeritus
Bloomberg School
of Public Health
University of Pittsburgh
Medical Center
Johns Hopkins University

USA

Dr. Henderson is a Distinguished Scholar at the Center for Biosecurity of the University of Pittsburgh; Professor and Dean Emeritus of the Johns Hopkins Bloomberg School of Public Health; and a Founding Director (1998) of the Johns Hopkins Center for Civilian Biodefense Strategies. From November 2001 through April 2003, he served as the Director of the Office of Public Health Emergency Preparedness and, later, as a Principal Science Advisor in the Office of the Secretary of the Department of Health and Human Services.

Dr. Henderson's previous positions include: Associate Director of the Office of Science and Technology Policy, Executive Office of the President (1990-93); Dean of the Faculty of the Johns Hopkins School of Public Health (1977-90); Director of the World Health Organization's global smallpox eradication campaign (1966-77); and Chief of the Surveillance Section of the Epidemiology Branch of the Centers for Disease Control (1961-66).

In 2002, he received the Presidential Medal of Freedom, the nation's highest civilian honor. He is the recipient of the National Medal of Science, the National Academy of Sciences' Public Welfare Medal, and the Japan Prize, shared with 2 colleagues. He has received honorary degrees from 17 universities and special awards from 19 countries.

Dr. Henderson is a member of the Institute of Medicine, a Fellow of the American Academy of Arts and Sciences, an Honorary Fellow of the National Academy of Medicine of Mexico, an Honorary Fellow of the Royal College of Physicians of London, an Honorary Member of the Royal Society of Medicine, and a Fellow of a number of professional medical and public health societies.

In June 2009, Prometheus Books published a book by Dr. Henderson entitled Smallpox: Death of a Disease. It is a personal account of the challenges, obstacles, and disasters faced by an intrepid international program in achieving the global eradication of smallpox. Dr. Henderson has authored more than 200 articles and scientific papers and 31 book chapters and is coauthor of the renowned Smallpox and Its Eradication (Fenner F, Henderson DA, Arita I, Jezek A, and Ladnyi ID. 1988. Geneva: World Health Organization), the authoritative history of the disease and its ultimate demise.

Dr. Henderson, a Lakewood, Ohio, native, graduated from Oberlin College, the University of Rochester School of Medicine, and the Johns Hopkins School of Hygiene and Public Health. He served as a medical resident at the Mary Imogene Bassett Hospital in Cooperstown, New York.

Timothy EVANS
Director
Health Nutrition and Population
The World Bank

USA

Tim Evans is the Senior Director of Health, Nutrition and Population at the World Bank Group.

From 2010 to 2013, Tim was Dean of the James P. Grant School of Public Health at BRAC University in Dhaka, Bangladesh, and Senior Advisor to the BRAC Health Program. From 2003 to 2010, he was Assistant Director General at the World Health Organization (WHO). Prior to this, he served as Director of the Health Equity Theme at the Rockefeller Foundation. Earlier in his career he was an attending physician of internal medicine at Brigham and Women's Hospital in Boston and was Assistant Professor in International Health Economics at the Harvard School of Public Health. He is a board member of a number of international health alliances.

Tim has been at the forefront of advancing global health equity and strengthening health systems delivery for more than 20 years. At WHO, he led the Commission on Social Determinants of Health and oversaw the production of the annual World Health Report. He has been a co-founder of many partnerships including the Global Alliance on Vaccines and Immunization (GAVI) as well as efforts to increase access to HIV treatment for mothers and innovative approaches to training community-based midwives in Bangladesh.

Tim received his Medical Degree from McMaster University in Canada and was a Research and internal Medicine Resident at Brigham and Women's Hospital. He earned a D.Phil. in Agricultural Economics from University of Oxford, where he was a Rhodes Scholar.

Taniya AKTER
Adolescent member
BRAC

Bangladesh

Most. Taniya Akter is 17 years old and is currently on her second year in Higher Secondary School. Her father, Md. Shiful Islam, is running a vegetable business and her mother Most. Golapi Begum is a housewife. Besides her studies, Tania is a member of a Kishori (Adolescent) Club of BRAC Adolescent Development Program since 2012. Through the club, Tania received the APON/Life-skill Based Education course which provided her with essential life skills such as communication, negotiation, decision making, problem solving, creative and critical thinking, as well as ethic-related education with focus on empathy and sympathy. The Life-skill Based Education also educated her within topics like gender, child rights, child marriage, dowry, sexual harassment, reproductive health, STI, and HIV/AIDS.

Tania comes from a very poor family and the opportunity of getting further education is therefore depending on her chances to undertake income generating activities. Recently, Tania got the opportunity to work as a Peer Leader for the 'English through IT' component of BRAC Adolescent Development Program. As a Peer Leader, Tania teaches English to her fellow club members. Through her leadership at the club, Tania has learned how to disseminate knowledge and how to share information with other girls in her community and beyond.

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OVERARCHING PLENARY

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BACKGROUND

The Plenary Session will provide an overview of the evolution of Global Health, and the important and evolution of improving equity globally. It would also assess the impact of social inequity on health. It is aimed to set the scene of the Conference. There is a consensus from every major forum that social inequity has serious impact on health and that inequity in health outcomes between the rich and the poor is unjust and unfair and should be reduced. This session should stimulate the global commitment to improve not only overall health indicators but also their discrepancy among different socio-economic status. It is expected that the post 2015 targets and indicators will include the reduction of inequity gap.

OBJECTIVES

- To provide an overview of the evolution of Global Health, its scope, issues, mechanism and processes.
- To discuss the evolution and the important of social inequity and its impact on health outcome
- To provide the current situation of Post 2015 development agenda process and the potential link between PMAC2015 and the negotiation process

MODERATOR

LINCOLN C. CHEN
President
China Medical Board

USA

Lincoln C. Chen is President of the China Medical Board (CMB). Celebrating its 100th anniversary in 2014, the CMB was endowed by John D. Rockefeller as an independent American foundation dedicated to advancing health in China and neighboring Asian countries in an interdependent world. CMB's strategic philanthropy seeks to spark innovation and strengthen partnerships in building university capacity in health policy sciences, health professional education, and global health.

Dr. Chen was the Taro Takemi Professor of International Health at the Harvard School of Public Health, Director of the University-wide Harvard Center for Population and Development Studies, and the founding Director of the Harvard Global Equity Initiative. He is currently a member of the HSPH Visiting Committee and co-chair of the Harvard FXB Center on Health and Human Rights. Dr. Chen served as Executive Vice-President of the Rockefeller Foundation and Representative of the Ford Foundation in India and Bangladesh. He also served as Special-Envoy of the WHO Director-General on Human Resources for Health, founding board chair of the Global Health Workforce Alliance, and founding member of the Advisory Board to the UN Secretary-General of the United Nations Fund for International Partnerships.

Dr. Chen currently chairs the Board of Trustees of BRAC USA, an affiliate of the world's largest anti-poverty NGO. He is also a board member of the Institute of Health Metrics and Evaluation (University of Washington), UBS Optimus Foundation, and the Public Health Foundation of India. He is a member of the Institute of Medicine, the American Academy of Arts and Sciences, the World Academy of Arts and Sciences, and the Council of Foreign Relations. He graduated from Princeton University, Harvard Medical School, and the Johns Hopkins School of Hygiene and Public Health. Dr. Chen did his internship and residency in internal medicine at the Massachusetts General Hospital.

Michel SIDIBÉ
Executive Director
The Joint United Nations
Programme on HIV/AIDS

Switzerland

Since his appointment as Executive Director of UNAIDS and Under Secretary-General of the United Nations by Secretary-General Ban Ki-moon in 2009, Michel Sidibé's vision of zero new HIV infections, zero discrimination and zero AIDS-related deaths has echoed around the world.

Under his leadership UNAIDS works to ensure that no one is left behind in the response to HIV and that everyone in need has access to lifesaving HIV services. He initiated the global call to eliminate HIV infections among children and his global advocacy has firmly secured HIV at the top of political agendas. His idea of shared responsibility and global solidarity has been embraced by the international community and has encouraged increased ownership of their epidemics by countries most affected.

Mr Sidibé has spent more than 30 years in public service. His passion for advancing global health began in his native Mali, where he worked to improve the health and welfare of the nomadic Tuareg people. He later became Country Director for Terre des Hommes. In 1987, Mr Sidibé joined UNICEF in the Democratic Republic of the Congo and went on to serve with UNICEF for a further 14 years, overseeing programmes across 10 francophone African countries and serving as country representative in a number of countries.

Mr Sidibé has been awarded honorary doctorates from Tuskegee University and Clark University, as well as an honorary professorship at Stellenbosch University. In 2012 he was named one of the 50 most influential Africans by the Africa Report and one of 50 personalities of the year by the French newspaper Le Monde in 2009. He received the Emerging Leader Award from the UN Foundation and the United Nations Association of the USA; is a Knight of the National Order of the Legion of Honour of France; an Officer of the National Order of Mali; an Officer of the National Order of Benin; a Chancellor of the National Order of Chad and was awarded an Order of Saint-Charles by Monaco. He also serves on the Global Board of Directors of Grassroot Soccer.

He holds two Post-Master's Diplomas—Social Planning and Demography—and Development and Political Economy—from the University of Blaise Pascal, Clermont-Ferrand, France. He also holds a Masters degree in economics.

Mr Sidibé is fluent in English and French and speaks several African languages. He is married and has four children.

Paul FARMER
Kolokotrones University Professor
Harvard University

USA

Medical anthropologist and physician Paul Farmer has dedicated his life to improving health care for the world's poorest people. He is a founding director of Partners In Health (PIH), an international non-profit organization that since 1987 has provided direct health care services and undertaken research and advocacy activities on behalf of those who are sick and living in poverty. Dr. Farmer began his lifelong commitment to Haiti in 1983 while still a student, working with dispossessed farmers in Haiti's Central Plateau. Starting with a one-building clinic in the village of Cange, Partners In Health's project in Haiti has grown to a multi-service health complex that includes a primary school, an infirmary, a surgery wing, a training program for health outreach workers, a 104-bed hospital, a women's clinic, and a pediatric care facility. Over the past twenty-five years, PIH has expanded operations to twelve sites throughout Haiti and ten additional countries around the globe. The work has become a model for health care for poor communities worldwide: Dr. Farmer and his colleagues in the U.S. and abroad have pioneered novel community-based treatment strategies that demonstrate the delivery of high-quality health care in resource-poor settings.

Dr. Farmer holds an M.D. and Ph.D. from Harvard University, where he is the Kolokotrones University Professor and the Chair of the Department of Global Health and Social Medicine at Harvard Medical School; he is also Chief of the Division of Global Health Equity at Brigham and Women's Hospital, Boston. Additionally, Dr. Farmer serves as the United Nations Special Adviser to the Secretary-General on Community Based Medicine and Lessons from Haiti.

Dr. Farmer has written extensively on health, human rights, and the consequences of social inequality. His most recent books are In the Company of the Poor: Conversations with Dr. Paul Farmer and Fr. Gustavo Gutierrez, Reimagining Global Health: An Introduction, and To Repair the World: Paul Farmer Speaks to the Next Generation. Other titles include Haiti After the Earthquake, Partner to the Poor: A Paul Farmer Reader, Pathologies of Power: Health, Human Rights, and the New War on the Poor, The Uses of Haiti, Infections and Inequalities: The Modern Plagues, and AIDS and Accusation: Haiti and the Geography of Blame. Tracy Kidder's book Mountains Beyond Mountains: The Quest of Dr. Paul Farmer, A Man Who Would Cure the World, chronicles the development of Dr. Farmer's work in Haiti and beyond.

Dr. Farmer is the recipient of numerous honors, including the Margaret Mead Award from the American Anthropological Association, the Outstanding International Physician (Nathan Davis) Award from the American Medical Association, a John D. and Catherine T. MacArthur Foundation Fellowship, and, with his PIH colleagues, the Hilton Humanitarian Prize. He is a member of the Institute of Medicine of the National Academy of Sciences and of the American Academy of Arts and Sciences.

Michael MYERS
Managing Director
The Rockefeller Foundation

USA

Michael Myers performs a number of leadership roles at The Rockefeller Foundation. He leads the Foundation's global health work including its Transforming Health Systems initiative and the campaign for universal health coverage. He also coordinates strategies for the Foundation's work in the United States with a focus on building inclusive economies in cities.

Mr. Myers joined The Rockefeller Foundation in 2010 and led the organization's successful centennial program, which included an array of global activities to build on past successes and to help shape the Foundation's future direction.

Prior to coming to The Rockefeller Foundation, Mr. Myers served in leadership capacities in the United States Senate for much of his career, including chief counsel and staff director to the late Senator Edward M. Kennedy. He worked on a range of issues, including health care, employment, economic development, refugees, immigration, and education. Before his career in government, Mr. Myers worked on refugee and international humanitarian matters for non-governmental organizations and the United Nations High Commissioner for Refugees.

Mr. Myers holds both a bachelor's and a master's degree in political science from Columbia University.

Sigrun MOGEDAL
Former Ambassador
of Norway on Global Health,
Founder of Foreign Policy
and Global Health Initiative

Norway

Dr. Sigrun Møgedal is a medical doctor by training and the former Norwegian Ambassador for Aids and Global Health Initiatives. After retirement from the Norwegian Ministry of Foreign Affairs she has been a Special Adviser associated with the Norwegian Knowledge Centre for the Health Services and served as a Special Advisor to the Executive Director of UNAIDS.

Her main areas of engagement have been in the HIV/AIDS response, health and development policy, strategy and delivery, global partnerships and governance.

Dr Møgedal served as a Commissioner on the UiO-Lancet Commission on Global Governance for Health (2011-2013) and as a lead expert in the Foreign Policy and Global Health Initiative established by Foreign Ministers of seven countries from 2006 and up to retirement. She was a founding member of the Board of the Global Health Workforce Alliance and the Chair of the Board from 2007 to 2010. She is a previous Board member of the Global Fund to fight against AIDS, TB, and Malaria (GFATM), the Global Alliance for Vaccines and Immunization (GAVI), UNITAID and the Global Forum for Health Research.

Dr Møgedal served as the State Secretary for International Development of the Norwegian Ministry of Foreign Affairs from 2000 to 2001. She was the Senior Executive Advisor for Global Initiatives at NORAD, served in research committees of the Norwegian Research Council and as a Moderator for the Ecumenical Council of the Church of Norway. In the period 1970-82 she worked in Primary Health Care Development in Nepal and as the Health Services Director of the United Mission to Nepal.

She is a member of the Independent Monitoring Board for the Polio Eradication Initiative, a Board Member of the Medicines Patent Pool and a Board Member of Norwegian Save the Children.

For her contributions to international health she received the Royal Norwegian Order of St. Olav in 2010.

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PLENARY 1.1 & 1.2

PRIORITY GLOBAL HEALTH ISSUES AND HEALTH RELATED POST-2015 DEVELOPMENT GOALS/TARGETS/INDICATORS

PLENARY 1.1 & 1.2

PRIORITY GLOBAL HEALTH ISSUES
AND HEALTH RELATED POST-2015 DEVELOPMENT
GOALS/TARGETS/INDICATORS

BACKGROUND

This sub-theme will consider how health is prioritized or de-prioritized and address the underlying challenges for policy coherence at the various levels of governance (local, national and global) as well as to identify the policy space to address key equity issues. The keynote speaker will set the scene, and parallel sessions will follow up in more specific terms to provide guidance on public health prioritization and the presentation of health in the Post-2015 process.

OBJECTIVES

- To look at perspectives from different stakeholders on priority global health issues and health related Post-2015 development goals/ targets/indicators
- Each session should strive to provide the following:
  - Recommendations on health related Post-2015 development goals/targets/indicators
  - A list of 5 priority global health issues according to the interests of each session
  - A mechanism and criteria to prioritize the issues identified by each session

KEYNOTE SPEAKER

Keizo TAKEMI
Senior Fellow
Japan Center for
International Exchange

Japan

Keizo Takemi is a Liberal Democratic Party (LDP) member of the Japanese House of Councilors who also served as State Secretary for Foreign Affairs in the Obuchi Cabinet in 1999, and the Senior Vice Minister of Health, Labor and Welfare in the first Abe cabinet. Within LDP, he is serving as Deputy Chairman of General Council and Chairman of the Special Committee on Global Health Strategy of the Policy Research Council. He is a Senior Fellow at the Japan Center for International Exchange (JCIE), and a professor at Tokai University. He was involved in various global initiatives, including the Commission on Information and Accountability for Women's and Children's Health, Global Health Workforce Alliance, WHO Expert Working Group on R&D Financing, and the International Organizing Committee of the Prince Mahidol Award Conference. He has also been serving as the Chair of the Parliamentary Caucus on Stop TB Partnership since March 2013, and the Chair of the Asian Forum of Parliamentarians on Population and Development (AFPPD) since October 2013.

KEYNOTE SPEAKER

Robert YATES
Consultant

United Kingdom

Robert Yates is an internationally recognised expert on universal health coverage (UHC) and progressive health financing. He is a senior fellow of Chatham House, Royal Institute of International Affairs, in London where he is Project Director of the UHC Policy Forum. His principal area of expertise is in the political economy of UHC, with a focus on advising political leaders and government ministries on how to plan, finance and implement national UHC reforms. He has a special interest in advising governments on how to replace inequitable private health financing (user fees and voluntary insurance) with more efficient and fairer public financing systems. His advice in this area has been influential in changing health financing policies in a number of developing countries. For example, in 2009 he was instrumental in six developing countries announcing that they would extend the provision of free public services at a UN General Assembly meeting chaired by the UK Prime Minister. He also successfully advised the President of Ghana in 2008 to provide immediate cover to all pregnant women under the National Health Insurance Scheme. Between 2010 and 2012 he was one of the leading international advisors to the Indian Government Planning Commission's High Level Expert Group on Universal Health Coverage.

Working as a senior health economist for the UK's Department for International Development (DFID) and WHO, for over fifteen years, he advised numerous governments in Africa and Asia on health systems reforms.

Rob trained and worked as a manager in the UK National Health Service before moving overseas in 1995 to manage a community based HIV/AIDS hospice in Swaziland. He then worked in the planning departments of the Ministries of Health in Mozambique and Uganda and has completed other postings in DR Congo and most recently, Indonesia.

He has a bachelor's degree in natural sciences and economics from the University of Cambridge and an MBA in health management from the Nuffield Institute, University of Leeds.

He has published papers in the Lancet and the WHO Bulletin on the importance of reducing financial barriers to achieve universal coverage. In August 2014 he published a WHO Bulletin editorial recommending that Governments consider funding rapid UHC reforms as a political strategy to reduce inefficient and environmentally damaging fuel subsidies.: **http://www.who.int/bulletin/volumes/92/8/14-143495/en/**

In recent years he has given lectures on pro-poor health financing and UHC at Harvard (Medical School and Kennedy School of Government), MIT, Columbia, Oxford, Cambridge and London Universities.

Rob is a member of the Health Thematic Group of the UN's Sustainable Development Solutions Network and was one of the leading authors of their report: Health in the Framework of Sustainable Development.: **http://unsdsn.org/wp-content/uploads/2014/02/Health-For-All-Report.pdf**

Alex ROSS
Director
World Health Organization's
Centre for Health Development
in Kobe

Japan

Mr. Alex Ross (MsPH) is the Director of the WHO Centre for Health Development in Kobe, Japan (WKC). A WHO global centre for excellence, the Centre focuses on research into health, social, and economic factors that contribute to health and development. For over a decade, WKC has led work on urbanization and health, emphasizing measurement of inequities, and development of practical approaches to redress them including intersectoral action for health. The Centre is transitioning to research directions focusing on universal health coverage, innovation and ageing. One ongoing initiative is encouraging more frugal technological and social innovations for ageing populations. A global centre, WKC leverages collaborations with Japanese and international universities.

An expert in public health policy and health systems, Mr Ross has developed domestic and global health policies, programmes, and innovative financing mechanisms over the past 25 years. These have focused on strengthening health systems, governance issues (such as decentralization), communicable and noncommunicable diseases, prevention programmes, and ageing populations. Prior to his current position, Mr Ross was Director for Partnerships and UN Reform in the Director-General's Office of WHO (Geneva) between 2007 and 2011, where he led development of WHO's partnerships policy, nurtured WHO's engagement with global health initiatives, UN agencies, non-governmental organizations and the private sector. Mr Ross was very involved in developing innovative health financing approaches, such as developing the Solidarity Tobacco Contribution concept, as well contributing to the creation of the Global Fund to Fight AIDS, TB and Malaria and UNITAID. Mr Ross held senior posts as Director in the Office of the Assistant Director-Generals for Communicable Diseases and for HIV/AIDS, TB and Malaria, WHO, between 2003-2007, where he was very involved in the WHO's "3x5 initiative", strategies to contain the H5N1 epidemic, and the development of the WHO Pandemic Influenza Preparedness framework.

Before joining WHO, Mr Ross served in senior domestic and international health positions: as a Senior Health Advisor for health systems, HIV/AIDS and integrated health policy for the UK Department for International Development (2001-2003); and as Deputy Chief for Health and Education in the USAID Bureau for Africa (1993-2001) He worked in the Office of the Assistant Secretary for Health, US Department of Health and Human Services (1990-93), the U.S. Congress House Energy and Commerce Committee as a health professional staff (1988), and the U.S. General Accounting Office (1987-89).

Mr Ross holds a B.S.P.H. and M.Sc. degrees from the University of California, Los Angeles (UCLA) School of Public Health, and has conducted doctoral level studies in public health at the Rand Graduate Institute.

David HARPER
Senior Consulting Fellow
Chatham House

United Kingdom

Professor David Ross Harper is the Managing Director of Harper Public Health Consulting Limited. He is also Senior Consulting Fellow at the Chatham House Centre on Global Health Security. Previously, David was Special Adviser to the Assistant Director-General for Health Security and Environment at the World Health Organization in Geneva, where his principal role was to advise on Global Preparedness for Health Security. In addition, he established and directed the Joint Task Force on Avian Influenza A(H7N9) and Middle East Respiratory Syndrome. Before March 2012, David was the Chief Scientist and Director General for Health Improvement and Protection in the UK Department of Health. He was responsible for protecting the population from risks posed by infectious diseases and environmental hazards; preparing for, and responding to, a range of health emergencies and disruptive challenges to health services; reducing the burden of conditions associated with poor lifestyles; and promoting health and wellbeing. He also held the international health and scientific development portfolios for the Department of Health. A scientist by training, David graduated in microbiology from the University of Dundee and gained his PhD in biochemistry from the University of Birmingham. He is a Fellow of the Society of Biology, a Fellow of the Faculty of Public Health of the Royal College of Physicians, and an honorary Fellow of the Royal Society of Public Health. He was awarded the Commander of the Order of the British Empire in 2002. He has an honorary Professorship at the University of Dundee, and an honorary Doctorate of Science from Cranfield University, where he is also a visiting Professor.

Akiko MAEDA
Lead Health Specialist
The World Bank

USA

Akiko Maeda currently holds the position of Lead Health Specialist at the Health, Nutrition and Population Department of the World Bank. She is currently leading the World Bank's strategy on Human Resources for Health for Universal Health Coverage.

Akiko has over 20 years of development experience in health and social programs, and has provided policy advice to senior Government officials and assisted in the design of health policy reform and health projects in the Middle East and North Africa, Asia and Europe. Her areas of expertise include health insurance and health financing reforms, health services reorganization, and human resources for health. Before joining the World Bank, Akiko held various positions with the Asian Development Bank (Philippines), UNICEF (Cambodia and Yemen) and UNDP (Yemen). She has a Ph.D. in Health Economics from Johns Hopkins School of Public Health; M.A. in Biochemistry & Molecular Biology from Harvard University; M.A. in Middle Eastern Studies also from Harvard University; and a Bachelor degree in Biochemistry from Princeton University.

Sihasak PHUANGKETKEOW
Permanent Secretary
Ministry of Foreign Affairs

Thailand

Mr Sihasak Phuangketkeow has been Permanent Secretary of Thailand's Ministry of Foreign Affairs since 2011. He had previously served at the Thai Embassies in Washington DC and Tokyo, and as Thailand's Consul-General in Hong Kong. He was Spokesman for the Ministry in 2002 before becoming Deputy Permanent Secretary in 2006. In 2007, he became Thailand's Ambassador and Permanent Representative to the United Nations and other international organizations in Geneva. During his tenure in Geneva, he was elected the President of the United Nations Human Rights Council between June 2010 and June 2011. He has also been an active contributor to the work of ASEAN. He was Thailand's Senior Officials Meeting Leader to ASEAN from 2006-7, and again since 2011. He was Thailand's Representative in the High-Level Task Force that drafted the ASEAN Charter, and the Chair of the High-Level Panel on an ASEAN Human Rights Body that drafted the Terms of Reference establishing the ASEAN Intergovernmental Commission on Human Rights.

Stefan NACHUK
Associate Director
The Rockefeller Foundation

Thailand

Stefan Nachuk has been an Associate Director with the Rockefeller Foundation since February 2007, and is based in Bangkok, Thailand. In this role, he is focused upon developing an initiative on the role of transforming health systems globally, with specific components focusing on strategic capacity building, leveraging the private sector, and developing a joint learning network for Universal Health Coverage. This work focuses both on support to a small number of countries, as well as regional capacity building and networking. In addition, Stefan also participates in a climate change adaptation initiative, with a special focus upon developing models of climate resilience in selected cities within Thailand, India, Vietnam, and Indonesia. Prior to joining Rockefeller, Stefan lived and worked in SE Asia for approximately 14 years, with a broad focus on decentralization, governance, and social development. Most recently, Stefan was a Senior Policy Specialist with the World Bank in Indonesia from 2003 through 2006.

Mandeep DHALIWAL
Director, HIV, Health and
Development Practice,
Bureau for Development Policy
UNDP New York

USA

Dr. Mandeep Dhaliwal is the Director of UNDP's HIV, Health and Development Practice. Dr. Dhaliwal brings to the organization 20 years of experience working on HIV, health, human rights and evidence-based policy and programming in low and middle-income countries. She is a member of the Human Rights Reference Group for the Global Fund to Fight AIDS, Tuberculosis and Malaria.

Dr. Dhaliwal, a physician and lawyer, joined UNDP in 2008 as the Cluster Leader: Human Rights, Gender and Sexual Diversities in the HIV/AIDS Group. She was the architect and team leader for the Global Commission on HIV and the Law. Prior to joining UNDP, she was a senior adviser to the Dutch Royal Tropical Institute's Special Programme on HIV/ AIDS.

From 2000 to 2006, Dr. Dhaliwal worked for the International HIV/AIDS Alliance's Policy, Research and Good Practice Team in the United Kingdom where she focused on issues of HIV care and treatment in developing countries. She was instrumental in expanding the International HIV/AIDS Alliance's technical support and policy work on issues of HIV care, treatment and support in Africa, Asia, Eastern Europe and Latin America. While at the Alliance, she led the development of an operations research initiative in Zambia on community engagement for anti-retroviral treatment.

From 1993 to 2000, she worked on HIV and human rights issues in India, including as the founding Coordinator of the Lawyers Collective HIV/AIDS Unit, a leading human rights organization, establishing the Unit's legal aid, public interest litigation, legal literacy, capacity building, research and advocacy work.

Dr. Dhaliwal is a British national and did her studies at the University of Ottawa in Canada.

Naoyuki KOBAYASHI
Deputy Director-General
(Human Dev. Dept.)
Japan International
Cooperation Agency

Japan

Naoyuki Kobayashi oversees JICA's official development assistance programs in the health sector for the Asia-Pacific region as deputy director-general at JICA's Human Development Department. His responsibility includes JICA's strategies in the areas of health workforce and MCNH, and also developing aid programs to support partner countries in the region. Previously, he served as director for the Maternal and Child Health Division and led his team to execute JICA's MNCH and reproductive health programs for all regions. As for his overseas assignment, he served as a deputy resident representative at the JICA Afghanistan Office and as an assistant resident representative in Egypt. He worked also for UNDP as program adviser to increase collaboration between the UN and Japan.

PRINCE MAHIDOL AWARD CONFERENCE 2015 | GLOBAL HEALTH POST 2015 ACCELERATING EQUITY

PARALLEL SESSION 1.1

SECURITY INTERESTS IN GLOBAL AND PUBLIC HEALTH

PARALLEL SESSION 1.1

SECURITY INTERESTS IN GLOBAL
AND PUBLIC HEALTH

BACKGROUND

Global health security issues feature prominently in national risk registers across the world. They are high on the agendas of Heads of State, driven by fear of pandemics, terrorism, natural disasters and conflicts. Preventing the risks from arising where this can be achieved, preparing for them, and being able to respond and recover from them when necessary are all essential to be able to create a sustainable future the global community.

This session will consider current and emerging health security risks and will provide a platform for discussion of key areas, including for example the vital need for a multi-sectoral approach and for close working between relevant international organizations. Opportunities to increase the prominence of health in the post-2015 agenda will be explored, together with any new approaches that may be required to build a system that is fit for purpose, sustainable and equitable.

OBJECTIVES

- To consider current and emerging global health security issues
- To identify priority areas
- To produce recommendations on post 2015 goals/targets/indicators

MODERATOR

David HARPER
Senior Consulting Fellow
Chatham House

United Kingdom

Professor David Ross Harper is the Managing Director of Harper Public Health Consulting Limited. He is also Senior Consulting Fellow at the Chatham House Centre on Global Health Security. Previously, David was Special Adviser to the Assistant Director-General for Health Security and Environment at the World Health Organization in Geneva, where his principal role was to advise on Global Preparedness for Health Security. In addition, he established and directed the Joint Task Force on Avian Influenza A(H7N9) and Middle East Respiratory Syndrome. Before March 2012, David was the Chief Scientist and Director General for Health Improvement and Protection in the UK Department of Health. He was responsible for protecting the population from risks posed by infectious diseases and environmental hazards; preparing for, and responding to, a range of health emergencies and disruptive challenges to health services; reducing the burden of conditions associated with poor lifestyles; and promoting health and wellbeing. He also held the international health and scientific development portfolios for the Department of Health. A scientist by training, David graduated in microbiology from the University of Dundee and gained his PhD in biochemistry from the University of Birmingham. He is a Fellow of the Society of Biology, a Fellow of the Faculty of Public Health of the Royal College of Physicians, and an honorary Fellow of the Royal Society of Public Health. He was awarded the Commander of the Order of the British Empire in 2002. He has an honorary Professorship at the University of Dundee, and an honorary Doctorate of Science from Cranfield University, where he is also a visiting Professor.

Jean Jacques MUYEMBE
Professor of Microbiology
University of Kinshasa

Democratic Republic of Congo

Medical doctor, University of Lovanium, Leopoldville (Kinshasa) in 1969 and PhD in Virology, University of Louvain, Belgium in 1973.He was appointed full professor of Microbiology at the Kinshasa University medical school in 1976.

He was appointed dean of the Faculty of Kinshasa University Medical school in 1976-1981.

In 1985 he served as vice-chairman of the WHO workshop held at Bangui(Central African Republic) on the African AIDS definition and during a WHO's mission conducted in 1996, he provided the first assessment of alarming HIV/AIDS prevalence in Kampala, Uganda.

In 1978-1986 he was actively involved in the surveillance/ investigation of human Monkeypox infection (MPX) throughout the DRC and the training of healthcare workers in collaboration with international teams (WHO,CDC..).

Since 1998 he is the Director of the National Institute for biomedical Research (INRB) and chief of the WHO/National Polio and Measles laboratories in charge of biological surveillance of Acute Flaccid Paralysis(Poliomyelitis) and measles/yellow fever for both DRC and Republic of Congo(Brazzaville)..

His main scientific field of interest is Ebola hemorrhagic fever (clinical, laboratory and epidemiological aspects including control measures) since 1976 when he was the first scientist to investigate the mysterious disease with a high fatality rate in Yambuku catholic mission.The causative agent of this disease was identified later as Ebola virus in a blood specimen of an infected Belgian nun he transferred to Kinshasa.

Since then, he was involved in several Ebola outbreaks in DRC and neighboring countries as the chairman of the international scientific and technical coordination committee. It was the case during the Kikwit Ebola outbreak in 1995 (DRC), in Mayibout2 (Gabon), 1996, Makokou (Gabon) and Mbomo (RCongo) in 2000. He was also involved in the control of Ebola outbreaks in Mweka (2007), Kaluamba (2008) Isiro (2912), and Boende (2014) in DRC.

He is Member of the WHO Advisory Committee on Variola Virus Research (WHO/HQ), and

Member of the African Advisory Committee on Health Research and development (AACHRD)/AFRO.

He serves as a scientific advisor to WHO in several expert groups and had received distinguished rewards such as The National Gold Medal for his scientific contribution and Paul Harris Fellow Award of Rotary International.

He is author and co author of more than 100 scientific papers in peer reviewed journals.

Virginia MURRAY
Consultant in Global
Disaster Risk Reduction
United Nations International
Strategy for Disaster Reduction
(UNISDR)

Switzerland

Professor Virginia Murray was appointed as Consultant in Global Disaster Risk Reduction for Public Health England in April 2014. This appointment is to take forward her work as vice-chair of the UN International Strategy for Disaster Reduction (ISDR) Scientific and Technical Advisory Group and is one of the members of the UNISDR Advisory Group for the Post-2015 Framework for Disaster Risk Reduction

Prior to this she was appointed as Head of Extreme Events and Health Protection, Public Health England in January 2011. With the Extreme Events team, she helped to develop evidence base information and advice on flooding, heat, cold, volcanic ash, and other extreme weather and natural hazards events.

Appointed as Visiting Professor in Health Protection, MRC-HPA Centre for Environment and Health, Imperial College and King's College, London (2004) and Honorary Professor at University College London (2013), she has published widely.

Dennis CARROLL
Special Representative
for Global Health Security
The United States Agency
for International Development

USA

Dr Dennis Carroll currently serves as the Director of the U.S. Agency for International Development's (USAID) Global Health Security and Development Unit. In this position Dr. Carroll is responsible for providing strategic and operational leadership for the Agency's programs addressing new and emerging disease threats. Dr. Carroll also serves as USAID's Special Representative for Global Health Security.

Dr Carroll was initially detailed to USAID from the U.S. Centers for Disease Control and Prevention as a senior public health advisor in 1991. In 1995 he was named the Agency's Senior Infectious Diseases advisor, responsible for overseeing the Agency's programs in malaria, tuberculosis, antimicrobial resistance, disease surveillance, as well as neglected and emerging infectious diseases. In this capacity Dr. Carroll was directly involved in the development and introduction of a range of new technologies for disease prevention and control, including: community-based delivery of treatment of onchocerciasis, rapid diagnostics for malaria, new treatment therapies for drug resistant malaria, intermittent therapy for pregnant women and "long-lasting" insecticide treated bednets for prevention of malaria. He was responsible for the initial design and development of the President's Malaria Initiative. Dr. Carroll officially left CDC and joined USAID in 2005 when he assumed responsibility for leading the USAID response to the spread of avian influenza.

Dr Carroll has a doctorate in biomedical research with a special focus in tropical infectious diseases from the University of Massachusetts at Amherst. He was a Research Scientist at Cold Spring Harbor Laboratory where he studied the molecular mechanics of viral infection. Dr. Carroll has received awards from both CDC and USAID, including the 2006 USAID Science and Technology Award for his work on malaria and avian influenza, and the 2008 Administrator's Management Innovation Award for his management of the Agency's Avian and Pandemic Influenza program.

Nigel LIGHTFOOT
Director
Connecting Organizations for Regional Disease Surveillance (CORDS)

France

Professor Nigel Lightfoot CBE has a long and distinguished career in public health and global health security and is now the Executive Director of CORDS (Connecting Organisations for Regional Disease Surveillance. He is a Senior Consulting Fellow of Chatham House and a Member of the Kangaroo Group in the European parliament.

Professor Lightfoot was until recently the Director for Emergency Response at the Health Protection Agency, leading on pandemic influenza, emerging health threats, CBRN response strategies and international relations in these areas. He continued this expert advisory work as consultant to the Department of Health, the Home Office and the Drinking Water Inspectorate.

Trained originally as a consultant medical microbiologist, Nigel served for several years in the Royal Navy. He was a Director in the Public Health Laboratory Service from 1982-2002 and appointed to the Department of Health as Head of CBRN Training and Scenario Development. He developed cutting edge multi-agency exercises for CBRN preparedness, and as Director of Emergency Response he set up the Emergency Response Division of the Health Protection Agency from its inception in 2003 until 2010. He was also a non-executive Director of the Centre for Applied Microbiology and Research, Porton Down, from 1994 to 2003.

Professor Lightfoot has enormous experience in public health and crisis management, He was responsible for the Health protection Agency pandemic influenza planning and response and led the public health response during the 2009 H1N1 pandemic. He was a member of the government crisis committee, COBR, for many years and led on pandemic and avian influenza outbreaks, flooding and the public health investigation into the murder of Alexander Litvinenko by Polonium 210 in London.

He is a past member of the Defence Service Advisory Council (CBRN Board), examining and informing MOD research in this area. He was appointed by Secretary of State for Defence to the Advisory Group on Medical Countermeasures - a body that advises on defence against chemical and biological weapons. As expert advisor to the Chief Medical Officer, he has made significant contributions to the Global Health Security Network of the G7 where he was co-chair of the Risk Management and Communication Working Group. Nigel's breadth of work is a testament to his talent and expertise - he led the Early Alerting and Reporting project resulting in a platform that combines all the public domain information on potential CBRN threats. He was a member of the Royal Society's Working group on Detection and Decontamination of Chemical and Biological Agents, and he has sat on Government Expert Inquiries into anthrax vaccine, quarantine of birds and the Foot and Mouth disease outbreak at Pirbright.

Professor Lightfoot was appointed CBE in the 2009 New Year's Honours List for services to public health.

Didier HOUSSIN
President
French Evaluation Agency
for Research and
Higher Education (AERES)

France

Didier HOUSSIN graduated from Paris-West Faculty of medicine and has been, since 1988, professor of surgery at the University of Paris-Descartes. For several years, a surgeon specialized in liver transplants, at Cochin hospital in Paris, he pioneered new techniques of pediatric transplants before being promoted to head of the Department of Surgery.

Following his promotion to Director of the French National transplants Agency (Etablissement français des greffes) between 1994 and 2003, he contributed to the resolution of the organ transplant crisis of the early 1990s. He then joined the Greater Paris University Hospitals (Assistance Publique – Hôpitaux de Paris) as Director of Medical policy from 2003 to 2005, contributing to the definition of the strategy of the largest hospital group in Europe. In 2005, he was appointed Director General for Health. In addition to the oversight of the French Health policy and to the response to several health crises of epidemic origin, he served as cross-government coordinator for pandemic flu preparedness from 2005 to 2011.

In 2011, he was nominated as president of the French Agency for the Evaluation of Research and Higher Education. In this context, during four years, he organized the evaluation of higher education programs, research activities, and higher education and research institutions in France and abroad.

In 2011, he was also appointed as health security advisor of the World Health Organization. From 2011 to 2013, he was president of its pandemic influenza preparedness advisory group. In 2014, he was president of its International Health Regulations review committee.

His contribution to public health was recognized in France by several distinctions and awards: officer in the national Order of the Legion of Honor in 2008; European trophy of the French High Commission for civil defense in 2009; Medal of Honor for health and social affairs in 2012. In 2013, he was appointed president of board of the French national Agency for food, environment and occupational health security.

Motivated by a deep interest in education and a passion for writing, he contributes to several higher education programs in France (University Paris VII, Sciences-Po Paris, Ecole nationale d'administration in Strasbourg, University Paris-Dauphine). Other than several original scientific articles, he has published three books in French: L'aventure de la greffe (Denoël Editor) in 2000; Maintenant ou trop tard, Essai sur le phénomène de l'urgence (Denoël Editor) in 2003; Face au risque épidémique (Odile Jacob Editor) in 2014.

His research into personal potential and collective action has culminated in his membership of the Courbevoie Jazz Band (section: tenor saxophone) since 2012.

BENEFIT SHARING – PANDEMIC INFLUENZA PREPAREDNESS FRAMEWORK, A MODEL FOR ACCELERATING EQUITY

By Professor Didier Houssin, President of the High Council for the evaluation of research and higher education, France

Health security at a global level is built upon an international treaty: the International Health Regulations. After many years of negotiations and following the 2003 SRAS crisis, it was adopted in 2005 by the 194 Member States of the World Health Organization (WHO) and entered into force in June 2007. Based upon the implementation of minimum core capacities for clinical and biological epidemiological surveillance, for rapid alert at a national level, and for various health control measures in airports, harbours, ships and at ground crossings, these Regulations have allowed significant progress in global health security. However, they face several challenges related to the difficulty, for many Member States, to put in place there minimum core capacities.

As early as 2006, the question of equity about the implementation of the International Health Regulations was raised. At the same time, Indonesia was severely exposed to contamination by H5N1 influenza viruses causing major damage to poultry, but also to humans. Candidate vaccines against such viruses with pandemic potential were prepared by several pharmaceutical companies, precisely using influenza virus strains circulating in Indonesia. Indonesia complained that it could not have access to such vaccines because they were contractually reserved by developed countries. Several countries refused then to continue sharing viruses, if a mechanism of compensation was not established that would allow developing countries to have access to such medical products as vaccines or anti-virals.

Negotiations to reach an international agreement on such a matter lasted several years. Following the 2009 pandemic flu due to a new H1N1 virus, the review Committee of the International Health Regulations formulated, at the end of 2010, the recommendation that an agreement be rapidly found.

It was found in 2011. In fact, in the domain of influenza viruses, very specific but also potentially very dangerous in terms of public health, an international agreement was adopted in May 2011 by all WHO Member States: the Pandemic Influenza Preparedness Framework

This Framework illustrates the attempt to combine the strengthening of health security at a global level and the implementation of a mechanism of equity: through this Framework, all countries are encouraged to virus sharing through the WHO global influenza surveillance network (GISN). This incitation is balanced by strong initiatives to provide benefit sharing to countries most in need.

In this Framework, benefit sharing is shaped upon two instruments: a partnership contribution which, each year, leads each pharmaceutical company using the GISN for its production of drugs, vaccines or diagnosis tools to contribute financially at a level corresponding to its sales revenue of influenza-related products; a standard material transfer agreement between each of these company and WHO, in order to define additional specific in-kind contributions that will be made available to WHO at the time of pandemic so that they can be equitably distributed to countries in need.

Using a series of criteria, the mechanism of equity is driven by WHO through the identification of the countries which, at the level of each of its six regions, should be the recipients of the funds contributed through the partnership compensation mechanism.

Recently signed, the PIP framework agreement has now entered the phase when actions, aiming at reinforcing clinical and biological epidemiological surveillance, drug regulation and health crises communication capacities, as well as performing burden of disease studies, can be implemented in countries most in need.

Implementing solidarity and equity in the context of health security, the PIP framework agreement constitutes a large private – public partnership, which is mobilizing three categories of partners: Member States, WHO and pharmaceutical companies.

Following a successful start and entering now the phase of implementation of the "equitable" measures, the PIP Framework is confronted to three challenging questions: how to demonstrate rapidly that the benefit sharing mechanism effectively reinforces the capacities of the countries most in need? How to preserve the benefit sharing compensation mechanism when virus sharing is, little by little, replaced by an exchange of immaterial gene sequence data? How to manage a potential extension of such a framework to viruses other than influenza viruses with pandemic potential, or even, to non-viral infectious agents?

EBOLA AND KEY LESSONS FOR THE FUTURE

By Dennis CARROLL

The ongoing Ebola epidemic in West Africa underscores that when weaknesses in one country's health system are ignored or underestimated the health security of the globe is at risk. In 2005 the IHR were revised to reflect the shared recognition that in an increasingly globalized world to effectively minimize the threat posed by "public health events of international significance" requires every national public health system to meet a minimum of "core competencies" in "event" detection and response. The recently launched "Global Health Security Agenda" - provides a global partnership to accelerate progress towards meeting the goals of the IHRs and for keeping the world safe and secure from infectious disease threats.

Since the revision of the IHRs the world's experience with zoonotic threats, such as avian influenza, MERS, and now Ebola have highlighted that when we fail to have in place multi-sectoral core competencies for prevention, early detection and control even a limited "spill over" of a novel pathogen from animals into humans can quickly spread and have global consequences. We have seen in in the global response to the ongoing Ebola epidemic that in responding to a new threat after it is actively spreading human-to-human leaves the world vulnerable as we struggle to develop and deploy timely and effective biomedical countermeasures.

The Ebola epidemic underscores the urgent need for the global community to recommit itself to building and strengthening those capacities that are critical to being able to identify threats and deploy a response before the threat poses an immediate threat to human wellbeing. Advances in our understanding of the drivers underlying disease emergence has begun to reshape our approaches to protecting the world from these threats. Outbreaks of emerging diseases, such as Ebola, are driven by a combination of ecological, political and socio-economic changes that are increasingly at play in the early part of the 21st century. These drivers reflect a convergence of global travel and trade, urbanization, land-use change and the lack of public health measures.

The recognition that animal populations, particularly wildlife, are the primary reservoir for emergent microbial threats has highlighted that there are "high risk" geographic areas where a combustible interplay between animal hosts, microbial agents, and people underlie disease emergence. This recognition, in turn, has led to the development of risk-based strategies that allow the targeting of disease detection to those places, populations, times and situations where the risk of "spill over" of microbial agents from animals into human populations is greatest. Collectively, these new capacities and insights has led to a rethinking of standard strategies for the "prevention, detection and response" of emerging and re-emerging infectious diseases and their progenitors to reflect a more inclusive and strategic partnership across the public health, animal health and environmental sectors.

Driven by these concerns public-and animal-health professionals, conservationists and ecologists over the past decade have formulated a global "One Health" paradigm which emphasizes the importance of aligning policy, professional skills and organization frameworks to enable multi-sectoral action. As we anticipate the emergence of threats similar to Ebola in the future strong capacities for expanded multi-sectoral surveillance, diagnosis and rapid reporting and control will be key to preventing localized outbreaks of newly emergent pathogens from becoming regional and or global threats.

DEMOCRATIC REPUBLIC OF CONGO (DRC): 30 YEARS OF EBOLA VIRUS DISEASE OUTBREAKS EXPERIENCE.

Jean Jacques MUYEMBE-TAMFUM,
National Institute of Biomedical Research, Kinshasa, DRC

The deadly Ebola hemorrhagic fever outbreaks were formerly sporadic, but are becoming more and more frequent in DRC. Since its first emergence in 1976, in the Equatorial Province, Ebola virus has reemerged several times in 1995 (Bandundu), in 2007- 2009 (Western Kasai). All these outbreaks were caused by Zaire ebolavirus (ZEBOV) with high fatality rates (up to 80%).

The 2012 Ebola outbreak in Isiro health zone was caused by a newly discovered species Bundibugyo ebolavirus (BEBOV). Since the beginning of 2012, the district of Haut Uélé, Oriental Province, was facing a severe epidemic of malaria associated with an epidemic of invasive salmonellosis with a high lethality rate mostly among children under 5-y. The whole province was on high alert as the western district of Kibaale in neighboring Uganda was experiencing an outbreak of EHF caused by Sudan ebolavirus.

On August 2, 2012, the surveillance team in Isiro reported unusual cases of a mysterious disease with fever and hemorrhagic syndrome that affected people in communities including health workers.

Two blood samples from one acute and one convalescent patients were tested positive for Bundibugyo ebolavirus (BEBOV) at the Uganda Virus Research Institute (UVRI). The DRC's Minister of Health, in compliance with the International Health Regulation (IHR, 2005), officially declared the emergence of Ebola Bundibugyo in DRC and requested technical assistance from WHO.

Contingency measures to contain the outbreak included isolation of patients in an isolation ward, protection of health workers with personal protecting equipment and improvement of hygiene and sanitation conditions, passive and active case detection and contact tracing, social mobilization and psychosocial support to convalescent and to Ebola affected families.

From May to November 2012, 77 cases were recorded, (36 laboratory confirmed, 17 Probable and 24 suspected) of whom 36 died (lethality rate 46.7%). 13 health workers were affected. The use of mobile laboratory (CDC/Atlanta and Winnipeg) at the epicenter of the outbreak was of utmost importance.

However, healthcare workers experienced difficulty in early recognizing the disease as most cases were mild diseases mimicking malaria or typhoid fever. The usual case definition to detect ZEBOV outbreak was not adapted to BEBOV outbreak. The most challenging were logistics as the Isiro district is a landlocked area and social mobilization as the communities continued to deny Ebola as the cause of the outbreak and to hide patients. Like in previous DRC's Ebola outbreaks, the Bundibugyo outbreak in Isiro was detected after a long delay (4 months).

The seventh reported outbreak of EVD occurred in Boende district, Equatorial province, from July to November 2014. This outbreak coincided with the unprecedented largest EVD outbreak in Western African countries (Guinea, Liberia and Sierra Leone).But the two epidemics were not linked, according to the sequencing and phylogenetic analysis of both viruses.

Using socio-cultural approaches, the Congolese team with the technical assistance of Doctors without borders, won the battle against Ebola without any dissemination.

The challenges we faced are as follows:

- overcome stigmatization in the community.
- deliver adequate educational messages.
- provide acceptable isolation wards to Ebola patients.
- Provide a safe and humanized burial during Ebola virus disease outbreaks.
- to overcome the socio-cultural aspects of Ebola outbreak
- solve logistics problems.

In conclusion, Ebola virus disease outbreaks are becoming more and more frequent in DRC. Most epidemics occurred in remote areas with difficult access. The key reason why there is a long delays in disease detection and notification, is the poor acknowledge of the disease by doctors and nurses who confuse and treat Ebola virus disease like malaria and typhoid fever .

All the 7 Ebola virus disease outbreaks were contained without further dissemination to neighboring countries.

Nevertheless the DRC has developed national expertise in managing Ebola virus disease outbreaks with skills in epidemiology, laboratory, case management and coordination of international control teams.

SECURITY INTERESTS IN GLOBAL AND PUBLIC HEALTH POST-2015 FRAMEWORK FOR DISASTER RISK REDUCTION IN GLOBAL AND PUBLIC HEALTH

Professor Virginia MURRAY, FRCP, FRCPath, FFPH, FFOM [1,2]

[1] Vice-chair Science and Technical Advisory Group (STAG), United Nations International Strategy in Disaster Risk Reduction

[2] Consultant in Global Disaster Risk Reduction, Public Health England

2015 will be marked by three landmark UN agreements:

- **Post-2015 Framework for Disaster Risk Reduction** (that will last 10-20 years, due for agreement in March 2015)[1]
- **Sustainable Development Goals** (September 2015)[2]
- **Climate change agreements through the UNFCCC** (December 2015).[3]

Better health is an important outcome from the 2015 UN Landmark agreements for disaster risk reduction, climate change and sustainable development. To achieve the best overall outcomes, an understanding of how health is included in and can be further strengthened in these global processes and agreements is imperative and opportunities exist to participate in these processes.

POST-2015 FRAMEWORK FOR DISASTER RISK REDUCTION

Disasters affect human lives by causing injury and long term impacts as well as destroying lives and livelihoods around the world with between 2000 and 2012, approximately 1.7 million people reported as dying in disasters and an estimated US$ 1.7 trillion of damage sustained.[4]

In 2005, the 2nd World Conference on Disaster Reduction adopted the Hyogo Framework for Action 2005-2015: Building the Resilience of Countries and Communities to Disasters (HFA) in Kobe, Japan. HFA was the first plan to explain, describe and detail the work that is required from all different sectors and actors to reduce disaster losses. It was developed and agreed on with the many partners needed to reduce disaster risk - governments, international agencies, disaster experts and many others - bringing them into a common system of coordination.[5] However, the absence of health/public health as an explicit component is considered to have diminished the overall conceptual framework for action.

What does disaster risk reduction (DRR) mean to health colleagues? DRR activities are wide and aim to reduce the impact from disasters on loss of life, injury or other health impacts, property damage, loss of livelihoods and services, social and economic disruption, or environmental damage. To build knowledge evidence based science should be considered in its widest sense to include the natural, environmental, social, economic, health and engineering sciences, and scientific capacities are interpreted broadly to include all relevant resources and skills of a scientific and technical nature.[6]

Evidence based science can play an essential role in these efforts, helping to inform policies and practices, and thus uncovering new ways to prevent, prepare for and respond to disasters and determining which technologies are most effective in reducing disaster risk. As a result of scientific research, science and technology are already helping to save lives and livelihoods, via programmes to prevent infectious disease outbreaks with vaccination, to forecast floods, detect tsunami waves and effectively communicate disaster risk to enhance community resilience.

The importance and necessity of this effort is further underscored by the fact that at the conclusion of the United Nations International Strategy in Disaster Risk Reduction (UNISDR) Scientific and Technical Committee report on 'Using Science for Disaster Risk Reduction' at the Global Platform in May 2013, the following recommendations were made because evidence base science is not used enough to reduce disaster risks.[7]

Evidence base science in health and public health for DRR is frequently upheld as good examples of improving knowledge. In part this knowledge and other data have led the UNISDR Scientific and Technical Advisory Group in collaboration of the Major Group on Science and Technology[8] to provide a voluntary commitment for an International partnership to mobilize science for action on DRR and resilience building. It brings together their commitment to work together to ensure science, engineering and technology, as well as health science, are embedded into disaster risk management and here health can be identified as a valuable part of the process.

In summary scientific data and information and tangible application of technology are critical to underpin well-informed policies and decisions across the public, private and voluntary sectors. Much scientific evidence exists but better links to policy- and decision-making are needed to continuously enhance our ability to forecast, reduce and respond to disaster risks thereby building resilience. Science and technical communities wish to strengthen the dialogue and collaboration with policy-makers and DRR practitioners at local, national, regional and global levels to identify needs and knowledge gaps, co-design, co-produce and co-deliver new knowledge, and make science more readily available and accessible and in particular deliver outputs in the following six areas:

(1) **Assessment** of current state of data availability and scientific knowledge on disaster risks and resilience (what is known, what is needed, what are the uncertainties, etc.);

(2) **Synthesis** of scientific evidence in a timely, accessible and policy-relevant manner;

(3) **Scientific advice** to decision-makers through close collaboration and dialogue to identify knowledge needs including at national and local levels, and review policy options based on scientific evidence; and

(4) **Monitoring and review** to ensure that new and up-to-date scientific information is used in data collection and monitoring progress towards disaster risk reduction and resilience building.

In addition, two cross-cutting capabilities need to be strengthened:

(5) **Communication and engagement** among policy-makers, stakeholders in all sectors and in the S&T domains themselves to ensure useful knowledge is identified, needs are met, and scientists are better equipped to provide evidence and advice.

(6) **Capacity development** to ensure that all countries can produce, have access to and use effectively scientific information

By taking the principles of evidence based science and technology to regional platforms on disaster risk reduction between May and July 2014 to Africa [9, 10,] the Americas [11, 12,] the Pacific and Asia [14,15] and the European Ministerial Meeting[16,] it was found that there was much support for this approach. Health issues were particularly identified at these meetings as follows:

- The Africa Regional Platform in May 2014 stated that 'Health is an imperative for disaster risk reduction and community resilience. Health status and targets should be among indicators for monitoring and reporting on disaster risk reduction achievements'[9]
- The Americas Regional Platform in May 2014 addressed health as a sector in particular and stated that
  - 'Note that 89% of the countries in the Americas are implementing national initiatives on safe hospitals and improving the resilience of new and existing health care services in order to ensure continuity of operations in the event of a disaster.
  - 'Affirm that protecting essential services, particularly schools and hospitals, is a social priority, a collective and political responsibility and is crucial for achieving resilient communities.

- 'Establish the development and implementation of safe school and hospital policies and programmes as a priority for action at the local, national and regional levels in order to protect and guarantee access to education and health services before, during and after disaster situations, as a contribution towards the achievement of the millennium development goals.'[11]

During all these Regional Platforms, WHO in partnership with many organisations have been active in promoting their recommendations for health and DRR[17] which address health as an outcome, health as a sector, with health identified as a valuable part to these UN landmark agreements. It was recommended that the International Health Regulations (2005) should be linked to the next framework on DRR to provide an international mechanism for the early detection, assessment and rapid response to public health emergencies with the potential for international spread, since these regulations provide a legal mandate for countries to comply with installing capacities for the management of events which may constitute a public health emergency of international concern.

UNISDR called for coherence and mutual reinforcement of the UN landmark agreements between a Post-2015 Framework for Disaster Risk Reduction, Sustainable Development Goals and the Conference of Parties to the UNFCCC in April 2014. This was addressed in part at Prepcom 1 in July 2014,[18] at Prepcom 2 in November 2014 and at the negotiations in January 2015. The negotiations on the Post-2015 Framework for Disaster Risk Reduction are likely to continue to the Third World Conference on Disaster Reduction which will be held in Sendai, Japan in March 2015.

OPPORTUNITIES FOR 'HEALTH/PUBLIC HEALTH' BE PART OF THESE AGREEMENTS

In summary the three UN landmark agreement of a post-2015 framework for disaster risk reduction, Sustainable Development Goals and the Conference of Parties to the UNFCCC for climate change all include 'health/public health' in their processes as part of the global negotiations. Health professionals should be more actively engaged in these international processes to ensure that health issues are addressed as clearly as possible. They can do this by supporting greater consideration of health outcomes by helping to understand and develop the role of the health sector and by strengthening the processes themselves, for example by participating in an International partnership to mobilize science for action on DRR and resilience building.[19]

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PRINCE MAHIDOL AWARD CONFERENCE 2015 | GLOBAL HEALTH POST 2015 ACCELERATING EQUITY

PARALLEL SESSION 1.2

A FINE BALANCE: SEEKING "WIN-WIN SOLUTIONS" FOR ACHIEVING HEALTH EQUITY AND PROMOTING ECONOMIC OPPORTUNITIES

PARALLEL SESSION 1.2

A FINE BALANCE: SEEKING "WIN-WIN SOLUTIONS" FOR ACHIEVING HEALTH EQUITY AND PROMOTING ECONOMIC OPPORTUNITIES

BACKGROUND

Global efforts to support Universal Health Coverage (UHC) efforts in low and middle income countries are creating investment opportunities that would not only improve access to health care, but also promote greater economic participation and empowerment especially among vulnerable and marginalized communities. These strategies will need to be addressed in the context of globalization of health care industry and increasing mobility of health workforce and patients. While globalization are creating substantive opportunities for entrepreneurial expansion in some segments of the health system, it may also be increasing the risk of segmentation and leaving many in the marginalized communities excluded from these economic opportunities.

What can be done to harness these opportunities and develop a "win-win" strategy that achieves both health equity and economic growth? Innovative investment in the education and business enterprises of community-based health workers, particularly among those otherwise too poor to access these opportunities --is one way of breaking the cycle of poverty and creating employment. These issues deserve further in-depth examination and active debates across national borders and professional boundaries.

OBJECTIVES

This session will examine the impact of the globalization of the health market on health equity and economic opportunities for LMICs from different perspectives: from the for-profit sector and government sector responding to opportunities created by globalization of the health market and their efforts to mitigate the downside risks; to those working with under-served communities who could benefit from greater engagement with the private sector and entrepreneurship, but face challenges in accessing these opportunities. The session will discuss different approaches to how countries are managing the tensions between health equity and economic opportunity, and whether they have succeeded in finding a "win-win solution".

MODERATOR

Akiko MAEDA
Lead Health Specialist
The World Bank

USA

Akiko Maeda currently holds the position of Lead Health Specialist at the Health, Nutrition and Population Department of the World Bank. She is currently leading the World Bank's strategy on Human Resources for Health for Universal Health Coverage.

Akiko has over 20 years of development experience in health and social programs, and has provided policy advice to senior Government officials and assisted in the design of health policy reform and health projects in the Middle East and North Africa, Asia and Europe. Her areas of expertise include health insurance and health financing reforms, health services reorganization, and human resources for health. Before joining the World Bank, Akiko held various positions with the Asian Development Bank (Philippines), UNICEF (Cambodia and Yemen) and UNDP (Yemen). She has a Ph.D. in Health Economics from Johns Hopkins School of Public Health; M.A. in Biochemistry & Molecular Biology from Harvard University; M.A. in Middle Eastern Studies also from Harvard University; and a Bachelor degree in Biochemistry from Princeton University.

Marla SALMON
Senior Visiting Fellow,
Evans School of Public Affairs

Professor of Nursing
and Public Health
University of Washington

USA

Dr. Marla Salmon is Professor of Nursing and Global Public Health, and Senior Visiting Fellow at the Evans School of Public Affairs at the University of Washington. Her career has focused on global health workforce capacity building and strengthening of health systems, involving public, private, and voluntary sector engagement. In recent years, this work has related to empowering women and strengthening health systems through investment in nursing and midwifery enterprise and training.

Salmon has held leadership roles in government, non-governmental organizations, and higher education, including: Director of the Division of Nursing, US Department of Health and Human Services (US Chief Nursing Officer); Chair of the Global Advisory Group for Nursing and Midwifery, World Health Organization; Chair of the National Advisory Committee for Nursing Education and Practice; Member, Clinton Administration's White House Taskforce on Healthcare Reform; and, Member, US Delegation to the World Health Organization.

In her academic work, Salmon has held faculty positions in both schools of public health and nursing, and served as dean of nursing at the University of Washington and Emory University. Prior to those roles, she was a professor at the University of Pennsylvania and the University of North Carolina. Salmon's research and publications have focused primarily on workforce capacity building and leadership development for health officers in the government context.

Salmon is a member of the Institute of Medicine and Fellow, where she served as Distinguished Nurse Scholar in Residence working with the Board on Global Health. She is a member of the American Academy of Nursing and has held numerous governance roles, including as Trustee for the Robert Wood Johnson Foundation, and is currently a Director for Grifols, S.A. and the Institute for Education of Students Abroad.

Salmon received her doctorate from the Johns Hopkins School of Hygiene and Public Health and holds degrees in nursing and political science (international) from the University of Portland. Her work in global health has benefitted from experiences as a Fulbright Scholar in Germany, a WK Kellogg Fellow, and a resident at the Rockefeller Foundation Bellagio Center.

Edson ARAUJO
Senior Economist
The World Bank

USA

Edson C. Araujo is Senior Economist at the World Bank's Health, Nutrition and Population Global Practice. At the World Bank he works primarily on health workforce issues, his work includes the analysis of health labor markets and the synergies between health workforce compensation and health financing policies, the assessment of health workforce performance and incentives and the application of stated preference methods to elicit health workers' employment preferences. Over the last few years, he has been involved in projects and research in Brazil, Mexico, India, Costa Rica, Liberia, and, most recently, in China. Prior to joining the World Bank he worked as a health economist in the University College London (the United Kingdom), the Brazilian Ministry of Health, and the Federal University of Bahia (Brazil). He graduated in economics from the Federal University of Bahia and specialized in health economics at University of York (U.K.) and Queen Margaret University (U.K.).

James BUCHAN
Professor
University of Technology,
Sydney

Australia

Professor Buchan has more than twenty five years specializing in policy analysis on the health workforce, developing strategic intelligence and policy advice at national level and internationally on the HR components of health sector effectiveness. The recent focus of his work has been on labour market analysis; health worker migration; health workforce pay, incentives and reward strategy; workforce planning; employment relations; performance management; and skill mix/ extended roles.

He is an Adjunct Professor, at the WHO Collaborating Centre, University of Technology, (UTS), Sydney, Australia; and a Professor at Queen Margaret University, Scotland.

Recent organisations for whom he has directed projects include OECD, WHO/ Western Pacific Region, the World Bank, Department of Health, Victoria, Australia. He has worked with health ministries and other national stakeholders in more than 50 countries, most recently including Moldova, Belarus, Vanuatu, Philippines, Solomon Islands, Cambodia, and Laos.

His background includes periods as a senior HR manager in the National Health Service in Scotland; senior policy analyst at the Royal College of Nursing, (RCN), UK; working as a HRH specialist at the World Health Organisation in Geneva; and most recently as a specialist adviser to Health Workforce Australia, a federal government agency responsible for national workforce policy and planning.

His other current commitments include being Associate Editor of the peer reviewed journal "Human Resources for Health"; and Policy Associate at the WHO European Observatory on Health Systems. Professor Catedrático Convidado, Instituto de Higiene e Medicina Tropical, Universidade Nova de Lisboa, Portugal (WHO Collaborating Centre).

Recent policy reports:

He contributed to the research report for the third global HRH Forum, in Recife in 2013: ***A Universal Truth: No Health Without Workforce*** http://www.who.int/workforcealliance/knowledge/resources/GHWA_AUniversalTruthReport.pdf

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PRINCE MAHIDOL AWARD CONFERENCE 2015 | GLOBAL HEALTH POST 2015 ACCELERATING EQUITY

PARALLEL SESSION 1.3

FOREIGN POLICY INTERESTS IN GLOBAL HEALTH

PARALLEL SESSION 1.3

FOREIGN POLICY INTERESTS
IN GLOBAL HEALTH

BACKGROUND

Countries around the world have increasingly recognized the innate cross-border nature of health issues and, hence, the importance of international cooperation in the field of public and global health. The success in curbing the epidemic of several diseases such as SARs, avian influenza and HIV/AIDS, to name but a few, has been possible thanks to international collaborations in the field of health and beyond. Besides, improvements in health and livelihood of the global population as seen in the progress in some of the United Nations Millennium Development Goals (MDGs) are the result of international cooperation.

In this light, it is becoming more common to see foreign policy being formulated to facilitate and enhance the cooperation in global health. The benefits of inter-linking the two do not only end in the realm of global health, but also provide significant opportunities for foreign policy interests. To begin with, countries, individually and as a group, with carefully designed health-oriented foreign policy stand to generate "soft power" that will bring them greater visibility in the international arena, while providing for other countries in need.

As the Post-2015 development agenda is now being formulated under the United Nations framework, it is apparent that public health issue remains at the forefront, be it the improvement of health of world population through the expansion of healthcare access and services, the prevention and combat of diseases and the advancement of medical research and technology. This highlights opportunities for countries to collaborate for the betterment of global health through their foreign policy.

OBJECTIVES

- To look into the correlation of global health and foreign policy - their merits, short comings and the way forward in the post-2015 development agenda, through the perspectives of key developed and developing countries as well as inter-governmental regional organisations. This may include analysis of prominent diplomacy tools such as trade schemes, aid schemes, international cooperation schemes – from the angles of donors and recipients.
- To identify the best approaches for public health and foreign policy makers to work closely together to advance the global health agenda while serving the interests of the nation and the international community.

MODERATOR

Sihasak PHUANGKETKEOW
Permanent Secretary
Ministry of Foreign Affairs

Thailand

Mr Sihasak Phuangketkeow has been Permanent Secretary of Thailand's Ministry of Foreign Affairs since 2011. He had previously served at the Thai Embassies in Washington DC and Tokyo, and as Thailand's Consul-General in Hong Kong. He was Spokesman for the Ministry in 2002 before becoming Deputy Permanent Secretary in 2006. In 2007, he became Thailand's Ambassador and Permanent Representative to the United Nations and other international organizations in Geneva. During his tenure in Geneva, he was elected the President of the United Nations Human Rights Council between June 2010 and June 2011. He has also been an active contributor to the work of ASEAN. He was Thailand's Senior Officials Meeting Leader to ASEAN from 2006-7, and again since 2011. He was Thailand's Representative in the High-Level Task Force that drafted the ASEAN Charter, and the Chair of the High-Level Panel on an ASEAN Human Rights Body that drafted the Terms of Reference establishing the ASEAN Intergovernmental Commission on Human Rights.

Sigrun MOGEDAL
Former Ambassador
of Norway on Global Health,
Founder of Foreign Policy
and Global Health Initiative

Norway

Dr. Sigrun Møgedal is a medical doctor by training and the former Norwegian Ambassador for Aids and Global Health Initiatives. After retirement from the Norwegian Ministry of Foreign Affairs she has been a Special Adviser associated with the Norwegian Knowledge Centre for the Health Services and served as a Special Advisor to the Executive Director of UNAIDS.

Her main areas of engagement have been in the HIV/AIDS response, health and development policy, strategy and delivery, global partnerships and governance.

Dr Møgedal served as a Commissioner on the UiO-Lancet Commission on Global Governance for Health (2011-2013) and as a lead expert in the Foreign Policy and Global Health Initiative established by Foreign Ministers of seven countries from 2006 and up to retirement. She was a founding member of the Board of the Global Health Workforce Alliance and the Chair of the Board from 2007 to 2010. She is a previous Board member of the Global Fund to fight against AIDS, TB, and Malaria (GFATM), the Global Alliance for Vaccines and Immunization (GAVI), UNITAID and the Global Forum for Health Research.

Dr Møgedal served as the State Secretary for International Development of the Norwegian Ministry of Foreign Affairs from 2000 to 2001. She was the Senior Executive Advisor for Global Initiatives at NORAD, served in research committees of the Norwegian Research Council and as a Moderator for the Ecumenical Council of the Church of Norway. In the period 1970-82 she worked in Primary Health Care Development in Nepal and as the Health Services Director of the United Mission to Nepal.

She is a member of the Independent Monitoring Board for the Polio Eradication Initiative, a Board Member of the Medicines Patent Pool and a Board Member of Norwegian Save the Children.

For her contributions to international health she received the Royal Norwegian Order of St. Olav in 2010.

Mmathari MATSAU

Deputy Director-General
for Health in South Africa

South Africa

Ms. Mmathari Matsau is the Deputy Director-General for Health in South Africa, responsible for International Relations.

Ms. Matsau has worked for almost all her life in the field of public health policy, as Director for Health Planning in Lesotho, a consultant for the World Bank and the African Development Bank. She has been working for the National Department of Health since June 1995, in Pretoria. As Chief Director for Operational and Technical Policy at the Department of Health in South Africa until the year 2000 she was responsible for: Policy and Planning, the National Health Information Systems, Quality Assurance, Health Systems Research and Epidemiology.

She was appointed Deputy Director-General for Strategic Programmes in 2000, responsible for key programmes in Communicable and Non-communicable Diseases, MCH, Pharmaceutical Services as well as Drug Policy. From 2006 to date, she has been the Deputy Director-General for International Health Development and Support, with main focus areas as:

Mainstreaming health in South Africa's bilateral and multilateral initiatives

- Building of strategies, alliances and partnerships with global health partners
- Monitoring of international health trends for domestication
- Promotion of South Africa's health priorities
- Mobilization of international resources to support national, regional and international policy objectives.

Hiroyuki YAMAYA
Director
Ministry of Foreign Affairs

Japan

Mr. Hiroyuki Yamaya, a graduate of Hitotsubashi University and bachelor of laws in 1994, is currently Director of Global Health Policy Division at Japanese Foreign Ministry. Prior to the current assignment since February 2014, he assumed Political Counselor (Head of Political Section) of the Embassy of Japan in Iran. From 2009 to 2011, he handled bilateral issues as well as NATO dossiers at the Embassy of Japan in Belgium. Before 2009, he worked, at the Foreign Ministry HQ or at Prime minister's Office, for intelligence analysis, defense and crisis management, se curity of Japanese nationals overseas, Francophone Africa relations, etc.

FOREIGN POLICY INTEREST IN GLOBAL HEALTH

Background Note, Sigrun Møgedal

The focus for this input to panel session 1.3 is the experience with the Foreign Policy and Global Health Initiative (FPGH) of seven Foreign Ministers (Thailand, Brazil, Indonesia, France, South Africa, Senegal and Norway), engaging together as an alliance of countries with a "break through" ministerial statement in 2007 ; creating an agenda for a global discussion of how health matters to foreign policy and how foreign policy can make a difference to health.

The question for discussion is whether the initiative has been able to "make impact on health a defining lens that countries will use to examine key elements of foreign policy and development strategies', as the Ministers intended. What is the outcome so far of this agenda at national and global level and how can a ministerial collaborative initiative like this keep momentum through changing governments?

How important is the political leadership for keeping such an initiative relevant and able to renew itself in a rapidly changing context? To what extent can lessons be drawn that are relevant for the post2015 global sustainable development agenda? What are related initiatives and developments and to what extent do they converge to build a readiness for change? What impact does UN resolutions have on the readiness to make foreign policy responsive to health, and in what way is WHO being enabled in its role as a global coordinating and directing authority in matters of health?

GENERAL BACKGROUND

The need for countries to protect themselves from cross-border exposure to health risks was not a new insight in 2006. A realization was already growing that in an interdependent world no country can manage exposure to public health risks and threats on their own. People, animals, goods, and skills travel around the world faster than ever before in human history. What was new was the commitment of seven Ministers of Foreign Affairs to get engaged, arguing that health needs a much stronger stronger strategic focus on the international agenda.

Bringing together and building on perspectives from four regions around the world, they agreed to make common vulnerability, shared risk and shared responsibility the major entry point for their effort. With collaboration across borders (rather than protection of "my borders") at the core, they recognized that a nation's pursuit of pure self-interest might undermine solutions that can respond to the challenges of growing interdependence. A respect for national sovereignty needed to be combined with the attributes of solidarity, transparency, trust, accountability and fairness in international action in achieving health security for all.

The world had already had the experience of pandemics, bioterrorism, and other threats to "global health security". The World Health Report 2007 - A safer future, presented the case for global public health security in the 21st century. Also the statement of the FPGH Ministers was organized around health security, with its three main themes: "Capacity for global health security", "Facing threats to global health security" and "Making globalization work for all".

Linking health and security was in itself controversial, because of the concern that security, when applied to health, should not be understood in the same way as the principles for protecting peace and security enshrined in the UN Charter. It should not be linked to the difficult tensions in the international community about "responsibility to protect" and the debated concepts of human security. While the pros and cons of "securitization of health" remain under debate, both in the academic community and among practitioners of health and international diplomacy, the recent experience of Ebola has again highlighted how national health security is also a matter of global health security. The devastating epidemic demonstrate the very the common (but different) vulnerabilities and risks, calling for shared responsibility both

in terms of preparedness and response - regardless how health security as a concept is debated and understood.

Rather than engaging in the debate on concepts, the seven ministers and their teams in capitals, in Geneva, and in New York, chose to be practical and issue oriented, geared to capture opportunities, both acting together in the group and acting with others, seeking to communicate better and differently across traditional alliances, regions, and blocs to find ways to bring the agenda forward at different arenas.

MAKING THE INITIATIVE "OPERATIONAL"

The Ministers established their "Expert group" to assist in formulating and moving the agenda and help linking action to concrete processes and negotiations highly relevant to the interface between health and foreign policy.

The diplomatic missions of the seven countries in Geneva gradually became the main "expert level" hub for the initiative, supported by the diplomatic missions in New York, particularly at the time of negotiations of an annual resolution on Global Health and Foreign Policy led by the FPGH group.

The initiative also took steps to facilitate closer collaboration between Ministers of Health and the Ministers of Foreign Affairs, both at the national and global levels. At the national level the experience has been mixed in achieving institutionalized collaboration between the two Ministries to achieve better policy coherence between foreign policy and global health. At the global level, the collaboration across ministries has been best expressed in the context of the diplomatic missions in Geneva. A regular meeting of Ministers of Health in the seven countries at the time of the World Health Assembly has been achieved. The Foreign Ministers or their representatives have in the same way sought to convene at the time of the opening of the UN General Assembly. Over the life cycle of FPGH, the lead Minister (Ministry) in driving the initiative in each country has been varying between health and foreign affairs.

The question remain as to how long an initiative such as this can maintain momentum, how dependent it is on political leadership and to what extent there is benefit in expanding the number of countries. The process itself must prove its value over time.

SETTING THE AGENDA IN THE UN GENERAL ASSEMBLY

Through skilled diplomacy by the seven countries, health in foreign policy was introduced on the agenda of the UN General Assembly, not as an occasional, sector-specific item, but as one of the pressing foreign policy issues of our time, calling for on-going attention and action. Based in the Ministerial declaration and with inputs from member country consultations, a comprehensive report from the UN Secretary General to the General Assembly in 2008 called for broadening the scope of foreign policy to include health.

Subsequently a series of 5 annual resolutions have been negotiated and agreed by the General Assembly. They identify key health-related challenges that must be addressed by foreign policy makers to improve collective action to achieve global health outcomes. They also point to key foreign policy issues affecting global health and the need to improve the understanding of health implications of policies adopted in the non-health sectors.

Each resolution asks the Secretary-General to recommend challenges, activities, and initiatives related to specific themes in the interface between foreign policy and global health, in close collaboration with the Director-General of the World Health Organization. Themes focused in the resolutions have had immediate relevance to on-going negotiations in WHO, where support and action from foreign policy was seen as essential, such as pandemic influenza preparedness, access to medical products, health information, human resources for health, universal health coverage and inclusive multi-sector and multi-stakeholder partnerships. The 2014 resolution that has just been adopted by the General Assembly has a main focus on the security of health workers in crises and conflict.

WHAT DIFFERENCE HAS THE INITIATIVE MADE?

It is no doubt that the initiative has been instrumental in setting a global agenda. Not alone, but as part of a number of processes originating from within and outside health,

such as the WHO Public Health Security agenda, the Health Promotion agenda and the Social Determinants of Health agenda. A growing body of research on Foreign Policy and Health has made the case. The FPGH Initiative contributed a different and surprisingly strong political momentum, with direct address to the foreign policy community.

The annual resolutions on Global Health and Foreign Policy at the UN General Assembly are main achievements. The way they call for regular reports from the UNSG and present consensus resolutions on concrete themes and issues, keep continuity of focus and bring together a number of related processes and agreements add value to what WHO can do on its own.

It is still up for judgment whether this effort succeeds in making health a critical tool for and an outcome of foreign policy. Higher awareness of the way both decisions and inaction have implications for the health of people all over the world among mainstream diplomats is critical. It is hard to measure how much the initiative has contributed to such awareness. But it is definitely easier to communicate on these challenges than what it was in the past.

Yet awareness is not enough to drive responsive actions for health equity. Mainstream diplomats themselves have little experience and remain ill-equipped to proactively engage in protecting health in negotiations not considered as "health", yet with strong health implications.

There is a need to turn to the real barriers for health equity and health security that are linked to foreign policy issues, structures and processes that remain unresolved or unattended. Systemic institutional dysfunctions and serious gaps in global governance are highlighted in the recent Lancet-Oslo Commission on Global Governance for Health . The FPGH initiative asked that the health impact of foreign policy decisions must be better understood, assessed, and accounted for, and include the challenges of competing interests across different policy areas, within a government as well as across countries and regions. The Commission took up these challenges and is in this sense a result of the FPGH Initiative.

MAINTAINING THE MOMENTUM FOR COLLABORATION AT POLITICAL LEVEL

While the FPGH initiative, through its seven years of existence, has "survived" changes in the post of Foreign Minister in all the seven countries, there has been a gradual shift from an active political agenda led by the Ministers to more of a maintenance agenda led by the diplomatic missions in Geneva. This is an important observation that says something about the "life cycle" of these kinds of initiatives.

Even though the international audience has been receptive to the "health in foreign policy" agenda, it has been harder to mainstream the awareness of the "impact on health" across the key elements of foreign policy and development strategies within the ministries of foreign affairs.

Such awareness is critical for building new practices, sustaining the attention of ministers, and generating the necessary momentum for their political leadership. The core group of countries is like-minded in terms of the purpose of their mutual engagement, but obviously different in perceptions, priorities, and preferences, which in itself represents the very potential of such an initiative.

In observing the processes in UN, New York, it appears that the diplomatic missions still consider health to be an issue for Geneva, and continue to rely on calling their health specialists for negotiations, rather than taking on health in the different domains of foreign policy as a case for "mainstream" diplomacy. This represent a clear limitation in the potential of the initiative.

The post2015 sustainable development agenda calls for the kind of interconnected action that the FPGH initiative is all about. This is the time when the cross-cutting and inter-connected focus of FPGH - together with the geopolitical potential of the group of seven countries could bring a real added value.

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Japan's Strategy on Global Health Diplomacy

June 2013, Government of Japan

1. Vision

- **Japan prioritizes global health in its foreign policy.** By fully mobilizing its knowledge and expertise, Japan contributes to realizing a world where every person can receive basic healthcare service.
- **Japan promotes universal health coverage,** while accelerating its efforts towards the achievement of the Millennium Development Goals (MDGs). Japan contributes to the solution of global health challenges and better health in the world through global collaboration and effective bilateral assistance as well as by utilizing its technology.

2. Background

Japan is in a unique position to make contributions in global health:

(1) Japan has achieved a society where people enjoy good health and longevity of life. Japan has maintained universal health care for more than 50 years. Japan has comparative advantage in the treatment and prevention of non-communicable diseases (NCDs).

(2) Japan paved the way toward the establishment of the Global Fund; introduced health as G8 agenda; and has been contributing to the achievement of the MDGs, including its announcement of the Global Health Policy 2011-2015.

(3) **Health is indispensable to achieve human security**.

3. Global Context

(1) Health-related MDGs are lagging behind, particularly in Sub-Sahara Africa. We need to continue our efforts on maternal and newborn health, nutrition, infectious diseases and health system strengthening.

(2) There are emerging global health challenges such as non-communicable diseases (NCDs) and ageing which are not covered by the MDGs.

(3) As the year 2015 approaches, we need to establish an effective post-2015 development agenda.

Call for **Universal Health Coverage**

4. Actions

(1) Mainstream Universal Health Coverage (UHC)

- Lead the efforts to **include the concept of UHC in the post-2015 development agenda**.
  - ✓ Position UHC as an exemplary effort to realize human security
  - ✓ Effectively advance UHC through close coordination with relevant international organizations and other partners
  - ✓ Capitalize on high-level events such as TICAD V and ASEAN-Japan Commemorative Summit Meeting (December 2013)
- Share Japan's expertise with the international society on achieving UHC

(2) Effectively Implement Bilateral Assistance towards the realization of UHC

- Strengthen coordination among loan, grant and technical assistance
- Strengthen strategic assistance based on national programme
- Strengthen assistance by improving the Japanese ODA Loan scheme (Newly applying preferential terms and conditions to Health and Medical Care and Services)
- Contribute by utilizing technologies of Japan

(3) Collaborate with Global Partners (Strategic Partnership)

- Promote global public private partnerships, e.g.,
  - ✓ Polio eradication in cooperation with the Gates Foundation
  - ✓ Establishment of GHIT-Fund to develop new health technologies
- Further strengthen strategic coordination between bilateral and multilateral assistance, working with the World Health Organization (WHO), the World Bank, the Global Fund and other organizations.
- Collaborate with regional and global initiatives as well as other donors

(4) Strengthen Human Resources for Global Health

- Improve skills of global health specialists of Japan to develop and implement health-related policies, programs and projects
- Collaborate with special agencies and their specialists of Japan (such as medical institutions, universities, local governments, and industries)
- Contribute to international organizations in terms of human resources

Japan's Strategy toward Health System Recovery in West Africa Affected by Ebola Crisis

December, 2014
Ministry of Foreign Affairs , JAPAN

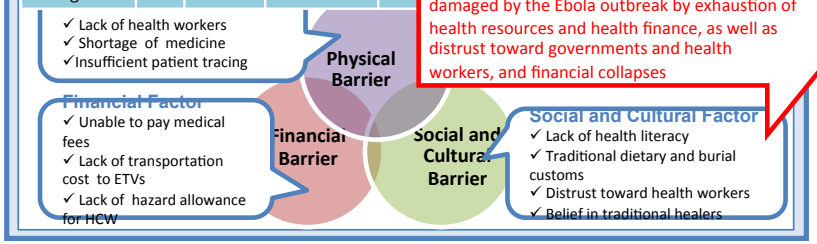
【The Ebola Outbreak caused by Vulnerable Health Systems 】

Vulnerable Health Systems

Source：WHO Country Profile 2012 and WHO Ebola Outbreak Data (Dec 3rd)

According to the World Health Report (WHO, 2000), health system rankings of the affected countries in West Africa had been already vulnerable among 191 countries before the Ebola

Health System Ranking in 2000		Physician Per 10,000	Nurse/ Midwife Per 10,000	U-five Mortality per1,000 LB	Maternal Mortality Per 100,000 LB	Ebola Case (Death)
Sierra Leone	191	0.2	1.7	182	1100	7,312 (1,583)
Liberia	186	0.1	2.7	75	640	7,635 (3,145)
Guinea	161	NA	NA	101	650	2,164 (1,327)
Nigeria	187	4.1	16.1	124	560	20(8)
Senegal	59	0.6	4.2			



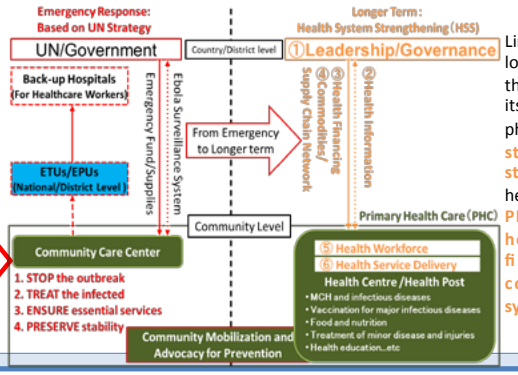
Vulnerable health systems have been further damaged by the Ebola outbreak by exhaustion of health resources and health finance, as well as distrust toward governments and health workers, and financial collapses

【Promotion of Universal Health Coverage（UHC） In West Africa 】

Why Promoting UHC in West Africa?

While the whole international community needs to contain the current public health crisis of Ebola outbreak first strategic efforts should be also made to prevent similar public health crisis in advance by rebuilding resilient health systems which enable everyone to access to essential health services when needed with affordable cost.

Ensure essential health services in countries with vulnerable health systems



Linking emergency response to longer term assistance through the HSS approach, Japan extents its assistance from emergency phase to longer term focusing on strengthening governance of states (top-down), community health in the key components of PHC(bottom-up) as well as health information, health financing and health commodities supply chain systems.

【Emergency Response：Ebola Outbreak Control and Damage Response】

Providing **emergency assistance worth 150 million USD** based on **UN five strategies**

1. STOP the outbreak Identifying/tracing patients , isolation, border control, safe/dignified burial

2. TREAT the infected Providing/transporting medicine/PPE,dispatching/training Ebola responders

3. ENSURE essential services Ensuring PHC, training community health workers, Food aid/ improving nutrition, providing relief supplies

4. PRESERVE stability Ensuring transportation, Ebola prevention awareness, refugee protection

From emergency assistance to mid-/long-term assistance without break.
With consideration to sustainability for rebuilding health system recovery in West Africa

5. PREVENT outbreaks in countries currently unaffected
Ebola prevention awareness, building infectious control capacity, strengthening emergency response center

【Longer Term Assistance : Rebuilding Health Systems Affected by the Ebola Outbreak】

- Building upon the commitment at TICAD V (2013) "to set aside **500 million dollars** to address health issues in Africa, and to launch training programs for **capacity development of 120,000 health workers**," as well as upon various assets from years of assistance, Japan will help Guinea, Sierra Leone, Liberia, and the entire West Africa region rebuild resilient health systems that are trusted by their peoples.
- Japan will support **the six building blocks of the health system – health services, commodities/supply chain, workforce, information, governance, and financing** – in the medium and long term, through its technical and financial assistance, with building regional and South-South cooperation and public-private partnerships.
- Japan will contribute to health security in the West African countries by strengthening the core competencies necessary for complying with the International Health Regulations of WHO.

① Leadership / Governance
- Providing advice on health administration and policies
- Strengthening supervision of and support to health facilities by health administration
- Ensuring UHC through health system strengthening

② Health Information
- Strengthening infectious diseases networks through Noguchi Memorial Institute for Medical Research
- Establishing and utilizing databases on health human resources

③ Health Financing
- Training courses on health financing for UHC
- Strengthening health financing system including RBF

④ Commodities/Supply Chain
- Development of new drugs and testing tools for NTDs and other diseases through（GHIT）
- Supply of vaccines for polio eradication
- Capacity building for maintenance of medical equipments

⑤ Health Workforce
- Establishment of national schools for public health
- Establishment of practical training center for maternal and child health
- Scholarship for study in Japan
- Reinforcement of networks for health human resources

⑥ Health Service Delivery
- Improving health services for rural areas and low-income households in urban areas
- Improving maternal and child health
- Nutrition improvement (PPP)

SOUTH AFRICA'S FOREIGN POLICY INTERESTS IN GLOBAL HEALTH – WORKING TOGETHER TOWARDS A COMMON GOAL

Mmathari K MATSAU
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South Africa

1. INTRODUCTION

A number of factors have contributed to the growing attention to the intersection between foreign policy, diplomacy and global health. Health threats from pandemics, infectious diseases, use of biological weapons and the recent outbreak of Ebola virus disease, should be seen as direct threats to national and global security.

The link between foreign policy and global health is also stimulated by the creation, negotiation, and operation of new international agreements, mechanisms and initiatives, such as the International Health Regulations 2005. There is also an increase in the foreign policy venues in which global health issues are discussed, such as the UN Security Council (UNSC); and the Group of 8 countries (G8). Furthermore, emerging countries from the Global South, such as Brazil, India, China and South Africa, have also stepped up their activities to improve global health.

South Africa, like many other emerging and transition countries, has a unique role to play in the 'global health enterprise' through building its own health system, addressing global health problems and helping other developing countries improve their populations' health. Moreover, South Africa is becoming an increasingly important component of the global health architecture and as a nexus of influence, individually as a nation, but also as a member of formations such as India-Brazil-South Africa (IBSA).

However, it is clear that while these factors are creating new opportunities, there are various shortcomings and challenges. This paper focuses on the correlation between global health and foreign policy – their merits, shortcomings and the way forward in the post-2015 development agenda, from the South African perspective. Furthermore, the paper identifies the best opportunities for public health and foreign policy makers to work effectively together to advance the global health agenda.

2. CORRELATION BETWEEN GLOBAL HEALTH AND FOREIGN POLICY

2.1 Merits – Why health matters in foreign policy

Global interdependence, with its massive volumes of international trade and travel means that health hazards anywhere in the world can potentially threaten citizens of every county. Border crossings of infectious diseases (such as SARS, influenza and now Ebola) and threats of bioterrorism, place health within the national security and development realm. Communicable diseases such as HIV/AIDS, TB and malaria pose serious international and regional stability by disrupting demographic, social, economic and political structures of states. In other countries in sub-Saharan Africa, foreign policy issues concerning access to essential medicines and resources for health programs, are a matter of national survival. In 2000, for the first time, the United Nations Security Council debated HIV/AIDS and in the same year the leading world economies comprising of the G8 committed to the establishment of the Global Fund.

Health has been elevated in international relations as a national economic, development and security interest. For instance, global health has been used as a means of furthering foreign policy goals. Global health is also used as means/instrument to pursue national interests such as security, the economy and trade. This view collapses the distinction between high and low politics and provides a new values based political space in international relations, with health and human dignity as the ultimate goal. Recognizing the close relationship between foreign policy and global health and their interdependence, the Foreign Ministers of seven countries issued the Oslo Ministerial Declaration, entitled "Global health – a pressing foreign policy issue of our time" in 2007.

Furthermore, health's integration into foreign policy is an evolving relationship where both spheres influence each other. This perspective has been informed by inclusion of the expertise of diplomats in the negotiations of international health agreements such as the Framework Convention on Tobacco Control (FCTC), the revised International Health Regulations (2005) and the presentation of health issues within non-health agreements. Thus, due to the impact of globalization on public health, the need for public health negotiators to work in partnership with diplomats, within the highly contested global policy agenda, is well recognized.

However, there are challenges: national interest approach to health exists in tension with an approach that calls for a global consensus on the morality of health. National interest does not necessarily value health for its own sake, nor as a special social good. Rather, health is neither handled politically nor as an evidence-based matter or for the sake of population health. An example is the current debates on tobacco control, alcohol, trans-fats and salt allowed in processed foods – major causes of chronic illness and serious public health threats. In many case health goes into foreign policy agenda as a relatively low priority, and at times comes into conflict with powerful economic interests, such as the pharmaceutical industry.

Why is a discussion on health and foreign policy important for South Africa? South Africa is a member of the G20, BRICS, Foreign Policy and Global health Initiative ("FPGH)) and is also part of the trilateral cooperation called IBSA (India, Brazil and South Africa). All these institutions have placed health high on the list of policy objectives. In principle, most G20 members agree on global health governance, including combating HIV and AIDS, Tuberculosis (TB) and malaria, and prioritization of maternal and child health. South Africa has put greater emphasis on "South-South" cooperation, to health systems, technology transfer, and social determinants of health. An inclusive approach that sets priorities and allocates resources in consultation with the affected parties; giving extra help to the most disadvantaged groups, and strong civic engagements of the HIV and AIDS programme, are a few examples of this type of health governance at work in South Africa. South Africa is able to, individually, advocate for the need to coordinate policies across sectors- such as trade and health policies across sectors – such as trade and health – to improve health outcomes. In the arena of access to essential medicines, especially ARVs, South Africa has already made notable progress in shifting norms towards an obligation to access.

2.2 Short comings of global health diplomacy

Lack of coordination and harmonization

The rise of new actors, new issues, creation of new processes and mechanisms, including active involvement of international networks in global health, has reflected a new form of diplomacy, referred to as 'global health diplomacy' (GHD). However, the current system of health governance has been described as ad hoc, fragmented and inadequate "to oversee the changing array of players and ensure that the right health issues are being tackled fairly, effectively, and efficiently". For example, global civil society actors and other transnational networks have advanced social justice approaches to health and have strongly argued for implementation of innovative mechanisms to address major global health issues. In contrast, pharmaceutical companies and many powerful states are driven by what can be termed a "market justice" approach to health, guided by financial imperatives and a belief in the ability of the market to bring equity. In practice, this often stands at odds with social concerns. Therefore, coordinated governance of health is required if we are to address the complex range of new and old health challenges we face

2.3 Way forward in the post-2015 development agenda

In line with the Africa Common Position on post-2015 development agenda, under the African Union South Africa proposes the following:

2.3.1 Unfinished business of health related MDGs

Remarkable advances have been made in some health-related MDGs, such as immunization coverage, and reversing the trend of the spread of HIV/AIDS. Notwithstanding the progress made, more needs to be done. For example, progress on the health-related MDGs such as child and maternal mortality, quality of health services, and access to sanitation is insufficient to achieve the targets by end of 2015 in many developing countries, especially in Africa. Reducing inequity in access to basic social services remains a major challenge for many African countries. The inclusive process used to formulate the post-2015 Development Agenda should: a) enhance Member States' ownership of development; b) generate the required political will to address the unfinished business of the MDGs; and C) respond to the emerging issues and gaps in implementation, particularly with regard to data collection and monitoring.

2.3.2 Non-communicable diseases

The progress report on WHA Resolution 65.3 on strengthening noncommunicable disease (NCDs) policies to promote active ageing noted, amongst other things, that 80% of all NCDs occur in developing countries. Progress in socio-economic and human development in Africa remains constrained by a very high disease burden. In South Africa, even as a country that still has to deal with high prevalence of communicable diseases and high rates of maternal and child health problems, we have realized that neglecting NCDs would be ill-advised and potentially highly damaging in the longer term. To not act now would have serious health implications for the population, serious cost implications for our health services, and of course major social, economic and development consequences. Areas for collaboration with foreign policy-makers in combating NCDs include introduction of regulations around trans-fats and salt allowed in processed foods; implementation of the FCTCT; introduction of legislation to reduce alcohol related harm, and also a more formalized intersectoral collaboration mechanisms.

2.3.3 Universal health coverage: the right choice, the smart choice

Access to affordable health care for all people is a crucial factor in alleviating poverty, promoting economic growth and creating more equitable societies. Universal health coverage (UHC) should be firmly embedded within the post-2015 development agenda. However, with 1 billion people still unable to access high quality basic health services, and 100 million being forced into poverty each year due to high out-of-pocket spending on health care, huge challenges remain. Experiences from other countries highlight the growing body of international evidence that UHC is the next logical step to improve health and reduce poverty for people worldwide, particularly those in low- and middle-income countries. Collaborative actions with foreign policy makers should ensure that all countries are empowered to prioritise UHC, to ensure that they are able to deliver on the promise of affordable and quality health care.

3. POTENTIAL CONTRIBUTIONS TO ADVANCE GLOBAL HEALTH AGENDA

3.1 Foreign policy in preparedness and management of disasters and disease emergencies

For national, regional and global mechanisms to be effective to deal with public health emergencies, they have to offer a coordinated response; this is only possible if there is equal capacity to identify risks and threats, to share information adequately, and to have the ability to make use of global instruments such as the IHR and other humanitarians laws. These have to be under-pinned by UN systems which effectively coordinate actions related to foreign policy in preparedness planning and action for global health security. The EVD crisis has exposed the weaknesses in the global health system, as all regions of the world remain vulnerable to the disease despite surveillance systems being on high alert. The overall paradigm therefore should be one of looking beyond a threat analysis and security concerns The focus should be on the development of countries' health systems and their citizens to maintain their sovereign status, economic viability and financial stability, with the support of the global community, the private sector, and civil society actors. Strengthening health systems and decreasing vulnerability to various natural and non-natural disasters are initial steps towards that goal.

3.2 Health systems and foreign policy

Ebola, and other recent infectious disease outbreaks, have revealed unacceptable gaps in the national health system and global capacity to prevent detect and rapidly respond to infectious disease threats. The current global shortage and maldistribution of trained health workers, lack of access to essential medicines, diagnostics and medical technologies, represent a major barrier to preparedness and to national and global health security and development. For example shortage of health workers is influenced by global economy, incentives for migration, and global negotiations for services. Therefore, collaborative actions should include strengthening of health systems, such as standardized policies on sharing human, technology and system resources.

3.3 Response to HIV/AIDS, TB, malaria

Sub-Saharan Africa remains the region that is most heavily affected by HIV, TB and malaria. A high prevalence of HIV, TB and malaria is not only a threat to personal health, but also to national and global security, trade, peace building, humanitarian and economic development. Hence, there is a need to mobilize a multi-stakeholder, multi-sector movement, with common purpose, to address these diseases. Furthermore, there is a need not only to commit to international agreements and political declarations, but also to monitor their implementation. There is also a need to raise awareness amongst diplomats and ambassadors about the impact of these communicable diseases on economies, institutional capacity, gender, human rights in order to bring these issues into country-level policy dialogue.

3.4 Health and environment

In recent decades, international connectivity has increased on many fronts, including the flow of information, movements of people, trading patterns, the flow of capital, regulatory systems, and cultural diffusion. The loss of biodiversity, global circulation of bioactive nitrogen compounds, and human-induced climate change have already reached levels that are apparently unsafe. On the economic front, the recent global financial crisis has underscored the domino-like interdependence of national economies. The projections by the United Nations that today's population of 7 billion will increase to 9.3 billion by 2050? should reactivate the debate about whether we can succeed in pursuing realistic objectives for a healthy climate without curtailing the actual number of humans pressing on the environment. It would seem there is a need for instruments similar to the WHO Framework Convention on Tobacco Control1, and the WHO Global Outbreak Alert and Response Network, in relation to the emergence of infectious diseases, that are brought about by the changing environment, as well as the United Nations Environmental Programme Montreal Protocol to protect the ozone layer.

3.5 Trade policies and measures to implement and monitor agreements

International trade policies and agreements such as International Health Regulations 2005, FCTC, Doha Declaration on TRIPS and Public Health need to be placed within the context of protecting and promoting health and wellbeing. There is a need to establish a universal, rules-based, open, non-discriminatory and multilateral trade system, including trade liberalization. Collaborative actions by foreign policy and health policy makers should affirm the interconnectedness of trade, health and development, including both trade and health policies in the formulation of all bilateral, regional and multilateral trade agreements. For example, ensuring equal and universal access to essential medicines, reduction of medicine prices, together with application of TRIPS flexibilities, can be an area where foreign policy and health policy makers can collaborate to improving health and achieving equity in health for all people worldwide.

3.6 Migration, health and foreign policy

The migration of people, both internal and cross-border, is a global phenomenon. The 2009 Human Development Report clearly positions migration as a key driver of human development. The movement of skilled and semi-skilled labour, and the ability of migrants to provide a range of resources to their linked households, contributes to social and economic development. However, for the development associated benefits of migration to be realized, migration itself must be managed in a healthy way; and population mobility must be recognized as a central public health imperative. Current policies have not kept pace with the growing challenges associated with volume, speed, diversity and disparity of modern migration flows, and do not adequately address the health inequalities, gaps and social protection including barrier to access to health services, goods and facilities. Collaborative actions should support the implementation of existing international agreements, humanitarian laws, mechanisms and initiatives, such as World Health Assembly, Resolution 61.17 on

improving health of migrants; Article 12 of the (ICESCR) the International Committee on Economic, Social and Cultural Rights adopted a General Comment on the right to health. Four main points for collaborative action should include (i) monitoring migrant health; (ii) partnerships, networks and multi-country frameworks; (iii) policy and legal frameworks, and (iv) migrant-sensitive health systems.

3.7 Natural disasters, armed conflicts and other crises

Although health needs during and after natural disasters and armed conflicts are similar, the differences arise from the political complexities of the latter, in which civilian populations serve as targets of war and human rights abuses aggravate health and protection needs. Collaborative actions should recognize that health can be a good entry point to initiate dialogue across borders and to spearhead the resolution of conflict ('smart power') and to develop the case for a health focus in post-conflict reconstruction. There should be a particular focus on women as care-givers, and girls and women threatened by rape and other forms of violence. Furthermore, there is a need to work with UN Peace Building Commissions, the Office for the Coordination of Humanitarian Affairs (OCHA), in cooperation with the WHO, for early and effective assistance to vulnerable groups in emergencies. Also, priority should be given to restoring a functioning health systems in the aftermath of disasters and conflicts, including ensuring equitable distribution of aid.

CONCLUSION

The post-2015 Development Agenda provides a unique opportunity for Africa to reach consensus on common challenges, priorities and aspirations, and to actively participate in the global debate on how to provide a fresh impetus to the MDGs and to examine and devise strategies to address key emerging development issues on the continent in the coming years. The post-2015 Development Agenda should also reaffirm the Rio Principles, especially the principle of common but differentiated responsibilities, the right to development and equity, and mutual accountability and responsibility, as well as ensure policy space for nationally tailored policies and programmes on the African continent.

PRINCE MAHIDOL AWARD CONFERENCE 2015 | GLOBAL HEALTH POST 2015 ACCELERATING EQUITY

PARALLEL SESSION 1.4

PHILANTHROPIC INTERESTS IN GLOBAL AND PUBLIC HEALTH

PARALLEL SESSION 1.4

PHILANTHROPIC INTERESTS
IN GLOBAL AND PUBLIC HEALTH

OBJECTIVES

To identify how philanthropic organizations' strategic objectives relate to post-2015 objectives for global health, and what synergies might be obtained from coordinated efforts in this space, both among philanthropic organizations and between philanthropic organizations and other donors.

KEY ISSUES

- What issues do philanthropic organizations identify as priority post-2015 objectives? Why, and what criteria are being applied to this prioritization? How do equity considerations impact upon these internal debates?
- Do foundations coordinate their efforts?
  In what ways might organizations work more effectively together to achieve common post-2015 objectives?
- How do philanthropies work to achieve their goals?
  How does philanthropy legitimize its efforts within global health?
- How do foundations cooperate with other types of donor agencies and/or governments to achieve these priority objectives?
  What barriers exist?

OUTPUTS

- A set of issues that philanthropic organizations feel are priorities for the post-2015 period.
- A set of associated criteria used to identify these priorities.
- A summary of key strategies that philanthropies use to achieve their objectives.
- A summary of factors that impact upon effective cooperation between philanthropies and other donors and/or governments.

MODERATOR

Stefan NACHUK
Associate Director
The Rockefeller Foundation

Thailand

Stefan Nachuk has been an Associate Director with the Rockefeller Foundation since February 2007, and is based in Bangkok, Thailand. In this role, he is focused upon developing an initiative on the role of transforming health systems globally, with specific components focusing on strategic capacity building, leveraging the private sector, and developing a joint learning network for Universal Health Coverage. This work focuses both on support to a small number of countries, as well as regional capacity building and networking. In addition, Stefan also participates in a climate change adaptation initiative, with a special focus upon developing models of climate resilience in selected cities within Thailand, India, Vietnam, and Indonesia. Prior to joining Rockefeller, Stefan lived and worked in SE Asia for approximately 14 years, with a broad focus on decentralization, governance, and social development. Most recently, Stefan was a Senior Policy Specialist with the World Bank in Indonesia from 2003 through 2006.

Daniel KRESS
Deputy Director,
Integrated Delivery
Bill and Melinda Gates
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USA

Daniel Kress, Ph.D. is Deputy Director for Primary Health Care and Health Financing in the Integrated Delivery group at the Bill and Melinda Gates Foundation in Seattle, Washington. Dan works on a variety of issues related to health systems, primary care, and health financing and economics that relate to uptake, coverage and equity for Foundation priorities.

Dan has been with the Foundation since 2004 and has worked in several different groups. Dan began his career as a Senior Program Officer in Global Health Policy and Advocacy under Raj Shah and Joe Cerrell and was promoted to Deputy Director for Policy and Finance. He served as Deputy Director in Vaccine Delivery then as Deputy Director for Health Economics and Finance in GH Policy and Advocacy. Prior to his current position in Integrated Delivery, Dan served as the Deputy Director and Chief Economist for the Policy Analysis and Financing team. Prior to joining the Foundation, Dr. Kress worked at the World Bank as Senior Health Economist in the Middle East and North Africa Region where he was responsible for health projects in Morocco and Iran. Dan has worked in over 20 countries around the world.

He received his doctorate in Economics from the University of North Carolina at Chapel Hill. He also attended the Université d'Aix-Marseille III in Aix-en-Provence, France. He received his undergraduate degrees in Economics and French at the University of Montana, Missoula, Montana.

Toomas PALU
Sector Manager for Health,
Nutrition and Population,
East Asia and Pacific Region
The World Bank

Thailand

Toomas Palu, MD, MPA, is the Manager of Global Health, Population and Nutrition Practice in the World Bank Group. He is currently managing the health programs in the East Asia and Pacific Region and a team of 35 health and development professionals. His key qualifications and experience include health policy and health sector reforms in middle-income transition economies and health systems strengthening in developing countries. He has also served as a Director in the Social Estonia Health Insurance Fund Management Board and as a Deputy Director of a tertiary care hospital. Toomas has a Medical Doctor degree from the Tartu University in Estonia and a Master of Public Administration degree from the Harvard University in the US. He has also studied Medical Anthropology and Social Policy in the Oxford University and health economics in the University of York in the UK.

Michael MYERS
Managing Director
The Rockefeller Foundation

USA

Michael Myers performs a number of leadership roles at the Rockefeller Foundation, including coordinating strategies for the Foundation's work in the United States and leading two key initiatives—the global Transforming Health Systems initiative and transportation issues in the U.S.

Mr. Myers joined the Rockefeller Foundation in 2010 and led the organization's successful centennial program, which included an array of global activities to build on past successes and to help shape the Foundation's future direction.

Prior to coming to the Rockefeller Foundation, Mr. Myers served in leadership capacities in the United States Senate for much of his career, including Chief Counsel and Staff Director to the late Senator Edward M. Kennedy. He worked on a range of issues, including health care, employment, economic development, refugees, immigration and education. Before his career in government, Mr. Myers worked on refugee and international humanitarian matters for non-governmental organizations and the U.N. High Commissioner for Refugees.

Mr. Myers holds both a bachelor's and a master's degree in political science from Columbia University.

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Lara BREARLEY
Senior Health Policy
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United Kingdom

Lara Brearley is a Senior Health Policy & Research Adviser at Save the Children UK. She has been leading the organisation's advocacy on universal health coverage and health in post-2015, and has authored various reports, briefings and articles. Lara participates in various global technical working groups, including the Countdown to 2015 health financing and health systems and policies working groups. She also provides technical support to Save the Children country programmes on health financing advocacy and broader RMNCH policy engagement. Lara is currently on secondment to the 3MDG Fund in Myanmar, working as a Technical Specialist on Health System Strengthening. Lara has an MSc in Health Policy, Planning and Financing from the London School of Economics and the London School of Hygiene and Tropical Medicine, and a first class MA(Hons) in History from Edinburgh University. Lara has previously worked for research institutes, NGOs, and the UN in Africa and Asia.

Jesse BUMP
Associate Professor
Georgetown University

USA

Jesse Bump is Assistant Professor in the Department of International Health at Georgetown University. He holds a PhD from the Institute of the History of Medicine at Johns Hopkins and an MPH in Global Health from the Harvard University School of Public Health. Before joining the faculty at Georgetown he was Takemi Fellow in International Health Policy at the Harvard School of Public Health. His research focuses on the political economy of current and historical public health problems in developing countries, community-directed programs, health system design, and health reform. His projects examine the influence of competition in international aid, agenda setting and universal health coverage, the political economy of health reform, and the politics of defining objectives in global health policymaking.

Piya HANVORAVONGCHAI
Southeast Asian Regional Coordinator
China Medical Board

Thailand

Dr. Piya Hanvoravongchai is a lecturer at the Department of Preventive and Social Medicine, Faculty of Medicine, Chulalongkorn University and an assistant director of the Thailand Research Center for Health Services System at Chulalongkorn University. In addition, he has been an advisor or a consultant to several international organizations including the World Bank, the World Health Organization, Global Health Workforce Alliance, GIZ, etc. Dr. Hanvoravongchai advises the Office of the Civil Service Commission in Thailand and Ministry of Public Health on health workforce planning and management. He sits on the financial development committee and the evaluation committee of Thailand Health Security Board (30 Baht Scheme). He is a member of the medical committee of Thailand Social Security Fund. He is also the Southeast Asia Regional Coordinator for the China Medical Board, a U.S. based foundation working to promote health development and medical education in China and in Asia. He also oversees the development of an online platform for health policy research and development in Asia, HealthSpace.Asia.

Dr. Hanvoravongchai has extensive work experience in Southeast Asia and globally. Prior to joining Chulalongkorn University, he was a lecturer at London School of Hygiene & Tropical Medicine. At the World Health Organization in Geneva, he worked as a Global Health Leadership Fellow and a research scientist on health financing policy and health system performance assessment in the Evidence and Information for Policy Cluster. Between 2003-2006, Dr. Hanvoravongchai was a research associate at Global Equity Initiative, Harvard University where he worked extensively on global health as part of the Joint Learning Initiative on Human Resource for Health. He was the first coordinator of the Asia Pacific Action Alliance on Human Resource for Health. Dr. Hanvoravongchai was a hospital director and a clinician in a Thai rural hospital and a research fellow at Thailand Health Systems Research Institute and at International Health Policy Programme-Thailand.

PRINCE MAHIDOL AWARD CONFERENCE 2015 | GLOBAL HEALTH POST 2015 ACCELERATING EQUITY

PARALLEL SESSION 1.5

MAXIMIZING SYNERGIES BETWEEN HEALTH AND INCLUSIVE DEVELOPMENT

PARALLEL SESSION 1.5

MAXIMIZING SYNERGIES BETWEEN
HEALTH AND INCLUSIVE DEVELOPMENT

BACKGROUND

This session will explore health in the context of sustainable, inclusive and equitable development in the post-2015 development agenda. It will examine the development dimensions of health from various perspectives and explore approaches on how to achieve more synergies between health and inclusive development and poverty reduction efforts. The session will give specific focus on marginalized populations such as LGBT, persons with disabilities, rural poor, migrants and indigenous people.

Health is integral to national and human development. Helen Clark, the Administrator of UNDP and the former Prime and Health Minister of New Zealand, stresses that "just as health shapes development, development shapes health." Millions are impoverished every year due to lack of financial protection for health expenditures. On the other hand, the Lancet Commission on Investing in Health recently estimated that up to 24% of growth in full income in low- and middle-income countries was due to better health outcomes. While health-development linkages have long been established, there is a need to explore innovative approaches for greater convergence of health and inclusive development. Special attention and dedicated investments are needed to ensure the most vulnerable and marginalized will benefit from such greater health-development convergence.

OBJECTIVES

- To examine how health of the population, particularly of marginalized groups, can be impacted by poverty and development measures, and vice versa;
- To examine how health considerations can be strategically integrated into global, regional and national efforts towards inclusive development;
- To explore key gaps, challenges and opportunities for innovations to maximize the development-health convergence in the context of the post-2015 development agenda.

MODERATOR

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Dr. Mandeep Dhaliwal is the Director of UNDP's HIV, Health and Development Practice. Dr. Dhaliwal brings to the organization 20 years of experience working on HIV, health, human rights and evidence-based policy and programming in low and middle-income countries. She is a member of the Human Rights Reference Group for the Global Fund to Fight AIDS, Tuberculosis and Malaria.

Dr. Dhaliwal, a physician and lawyer, joined UNDP in 2008 as the Cluster Leader: Human Rights, Gender and Sexual Diversities in the HIV/AIDS Group. She was the architect and team leader for the Global Commission on HIV and the Law. Prior to joining UNDP, she was a senior adviser to the Dutch Royal Tropical Institute's Special Programme on HIV/ AIDS.

From 2000 to 2006, Dr. Dhaliwal worked for the International HIV/AIDS Alliance's Policy, Research and Good Practice Team in the United Kingdom where she focused on issues of HIV care and treatment in developing countries. She was instrumental in expanding the International HIV/AIDS Alliance's technical support and policy work on issues of HIV care, treatment and support in Africa, Asia, Eastern Europe and Latin America. While at the Alliance, she led the development of an operations research initiative in Zambia on community engagement for anti-retroviral treatment.

From 1993 to 2000, she worked on HIV and human rights issues in India, including as the founding Coordinator of the Lawyers Collective HIV/AIDS Unit, a leading human rights organization, establishing the Unit's legal aid, public interest litigation, legal literacy, capacity building, research and advocacy work.

Dr. Dhaliwal is a British national and did her studies at the University of Ottawa in Canada.

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Khama Rogo is Lead Health Sector Specialist with the World Bank and Head of the World Bank Group's Health in Africa Initiative. Prior to his WB career, he taught Obstetrics and Gynecology at the University of Nairobi, before becoming the Vice President of Medical Affairs Africa for Ipas. A native of Kenya, Prof Rogo received his MD and M.MED from the University of Nairobi and earned a Fellowship and PhD in Gynecologic Oncology in Sweden. A prominent advocate and global authority on reproductive health issues, he is a visiting professor at several universities and author of over 100 papers and book chapters. He has been a consultant to WHO, UNFPA, UNICEF, USAID, and DFID, and advisor to many other bilateral and unilateral international organizations. Prof. Rogo is past president of the Kenya Medical Association and Kenya Obstetrical and Gynecological Society. He was also the chairman of Kenya's National Council for Population and Development, and served on the Gender Advisory Panel of WHO, the Advisory Committee of the David and Lucile Packard Foundation, and the board of the Center for African Family Studies. He is currently on the board of INTRAHEALTH, among other responsibilities.

Chong CHAN YAU
President
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Hong Kong

Mr. Chong Chan-yau graduated from the University of Hong Kong with a Bachelor of Arts Degree, majoring in English Studies and Psychology. He later obtained a Master Degree in Information System from the London School of Economics and Political Science.

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Mr. Chong served as Vice-President of the Asia-Pacific Region of the World Blind Union between 1988 and 1996. He was the Chairman of the Organizing Committee of the 2014 Midterm General Assembly of the Asia-Pacific Region of the World Blind Union.

He has served as an Administrative Officer in the Hong Kong Government, Executive Director of Oxfam Hong Kong, and Director of the HKU Student Development of the Centre for Development and Resources for Students.

He received one of the Ten Outstanding Young Persons Awards, MBE from the British Government, the Poverty Alleviation Award from the China Foundation for Poverty Alleviation, and the University of Hong Kong Honorary University Fellowships in 2012.

Chris BEYRER
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Chris Beyrer MD, MPH, is Professor of Epidemiology, International Health, and Health, Behavior and Society at the Johns Hopkins Bloomberg School of Public Health in Baltimore. He serves as Director of JHU's HIV Training Program in Epidemiology and Prevention Science, and founded and directs the Johns Hopkins Center for Public Health and Human Rights. He is Co-Principal Investigator of the JHU Center for AIDS Research, CFAR. He is a member of the HIV Prevention Trials Network's MSM Working Group, and Protocol Chair for HPTN 078. He currently serves as Co-Chair of the Epidemiology and Natural History Planning Group of the Office of AIDS Research of the U.S. NIH. He has extensive experience in conducting international collaborative research and training programs in HIV/AIDS and other infectious disease epidemiology, in infectious disease prevention research, HIV vaccine preparedness, in health and migration, and in health and human rights. Dr. Beyrer has done research on HIV in Thailand, Burma, China, India, South Africa, Malawi, Tanzania, Russia, Tajikistan, and Kazakhstan and is the author of over 200 scientific papers. He became President of the International AIDS Society in July, 2014.

Paula VIVILI NOUMEA
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Dr Paula Vivili has worked for 19 years in Tonga and the Pacific region. His area of expertise in Non- Communicable Diseases (NCDs) and has also been involved in Health Systems Strengthening work both at national and regional level. He was involved with setting up the Tonga Health Promotion Foundation and served as a board member for five years. Paula joined the Secretariat of the Pacific Community (SPC) in November 2013 and his current role involves maximising integration and coordination of partners' contributions to assist SPC's 22 member Pacific Island Countries and Territories mostly on policy interventions and issues.

Paula received training in Nutrition (Otago University), Medicine (Fiji School of Medicine), Ophthalmology (University of Auckland) and International Public Health (University of Sydney).

HIV in men who have sex with men 1

Global epidemiology of HIV infection in men who have sex with men

Chris Beyrer, Stefan D Baral, Frits van Griensven, Steven M Goodreau, Suwat Chariyalertsak, Andrea L Wirtz, Ron Brookmeyer

Epidemics of HIV in men who have sex with men (MSM) continue to expand in most countries. We sought to understand the epidemiological drivers of the global epidemic in MSM and why it continues unabated. We did a comprehensive review of available data for HIV prevalence, incidence, risk factors, and the molecular epidemiology of HIV in MSM from 2007 to 2011, and modelled the dynamics of HIV transmission with an agent-based simulation. Our findings show that the high probability of transmission per act through receptive anal intercourse has a central role in explaining the disproportionate disease burden in MSM. HIV can be transmitted through large MSM networks at great speed. Molecular epidemiological data show substantial clustering of HIV infections in MSM networks, and higher rates of dual-variant and multiple-variant HIV infection in MSM than in heterosexual people in the same populations. Prevention strategies that lower biological transmission and acquisition risks, such as approaches based on antiretrovirals, offer promise for controlling the expanding epidemic in MSM, but their potential effectiveness is limited by structural factors that contribute to low health-seeking behaviours in populations of MSM in many parts of the world.

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See Online for appendix

Introduction

In 2012, men who have sex with men (MSM) are at substantial risk for HIV infection in virtually every context studied (panel 1).[1,3,4] This risk has been present since the syndrome now known as AIDS was first described in previously healthy homosexual men in Los Angeles (CA, USA) in 1981.[5–7] Despite decades of research and community, medical, and public health efforts, high HIV prevalence and incidence burdens have been reported in MSM throughout the world.[8] In many high-income settings—including Australia, France, the UK, and the USA—overall HIV epidemic trends are in decline except in MSM, where they have been expanding in the era of highly active antiretroviral therapy (HAART) in what have been described as re-emergent epidemics in MSM.[9,10] In the USA, HIV infections in MSM are estimated to be increasing at roughly 8% per year since 2001.[9] And in much of Africa, Asia, and Latin America, the highest rates of HIV infection in any risk group are in these men.[8]

However, our understanding of worldwide epidemiology is far from complete. By the end of 2011, 93 of 196 countries had not reported on HIV prevalence in MSM in the previous 5 years.[11] In several regions, notably the Middle East, north Africa, and sub-Saharan Africa, data for HIV infections in MSM are only emerging.[12,13] Data gaps and challenges to HIV research, surveillance, and epidemiological characterisation in MSM are largely the result of the hidden and stigmatised nature of MSM populations in much of the world, and of ongoing criminalisation of homosexuality and other forms of same-sex behaviour.[11] These structural realities have limited our understanding, and might also have crucial roles in the vulnerability of MSM to HIV.[14,15] We review the global epidemiology and disease burden of HIV infection in MSM; individual-level, couple, and network-level risks for HIV acquisition and transmission; biological aspects of anorectal HIV transmission; and molecular epidemiology advances, with the aim of understanding why MSM continue to bear such disproportionate burdens of HIV. We also developed and report on stochastic agent-based simulation models of HIV transmission to further clarify the drivers of HIV spread in MSM.[16] Finally, we discuss the public health importance of our emerging understanding of the epidemiology of HIV in MSM.

Disease burden of HIV in MSM

We did a comprehensive search for HIV burden and risks in MSM from Jan 1, 2007, to June 30, 2011 (search criteria in the appendix). We retrieved 2105 unique citations, and we identified and reviewed 68 additional surveillance studies in the public domain. We included country progress reports submitted to the UN General Assembly Special Session on HIV/AIDS (UNGASS). We obtained data from 82 peer-reviewed publications on disease burden of HIV in MSM, from 12 of the 68 surveillance reports, and from 38 of 186 country progress reports submitted to UNGASS in 2010.

Figure 1 shows aggregate HIV prevalence estimates in MSM by region derived from the comprehensive search (references in the appendix). Pooled HIV prevalence ranged from a low of 3·0% (95% CI 2·4–3·6) in the Middle East and north Africa region to a high of 25·4% (21·4–29·5) in the Caribbean. The CIs for these pooled estimates must be interpreted with caution, since they only account for sampling variation and not the inherent biases of non-representative samples, and so undoubtedly underestimate actual variances. Nevertheless, HIV prevalences were relatively consistent across North, South, and Central America, south and southeast Asia, and sub-Saharan Africa (all within the 14–18%

Key messages

- HIV epidemics in men who have sex with men (MSM) are expanding in countries of all incomes in 2012, and these epidemics are characterised by high HIV burdens, substantial clustering of infections within networks, and high forces of infection.
- The disproportionate HIV disease burden in MSM is explained largely by the high per-act and per-partner transmission probability of HIV transmission in receptive anal sex.
- The molecular epidemiology of HIV in MSM shows substantial clustering of HIV infection, a high frequency of multiple transmitted variants, and more rapid spread through networks, challenging vaccine and other biomedical approaches to prevention.
- If the transmission probability of receptive anal sex was similar to that associated with unprotected vaginal sex, 5 year cumulative HIV incidence in MSM would be reduced by 80–98%.
- Role reversal in MSMs, whereby individuals practise both insertive and receptive roles, helps HIV spread by overcoming the low transmission rates from receptive to insertive partners. Our modelling shows that limiting MSM to either insertive or receptive roles (50% for each, as in heterosexual networks) reduced 5 year cumulative HIV incidence by 19–55% in high-prevalence scenarios.
- Casual partnerships are also a substantial driver of the epidemic in MSM. If unprotected anal intercourse in casual partnerships instead happened within long-term main partnerships, HIV prevalence would be reduced by 29–51%.

Panel 1: **Taxonomies of men who have sex with men, sexual orientation, and gender identity**

Men who have sex with men (MSM) is a term introduced in 1992 to attempt to capture a range of male–male sexual behaviours and avoid characterisation of the men engaging in these behaviours by sexual orientation (homosexual, bisexual, heterosexual, or gay) or gender identity (male, female, transgender, queer).[1] MSM includes gay-identified men, heterosexually identified men who have sex with men, bisexual men, male sex workers who can have any orientation, men engaging in these behaviours in all male settings, such as prisons, and the rich and wide array of traditional identities and terms for these men across cultures and subcultures. Biological men who choose female identities are generally referred to in work on HIV as transgender or transgender women if they have undergone gender-reassignment surgery. Transgender people born male might share some biological risks with MSM, most importantly receptive anal intercourse, but their female gender identity places them in quite different categories from MSM; hence they are not included as a subgroup of MSM in this Series.

Scientific work suggests that sexual orientation in men represents a lifelong preference for sexual and romantic partners of the opposite, same, or both sexes.[2] MSM is a broader category and includes non-gay-identified MSM, those married to women, and other subgroups who might be more hidden, difficult to reach for surveillance, and less willing to disclose sexual practices than gay-identified men, challenging epidemiological characterisation and HIV responses. This is particularly true in contexts where same-sex behaviour is stigmatised or criminalised. Nevertheless, MSM has become the standard term in the work on HIV. We use the term recognising its shortcomings.

range). Comparing HIV infection levels in MSM with UNAIDS 2009 estimates of general population adult male HIV prevalence shows that levels in MSM are substantially higher in every context (figure 2).[18] Most countries worldwide had not reported HIV rates in the previous 5 years in MSM, so these are aggregate regional values of available and present data. Figure 2 depicts HIV prevalence in MSM in countries where prevalence data could be obtained through peer-reviewed publications, behavioural surveillance reports, or UNGASS reports.

Figure 3 shows HIV incidence in MSM, which was available from 27 peer-reviewed publications. Data were reported from 15 countries overall; reports included nine from the USA, three from Europe, six from Asia, six from Latin America, two from Australia, and one from Africa (Kenya; references in the appendix). Overall incidences show sustained epidemic patterns, with no evidence of declines. The two Asian states for which incidence was available, China and Thailand, both show rising rates of HIV infection. Kenya, the only African country with an incidence report, had the very high rate of greater than 20% annual incidence in a selected sample of men who have sex with men only, in Mombasa.[19]

These findings suggest several important patterns for epidemiology in MSM. First, incidence continues to be sustained at levels sufficient for epidemics in the MSM population to continue, and, in some settings, expand. The available incidence data from Thai, Chinese, and Kenyan samples of MSM suggest these epidemics are in rapid expansion phases. With only one African incidence report, it is clear that more work needs to be done to understand the emerging HIV epidemics in African MSM.

The available epidemiological data must be interpreted with some caution. Probability and population-based sampling methods have been important in measuring HIV epidemics. Demographic and related household-based survey approaches have helped define HIV spread at community levels and provide important denominators for assessment of HIV prevalence and incidence densities.[20,21] These approaches are problematic for hidden and stigmatised populations, and for measures of socially constrained behaviours. Many of the key epidemiological and population-based studies of HIV in developing countries collect no measures of male same-sex behaviour, restricting our understanding of this component of global HIV.[11] When MSM risk assessment has been included, strong social response biases have often made such assessments unreliable. Size estimation of the numbers of MSM in any particular population have also been limited by the hidden nature of these men, heterogeneity in the populations, and low rates of participation (panel 2).[31,32]

These realities have led to many innovations in sampling, surveillance, and size estimation research in MSM. Past innovations have included the use of respondent-driven sampling, with its well described limitations, venue-day-time sampling, internet-based sampling, and the use of molecular methods for biological sampling. Size estimation approaches have included capture–recapture, multiplier methods, and the wisdom-of-the-crowd approach.[14] Although no single method or approach is ideal or sufficient, the body of evidence on HIV in MSM is nevertheless substantial and growing.

Risks for HIV infection

Individual-level risks for HIV acquisition in MSM have been well documented, and include unprotected receptive anal intercourse, high frequency of male partners, high number of lifetime male partners, injection drug use, high viral load in the index partner, African-American ethnic origin (in the USA), and non-injection-drug use, including use of amphetamine-type stimulants (ATS).[33–35] Recent data suggest individual-level risks might be insufficient to explain the high transmission dynamics evident in MSM outbreaks, and that biological, couple, network-level, and community-level drivers might be crucial to understand why HIV transmission rates remain so high in MSM populations.[36] These factors might be crucial to understand why HIV prevalence rates in these men seem to have increased in the HAART era, both in settings where HIV epidemics are newly described or emerging and in settings where MSM have access to a broad range of HIV services, civil liberties, and organised and visible community structures.[10,37–39] Present understanding of the role of HAART is that new infections should decline in populations where more people have reduced likelihood of transmission because of the effect of HAART on viral load.[40]

A framework for characterising HIV epidemics in MSM in wider epidemiological contexts has been proposed.[8] This approach described four epidemiological scenarios for epidemics in MSM in low-income and middle-income countries. The first, primarily in South America, was characterised by MSM predominance—these men were the largest contributors to HIV prevalence in general populations with very low rates of infection. In the second scenario, which was found in eastern Europe and central Asia, epidemics in MSM were within HIV epidemics primarily driven by injection drug use. Epidemics in MSM during widespread epidemics in heterosexual people were generally evident in southern and eastern Africa, and here men had substantial HIV acquisition risks both from female and male partners. And finally epidemic contexts where heterosexual spread, sex work, MSM risks, and injection drug use were all contributors to HIV spread were evident in the complex epidemics of south and southeast Asia.

The role that sex with female partners might have in HIV risks for MSM has been studied in several populations. By contrast with widely held views, the data suggest that men who have sex with men and women have somewhat lower rates of HIV infection than men who only report sex with men.[41] These men might be more likely to use condoms with male partners than other MSM, or they might be less likely to engage in receptive anal intercourse than men who are willing to report exclusively male sex partners.[41–44]

ATS have been widely reported as risk factors mediating higher risk sexual practices in MSM, including recent reports from San Francisco (CA, USA)[45] and Bangkok (Thailand).[46] San Francisco MSM who self-reported stimulant use during sex were much more likely to report serodiscordant unprotected anal intercourse (UAI) compared with when no drug use.[45] In Bangkok, MSM reporting ATS use increased significantly from 3·6% in the previous three months in 2003 to 17·5% in 2005, and 20·8% in 2007 (p for trend <0·001). HIV prevalence in this cohort increased from 17·3% in 2003, to 28·3% in 2005, and 30·8% in 2007 (p for trend <0·001).[46] Of 595 young MSM in the USA aged 12–24 years, greater than 10% (64 of 595) reported recent ATS use.[47] Young MSM reporting drug use also reported higher risk sexual practices including serodiscordant sex, sex with an injecting drug user, and more sexual partners.[47]

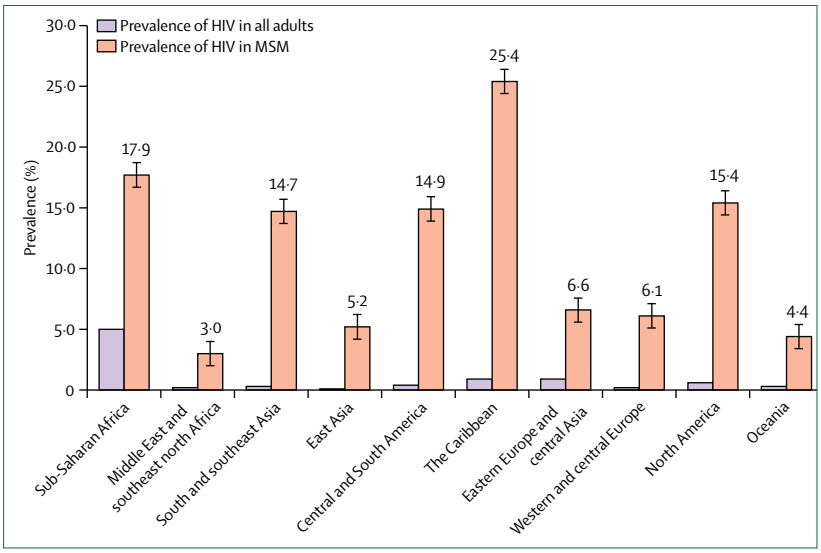

Figure 1: **Global prevalence of HIV in MSM compared with regional adult prevalence reported by UNAIDS, 2010**
We obtained prevalence estimates of HIV reported in MSM by country from reports published after 2007 from studies done during or after 2000. Prevalence in all adults was from UNAIDS 2010.[17] We include prevalence reported from biobehavioural surveillance without methods, sample size, or number positive in the prevalence map but not regional prevalence estimates. Error bars are 95% CIs. MSM=men who have sex with men.

Seroadaptive behaviours and risks

Seroadaptation, including serosorting and strategic or seropositioning, are strategies MSM have used as prevention approaches based on self and partner HIV status.[48] Serosorting refers to choosing HIV-concordant sex partners, whereas seropositioning refers to a choice of sex acts based on serostatus. These behaviours have not been rigorously assessed as HIV prevention approaches, and some might pose unintended risks for MSM when partner or sex-act choices reduce condom use.[49] It is well established that people with acute and early HIV infection are highly infectious, so men with a recent HIV negative test, yet newly infected, might be risky partners. Deliberate avoidance of condoms, or barebacking, is also a concern.

Barebacking was defined in 2004 as "intentional condomless anal sex in HIV-risk contexts".[50] Reports from US and UK studies, primarily through analysis of internet barebacking sites, suggested that some MSM, including men living with HIV, were deliberately seeking anal sex

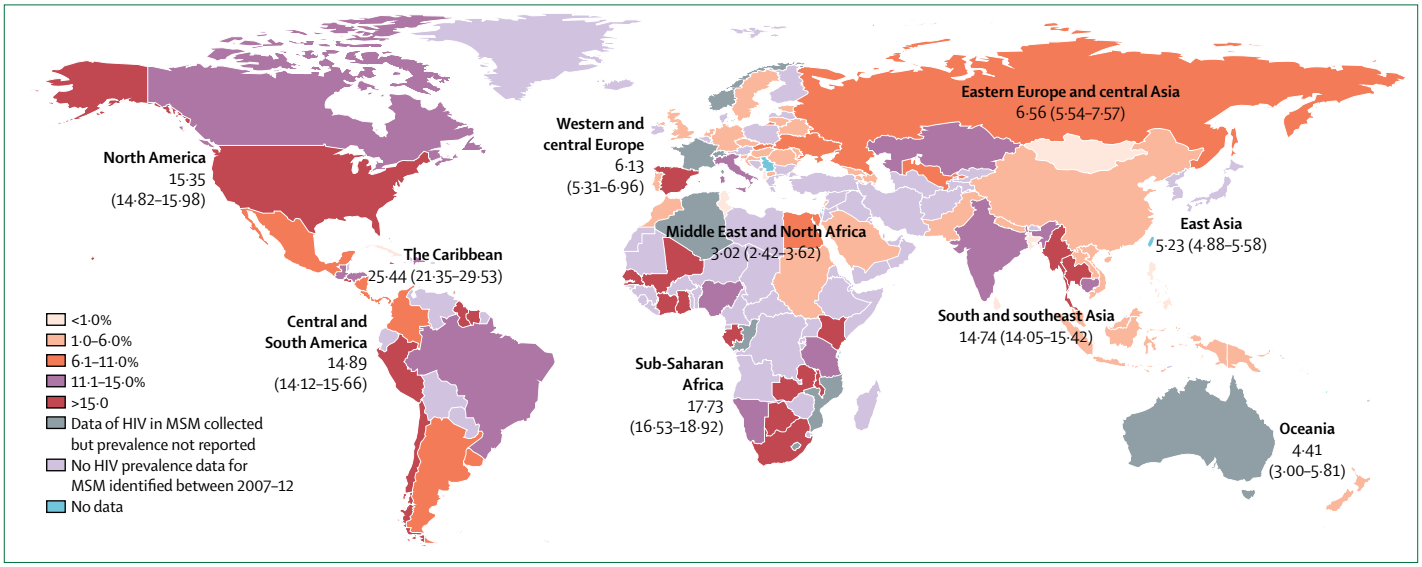

***Figure 2*: Global HIV prevalence in MSM, from studies published 2007–11**
Data are prevalence (95% CIs). Sources listed in the appendix. MSM=men who have sex with men.

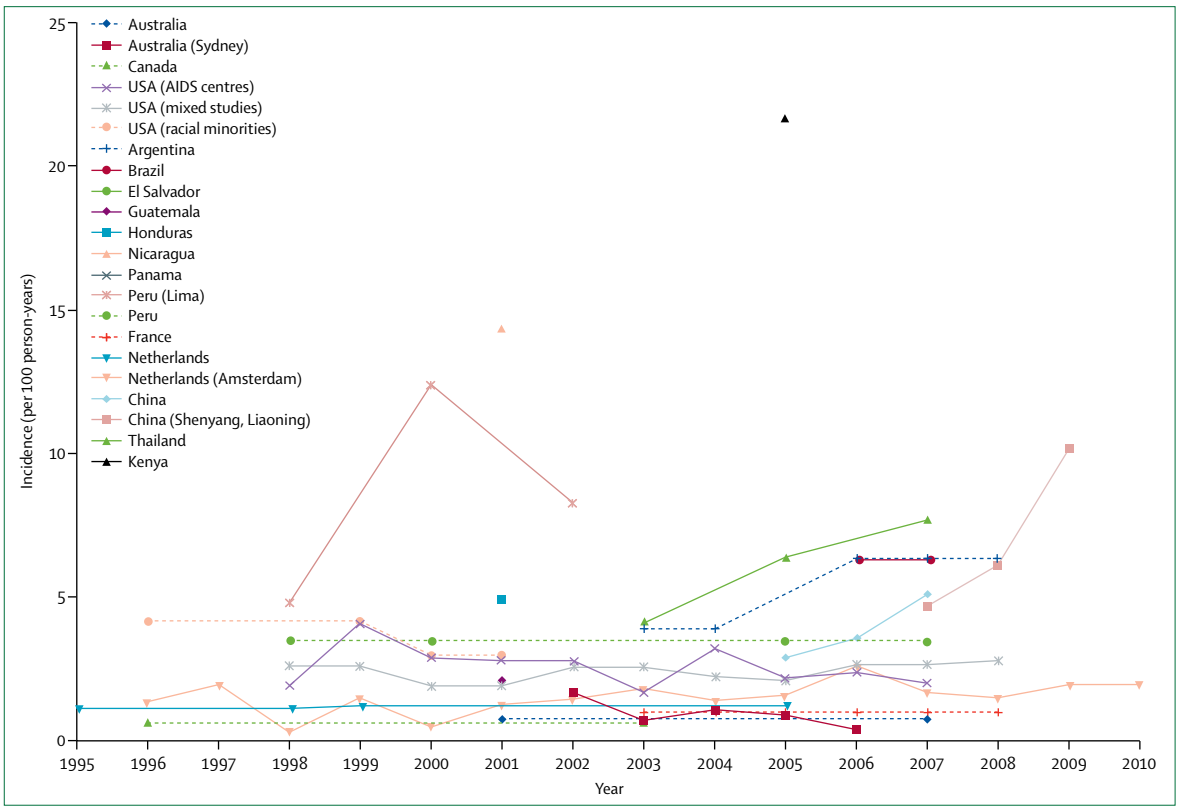

***Figure 3*: HIV incidence in MSM populations, 1995–2010**
Dashed lines represent cohort studies that report only total incidence over the study period. Authors were contacted for yearly incidence but these data were not provided. MSM=men who have sex with men.

without condoms.[51,52] Barebacking in HIV concordant sex partners was associated with transmission of other sexually transmitted infections (STIs) and with superinfection of HIV-positive MSM—transmissions that might include drug-resistant HIV variants.[53,54] A 2009 meta-analysis of US studies[55] identified that most

MSM who were aware of their HIV status protected partners from HIV infection, but that condomless sex was more common between HIV-positive partners, at some 30% (95% CI 25–36). A consistent finding across US studies has been that ethnic minority MSM are less likely to engage in these risk behaviours than are other MSM.[55]

Network-level risks

In MSM, sexual-network-level risks can be both important drivers of HIV spread and key entry points for the delivery of interventions.[56–58] Larger networks can provide more opportunity for exposure to varied sexual practices and HIV-positive potential partners. In a study of Australian MSM,[59] the number of reported anal sex partners was higher with increased size and decreased network density (odds ratio [OR] 0·014, 95% CI 0·002–0·008). Larger sexual networks have also been associated with increased reporting of UAI in MSM in Shanghai, China.[60,61] These findings are consistent with studies of US MSM where social networks have been associated with a greater number of male partners (p=0·03) and transactional sex (p=0·0009).[62] These network-level risks might have particularly important roles for ethnic and racial minority MSM communities, including black MSM in Canada, the UK, and the USA.[47]

Structural risks

Structural factors can also mediate risks for HIV acquisition and transmission in MSM. Although structural risk factors are the least studied of risk factors for HIV in epidemiological assessments, they are relevant targets for prevention in many contexts.[37] In many high-income settings, ethnic and racial minority MSM carry a disproportionate burden of HIV.[63] These issues are explored in the fifth report in *The Lancet* HIV in MSM Series,[64] which shows that the increased burden of disease is not explained by higher risk sexual practices in these men.[65,66] Rather, black MSM seem to have higher rates of untreated STIs (OR 1·64, 95% CI 1·07–2·53), and HIV-positive black MSM are less likely to be aware of their serostatus and less likely to be taking antiretrovirals (0·43, 0·30–0·61) compared with white MSM.[63,67,68] Since antiretroviral use and access is low in black MSM, we would expect mean community viral load to be higher in sexual networks in black MSM compared with those in white MSM. Also, higher rates of untreated STIs within these sexual networks would facilitate transmission in cases of similar levels of condom use. Higher prevalence of STIs and undiagnosed HIV infection are markers of suboptimum access to health care.[69] The lack of access to clinically competent and appropriate health care has also been noted to reduce HIV-related health-seeking behaviour in African MSM. In a study of MSM in Botswana, Malawi, and Namibia,[70] any interaction with health care was associated with MSM reporting fear of seeking health care (2·6, 1·6–3·9), having been denied health-care services (6·4, 2·5–16·1), and having been blackmailed (2·1, 1·4–3·2).[70] Decreases in health-seeking behaviour because of human rights abrogation have also been reported from Lesotho, Senegal, and South Africa.[71–73]

***Panel 2:* Sampling, biases, and innovations for MSM HIV surveillance and research**

In earlier years of the HIV epidemic, non-probability methods such as convenience and snowball sampling were commonly used for research and surveillance in men who have sex with men (MSM), injecting drug users, and sex workers.[22] In convenience sampling, study participants are drawn from segments of the population accessible to researchers. During snowball sampling, individuals are asked to refer their peers with similar risk characteristics. Both methods are subject to selection bias and study results cannot be generalised. However, over the past two decades substantial progress has been made in creating alternative sampling frames that allow random sampling and can yield probability estimates of hard-to-reach population variables. Venue-day-time (VDT) sampling uses a sampling framework based on counts of venue visits of populations of interest (from MSM venues such as bars, clubs, saunas, and others) in specified timeframes.[23] First, VDT units are randomly or otherwise selected, with subsequent random or other sampling of venue attendees for study purposes. Data obtained need adjustment for clustering effects and must be weighted for the frequency of venue attendance of enrollees.[23]

Respondent-driven (RD) sampling elaborates on traditional snowball sampling with several mathematical procedures.[24] Although the sampling of participants is non-random, investigators have suggested that study results become generalisable when a sample reaches a specific equilibrium state, such that distributions on key variables of interest remain stable despite accrual of additional participants.[25,26] At this equilibrium point, additional waves of recruitment will no longer change or add to the demographic composition of samples. Since RD sampling will generally oversample people with large network sizes, data should be weighted for individual network sizes of participants.[25,26]

More recently, the internet has provided ample opportunities to access and research previously hard-to-reach and hidden populations in relative privacy and anonymity. Both VDT and RD sampling and several other methods and approaches are being adapted at present for use via the internet.[27–30] Nevertheless, the fundamental problems of research in hard-to-reach populations at risk for HIV infection remain, such as the absence of proper sampling frames, the lack of probabilistic sampling methods, and the resultant restricted generalisability of study findings.

Biological factors

The biology of anal sex, the gut tropism of HIV-1,[74] and the practices and behaviours associated with anal sex, might at least partly explain the high transmission efficiency of HIV infection for this practice. A recent systematic review and meta-analysis of HIV transmission risks in anal sex[24] reported a 1·4% per-act probability (95% CI 0·2–2·5) of transmission for anal sex and a 40·4% per-partner probability (6·0–74·9).[24] Per-act probabilities did not differ for MSM or heterosexual anal sex. The 1·4% per-act probability is roughly 18-times greater than that which has been estimated for vaginal intercourse.[75] This review also noted that per-partner risks for infection were similar for people reporting exclusive unprotected receptive anal intercourse and both unprotected receptive and insertive anal intercourse—common behavioural patterns for most MSM worldwide. Only self-reporting of exclusive unprotected

insertive anal intercourse had lower, but still substantial, per-partner risks: 21·7% (0·2–43·3).[24]

In addition to the high per-act and per-partner probability of infection noted in receptive anal sex, the likelihood that significant proportions of MSM engage in both receptive and insertive anal sex might have a crucial role in enhancing the efficiency of HIV spread within MSM networks, as opposed to heterosexual ones.[75,76] In networks of heterosexual spread, insertive and receptive roles are biologically determined and transmission probabilities from women to men might be lower, and can be reduced further with male circumcision. For MSM, uniquely, the relatively low HIV acquisition probability for insertive anal sex can be overcome in MSM populations since individual MSM can become infected through receptive sex and then transmit through insertive sex. It might also be relevant that substantial proportions of MSM—including high-risk subsets such as young MSM, men who use stimulants or alcohol with sex, and MSM who trade or sell sex—might have more partners than is common in other sexually active groups.[4] High rates of acute HIV infection in MSM might further drive incidence, since acute and recently infected people can be more infectious.[77] And male dyads might have substantial rates of extra-dyadic sex partners.[34]

STIs have also been associated with biological risk for HIV infection in MSM, notably syphilis and infection with herpes simplex virus type 2, and more recently, anal infection with human papillomavirus.[78] For MSM, oropharyngeal and anal STIs can also be associated with HIV infection. Infection with hepatitis C virus is also sexually transmitted between men, and might be facilitated by HIV co-infection in MSM.[79] The hidden and stigmatised nature of male same-sex behaviour in many settings might limit access to STI treatment and care for MSM and exacerbate the biological role of undiagnosed and untreated STIs.[70] Higher rates of undiagnosed and untreated syphilis have been reported,[63] and associated with the substantially higher rates of HIV infection noted in US black MSM.[63] Fear of discrimination and blackmail has been associated with reducing willingness to seek care for STIs in MSM in a three-country study in southern Africa.[70]

Adult-male circumcision has been shown to reduce men's risk of acquiring HIV infection from women by roughly 60% in three African trials.[80–82] The epidemiological evidence for circumcision and HIV risk in MSM has been inconsistent.[83,84] This is presumably because receptive anal intercourse, where a man's own circumcision status is irrelevant, has such a higher per-act transmission probability than anal or vaginal insertive sex.[24] MSM who engage only in insertive sex with other men are a minority, but such practice might plausibly lower their risk of HIV acquisition if circumcised. No trial of circumcision in MSM has been done. One large prospective study in MSM in the USA[85] recorded lack of circumcision associated with incident HIV infection after adjustment for sexual practices and substance use (adjusted OR 2·0, 95% CI 1·1–3·7), but a large study of black and hispanic MSM in the USA did not identify any protection in circumcised MSM.[86] The Sydney Health in Men cohort study[87] also did not identify differences in HIV acquisition by circumcision status in homosexual men.[87] In a subsequent analysis of these data assessing men with higher insertivity ratios (a higher proportion of reported insertive sex) a slight protective effect was noted for circumcision.[88] In the only African study of circumcision status and HIV risk in MSM,[89] the investigators reported lower HIV prevalence in circumcised MSM (adjusted OR 0·2, 95% CI 0·1–0·2); however, most also reported female sex partners.

Molecular epidemiology of HIV-1 in MSM

Recent reports from molecular epidemiology, phylodynamic studies, and HIV virology are providing insights into transmission and acquisition risks for MSM, transmission dynamics in MSM networks, and challenges to HIV prevention for these men. In a 2008 report on HIV transmission dynamics across the city of London,[38] episodic bursts of transmission in large linked clusters were identified as characteristics of transmission within MSM populations.[38] About 25% of all HIV infections in MSM were linked to one of several clusters. Later work noted that only 5% of infections in UK heterosexuals were similarly linked, and that infections were spreading much more slowly within heterosexual networks than homosexual ones.[90] Investigators who used single-genome amplification and a model of viral evolution in a cohort of acutely infected US MSM[91] noted that MSM were more than twice as likely as heterosexually exposed people to be infected with multiple HIV viruses (p=0·042). They also reported on the other available studies (n=5), which showed that this substantially higher rate of multiple-variant transmission held for MSM compared with heterosexual samples (p=0·008), and that 38% of acutely infected MSM had multiple variants. The investigators attributed this higher rate to the epidemiological risks these men reported: receptive anal intercourse with many partners and the differing anatomical and immunohistological characteristics of the male and female genital tracks and the lower gastrointestinal tract.[91] Greater genetic variation in infection, faster spread in networks, and clustering of HIV infections in high-transmission bursts are clearly features of real relevance for understanding the epidemiology of HIV in MSM.

Figure 4 shows the results of a HIV-1 molecular epidemiology search in MSM (search strategy in appendix). HIV-1 subtype data were available for MSM samples in 14 countries, including at least three in Africa, the Americas, Asia, and western Europe. For North and South America, and for western Europe, subtype B continues to predominate in MSM (figure 4). This seems to be the case despite many reports of increasing non-B subtype variants in heterosexual transmission cases in

Europe, largely attributable to HIV cases in African migrant populations to Europe.[90,92] Several reports from Europe, the UK, and the USA noted high levels of clustering of MSM sequences, suggesting dense networks of spread.[38,90,91] Clustering of infections has been significantly associated with visiting bath houses,[93] group sexual exposures,[91] homosexual versus heterosexual network membership,[94,95] and younger age.[95]

For Africa, where data were restricted to Kenya, Senegal, and South Africa, the mix of HIV variants in MSM seemed similar to those variants circulating in the wider population of those at risk in each country, which suggested local spread.[96,97] In the multiethnic MSM population of Cape Town (South Africa) and surrounding township communities, an early segregation of HIV subtypes by race and risk group was reported in the 1980s, with B-clade infection recorded in white gay men, and C-clade infections in African heterosexual populations. This segregation seems to have changed. Reports on subtypes in Cape Town MSM identified clade-C variants in 92% of black MSM, 69% of so-called Cape Coloured MSM, and 36% of white MSM, suggesting substantial bridging across these populations.[97]

For Asia the situation is somewhat more complex. Subtype B predominated in Mongolia, in Beijing in 2007, and in Taiwan,[93,98,99] but more recent reports from China suggested an increase in non-B-clade infections in MSM with an increase in the CRF01_AE subtype predominant in southeast Asia.[100] In Thailand and in Singapore, the CRF01_AE virus predominates in all populations, and also accounted for most infections in MSM.[95,96] Although subtype C predominates in India, there have been no recent reports that disaggregated HIV variants by risk group for that large population.

Taken together, these notably incomplete findings suggest several patterns for MSM. First, in the northern hemisphere, and in the Americas overall, subtype B continues to predominate in MSM and to circulate with substantial clustering in large MSM networks. In Africa and Asia, outbreaks in MSM seem more embedded within wider epidemic contexts, with the subtypes in MSM generally related to the diversity of epidemic contexts, with some variation in proportions of infections by risk category.

Modelling HIV risk in MSM

We developed a stochastic agent-based network simulation model of HIV transmission to show the size of some key drivers of HIV epidemics for MSM discussed above (details given in the appendix). These drivers include the high per-act transmission rate for anal sex relative to vaginal sex; the unique ability for MSM to be role versatile within high-transmission acts; and the existence of high numbers of partners within a subset of the population. The model thus shares some goals of previous work (Goodreau SM, unpublished), but extends it into a much more detailed modelling framework for both the underlying biology and behaviour. This framework was originally developed and parameterised for the Prevention Umbrella for MSM in the Americas (PUMA) project (Goodreau SM, unpublished). Since some of these are inherent to MSM, the model is not meant to be an explicit representation of any specific intervention. Rather, it is structured as a counterfactual experiment—eg, if anal sex were as infectious as vaginal sex, with all other things being equal, how much smaller would the HIV epidemic be in specific populations of MSM? Country-specific model inputs include demographics: sexual behaviours within main and casual partnerships, circumcision

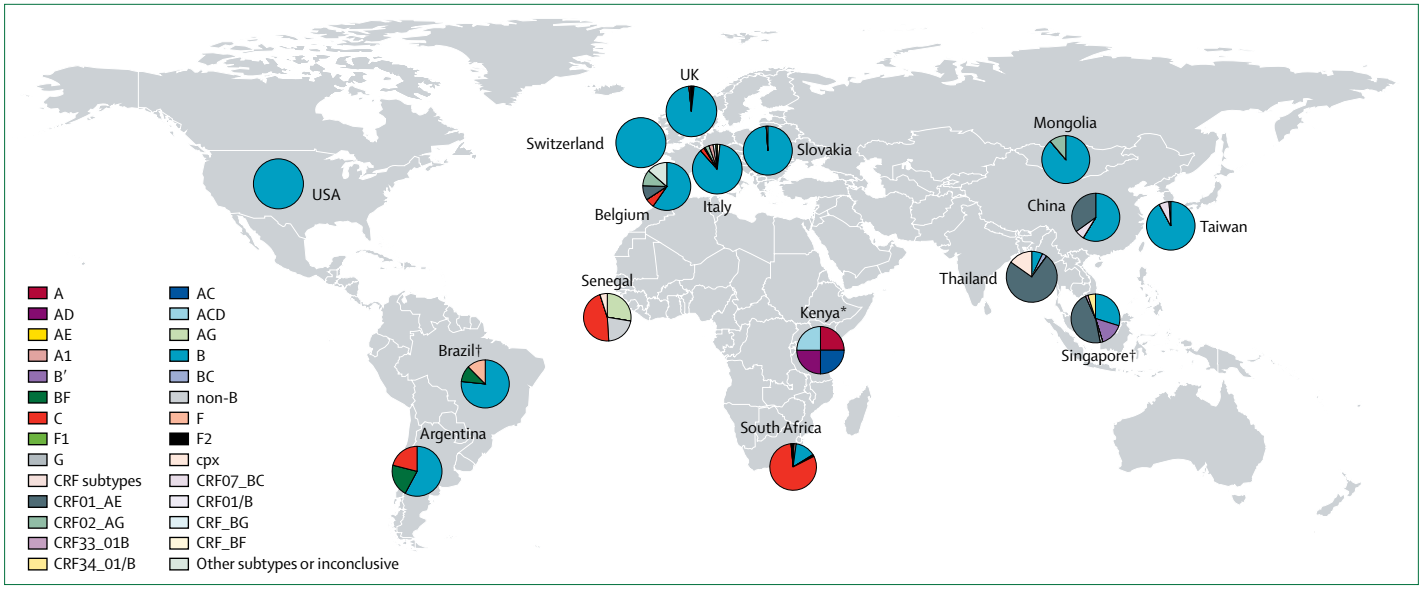

Figure 4: **Molecular epidemiology of HIV subtypes in MSM, 2007–11**
Study details and references in the appendix. MSM=men who have sex with men. *Proportions by subtype not reported. †Proportions for all samples, MSM proportions not reported.

prevalence, testing frequencies, and existing treatment levels. The model was first parameterised with multiple datasets from urban USA (a high-income country) and urban Peru (a middle-income country). We then considered additional scenarios in which testing and treatment were both much less common (both at a third of present levels), as an attempt to roughly represent the situation in low-income countries with low access or use of health services by MSM. We ran all models with an initial prevalence of 15%, similar to worldwide HIV prevalence for MSM. We repeated the exercise for other initial prevalence values, with qualitatively similar results (not shown). Initial population size for all runs was 5000 men in each country.

We computed the cumulative number of infections over a 5 year period for our baseline model, and for each counterfactual scenario. We then calculated the fraction of infections attributable to each factor by comparing the proportion reduction in cumulative incidence from baseline to counterfactual. Specific scenarios we considered were those in which transmission rates for unprotected anal sex were lowered to match those for unprotected vaginal sex; scenarios where all men were restricted to a specific role (50% insertive and 50% receptive); the combination of these first two scenarios; and a scenario where all casual UAI was replaced by an equal amount of UAI within the setting of new main partnerships, the duration and UAI frequency for these new main partnerships matched values noted in the main partners data, and the number of partnerships added was that needed to maintain the overall amount of UAI from baseline. We summarise our findings in figure 5.

The greatest reductions were associated with the scenarios that entailed reducing transmission probabilities to those of vaginal intercourse; in all settings, this quickly reduced incidence by greater than 80%, and in some by as much as 98%. This emphasises that the biological factors specific to anal sex have a fundamental effect in driving HIV epidemics in MSM worldwide. The ability of MSM to be role versatile also predisposes them to large epidemics—removing this practice so as to mimic a heterosexual population in this regard reduced incidence by 19–55%, although we recognise that changing sexual practices on the scale needed to see these effects is an unrealistic prevention goal. This metric revealed major differences by setting, since role versatility is much more prevalent in US MSM than Peruvian MSM. The existence of high casual numbers of UAI partners for some men also facilitates HIV transmission, but to a lower extent than the specific biological factors of anal sex, and about as much as the existence of role versatility. Converting all casual UAI into the same amount of UAI within long-term main partnerships reduced HIV prevalence by 29–51%. Here too there were regional differences, with HIV prevalence dropping more in the high prevalence Peru scenario than the US one, since a higher proportion of UAI happens within the context of casual contacts in Peru than in the USA.

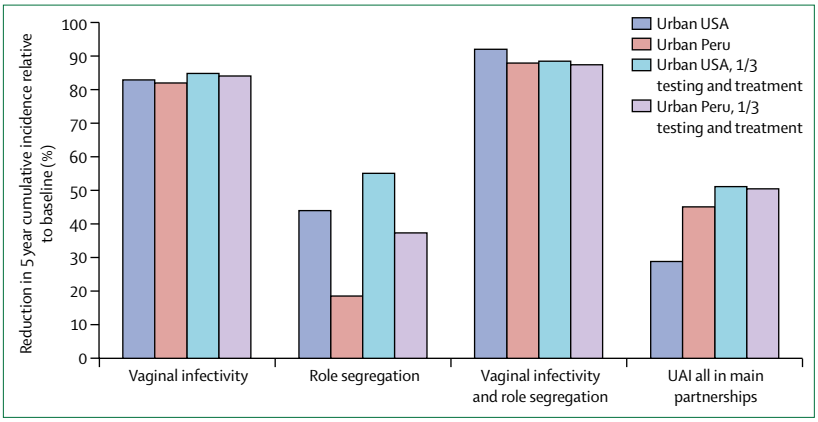

Figure 5: **Agent-based stochastic modelling results for HIV infection in MSM in urban Peruvian and urban US scenarios**

Percent reduction in cumulative incidence for each scenario and location, for runs with 15% initial prevalence. In the role segregation scenario, all men are assigned fixed and mutually exclusive roles in anal sex, 50% insertive and 50% receptive, mimicking heterosexual networks. MSM=men who have sex with men. UAI=unprotected anal intercourse.

Public health significance

Our findings on the epidemiology of HIV in MSM have many implications for HIV prevention, treatment, and care. The second[101] and third[102] reports in this Series will address these implications in detail and propose a targeted set of interventions for prevention for these men. First, the high transmission probability, high force of infection, and the potent effect of prevalent HIV infections in networks clearly suggest that interventions to reduce infectiousness, such as HAART for HIV-positive MSM, will probably be essential to achieve control of these epidemics. Our modelling outputs suggest that even substantial behaviour change, such as reductions in extra-primary partnerships, would not reduce transmission frequency enough to control HIV incidence in MSM networks. Interventions that reduced the probability of acquisition for men engaging in unprotected receptive anal intercourse, such as oral pre-exposure prophylaxis, rectal microbicide, or successful treatment for prevalent HIV infections, will probably be key. The high burden of infections in MSM demands more vigorous and scientifically informed responses, and the development and implementation of strategies to address the high biological risks associated with anal sex.

The molecular epidemiology of HIV in MSM also has several important implications for public health. An HIV vaccine based on subtype B (assuming subtypes, as currently understood, have roles in vaccine design) would have wide applicability in Europe, North and South America, and parts of Asia. This reality has already been of proven use to HIV vaccine trials.[85] The CRF01_AE component, proposed for trials in MSM in Thailand, would protect against an additional and substantial proportion of infections in MSM in Asia. The apparent clustering of transmission events in MSM, the speed with which HIV can move through MSM networks, and the reported high heterogeneity of HIV in acute infections in MSM might be

a challenge to HIV vaccines for this route of exposure. That daily oral pre-exposure prophylaxis with a combination of emtricitabine and tenofovir disoproxil fumarate is so far the only biomedical intervention with evidence for efficacy in MSM[102] suggests that this intervention might address these dynamics and might eventually be combined with vaccine strategies. Viral suppression within high-density networks of MSM might also be an approach fit to the molecular epidemiology of MSM transmission.

However, the public health importance of our new understanding might be affected by several important factors. First, the available data for HIV prevalence and incidence in MSM remain incomplete, with only one incidence estimate from Africa, two from Asia, and very few prospective cohorts of MSM in any setting. More than 30 years after the discovery of a viral infection in this population, 93 countries have no available reports on MSM in the past 5 years. What data we do have are hampered by the lack of population-based measures of the prevalence of same-sex behaviours in men, the size of the populations at risk, and the great diversity of these populations in differing social, cultural, and political contexts. Social response biases against reporting some behaviours, including receptive anal sex, are likely to affect risk factor assessment.

Improved size estimation approaches are urgently needed. Encouragingly, these limitations have led to a range of innovations in epidemiology and are proving of use to the description of other hidden, stigmatised, or otherwise hard-to-reach populations.[103,104]

Other biases in the global evidence base include the disproportionate urban sampling of MSM populations, the relative lack of data from the Middle East and north African region, and the lack of data for adolescents in sexual and gender minorities, who are systematically undersampled in most contexts. What data are available on younger MSM suggest that they are high-incidence groups in need of targeted interventions, and that waiting until they are aged 18 years, or older, is, as with girls in many high-risk transmission contexts, inadequate to protect them against early acquisition of HIV.[105]

If HIV infection in MSM is heavily biologically determined, do present approaches to HIV programming for MSM, which rely heavily on information, education, and behaviour change strategies, make sense? The epidemiology suggests that urgent reform is needed. Programmes and research efforts need to be informed by the realities of HIV transmission risks for MSM. The reduction of those risks will probably need combination approaches, the use of antiretrovirals for both treatment and prevention, and much greater understanding of why these men, their networks, and their communities, continue to bear such heavy burdens of HIV. HIV remains uncontrolled in MSM in 2012. This reality demands reinvigorated effort, new approaches grounded in biology and epidemiology, and concerted effort to reduce the structural risks that aid and abet HIV spread in these men.

Contributors

CB, RB, and FvG designed the study. SDB, ALW, and CB searched for and reviewed published work. ALW and SDB produced the figures. SDB and ALW assessed the systematic review. SMG did the mathematical modelling. CB, RB, and FvG were involved in the interpretation and writing of the report.

Conflicts of interest

We declare that we have no conflicts of interest.

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HIV in men who have sex with men 1

Global epidemiology of HIV infection in men who have sex with men

Chris Beyrer, Stefan D Baral, Frits van Griensven, Steven M Goodreau, Suwat Chariyalertsak, Andrea L Wirtz, Ron Brookmeyer

Epidemics of HIV in men who have sex with men (MSM) continue to expand in most countries. We sought to understand the epidemiological drivers of the global epidemic in MSM and why it continues unabated. We did a comprehensive review of available data for HIV prevalence, incidence, risk factors, and the molecular epidemiology of HIV in MSM from 2007 to 2011, and modelled the dynamics of HIV transmission with an agent-based simulation. Our findings show that the high probability of transmission per act through receptive anal intercourse has a central role in explaining the disproportionate disease burden in MSM. HIV can be transmitted through large MSM networks at great speed. Molecular epidemiological data show substantial clustering of HIV infections in MSM networks, and higher rates of dual-variant and multiple-variant HIV infection in MSM than in heterosexual people in the same populations. Prevention strategies that lower biological transmission and acquisition risks, such as approaches based on antiretrovirals, offer promise for controlling the expanding epidemic in MSM, but their potential effectiveness is limited by structural factors that contribute to low health-seeking behaviours in populations of MSM in many parts of the world.

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This is the first in a Series of six papers about HIV in men who have sex with men

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See Online for appendix

Introduction

In 2012, men who have sex with men (MSM) are at substantial risk for HIV infection in virtually every context studied (panel 1).[1,3,4] This risk has been present since the syndrome now known as AIDS was first described in previously healthy homosexual men in Los Angeles (CA, USA) in 1981.[5–7] Despite decades of research and community, medical, and public health efforts, high HIV prevalence and incidence burdens have been reported in MSM throughout the world.[8] In many high-income settings—including Australia, France, the UK, and the USA—overall HIV epidemic trends are in decline except in MSM, where they have been expanding in the era of highly active antiretroviral therapy (HAART) in what have been described as re-emergent epidemics in MSM.[9,10] In the USA, HIV infections in MSM are estimated to be increasing at roughly 8% per year since 2001.[9] And in much of Africa, Asia, and Latin America, the highest rates of HIV infection in any risk group are in these men.[8]

However, our understanding of worldwide epidemiology is far from complete. By the end of 2011, 93 of 196 countries had not reported on HIV prevalence in MSM in the previous 5 years.[11] In several regions, notably the Middle East, north Africa, and sub-Saharan Africa, data for HIV infections in MSM are only emerging.[12,13] Data gaps and challenges to HIV research, surveillance, and epidemiological characterisation in MSM are largely the result of the hidden and stigmatised nature of MSM populations in much of the world, and of ongoing criminalisation of homosexuality and other forms of same-sex behaviour.[11] These structural realities have limited our understanding, and might also have crucial roles in the vulnerability of MSM to HIV.[14,15] We review the global epidemiology and disease burden of HIV infection in MSM; individual-level, couple, and network-level risks for HIV acquisition and transmission; biological aspects of anorectal HIV transmission; and molecular epidemiology advances, with the aim of understanding why MSM continue to bear such disproportionate burdens of HIV. We also developed and report on stochastic agent-based simulation models of HIV transmission to further clarify the drivers of HIV spread in MSM.[16] Finally, we discuss the public health importance of our emerging understanding of the epidemiology of HIV in MSM.

Disease burden of HIV in MSM

We did a comprehensive search for HIV burden and risks in MSM from Jan 1, 2007, to June 30, 2011 (search criteria in the appendix). We retrieved 2105 unique citations, and we identified and reviewed 68 additional surveillance studies in the public domain. We included country progress reports submitted to the UN General Assembly Special Session on HIV/AIDS (UNGASS). We obtained data from 82 peer-reviewed publications on disease burden of HIV in MSM, from 12 of the 68 surveillance reports, and from 38 of 186 country progress reports submitted to UNGASS in 2010.

Figure 1 shows aggregate HIV prevalence estimates in MSM by region derived from the comprehensive search (references in the appendix). Pooled HIV prevalence ranged from a low of 3·0% (95% CI 2·4–3·6) in the Middle East and north Africa region to a high of 25·4% (21·4–29·5) in the Caribbean. The CIs for these pooled estimates must be interpreted with caution, since they only account for sampling variation and not the inherent biases of non-representative samples, and so undoubtedly underestimate actual variances. Nevertheless, HIV prevalences were relatively consistent across North, South, and Central America, south and southeast Asia, and sub-Saharan Africa (all within the 14–18%

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PRINCE MAHIDOL AWARD CONFERENCE 2015 | GLOBAL HEALTH POST 2015 ACCELERATING EQUITY

PARALLEL SESSION 1.6

HEALTH-RELATED POST-2015 DEVELOPMENT GOALS AND TARGETS

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HEALTH-RELATED POST-2015 DEVELOPMENT GOALS AND TARGETS

BACKGROUND

With the health-related MDGs and targets held up high as a global aspiration , the international community has worked in a concerted effort to reduce under-5 and maternal mortality rates as well as infectious diseases over the past years. As a result, improvement in health-related indicators has been observed.

Although there have been trends of reductions of mortality rates in every region, the degree of reduction varies. There are prospects that in many countries, especially in Africa, the health-related MDGs may not be fully achieved by the end of 2015. A criticism of the current MDGs is that the concept of equities in the provision of health services among different segments of the population is not well embedded. This is closely linked to the fact that health-related MDG indicators are "typically worst among the poorest, in rural areas, among children of less educated mothers, and for boys (under-5 mortality) "(UNICEF 2010).

Another aspect that needs attention is the fact that public health must consider the total health system including prevention, promotion and surveillance, and not only the eradication of a particular disease.

To further reduce mortality rates and to fully achieve the MDGs, it will be necessary for the international community to not only pursue the current path but also seek to address the standing issues that prevent us from protecting the lives of people and from fully achieving the MDGs. Building on the success and the lessons learned for the past 14 years will also be very important.

This session aims to review the achievements of and the lessons learned from the implementation of the current MDGs and explore ways of solving global health issues as possible Post-2015 development goals and targets, taking into account the acceleration of health equity as the central factor.

OBJECTIVES

The objective of this session is to review the current status of the MDGs, successes as well as challenges, and to discuss what is needed to be done to accelerate equity and further reduce mortality rates in the Post-2015 agenda.

MODERATOR

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Naoyuki Kobayashi oversees JICA's official development assistance programs in the health sector for the Asia-Pacific region as deputy director-general at JICA's Human Development Department. His responsibility includes JICA's strategies in the areas of health workforce and MCNH, and also developing aid programs to support partner countries in the region. Previously, he served as director for the Maternal and Child Health Division and led his team to execute JICA's MNCH and reproductive health programs for all regions. As for his overseas assignment, he served as a deputy resident representative at the JICA Afghanistan Office and as an assistant resident representative in Egypt. He worked also for UNDP as program adviser to increase collaboration between the UN and Japan.

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Dr. Gloria Quansah Asare is a Medical Doctor and a Public Health Consultant and is currently the Deputy Director-General of the Ghana Health Service.

She has extensive experience in Programme Management and research, having been the Director of the Family Health Division from 2008 to 2013 and the National Family Programme Manager prior to that.

Dr. Asare is a passionate advocate for Family Planning, Reproductive Health Commodity Security, Maternal, Child and Adolescent Health and Health Systems Strengthening. She strongly believes in innovations in technology, research and capacity building, performance and quality improvement, information sharing, good governance and staff motivation as important aspects of health systems strengthening. She has participated in and made presentations at several meetings at the local, national and global levels.

She is a Foundation Fellow of the Public Health Faculty of the Ghana College of Physicians and Surgeons, a part-time lecturer and former Deputy Head of the Population, Family and Reproductive Health Department of the University of Ghana School of Public Health and the Department of Community Health of the University of Ghana Medical School .

She is a Member and Global South (Developing Country) Representative of the Reproductive Health Supplies Coalition Executive Committee since 2013.

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ICS Integrare/Options Consultancy

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Laura Sochas is a health economist working with Options Consultancy Services on maternal and newborn health programmes. She was part of the State of the World's Midwifery 2014's secretariat at Integrare ICS, designing a health workforce projection model and contributing to data collection management and quantitative analysis. Previously, she worked in Lesotho for multilateral development institutions such as the European Commission and the World Food Programme. She holds a Masters of Public Administration from the London School of Economics and a BA from Oxford University, Merton College.

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Dr. Amos Channon is an Associate Professor in Department of Social Statistics and Demography at the University of Southampton. Amos has a key role in the university as the Deputy Director of the Southampton Economic and Social Research Council funded Doctoral Training Centre, one of only 21 centres for PhD training funded by the ESRC. This role includes responsibility for training of 70 students, alongside the day-to-day running of the centre.

Amos' research interests are wide ranging and encompass many related issues, although mainly focus on the broad topic of population and global health. In particular, Amos has a background in cross-national comparison and measurement of health inequalities over time in low and middle income countries, especially with regard to maternal and child health. Published research on this has highlighted the need to consider the context within which maternal and child health are analysed and assessed. Multi-country studies have enabled the identification of countries where service use has greatly increased while reducing inequality between the rich and poor. Amos has studied policies in countries which are exemplars of good practice and can be implemented elsewhere and made policy recommendations. A further aspect of research which Amos is working on relates to the demography of the Gulf region, from Kurdistan to Oman. Due to the high levels of migration and the unbalanced sex ratios the region is extremely interesting demographically, while the health of the population has generally not been examined. Other work by Amos has considered birthweight, health policy and the increasing role of the private sector in healthcare in lower income setting countries.

A major project which Amos is currently engaged with is research on the links between health and social care in the United Kingdom, with a focus on age-related macular degeneration. As part of the EPSRC funded Care Life Cycle project this work is focusing on the social care need of individuals over time, investigating how this changes and what factors are related to this social care need. Amos teaches on a range of undergraduate and postgraduate degree courses and supervises PhD students studying a variety of subjects.

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James Headen Pfitzer is the legal advisor for the Assistant Director General's Office of the Health Systems and Innovation Cluster at the World Health Organization in Geneva, Switzerland where he handles external engagement, strategy and legal issues. Previous to that he was the legal and strategy advisor for the Assistant Director General's Office of the Health Security and Environment Cluster at WHO. Mr Pfitzer handles legal issues, negotiations and consensus building related to partnership activities as well as those associated with international law. Mr Pfitzer was appointed by the WHO Director General as the health focal point in the UN Secretary General's Office in New York for the Post-2015 Development Agenda and also handled negotiations and consensus building with Member States related to the 2009 pandemic of Influenza A (H1N1). Other subjects covered by Mr Pfitzer include Ebola treatments, innovation in public health, eHealth, health systems strengthening, antimicrobial resistance, Essential Medicines and Health Products, Universal Health Coverage, and others. In addition to WHO Headquarters in Geneva, Mr Pfitzer works closely with WHO Regional Offices and Country Offices as well as with partner institutions including the Asian Development Bank, World Bank, Islamic Development Bank, African Development Bank, and others.

Mr Pfitzer is an American trained lawyer and earned his Legal Master's degree from the World Trade Institute at the University of Bern, Switzerland. Prior to joining WHO, Mr Pfitzer was a Legal Officer at the World Trade Organization (WTO) in Geneva, Switzerland, where he was a member of the WTO Secretariat and assisted in the adjudication of trade law disputes between WTO Member States. Mr Pfitzer has written several publications on dispute settlement and international arbitration, including detailed analyses of the WTO dispute settlement system and potential reform with focus on burden of proof and standard of proof issues as well as those related to transparency and public participation. Mr Pfitzer is currently pursuing his PhD in International Law with a focus on due process protections in dispute settlement.

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Dr. Shibuya is Professor and Chair of Global Health Policy at the University of Tokyo's Graduate School of Medicine and President of the Japan Institute for Global Health. He obtained his MD at the University of Tokyo DrPH in international health economics at Harvard University. After teaching at Teikyo University in Tokyo, he joined the WHO's Global Programme on Evidence for Health Policy in 2001 and was chief for the Health Statistics and Evidence Unit from 2005 until 2008. He has published widely on mortality, causes of death, burden of disease, risk factors, cost-effectiveness, priority settings, and health system performance assessment. He spearheaded the future strategic directions of the Japanese global health policy agenda after the Hokkaido Toyako G8 Summit in 2008. He has led the Lancet Series on Japan published in 2011 in an effort to jump start the debates on Japanese domestic and global health policy reform. He is currently an advisor to the central and local governments.

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Universal Health Care and Equity: Evidence from maternal health

Sarah Neal

Andrew Amos Channon

Sarah Carter

Introduction

As national and international policy makers seek to address the unfinished Millennium Development Goal (MDG) agenda as well as develop new goals and indicators to guide development there has been growing demand to place universal health coverage (UHC) as a central pillar for such efforts (Vega 2013). The World Health Organization (WHO) define UHC as all people receiving quality health services that meet their needs without being exposed to financial hardship in paying for the services. Achieving this goal requires progress in three dimensions: expanding essential health services, increasing access to a greater proportion of the population and reducing out-of-pocket payments (World Health Organisation 2014).

The MDGs have been justly criticised for failing to take into account issues of equity when monitoring progress (e.g. Gwatkin 2002). There is strong commitment that equity is "hard-wired" into any post-MDG Goals and strategies, which was embodied by the High Level Panel of Eminent Persons in their acknowledgement that future development agenda's must "leave no person behind" (United Nations 2013).

Maternal health care is a key aspect of service provision in it's own right, but it can also be seen as a marker for wider health systems function. The majority of middle and lower income countries have achieved an increase in the percentage of women receiving antenatal care, skilled care at birth and postnatal care since 1990, but for many countries universal coverage is still a distant goal. For many countries reaching 80% coverage for these maternal health interventions, even at the national aggregate level, will be extremely challenging: in some progress has been poor to date, and many countries will be starting their journey towards UHC from a low baseline.

This study examines the feasibility of the target of 80% coverage for all populations regardless of income and place of residence outlined in the WHO framework for monitoring progress to universal coverage (WHO 2014) with regards to antenatal care and skilled care at delivery.

Data and Methods

DHS data are large, nationally representative surveys providing information on a range of health care indicators that are normally comparable across time and place (ICF International

2014). The data on inequalities in coverage and the progress needed to reach 80% target is based on 35 surveys from low and middle income countries (see Appendix 1 for a list of countries and survey years). Data on economic status are provided by asset wealth indices, which are constructed using principle component analysis using information on a household's assets. These were grouped into quintiles and provide a relative measure of wealth. Place of residence (urban or rural) is also provided by the survey.

Criteria for inclusion in this study was that there were three surveys available, with the first and last at least 10 years apart, with the earliest dating from after 1990 and the latest after 2005. Children born in the five years prior to the survey were included in the analysis. The results are based on simple percentages of women who had sufficient ANC and had a SBA within each income group and place of residence. All analyses were weighted to account for the differential chances of selection into the sample. Changes over time are measured as average annual change in percentage points. Annual percentage rate of change was not used as this can show misleadingly sharp improvements for countries with a very low baseline.

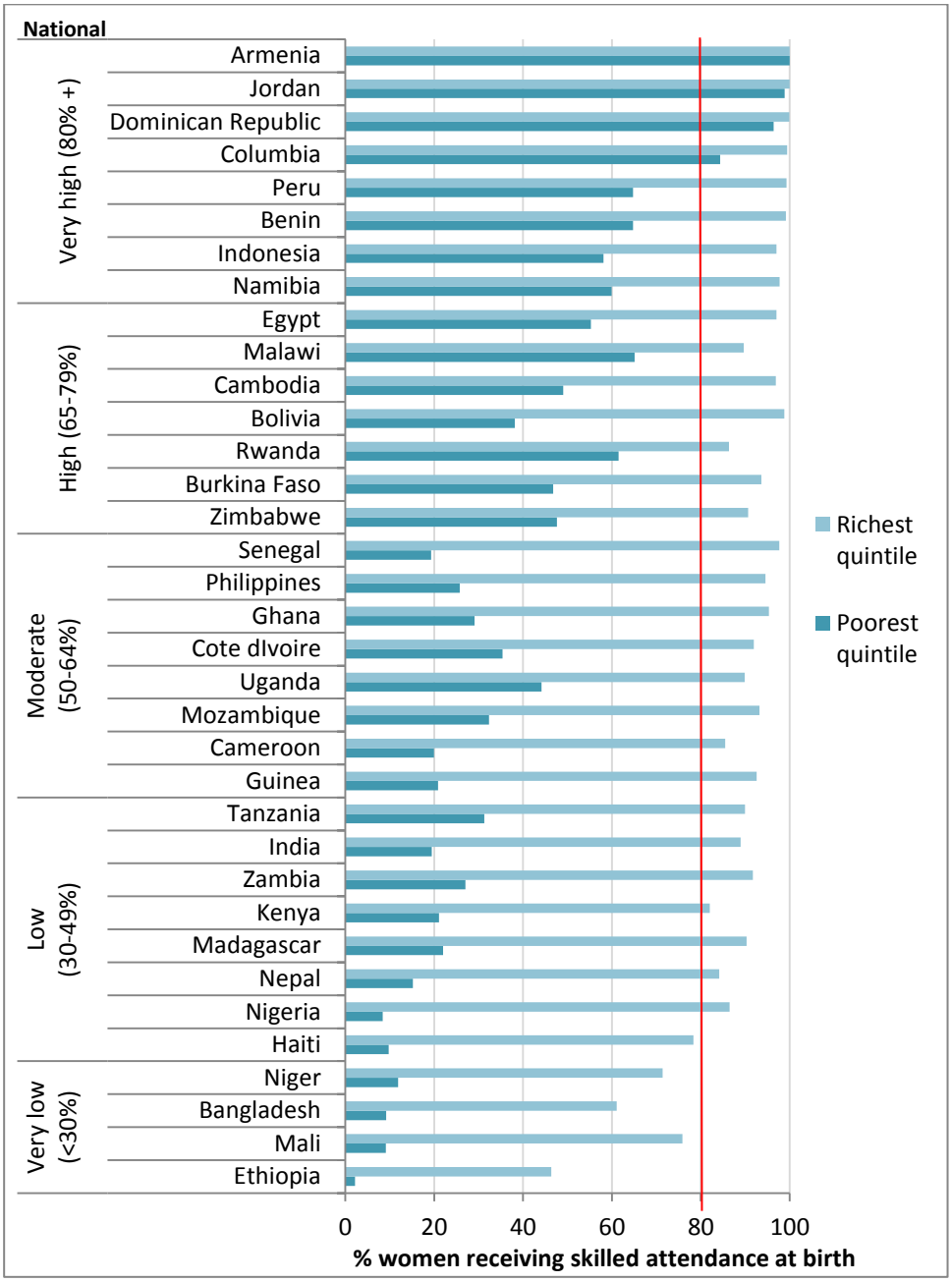
Results

How great is the current gap between rich and poor for maternal health services?

Out of the 35 countries included in the study only eight have reached the 80% coverage target for national level SBA coverage, and six for ANC. Six countries have achieved 80% coverage for both services (Indonesia, Jordan, Namibia, Colombia, Armenia and Peru). Figure 1 demonstrates the huge difference in the gap between current coverage and the 80% target for SBA for the poorest and richest quintiles in many of the individual countries included in the analysis. Five of the six countries with the lowest coverage currently have less than 10% of women in the poorest quintile accessing SBA: in Ethiopia the figure is only 2%. Coverage for the poorest quintile remains below 50% for the majority of countries. The poorest have reached the 80% coverage target in only four countries (Dominican Republic, Jordan, Armenia and Colombia): these countries have achieved overall coverage of at least 90%. Even in countries which have reached the 80% target at a national level the poorest may have very limited access to SBA: in Indonesia only 58% of the poorest women receive skilled care at birth, and in Namibia the figure is 60%. On the other hand, the richest

quintile has already reached 80% coverage in all but five countries, which are those with the lowest overall coverage.

Figure 1: SBA coverage for poorest and richest quintiles in 35 countries (80% coverage target marked in red)



What progress is needed to reach the 80% coverage target by 2030?

As the 80% target is absolute rather than relative, the progress required by countries with currently poor coverage is far greater than for those who have already achieved higher coverage. Table 1 shows the annual percentage increase in coverage required for both SBA

and ANC in order to reach the 80% coverage target dissagregated by wealth quintile using data from the most recent DHS as a baseline. Countries have been grouped into five categories based on their overall national percentage of women with SBA and ANC. The lowest coverage group countries will need to increase coverage each year by an average of 2.9 and 3.1 percentage points for SBA and ANC respectively at a national level. For the poorest quintile within the lowest coverage group the growth required is even greater: an annual increase of on average 3.6 and 3.8 percentage points is required for SBA and ANC. However, for the richest quintile all but the lowest coverage group have already reached the target for SBA, and all but the lowest two groups for ANC. Table 2 shows the progress required for the different coverage groups disaggregated by urban and rural residence. In the lowest coverage group service use amongst rural residents will need to increase by an average of 3.3 percentage points each year compared to a much more modest 0.9% amongst urban dwellers for SBA: the differences are somewhat less for ANC. The progress needed by rural residents in the "high" coverage group for SBA (0.8 percentage points per annum) is only slightly less than that needed by the richest quintile of the poorest coverage group (0.9% per annum).

Table 1: Required annual percentage point increase in coverage required to attain 80% coverage by 2030, by coverage group and wealth quintile

National %	**Wealth Quintile**					
SBA	**Poorest**	**Poorer**	**Average**	**Richer**	**Richest**	**Overall**
<30%	*3.6*	*3.4*	*3.2*	*2.7*	**0.9**	*2.9*
30-49%	*2.9*	*2.5*	*1.8*	**0.8**	-	*1.7*
50-64%	*2.6*	*1.6*	**0.9**	**0.1**	-	*1.1*
65-79%	**1.4**	**0.8**	**0.4**	-	-	**0.4**
80% +	**0.1**	-	-	-	-	-
ANC						
<30%	*3.8*	*3.6*	*3.3*	*2.9*	*1.6*	*3.1*
30-49%	*2.5*	*2.2*	*2.0*	*1.5*	*0.8*	*1.8*
50-64%	*2.1*	**1.6**	**1.2**	**0.6**	**0.0**	**1.1**
65-79%	**1.1**	**0.7**	**0.3**	**0.0**	-	**0.4**
80% +	-	-	-	-	-	-

Figures in **Bold** indicate that growth is on track to meet the 80% target by 2030; figures in *italics* indicate that growth is not on track to meet the 80% target (based on longer term trends)

Table 2: Required annual percentage point increase in coverage required to attain 80% coverage by 2030, by coverage group and place of residence

National %	Place of Residence		
SBA	**Urban**	**Rural**	**Overall**
<30%	*0.9*	*3.3*	*2.9*
30-49%	**0.2**	*2.2*	*1.7*
50-64%	**-**	*1.7*	**1.1**
65-79%	-	**0.8**	**0.4**
80% +	-	-	-
ANC			
<30%	*1.9*	*3.4*	*3.1*
30-49%	*1.1*	*2.1*	*1.8*
50-64%	**0.4**	**1.6**	*1.1*
65-79%	**-**	*0.6*	**0.4**
80% +	-	-	-

Figures in **Bold** indicate that growth is on track to meet the 80% target by 2030; figures in *italics* indicate that growth is not on track to meet the 80% target.

To establish how required progress compares with past progress we examined past trends in coverage. Table 3 shows the average annual percentage increase in coverage for SBA and at least four ANC visits over two different time periods by quintiles. The first is growth over a period of over a decade, calculated using the most recent survey and a survey at least 10 years previously. The second period is shortened, calculating the growth between the most recent two surveys, with a mean period of 5.6 years. Growth has been faster in the most recent period for most quintiles than over the longer timescale for SBA in the very low, low and medium coverage countries. In the high coverage group the percentage of women receiving SBA increased fastest for the most recent period for the poorest and poorer groups, while it has recently slowed down for the other wealth quintiles. For the richest quintile growth was fastest across all quintiles in the longer time period. For ANC there are mixed results, although in general growth in the percentage receiving sufficient care has recently slowed or is stagnant.

Table 3: Average annual percentagepoint change between two surveys for SBA and ANC: disaggregated by wealth quintiles

	Average time period 11.9 years						*Average time period 5.6 years*					
SBA	**Poorest**	**Poorer**	**Average**	**Richer**	**Richest**	**Overall**	**Poorest**	**Poorer**	**Average**	**Richer**	**Richest**	**Overall**
<30%	0.3	0.3	0.4	0.5	1.0	0.4	0.2	0.4	0.5	1.1	1.8	0.6
30-49%	0.2	0.6	0.9	1.1	0.9	0.6	0.5	0.8	1.7	1.7	1.1	1.1
50-64%	0.7	1.2	1.1	0.7	0.6	0.8	0.6	2.1	1.4	0.5	0.7	1.1
65-79%	2.5	3.0	3.2	3.2	2.0	2.8	3.1	3.6	3.1	2.6	1.0	2.8
80% +	1.5	1.5	1.1	0.9	0.4	1.2	1.5	1.3	0.8	0.5	0.1	0.9
ANC												
<30%	0.5	0.7	1.0	1.3	1.2	0.9	0.5	0.9	1.0	1.3	1.3	1.0
30-49%	0.3	0.3	0.4	0.5	0.5	0.4	0.2	0.8	0.8	0.9	0.2	0.6
50-64%	1.1	1.6	1.7	1.6	1.1	1.5	1.1	1.6	1.5	1.5	0.7	1.3
65-79%	1.7	1.8	1.6	1.5	0.9	1.6	1.8	1.8	1.4	1.0	0.2	1.3
80% +	2.3	1.8	1.0	0.7	0.5	1.4	2.3	1.9	1.1	1.0	0.4	1.3

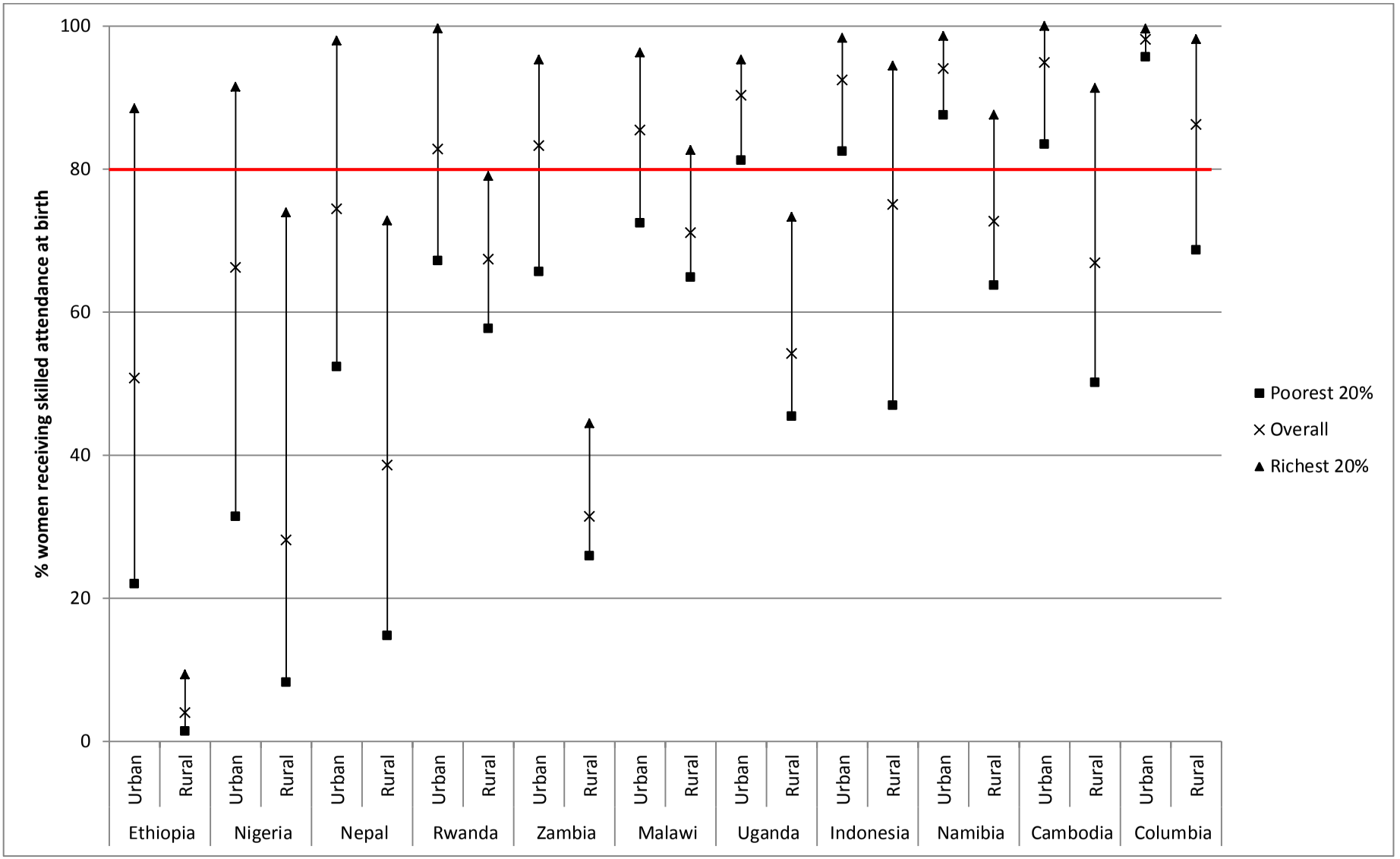
Table 4 : Average annual percentage point change between two surveys for SBA and ANC: disaggregated by place of residence

	Average time period 11.9 years			*Average time period 5.6 years*		
SBA	**Urban**	**Rural**	**Overall**	**Urban**	**Rural**	**Overall**
<30%	0.7	0.3	*0.4*	0.8	0.3	0.6
30-49%	0.8	0.6	*0.6*	1.4	0.9	1.1
50-64%	0.2	0.8	*0.8*	0.4	1.4	1.1
65-79%	2.0	2.5	2.8	-	3.2	2.8
80% +	0.6	1.5	1.2	-	1.2	0.9
ANC						
<30%	0.6	0.9	0.9	-0.1	0.8	1.0
30-49%	0.3	0.3	0.4	0.4	0.5	0.6
50-64%	1.0	0.8	1.5	1.1	0.9	1.3
65-79%	1.1	1.9	1.6	0.7	1.7	1.3
80% +	0.7	2.1	1.4	0.8	2.2	1.3

Combining the urban / rural and socio-economic dimensions

Simply disaggregating urban and rural areas by wealth quintile offers a limited contribution to the measurement of inequalities. The wealth measure used within the DHS is made up overwhelmingly of rural residents, simply as an artefact of its construction as more rural than urban dwellers are usually interviewed. Figure 2 shows the percentage of women with a skilled birth attendant at the latest time point, split by urban/rural and for the richest and poorest quintiles within place of residence. Ten countries have been selected in order to show the disparities within and between place of residence. Wealth has been calculated, using the standard PCA analysis, for urban and rural areas separately. Firstly it is clear that there are large differences in coverage between urban and rural areas in all countries. In urban areas 7 out of the 10 countries have coverage above 80%; in rural areas only 1 country passes this threshold. However the poorest in urban areas are often lagging badly, with coverage far lower than their richest counterparts. In some countries the richest rural dwellers have higher access to an SBA than poor urban residents, while in others all rural women, irrespective of wealth, have extremely poor access in comparison to urban women.

Figure 7: SBA coverage for urban and rural residents, split by wealthiest and poorest quintiles for selected countries



Discussion

The rate of progress needed for the countries with lowest coverage to reach the 80% at the national aggregate level is extremely challenging, but not completely unprecedented at an individual country level. We have already provided the examples of Cambodia and Rwanda, both of whom have exceeded the required percentage increase needed to reach 80% by 2030 for both the country as a whole and those in the poorest quintile. While no other countries have reached the required level of increase over the medium term, several countries have demonstrated rapid growth over recent years. Burkina Faso and Uganda have both achieved rates of progress of over 3 percentage points a year for both the whole country and the poorest quintile for the period between the last two surveys for SBA. With the exception of Cambodia no countries have achieved the required rate of progress for ANC across all three surveys, but several countries such as Nepal and Egypt have made progress at a national level which is almost sufficient (3.6% and 3.0% respectively), although progress is much slower for the poorest quintile. Rigorous analysis should be carried out to ascertain the drivers behind progress in these countries, particularly when the gains embrace the poorest, and lessons learnt should be collected and widely disseminated.

The UHC goal is an absolute rather than a relative target: countries with the lowest coverage will need to make the most progress. These are countries where the infrastructure is weakest, and attempts to increase coverage of key MNH interventions will require health system strengthening and in particular a massive focus on developing a workforce that can provide an adequate level of care to women and their babies. This will require substantial investment, and donors and national governments will need to ensure funding is adequately allocated and focussed

How should progress with equity be monitored?

Over the years a number of approaches to capturing the dynamics of inequitable access have been developed and proposed. While more complex measures may offer insight into the dimensions of inequality, they often have the disadvantage that they are more difficult to understand and utilise for a generalist audience and are difficult to compare across time and place. Our study clearly highlights the importance of measuring equity concurrently by place of residence and wealth. Access is normally measured by urban/rural residence and wealth separately but this fails to capture the interactions between these two factors. We

strongly recommend that wealth quintiles are measured separately for urban and rural residents. The rural poor are usually the most poorly served for health services, and the level of their disadvantage is often underestimated in overall national quintiles if the poorest quintile contains a small proportion of urban residents.

Conclusion

For many countries which currently have poor levels of access to maternal health services reaching the target of 80% coverage, even at national level, will be challenging. For other countries this target is not challenging enough and the target of true universal coverage – 100% for all groups – should be set in order to drive access forward further. It has been shown that in many countries with good overall coverage many groups, mainly the poor and the rural, are still left behind. Ensuring universal coverage is achieved for the poorest and those living in rural areas is a challenge that will require sustained commitment from Governments, donors and international policy makers, although there is little evidence about the best ways to do this. Lessons much be carefully gathered, learnt and disseminated from countries that have made fast and equitable progress in order to effectively focus efforts and resources. The 80% target overall is a positive step to drive the UHC agenda, but needs to be carefully managed and measured in order that progress with equity across all groups is achieved.

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EQUITY AND EFFECTIVE COVERAGE IN POST-2015: WHAT ARE THE WORKFORCE IMPLICATIONS?

Campbell, J., Pozo-Martin, F., Sochas, L., Homer, C., ten Hoope Bender, P., Nove A., Guerra-Arias, M. (2015)

Equity and effective coverage in post-2015: what are the workforce implications?

Background

Those most invested in RMNH worldwide are waking up to the importance of the health workforce to achieve their vision of every woman and newborn getting the care they need. The 2013 iERG report called for the delivery of "an expanded and skilled health workforce, especially in Sub-Saharan Africa, which serves women and children with measurable impact". The Lancet Series on Midwifery 2014 has established the midwifery workforce, the package of services they provide and the values and philosophy embodied in this care as the key to achieving our post-2015 vision to end preventable maternal and newborn deaths. Acting on such recommendations requires policies that ensure the health workforce enables universal coverage of quality care (ten Hoope-Bender et al, 2014). Such policies must be informed by the number, type, and distribution of health workers needed to ensure that every woman and newborn's right to health is respected.

Past efforts to estimate health workforce needs have used *workforce-to-population ratio methods*, whereby a threshold or benchmark of workforce density for a given population is proposed (Campbell, J. et al, 2013). Workforce to population ratios have the multiple advantages of being simple to calculate, easy to communicate, and of being derived based on observed realities. On the downside, they assume that needs are similar across countries or sub-national areas, they are usually based on headcounts of health workers as opposed to full-time equivalents, and most do not specify the type or skills of health workers that are required to deliver quality care (Gabrysch et al, 2012). Given new developments in the availability of health workforce data, disaggregation of demographic indicators at the 100m2 level worldwide[1], and basic consensus on the list of essential interventions needed (PMNCH, 2011), it is now possible to derive methods that may better enable us to reach equitable and effective coverage.

As part of the State of the World's Midwifery 2014 (SOWMY) (UNFPA et al., 2014), we demonstrated the potential of an adjusted service target model, **E**ffective **Co**verage **Mod**elling (ECoMod), for estimating the number of full-time equivalent RMNH workers needed to deliver universal, effective coverage of midwifery care.

Methods

Based on country reported SOWMY data for 2012, we assessed the extent to which the current midwifery workforce was able to meet each of the 73 countries' need for universal and effective coverage of key RMNH interventions. We also estimated this "met need" between 2012 and 2030 under business-as-usual and alternative policy scenarios.

[1] www.worldpop.org.uk

ECoMod follows an 'adjusted service targets-based approach' to estimating workforce need (Dreesch et al., 2005). This approach defines need according to the epidemiological and demographic profile of the population under study, and the interventions which evidence indicates will result in good SRMNH. Estimates of the level of met need can be understood through the following formula, although the process of relating workforce availability to workforce requirements is described in more detail below.

$$\frac{\textbf{Workforce availability}\textit{: volume of essential SRMNH services that can be provided by the midwifery workforce (expressed in hours of work)}}{\textbf{Workforce requirements}\textit{: volume of essential SRMNH services required by women and newborns (expressed in hours of work)}} \times 100$$

To calculate workforce requirements (i.e. the denominator in the above formula), the following steps were followed, using Excel software:

1. Identify which services women and newborns need to achieve good SRMNH. For this, we used the 46 essential interventions for SRMNH care recommended by the Partnership for Maternal, Newborn and Child Health (PMNCH, 2011) and set out in Annex 1. Evidence shows that these interventions are both effective in reducing maternal and newborn mortality and feasible to deliver even in low-resource settings.
2. Quantify the number of health worker-patient 'contacts' needed to deliver the 46 interventions to all who need them. This was estimated on the basis of the specific demographic group needing the intervention, how many were part of that group in each country, what share of the demographic group needed the intervention, and how many contacts were required to deliver the intervention to each woman. Full details on assumptions, demographic and epidemiological data sources can be found in Annex 4 of the 2014 State of the World's Midwifery report (UNFPA et al., 2014)
3. Convert the number of 'contacts' into the number of hours of health worker time required to deliver the contacts, based on the estimates of the average time needed to deliver each intervention, as used in the OneHealth tool (Futures Institute, 2013) and a Delphi survey for those interventions not covered in the OneHealth tool.
4. Estimate how need will change between 2012 and 2030 on the basis of demographic projections (medium scenario, UN Population Prospects 2012). Epidemiological assumptions remain the same across time.

To calculate workforce availability (i.e. the numerator in the above formula), we used data from the State of the World's Midwifery (SOWMY) 2014 survey. These data were self-reported by key stakeholders in each country including ministries of health, midwifery associations, midwifery schools, and validated by UNFPA and WHO staff. If the country was not able to provide the requested information), we resorted to figures in the WHO Global Health Observatory database (WHO, 2014). The following steps were followed:

1. Allocate all SRMNH workers[2] to one of seven ISCO codes (International Labour Organization, 2013) based on the responsibilities specified in their job descriptions, and not their cadre name.

[2] These were defined as "the health professionals whose primary function includes health services provided to women during pregnancy, labour and birth, as well as postpartum care for mothers and newborns".

2. Convert the number of workers available in each ISCO category, as reported in SOWMY data, to a number of working hours, based on % time spent on RMNH, WISN assumptions on % spent on clinical activities compared to administrative activities, hours worked per week and weeks worked per year.
3. Use SOWMY data to estimate other key model inputs: hours available by workers' age group, enrolment and graduate numbers between 2010 and 2015, retirement ages, and voluntary attrition rates. Age-specific death rates by region were extracted from secondary sources. Assumptions replacing inconsistent or missing data are described in Annex 5 of the SOWMY report (UNFPA et al., 2014).
4. This data is inputted to an Excel-based stock-and-flow workforce projection model, whereby the workforce in each year is a function of current stock, new graduates joining the workforce in each year, and losses due to premature death, attrition, and retirement. Thanks to a sophisticated cohort analysis, the model progresses workers over time from 2012 to 2030 in order to make accurate predictions about age-related death rates and timing of retirement.

The process of relating workforce availability to workforce requirements involved considering which type of health worker was suitable for delivering each intervention, according to the following steps:

1. Each ISCO category of health worker was assumed competent to deliver a certain subset of the 36 interventions, based on Optimize MNH (WHO, 2012) and OneHealth (Futures Institute, 2013) assumptions. Health workers were ranked according to the number of essential interventions they were assumed competent to deliver.
2. Starting from the health worker category with narrowest scope of practice, their total time available (calculated in the section above) was iteratively distributed, 2 hours at a time, across the interventions they were competent to deliver. Once the time of a health worker category was "spent", the next category's time was distributed according to the same rules, until the total time requirement for an intervention was met.

Results

73 countries with the greatest burden of maternal and newborn mortality and morbidity were included in the analysis. For each country, workforce availability, workforce requirement, and met need estimates were computed under 6 scenarios:

i. business-as-usual
ii. reduction of pregnancies by 20% by 2030
iii. doubling of midwife, nurse and physician graduates by 2020
iv. increase in efficiency by 2% per year until 2030
v. halving of attrition between 2012 and 2017
vi. best case scenario combining scenarios ii-v above

Table 1, summarising results for met need, shows that readiness of the health workforce to provide universal coverage of essential interventions differs greatly between countries, with the average country only having the workforce to deliver half of what is required. While improvements are predicted between 2012 and 2030 even under business as usual, further improvements are possible in the challenging yet feasible best case scenario. Results by country are reported in the SOWMY

2014 report's country briefs (UNFPA 2014) as a means to prompt debate and discussion on workforce planning and the quality of workforce data.

Table 1: Met need results

Year	Mean	Maximum	Minimum
2012	51%	100% (n=5)	6% (n=1)
2030 (business as usual scenario)	60% 2012-2030 Increase in 45 countries 2012-2030 Decrease in 19 countries 2012-2030 Constant in 9 countries	100% (n=11)	5% (n=1)
2030 (best case scenario)	87% 2012-2030: Increase in 67 countries 2012-2030: Decrease in 1 country 2012-2030: Constant in 5 countries	100% (n=24)	28% (n=1)

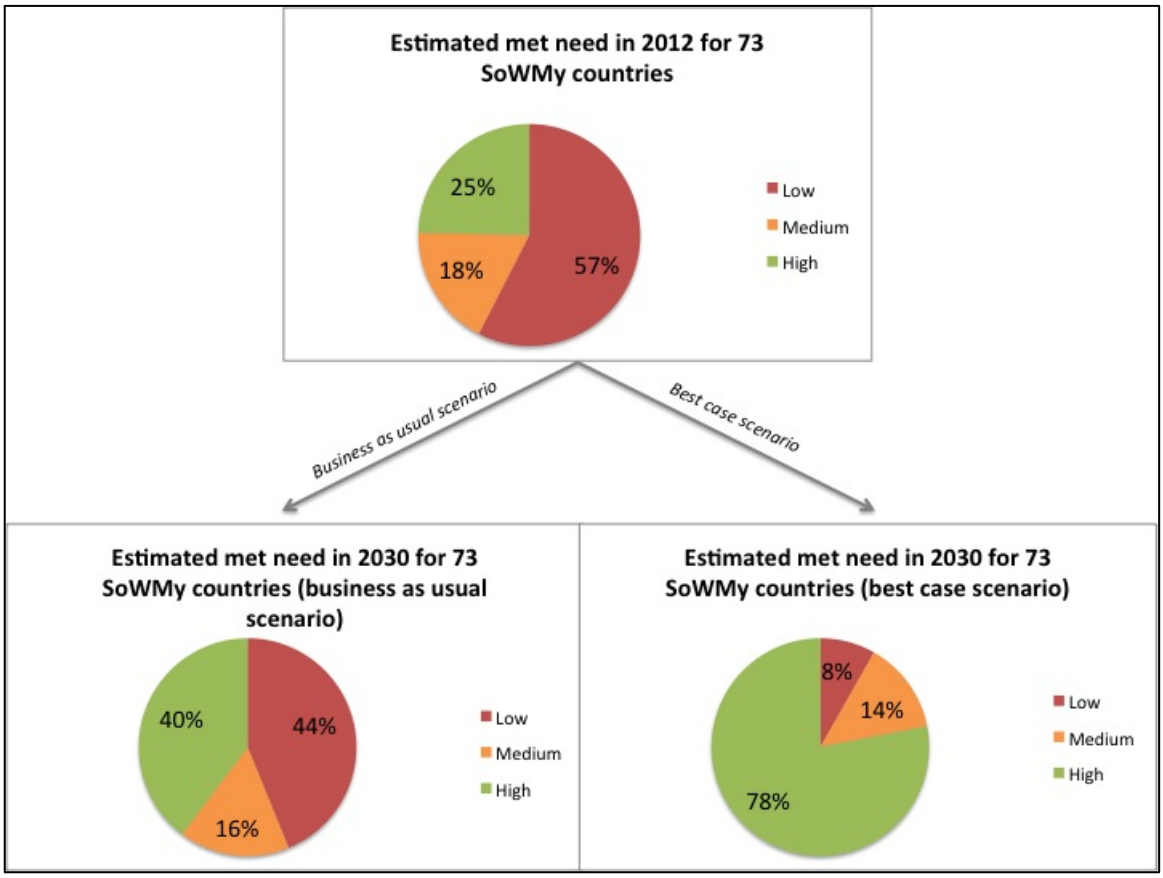
To further examine the impact of the best case scenario, we classified countries into 3 categories of met need: low (met need is less than or equal to 50%); medium (met need is between 51-75%) and high (met need is greater than 75%) (see figure 1). Again, we observe a slightly higher proportion of countries achieving medium or high coverage in the 2030 business as usual scenario compared to the 2012 current situation. However, only the combined efforts of policy changes (which span workforce and population policies) can deliver universal health coverage in a substantial majority of countries.

Conclusions

We have demonstrated proof of concept for a modelling approach to workforce planning that enables the delivery of universal and effective coverage for midwifery care. It achieves this by supporting planning on the basis of actual population needs, taking into account the size of different demographic groups and the incidence of maternity and newborn health issues in the population. It facilitates planning of quality care by recognising that health workers have a limited number of working days and spend only part of those working days on clinical work, and only part of their clinical work on maternity care.

Quality of care is also explicitly built into the model by assigning specific skills and scopes of practice to different health care workers, acknowledging that some interventions require a team of health workers. The model is well suited to planning for the future through its sophisticated cohort analysis of the health workforce and its use of demographic patterns to adjust the future scale of need. It can usefully be applied to sub-national areas where workforce data is available, enabling analysis of the equity of workforce distribution between regions. Ultimately, beyond answering workforce planning questions, this model challenges us to think through the complexities of what we are aiming to achieve: enabling every woman to access the midwifery care she needs, wants, and has a right to.

Figure 1: Changes in met need category for countries from 2012 to 2030, business as usual and best-case scenarios.



Annex 1: Essential interventions for SRMNH care

Pre-pregnancy interventions
Family planning (advice, hormonal and barrier methods)
Family planning (surgical methods)
Prevention and management of sexually transmitted infections, HIV
Folic acid fortification/ supplementation to prevent neural tube defects
Antenatal interventions
Iron and folic acid supplementation
Tetanus vaccination
Prevention and management of malaria with insecticide treated nets and antimalarial medicines
Prevention and management of sexually transmitted infections and HIV, including with antiretroviral medicines
Calcium supplementation to prevent hypertension (high blood pressure)
Interventions for cessation of smoking
Screening for and treatment of syphilis
Low dose aspirin to prevent pre-eclampsia
Antihypertensive drugs (to treat high blood pressure)
Magnesium sulphate for eclampsia
Antibiotics for preterm prelabour rupture of membranes
Corticosteroids to prevent respiratory distress syndrome in preterm babies
Safe abortion
Post abortion care
Reduce malpresentation at term with External Cephalic Version
Induction of labour to manage prelabour rupture of membranes at term (initiate labour)
Childbirth interventions
Prophylactic uterotonics to prevent postpartum haemorrhage (excessive bleeding after birth)
Manage postpartum haemorrhage using uterine massage and uterotonics
Social support during childbirth
Active management of third stage of labour (to deliver the placenta) to prevent postpartum haemorrhage (as above plus controlled cord traction)
Management of postpartum haemorrhage (as above plus manual removal of placenta)
Screen and manage HIV (if not already tested)
Caesarean section for maternal/foetal indication (to save the life of the mother/baby)
Prophylactic antibiotic for caesarean section
Induction of labour for prolonged pregnancy (initiate labour)
Management of postpartum haemorrhage (as above plus surgical procedures)
Postnatal interventions (mother)
Family planning advice and contraceptives
Nutrition counselling
Screen for and initiate or continue antiretroviral therapy for HIV

Treat maternal anaemia
Detect and manage postpartum sepsis (serious infections after birth)
Postnatal interventions (newborn)
Immediate thermal care (to keep the baby warm)
Initiation of early breastfeeding (within the first hour)
Hygienic cord and skin care
Neonatal resuscitation with bag and mask (by professional health workers for babies who do not breathe at birth)
Kangaroo mother care for preterm (premature) and for less than 2000g babies
Extra support for feeding small and preterm babies
Management of newborns with jaundice ("yellow" newborns)
Initiate prophylactic antiretroviral therapy for babies exposed to HIV
Presumptive antibiotic therapy for newborns at risk of bacterial infection
Use of surfactant (respiratory medication) to prevent respiratory distress syndrome in preterm babies
Continuous positive airway pressure (CPAP) to manage babies with respiratory distress syndrome

Source: PMNCH (2011)

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ACHIEVEMENT AND CHALLENGES IN HEALTH-RELATED MDGS IN GHANA AND HEALTH AGENDAS FOR POST-2015

Gloria Joyce Quansah Asare

Ghana has mainstreamed the MDGS in the national development framework - the Ghana Shared Growth and Development agenda 2010 -2013.

Ghana's status as a lower middle-income country with high GDP (1,850.20 USD (2013),per capita, GSS) rich natural resources including gold, bauxite, manganese, timber, cocoa and oil in the recent past, has not consistently improved human development indicators, we continue to face significant challenges across development sectors and services, with wide disparities in regional and district poverty levels and marked socioeconomic divide. Indications are that MDGs goals 1 and 2 are likely to be attained by 2015, while MDG6 is potentially achievable, 3 and 7 are likely to be partially achieved while in spite of some improvements, MDGs 4 and 5 are unlikely to be achieved.

There has been a slowing down or stagnation in health indicators - MMR of 350 per 100,000 live births (42%) in 2008 from estimated 740 in 1990; A reduction of Under Five Mortality rate with a significant 60% of infant deaths occurring in the neonatal period (30 per 1000 live births). An improvement in coverage of antenatal care and skilled delivery with major challenges in quality and equity, with marginal improvements in modern contraceptive prevalence rate and unmet need for Family Planning and disturbing trends in adolescent fertility with low access to SRH services. Improvements in resources and improvements have been recorded for Malaria, Tuberculosis and HIV and AIDS. While together with reduction in poverty indicators, underweight among children under five has reduced significantly and met the target, stunting remains high (28% in 2008 and 23% in 2011) generally with minimal improvements across regions and worsening in the Northern Region. All health indicators are worst for the rural, uneducated poor and also an emergence of an increasing urban poor population. Reference is often made to the Northern-Southern Divide but in every region there are districts with extremely poor human development indicators often coupled with limited geographic and financial access. The Free maternity care Policy through the National Health Insurance Scheme (NHIS) has been implemented since 2008 with increases in coverage.

An MDG assessment (2012) reported a steady increase in the number of facility-based deliveries from about 300,000 in 2007 to about 500,000 in 2011. The utilisation rate reported by the Ghana Health Service in 2011 (66%) was confirmed by population-based data of the 2011 Multiple Indicator Cluster Survey. The institutional maternal mortality ratio (GHS) declined from 230 per 100,000 in 2007 to 170 in 2011. Equity in the utilisation of health facilities for deliveries increased as documented by successive population surveys. There are, however, still persistent regional and social disparities in access.

Ghana has developed an MDG5 acceleration Framework (MAF) 2012 to 2015 and had a significant pledge from the EU of 51 million Euros to support three core areas of Family Planning, Skilled attendance and Emergency Obstetric and

Newborn Care while also covering cross cutting areas of human resources for health, social and behavioural change, financial management, monitoring and evaluation. This is in addition to other support in RHCS, Nutrition, Reproductive and Child Health by Government and other Development Partners.

Underlying these challenges are the lack of appreciation and hence resources towards of universal access to Sexual and Reproductive Health (SRH) globally, at the onset of the setting of MDG goal targets; suboptimal quality of care in many instances, minimal integration of resources for programmes and research as well as difficulty in scaling up of evidence-based interventions from pilot phase.

Indeed, Family Planning affects and can have a positive influence on all 8 MDGS but was largely neglected by global and national levels. Integration of MCH/RH/FP/PMTCT programming and service delivery, the appreciation of quality education to at least secondary level, with improved access to tertiary and vocational education, total development opportunities for the youthful population.

Reference is often made to Ghana and Malaysia having gained independence in 1957 with similar socio-economic indicators; but today with significant investment in and contribution from education and family planning services and with strengthened leadership and commitment at all levels, Malaysia is one of the Asian Tigers.

Post 2015, with a rights-based approach to development, we should see a bridging of the wide gaps in development globally and at all levels. Ghana like all nations have to own their development improving infrastructure and technology including ICT; improving energy and industry sectors; quality and equitable education and health services must be attained with gender mainstreaming. There is a need to strengthen health systems, building capacity at local (decentralized) levels and improving the monitoring and mentoring role of the higher levels; a life cycle approach to health should be adopted, ensuring a continuum of care especially in MNCH- pregnancies wanted, healthy pregnancy, safe delivery, ensuring survival of the children with optimal potential by preventing stunting; boost adolescent health and development programming and services (getting optimal benefit of the demographic dividend) and enhance health and productivity of the aged; building capacity for communicable and non-communicable diseases by communities and health services; striking a good balance between public health and clinical care and increase in resources for research and social and behavioural communication with accountability by all stakeholders in development. This should include advocacy for effective partnerships at all levels which are well-defined, implemented and monitored. There is need for reinforced multi-sectoral approach to health and development in general with strengthened leadership and commitment by all.

PRINCE MAHIDOL AWARD CONFERENCE 2015 | GLOBAL HEALTH POST 2015 ACCELERATING EQUITY

PARALLEL SESSION 1.7

ENSURING EQUITABLE AND SUSTAINABLE ACCESS TO HEALTH COMMODITIES AND SERVICES IN MICS IN THE POST-2015 DEVELOPMENT AGENDA

PARALLEL SESSION 1.7

ENSURING EQUITABLE AND SUSTAINABLE ACCESS TO HEALTH COMMODITIES AND SERVICES IN MICS IN THE POST-2015 DEVELOPMENT AGENDA

BACKGROUND

There are over 100 middle-income countries (MICs) accounting for 70% of the world's population, 75% of the world's poor, and the greatest proportion of the world's disease burden. Despite increased Gross Domestic Product (GDP) and Gross National Income (GNI), many MICs are still unable to provide key elements that contribute to improved access to essential health commodities for their citizens. This is partly because as many low-income countries (LICs) move to achieve middle-income status, they generally lose eligibility for certain global health resources (e.g. finance and access to low prices) reserved for LICs. In summary, while LICs continue to experience problems in access, it is difficult for middle-income countries to transition to self-sufficiency, if they cannot provide essential health commodities.

OBJECTIVES

- To understand strategies that major actors are exploring towards increasing equitable access in MICs.
- To identify challenges/bottlenecks in ensuring equitable and sustainable access to essential health commodities in MICs.
- To discuss the ways forward to promote equity and sustainability around key dimensions of access in MICs.

MODERATOR

John Mac ARTHUR
Director
Thailand MOPH - US CDC Collaboration
Centers for Disease Control and Prevention

Thailand

Dr. MacArthur earned his medical degree from Georgetown University and subsequently completed residencies in Family & Community Medicine at the University of California at San Francisco and Preventive Medicine at Johns Hopkins School of Hygiene & Public Health. In addition, he holds a Master of Public Health in International Health from Johns Hopkins. Prior to coming to the US Centers for Disease Control and Prevention (CDC), Dr. MacArthur worked with refugees on the Thai-Burma border and was posted to WHO/PAHO in Kingston, Jamaica. He spent two years as an Epidemic Intelligence Service Officer in the Malaria Branch where he spent 16 years. During his early tenure in Atlanta, Dr. MacArthur's malaria interests included the development of therapeutic efficacy surveillance systems to monitor antimalarial drug resistance, implementation of artemisinin combination therapy (ACT) in South America and Africa, post-marketing surveillance for adverse drug reactions, and assessing the role of ACTs in pregnancy. He served as the CDC lead for the Amazon Malaria Initiative before accepting a detail to the USAID Regional Development Mission/Asia where he managed over $100 million of infectious disease funds focusing on malaria, tuberculosis, dengue and influenza throughout the Asia region. He returned to Atlanta to lead CDC's component of the US President's Malaria Initiative; a $650 million malaria control program in African and Southeast Asia. Currently, Dr. MacArthur serves as the Director of the Thailand MOPH – US CDC Collaboration where he leads CDC's team of 200 staff involved in programs ranging from HIV/AIDS, to migrant and refugee health, to Global Health Security.

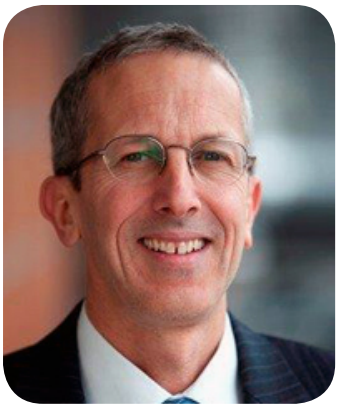
Mark DYBUL
Executive Director
Global Fund

Switzerland

Mark Dybul is the Executive Director of the Global Fund to Fight AIDS, Tuberculosis and Malaria. Dybul has worked on HIV and public health for more than 25 years as a clinician, scientist, teacher and administrator.

After graduating from Georgetown Medical School in Washington D.C., Dybul joined the National Institute of Allergy and Infectious Diseases where he conducted basic and clinical studies on HIV virology, immunology and treatment optimization, including the first randomized, controlled trial with combination antiretroviral therapy in Africa. Dybul became a founding architect and driving force in the formation of the President's Emergency Plan for AIDS Relief, better known as PEPFAR. After serving as Chief Medical Officer, Assistant, Deputy and Acting director, in 2006 he was appointed as its leader, becoming U.S. Global AIDS Coordinator, with the rank of Ambassador at the level of an Assistant Secretary of State. He served until early 2009.

Dybul is a Professor of Medicine, Department of Medicine, Georgetown University School of Medicine, 2014 to present. He has written extensively in scientific and policy literature, and has received several Honorary Degrees and awards.



Robert NEWMAN
Managing Director
Policy & Performance
Global Alliance for Vaccines and Immunization (GAVI)

Switzerland

Dr Robert D. Newman is a pediatrician and is currently the Managing Director for Policy and Performance at the Gavi, the Vaccine Alliance, in Geneva, Switzerland. In that role, he oversees organizational strategy setting, market shaping, policy development, business planning, and monitoring & evaluation.

Before joining Gavi, Dr. Newman was Director of the Global Malaria Programme at the World Health Organization (WHO) in Geneva from 2009 to 2014. Prior to that, he spent 9 years at the Centers for Disease Control and Prevention in Atlanta in the Malaria Branch, where he also served as the CDC team lead for the US Presidents Malaria Initiative from 2006 to 2009. He has also spent time in the field, first studying Cryptosporidium in a favela in Brasil in the early 1990s, and then as Country Coordinator of Health Alliance International in Mozambique in the late 1990s supporting the government in its efforts to improve maternal and child health.

Dr. Newman received his BA in English Literature from Williams College, his MD from Johns Hopkins University, and his MPH from the University of Washington. He completed his residency in Pediatrics at the University of Washington--Seattle Children's Hospital in 1996, and stayed on to complete a National Research Service Award fellowship in General Pediatrics in 1998. He has published more than 60 peer-reviewed articles on malaria and other infectious diseases.

Saul WALKER
Senior Health Advisor
UK Department for International Development (DFID)

United Kingdom

Saul Walker is Head of the Directors Office for Asia, Caribbean and Overseas Territories at the UK Department for International Development, and the Senior Regional Health Advisor for Asia. He recently returned to DFID following a posting as a senior health specialist for the World Bank Mozambique Country Office, where he led work on pharmaceutical policy and health financing. From 2007 – 2011, Saul led work on access to medicines policy in DFID's Policy Division, including serving as the UK representative on the Global Fund's market dynamics committee. Prior to work at DFID, he was Executive Director for Policy at the International Partnership for Microbicides (2005 – 2007), and Senior Policy Advisor for the International Aids Vaccine Initiative (2001 – 2004). At both organisations he led work focusing on strategies for the future introduction of new HIV prevention technologies as components of comprehensive HIV prevention strategies. He holds Master's degrees from the University of Cambridge and University of Warwick.

Manica BALASEGARAM
Director
Medecins sans Frontieres

Switzerland

Dr Balasegaram is a medical doctor who trained at the University of Nottingham, United Kingdom. He received further post-graduate training in internal and emergency medicine in the UK and Australia. He joined MSF in 2001, working as a doctor in the field in several countries in Sub-Saharan Africa and Southern Asia.

After gaining significant operational research experience, Dr Balasegaram became Head of the Manson Unit – a London-based medical research and implementation arm of MSF – in 2005. He then joined MSF partner organisation Drugs for Neglected Diseases initiative (DNDi) in 2008, where he worked for four and a half years, finishing as DNDi's Head of Leishmaniasis Clinical Development Team before joining the Access Campaign.

Dr Balasegaram has worked extensively on issues around access to medicines, with a particular focus on tropical and neglected diseases; to this end he has considerable training in both Public Health and Tropical Medicine from the London School of Hygiene and Tropical Medicine, with significant work experience in both areas. He also has substantial experience in clinical trials and drug development working as a site investigator, principal investigator and project manager.

Doreen Mulenga
Deputy Director
Supply Programme
UNICEF COPENHAGEN

Denmark

Dr. Doreen Mulenga is a public health physician with over 20 years' experience that includes clinical work, primary health care, national and international public health in Botswana, Nigeria, Zambia and USA. She is currently the Deputy Director, Supply Programmes in UNICEF Copenhagen.

Prior to that she was the UNICEF Representative in Botswana where she was responsible for managing the UNICEF Botswana office activities related to accelerating child survival, development and protection programs.

Her work experience includes responsibilities for managing the programme coordination activities related to accelerating UNICEF's global response to the HIV and AIDS pandemic focused on prevention of mother to child transmission of HIV, paediatric HIV treatment, prevention of HIV among adolescents as well as care and support for children orphaned or made vulnerable as a result of HIV/AIDS.

Prior to joining UNICEF, Dr. Mulenga was the Deputy Programme Manager in the Zambia national HIV/AIDS/STD and TB programme. She obtained a Medical Degree from University of Zambia in 1988 and a Masters in Public Health from University of Wollongong (Australia) in 1993.

Adetokunbo LUCAS
Adjunct Professor
Harvard School of
Public Health

USA

Adetokunbo Oluwole Lucas, OFR MD, DSc, FRCP, FFPH, FRCOG, (1931–) of Ibadan in the Nigeria Federal Republic of Nigeria and the Harvard School of Public Health in Boston, is a global health leader for Africa and a recipient of both the annual Prince Mahidol Award in 1999 for his support of strategic research on the tropical diseases, such as malaria, schistosomiasis, the filariases, leishmaniasis, Chagas disease, African trypanosomiasis, and leprosy, and the 2013 Jimmy and Rosalynn Carter Humanitarian Award from the National Foundation for Infectious Diseases (NFID). Often known simply as Ade Lucas, he has also served for ten years as the Director of Special Programmes for Research and Training in Tropical Diseases based at the World Health Organization in Geneva, Switzerland. He is currently Adjunct Professor of International Health Department of Global Health and Population of the Harvard School of Public Health. He works largely in his home nation of Nigeria and travels frequently to the United Kingdom and to the Harvard School of Public Health in the United States.

http://en.wikipedia.org/wiki/Adetokunbo_Lucas

PRINCE MAHIDOL AWARD CONFERENCE 2015 | GLOBAL HEALTH POST 2015 ACCELERATING EQUITY

PLENARY 2

MOVING TOWARDS NEW GLOBAL HEALTH GOVERNANCE

PLENARY 2

MOVING TOWARDS NEW GLOBAL HEALTH GOVERNANCE

BACKGROUND

This sub-theme will address both the issues of "global health governance" as well "global governance for health":

On global health governance, discussions will be held around the following issues:

- The role of state actors – UNAIDS, WHO, UNICEF, GAVI, World Bank, G8, G20, regional health collaborations and others;
- The role of the non-state actors – private sector, social enterprise and civil society organizations, especially in terms of health in critical underprivileged groups;
- Appropriate and effective monitoring and evaluation mechanisms as well as global health information systems to ensure transparency, accountability and fit for purpose.

On global governance for health, discussions will be held around:

- Social, political and commercial determinants of health and "health in all policies;"
- Appropriate coordination mechanisms to ensure that health is being considered in broader policy development (joined-up government at all levels);
- Appropriate instruments to assess the potential health and social impact of policies during the policy development process.

OBJECTIVES

- Discuss how global health governance and global governance for health can be moved from governance by states and by market forces towards governance by partnership in the Post-2015 process.
- Each parallel session should address the following:
  - Diagnosis – What is the current situation, successful cases and challenges (inefficiencies, non-inclusiveness, lack of transparency, inequities, etc.)?
  - Possible treatments – How to move from this situation towards more efficiency, equity, better partnerships, increased inclusiveness and engagement by all stakeholders in the Post-2015 era?
  - Development of a new feasible governance mechanism for improving the situation – a call for change.

MODERATOR

Jan BEAGLE
Assistant Secretary-General
The United Nations

Deputy Executive Director
The Joint United Nations
Programme on HIV/AIDS

Switzerland

Ms Beagle is Assistant Secretary-General of the United Nations and Deputy Executive Director of UNAIDS. She has more than 30 years' experience in the political, development, management and interagency areas of the United Nations.

Ms Beagle leads UNAIDS' work in promoting effective governance of the Joint Programme and provides strategic direction to overarching management functions, in the areas of human resources, finance, budget, information technology and administration, to enhance UNAIDS' capacity to implement its mandate and vision.

Prior to this role, she served as Deputy Director-General of the United Nations Office in Geneva, as Assistant Secretary-General for Human Resources Management, and in senior positions in the Executive Office of the Secretary-General, the Office of the Administrator of UNDP, and the Department of Political and Security Council Affairs. Ms Beagle began her career with the New Zealand Ministry of Foreign Affairs, including as a delegate of New Zealand to the United Nations.

Ole Petter OTTERSEN
Rector
University of Oslo

Norway

Ole Petter Ottersen MD, PhD is Professor of Medicine and since 2009 the Rector (President) of University of Oslo. He is currently Chair of the Norwegian Association of Higher Education Institutions (UHR) for 2013-2015.

Ottersen was Dean of Science at the Medical Faculty, University of Oslo, from 2000 to 2002. In 2002 he was appointed Director of Centre for Molecular Biology and Neuroscience, http://www.cmbn.no, a Centre of Excellence sponsored by the Research Council of Norway. From 2006 to 2009 Ottersen was Chief Editor of "Neuroscience" – the journal of the International Brain Research Organization (IBRO). Ottersen has received several international awards for his research on brain function and disease. He chaired the Lancet-University of Oslo Commission on Global Governance for Health whose report was launched on February 11, 2014.

Alex ROSS
Director
World Health Organization's
Centre for Health Development
in Kobe

Japan

Mr. Alex Ross (MsPH) is the Director of the WHO Centre for Health Development in Kobe, Japan (WKC). A WHO global centre for excellence, the Centre focuses on research into health, social, and economic factors that contribute to health and development. For over a decade, WKC has led work on urbanization and health, emphasizing measurement of inequities, and development of practical approaches to redress them including intersectoral action for health. The Centre is transitioning to research directions focusing on universal health coverage, innovation and ageing. One ongoing initiative is encouraging more frugal technological and social innovations for ageing populations. A global centre, WKC leverages collaborations with Japanese and international universities.

An expert in public health policy and health systems, Mr Ross has developed domestic and global health policies, programmes, and innovative financing mechanisms over the past 25 years. These have focused on strengthening health systems, governance issues (such as decentralization), communicable and noncommunicable diseases, prevention programmes, and ageing populations. Prior to his current position, Mr Ross was Director for Partnerships and UN Reform in the Director-General's Office of WHO (Geneva) between 2007 and 2011, where he led development of WHO's partnerships policy, nurtured WHO's engagement with global health initiatives, UN agencies, non-governmental organizations and the private sector. Mr Ross was very involved in developing innovative health financing approaches, such as developing the Solidarity Tobacco Contribution concept, as well contributing to the creation of the Global Fund to Fight AIDS, TB and Malaria and UNITAID. Mr Ross held senior posts as Director in the Office of the Assistant Director-Generals for Communicable Diseases and for HIV/AIDS, TB and Malaria, WHO, between 2003-2007, where he was very involved in the WHO's "3x5 initiative", strategies to contain the H5N1 epidemic, and the development of the WHO Pandemic Influenza Preparedness framework.

Before joining WHO, Mr Ross served in senior domestic and international health positions: as a Senior Health Advisor for health systems, HIV/AIDS and integrated health policy for the UK Department for International Development (2001-2003); and as Deputy Chief for Health and Education in the USAID Bureau for Africa (1993-2001) He worked in the Office of the Assistant Secretary for Health, US Department of Health and Human Services (1990-93), the U.S. Congress House Energy and Commerce Committee as a health professional staff (1988), and the U.S. General Accounting Office (1987-89).

Mr Ross holds a B.S.P.H. and M.Sc. degrees from the University of California, Los Angeles (UCLA) School of Public Health, and has conducted doctoral level studies in public health at the Rand Graduate Institute.

Carmen BARROSO
Regional Director
of International Planned
Parenthood Federation iERG /
International Planned
Parenthood Federation

USA

Dr. Carmen Barroso is a member of the Independent Expert Review Group of the Global Strategy on Women and Children's Health, appointed by the Secretary General of the UN and is a member of a new Lancet Commission on Adolescent Health. Last year she was also a member of the UN Secretary-General Independent Expert Advisory Group on the Data Revolution for Sustainable Development.

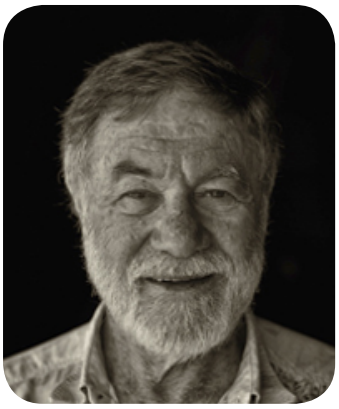
A native of Brazil, Dr. Carmen Barroso was a professor of sociology at the University of Sao Paulo, Brazil, and a senior researcher with the Carlos Chagas Foundation, where she created Brazil's first and foremost women's studies center. She was a Presidential appointee to the National Council on Women's Rights and wrote a regular op-ed column in one of the major Brazilian newspapers.

In 1991 Dr. Barroso became the first non-American woman to be appointed as director in a major US foundation. She was the Director of the MacArthur Foundation's Population and Reproductive Health program until 2003. Under her leadership, the program funded hundreds of local organizations in Africa, Asia, and Latin America, and helped bring the voices and experiences of women from the Global South to international policy fora. In particular, Dr. Barroso has been recognized by the media and academics for the influential role she played in making sexual and reproductive health and rights central to development policy at the landmark 1994 International Conference on Population and Development.

Since 2003, Dr. Barroso has served as the Regional Director of International Planned Parenthood Federation/Western Hemisphere Region. Through its 41 Member Associations in the Americas and the Caribbean, IPPF/WHR provides nearly 33 million services annually. As the director of one of the most dynamic regions of IPPF, and as a member of the IPPF global senior team, Dr. Barroso has been a leader in innovation both in advocacy and services, especially for young women.

She has served on several boards and international commissions, including the Millennium Project Task Force on MDG 3, and the Brazilian Commission on Reproductive Health, a pioneer effort for engaging multiple stakeholders in accountability for women's health policies.

Dr. Barroso holds a PhD from Columbia University in Social Psychology. She was a Visiting Scholar at the Population Department of Cornell University and received numerous academic and public service awards and honors, including Ford Foundation and Fulbright Scholarships. Most recently she was named one of the 21 women leaders of the 21st Century by Women's eNews. Dr. Barroso has published numerous articles in professional journals and popular media in Brazil and internationally, and has consulted for many international and intergovernmental agencies.



David SANDERS
Founding Director
of the School of Public Health
University of the Western Cape
and People's Health Movement

South Africa

David Sanders, Emeritus Professor and founding Director of the School of Public Health at the University of the Western Cape, South Africa, is a paediatrician qualified in Public Health. He has over 30 years' experience of university teaching and health policy development in Zimbabwe and South Africa, having advised governments, NGOs and several UN agencies on primary health care, child health and nutrition, and health human resources. He has published three books on the political economy of health, and over 140 scientific articles in these areas. In 2004/5 he was Heath Clark lecturer at the LSHTM, is Visiting Professor at the Centre for International Health at the University of Bergen, Norway, and Honorary Professor in the School of Medicine, Flinders University of South Australia and in the Department of Paediatrics and Child Health, University of Cape Town. In 2012 he was awarded an Honorary Doctorate by the University of Cape Town in recognition of his contribution to the development of the global policy of Primary Health Care, and in 2014 received the Public Health Innovation and Lifetime Achievement (PHILA) Award of the Public Health Association of South Africa. He was on the Steering Committee of the United Nations Standing Committee on Nutrition for several years. He is a founder and on the Global Steering Council of the Peoples Health Movement and has been a contributor and editor of Global Health Watch.

PRINCE MAHIDOL AWARD CONFERENCE 2015 | GLOBAL HEALTH POST 2015 ACCELERATING EQUITY

PARALLEL SESSION 2.1

GLOBAL HEALTH GOVERNANCE: WHO AND HOW?

PARALLEL SESSION 2.1

GLOBAL HEALTH GOVERNANCE:
WHO AND HOW?

BACKGROUND

The governance of global health has become a topical issue because of the proliferation of global health institutions over the last two decades. The list includes UNAIDS, the International AIDS Vaccine Initiative and many other partnerships for new product development, the GAVI Alliance, the Global Fund, UNITAID as well as bilateral initiatives such as PEPFAR and new funders, notably the Bill & Melinda Gates Foundation. The role of WHO was reviewed in a recent report from Chatham House. This session will explore different perspectives on the role of WHO and other organizations in the field of global health and how the issues of leadership and coordination in global health can best be addressed.

OBJECTIVES

The session will seek to elucidate how global health governance can be improved including consideration of how the various institutions can coordinate their activities better and what role WHO should play in exercising leadership and improving coordination.

MODERATOR

Charles CLIFT
Senior Consulting Fellow
Chatham House

United Kingdom

Charles Clift is currently a Senior Consulting Fellow in the Centre on Global Health Security at Chatham House in London. He is an economist who spent much of his career at the UK Department for International Development, latterly as a senior adviser on access to medicines. He has specialized in the relationship between intellectual property rights, innovation and access to medicines in developing countries. He was previously head of the secretariat for the UK Commission on Intellectual Property Rights (2001-2), the World Health Organization's Commission on Intellectual Property Rights, Innovation and Public Health (2004-6) and was the principal author of the report of WHO's Consultative Expert Working Group on Research and Development: Financing and Coordination (2011-12).

At Chatham House he was responsible for supporting the Centre's Working Groups on Governance and Financing which aimed to identify sustainable methods for improving global health security and access to health care and to influence international and national policy-makers, in particular in relation to the post-2015 sustainable development goals. He also leads on the Centre's programme on antimicrobial resistance. Recent publications, available on the Chatham House website, include The Role of the World Health Organization in the International System (2013) and What's the World Health Organization For? (2014).

He is also chair of the Medicines Patent Pool Foundation, a Swiss NGO seeking to make available more affordable and better adapted treatments for HIV/AIDS in developing countries.

David LEGGE
Scholar Emeritus
La Trobe University

Australia

David Legge started his career in internal medicine but early on moved into health services research, health policy and planning and public health. From 1977 to 1983 he was involved in pioneering work in quality assurance in internal medicine. During this time he was also involved in providing educational programs in public health and health services management for lay members of community health centre board committees and supporting consumer activism in health care.

From 1984 to 1989 he worked in the Victorian State Health Department supporting the structured involvement of local communities in health planning, health promotion and health system accountability. After a five year stint at the Australian National University (1990-1994) exploring various aspects of health development, he moved to La Trobe University in Melbourne where he has been based since 1995.

Since coming to La Trobe David has undertaken research and teaching in the political economy of health, comparative health systems, primary health care, policy capacity, and international health policy. Since 1996 he has been teaching health policy and management in China, as part of La Trobe's China Health Program, and researching the health challenges associated with China's economic and political transition. From 1998 to 2006 David was academic coordinator for the Victorian Public Health Training Scheme, a broadly based in-service training program for public health practice. David was also a research theme leader in the C ooperative Research Centre for Aboriginal Health for two years to 2005 and in this role was instrumental in fostering research development in Indigenous PHC in Australia.

David Legge was awarded the Sidney Sax Medal by the Public Health Association of Australia in 2003. The award remembers Dr Sidney Sax who was a student of Dr Sidney Kark in South Africa and who emigrated to Australia where he made an outstanding contribution to health system development and primary health care.

David has been active in the People's Health Movement (PHM) since 2000 when it was formed and since 2012 has been co-chairperson of the global Steering Committee of PHM. Among his involvements with PHM, David has been academic coordinator of the International People's Health University (IPHU), a short course program in the political economy of health for health activists, and has been closely involved in PHM's WHO Watch project, which involves a systematic engagement with the governing bodies of WHO.

Andrew CASSELS
Senior Fellow
Graduate Institute, Geneva

Switzerland

Andrew Cassels worked for the World Health Organization from 1998 to 2014. He is now a Senior Fellow in the Global Health Programme at the Graduate Institute for International and Development Studies in Geneva and has established GH Associates, a consultancy firm. From 2009-2014 he was the Director of Strategy in the office of the Director-General, responsible for work on WHO reform, global health governance and health in the post-2015 agenda.

Andrew Cassels graduated in medicine from St John's College, Cambridge, UK in 1975, and in public health from the London School of Hygiene and Tropical Medicine in 1984. His international career began in Nepal where he worked as the director of a non-government organisation in the field of tuberculosis control, community development and the financing of essential drugs. After a further long-term assignment in Odisha, India, he was appointed to the staff of the Liverpool School of Tropical Medicine. There he established a post-graduate course on the management of primary health care, and developed a research programme focusing on health systems strengthening and donor policies in the health sector. Between 1992 and 1998, he worked as a senior adviser to a wide range of governments, as well as to several multilateral and bilateral development agencies. He has published on issues related to health systems and health sector reform and pioneered new approaches to development assistance in health, including sector-wide approaches.

Anne MILLS
Professor
London School of Hygiene
and Tropical Medicine

United Kingdom

Anne Mills is Deputy Director and Provost of the London School of Hygiene & Tropical Medicine, and Professor of Health Economics and Policy. She has researched and published widely in the fields of health economics and health systems in low and middle income countries and continues to be involved in research on health insurance developments in South Africa, Tanzania, India and Thailand. She has had continuing involvement in supporting capacity strengthening in health economics in universities, research institutes and governments, and has been involved in numerous policy initiatives including WHO's Commission on Macroeconomics and Health and the 2009 High Level Taskforce on Innovative International Finance for Health Systems. She was President of the International Health Economics Association (iHEA) for 2012-13 and in 2013 was elected Fellow of the Royal Society.

Ariel PABLOS-MENDEZ
Assistant Administrator,
Bureau for Global Health
The United States Agency for
International Development

USA

Dr. Ariel Pablos-Méndez, physician, scholar, diplomat and a creative leader in global health, was appointed in 2011 by President Barack Obama and Secretary of State Hillary Clinton, with the consent of the U.S. Senate, to lead the Global Health program of USAID, the premier agency in international development. USAID's vision, guided by the U.S. Global Health Initiative, aims to end preventable child and maternal deaths, and to catalyze an AIDS-free generation with approaches such as empowering women, fostering country ownership and strengthening health systems in low-income countries.

Dr. Pablos-Méndez began his public health career at Columbia University working on the emergence of multi-drug resistant tuberculosis in New York City in 1991; in 1997 he led the Global Surveillance Project on Anti-Tuberculosis Drug Resistance at the World Health Organization (WHO). In both instances, his research and publications brought about significant and successful policy changes in the field. He also served as Director of Knowledge Management at WHO in Geneva, 2004-2007, revamping WHO's flagship publications, working to bridge the know-do gap in public health and promoting e-Health in the developing world.

In 2007, he returned to the Rockefeller Foundation as Managing Director, where he was a program officer from 1998 to 2004 spearheading public-private partnerships in R&D for diseases of poverty (e.g. the Global Alliance for TB Drug Development), the Foundation's strategy on AIDS treatment in Africa (2001), and the Joint Learning Initiative on Human Resources for Health. From 2007-2011 he developed and led the Foundation's initiative on the transformation of health systems towards universal health coverage.

Dr. Pablos-Méndez received his M.D. from the University of Guadalajara (Mexico) and his M.P.H from Columbia University (New York), where he was a Professor of Clinical Medicine and Public Health. He has over 100 publications and has served in various boards and international commissions.

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Dr Balasegaram is a medical doctor who trained at the University of Nottingham, United Kingdom. He received further post-graduate training in internal and emergency medicine in the UK and Australia. He joined MSF in 2001, working as a doctor in the field in several countries in Sub-Saharan Africa and Southern Asia.

After gaining significant operational research experience, Dr Balasegaram became Head of the Manson Unit – a London-based medical research and implementation arm of MSF – in 2005. He then joined MSF partner organisation Drugs for Neglected Diseases initiative (DNDi) in 2008, where he worked for four and a half years, finishing as DNDi's Head of Leishmaniasis Clinical Development Team before joining the Access Campaign.

Dr Balasegaram has worked extensively on issues around access to medicines, with a particular focus on tropical and neglected diseases; to this end he has considerable training in both Public Health and Tropical Medicine from the London School of Hygiene and Tropical Medicine, with significant work experience in both areas. He also has substantial experience in clinical trials and drug development working as a site investigator, principal investigator and project manager.

Srinath REDDY
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India

Prof. K. Srinath Reddy is presently President, Public Health Foundation of India (PHFI) and formerly headed the Department of Cardiology at All India Institute of Medical Sciences (AIIMS). He was appointed as the First Bernard Lown Visiting Professor of Cardiovascular Health at the Harvard School of Public Health in 2009. He is also an Adjunct Professor of the Rollins School of Public Health, Emory University and Honorary Professor of Medicine at the University of Sydney. PHFI is engaged in capacity building in Public Health in India through education, training, research, policy development, health communication and advocacy.

Having trained in cardiology and epidemiology, Prof. Reddy has been involved in several major international and national research studies including the INTERSALT global study of blood pressure and electrolytes, INTERHEART global study on risk factors of myocardial infarction, national collaborative studies on epidemiology of coronary heart disease and community control of rheumatic heart disease. Widely regarded as a leader of preventive cardiology at national and international levels, Prof. Reddy has been a researcher, teacher, policy enabler, advocate and activist who has worked to promote cardiovascular health, tobacco control, appropriate nutrition across the life course, chronic disease prevention and healthy living across the lifespan. He edited the National Medical Journal of India for 10 years and is on editorial board of several international and national journals. He has more than 400 scientific publications in international and Indian peer reviewed-journals.

He has served on many WHO expert panels and has been the President of the World Heart Federation (2013-14). He also chairs the Core Advisory Group on Health and Human Rights for the National Human Rights Commission of India and is a member of the National Science and Engineering Research Board of Government of India. He recently chaired the High Level Expert Group on Universal Health Coverage, set up by the Planning Commission of India. He has also served as the President of the National Board of Examinations which deals with post-graduate medical education in India.

Prof. Reddy is a member of the Leadership Council of the Sustainable Development Solutions Network (ww.unsdsn.org), established to assist the United Nations in developing the post-2015 goals for sustainable development. He chairs the Thematic Group on Health in the SDSN.

His contributions to public health have been recognized through several awards and honours. They include: WHO Director General's Award for Outstanding Global Leadership in Tobacco Control (World Health Assembly, 2003), Padma Bhushan (Presidential Honour, India, 2005), Queen Elizabeth Medal (Royal Society for Health Promotion, UK, 2005), Luther Terry Medal for Leadership in Tobacco Control (American Cancer Society, 2009), Membership of the US National Academies (Institute of Medicine, 2005), Fellowship of the London School of Hygiene and Tropical Medicine (2009), Fellowship of the Faculty of Public Health, UK (2009), Cutter Lecture (Harvard, 2006), Koplan Lecture (CDC, 2008), Gopalan Oration (2009), Ramalingaswami Oration (2010), Paul Dudley White Lecture (AHA, 2010), Sheth Lecture (Emory, 2012), Philip Poole Wilson Memorial Oration (AIIMS-UKIERI, 2012), Sir John Wilson Oration (IAPB,2012), Doctor of Science (Honoris Causa) conferred by University of Aberdeen, Scotland (2011), Dr. NTR Medical University (2o11), University of Lausanne, Switzerland (2012), and University of Glasgow, Scotland (2013) and Doctor of Literature (Honoris Causa) conferred by the Jodhpur National University, India (2013) & Doctor of Science (Medicine), Honoris Causa, University of London, UK (2014).

He has also won prestigious literary awards such as: the Global Peace Essay contest organized by Economists Allied for Arms Reduction – ECAAR – and judged by 9 Nobel Laureates and the Times of India Essay contest on Human Rights and Media. He was a prize winning debater and quizzer at school and college levels.

WHO Reform and Global Health Governance: a Civil Society Perspective[1]

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The crisis in global health reflects a failure of global health governance (GHG)

We face an ongoing global health crisis

'Crisis' is used here to describe a situation of massive avoidable and remediable death, disability and distress which the world has not effectively addressed.

The dimensions of this crisis, as they relate to the social determination of health, can be gauged by the following all-too-familiar indicators: hunger; lack of sanitation and clean water; unemployment, marginalisation and alienation; poor infrastructure, the rising burden of non-communicable diseases; violence, interpersonal, communal and outright war; health issues specific to women or disproportionately burdensome for women; and health issues arising from racism, stigma and discrimination.

The dimensions of crisis in relation to health care are equally familiar. Indicators include: health practitioner migration; the dismantling of health systems through structural adjustment, tax competition, and imposed austerity; the vertical fragmentation of health systems driven by vertical disease focused public private partnerships (PPPs); privatisation of health care; and absurd price barriers to accessing certain medicines, such as sofosbuvir for Hepatitis C.

The current Ebola epidemic reflects the crisis of GHG in a nutshell. The conditions for the Ebola crisis in West Africa were put in place by the displacement of people from their land by foreign owned agribusiness [1]; by the exploitation of the mineral wealth by transnational mining corporations [2]; and by a global tax regime which supports transnational tax evasion [3] and deprives governments of legitimate revenues.

The shortcomings in the Ebola response reflect ongoing brain drain; the weakening of primary health care through vertically organised disease-focused programs; the neglect of Ebola treatment and prevention because of the profit driven model of pharmaceutical R&D; the donor chokehold over WHO [4] and the dysfunctions associated with WHO's regional structures.

The failure to address the global health crisis is due in part to the disabilities of the World Health Organisation

The disabilities which constrain WHO's response to the global health crisis are complex but three issues stand out:

1. This paper is an elaboration of a background note prepared for a panel session in the 2015 Prince Mahidol Award Conference, January 2015. The advice of FEB and JK is gratefully acknowledged.

- Inadequate and conditional finance
- Regional dysfunction
- Lack of accountability of member states

Inadequate and conditional finance

Two major disabilities flow from the continuing freeze on assessed contributions: donor dependence *and* inadequate resources in absolute terms.

WHO's dependence on donor financing has led to donor capture of WHO's operational agenda; with gross misalignments between priorities identified in the Assembly and expenditures underwritten by donors.

Much more destructive has been the competition for donor funds between clusters, departments and regions; forced to compete for visibility through workshops, publications, projects and governing body resolutions. Collaboration suffers when colleagues are seen as competitors.

Beyond donor capture and the fragmenting effect of internal competition, is the fact that WHO's budget is in absolute terms inadequate. Kickbusch[5] notes that the annual budget of WHO is comparable to that of the Geneva Cantonal Hospital. She compares the WHO budget to the global cost of the SARS epidemic and to the huge budgets of the Global Fund and the Gates Foundation.

The picture of WHO begging for funds for airfares and equipment in the response to the Ebola crisis epitomises the damage to GHG being rendered through the continuing freeze on assessed contributions (ACs).

Regional dysfunction

WHO's regional system is unique among intergovernmental organisations. There are important benefits which arise from this decentralisation but there are also significant disabilities.

The Joint Inspection Unit [6] found in 2012 that failings in WHO's decentralised structures contribute to duplication and inefficiency. It suggested that the powers of the Regional Directors 'as elected officials' weaken the authority of the Director-General (DG). Chow [7] recalls that appointments of WHO country representatives have many times been blocked for political reasons associated with competition between regions and headquarters.

The JIU noted that Regional Directors are not subject to any formal performance assessment by either the DG or the Regional Committees. It called for 'better defined monitoring and accountability mechanisms for Regional Directors' and reiterated an earlier proposal (JIU/REP/93/2) to empower the DG to both select and nominate regional directors for confirmation by the Executive Board.

The *de facto* election of regional directors (RDs) by the regional committees (RCs) is a major factor in WHO's regional dysfunction. The RD has an incentive to not challenge national health authorities because the RDs are themselves accountable to MSs for re-election. Ministers of Health may not welcome activist heads of WHO country offices or RDs if such pressures might cause political difficulties domestically. Conversely MOH officials may be less than confrontational with the RD if they are anticipating an appointment in the regional office after leaving the MOH.

Both RD and MOHs have an incentive to caucus against HQ; arguing for larger share of budget and greater programmatic control. This includes caucusing against institutional reform which might weaken the region vis a vis the centre. A recent review conducted by Chatham House [8] noted ' there is a very strong interest in maintaining the status quo'.

Chow also argues [7] that Country Offices should be working with a range of stakeholders including local health workers and civil society as well as the ministry of health. It seems that while the RD is beholden to the MOH for election he/she is unlikely to countenance such an extension of country office work, even if it would make the Organisation more effective.

Lack of accountability of member states

Collectively WHO's MSs are responsible for the proper funding of WHO. Collectively they have failed this responsibility. Collectively MSs are responsible for the coherent functioning of all three levels of the Organisation. Collectively they have failed this responsibility.

Individually MSs are responsible for the quality of policy analysis underpinning their contributions to governing body debate. Not all MSs live up to this obligation. More importantly MSs should be accountable for implementation of governing body resolutions, which they are not.

There are models in other intergovernmental organisations which could be used to strengthen the accountability of MSs to their peers, preferably from beyond their region. These include the universal periodic reviews held by the Human Rights Council, the periodic reporting of the World Heritage Committee and OECD reports on member countries.

Ultimately the constituency, to which MS officials are presumed to be accountable, is the domestic electorate and there are precedents (NCDs, tobacco control, breastfeeding) which illustrate the possible roles which could be played by professional constituencies and community based organisations in mediating such accountability.

Current WHO reform program

The WHO is presently going through a major reform, focusing on management, financing and governance. It is a reform which combines both the 'wearing of no clothes' (as in the folktale about the Emperor's new clothes) *and* the 'ignoring of elephants in the room'.

Some prominent examples of 'wearing no clothes' include:

- the absurd 'financing dialogue',
- the complex procedures proposed for 'allocating budget space' (the current jargon for expenditure budgeting),
- the complex bureaucratic protocols under development to address conflict of interest; even while auctioning WHO's name to the highest bidder through the financing dialogue.

Some of the more prominent 'elephants' which are being ignored in the reform program, include:

- the insistence of the big donors on maintaining their control over the agenda;
- the reluctance of MS to address dysfunctional regional structures; and
- the lack of accountability of MS for their custody of the Organisation.

Clearly WHO does need reform but a reform program which fails to address the main disabilities can only be a disappointment.

The disabilities of WHO reflect the wider failure of GHG

The disabilities facing WHO are part of a broader failure of global health governance which reflect:

- the dominance of the legitimation agenda in development assistance for health,
- the dominance of 'national interests' thinking global health policy making,
- the continuing influence of the corporate agenda over nation state policies, and
- declining power of the Enlightenment vision.

The legitimation agenda

A core element of the crisis in GHG is the domination of development assistance policies by the need to legitimise the contemporary global regime and thereby obscure the need for global economic reform.

The World Bank's stratified health care model has been promoted with glossy reports and continuing funding since 1993. The urgency behind this approach to 'universal health cover' was the need to recover some patina of legitimacy for the international financial institutions following the widespread disillusionment associated with structural adjustment. By the end of the 1980s the damage that structural adjustment was doing to health outcomes [9] had stoked widespread criticism of the brutality of the IMF's policing [10] of what was often 'odious debt' [11].

This pattern was repeated in the early 2000s when a rush of vertical, disease-focused public private partnerships (PPPs) were established (and funded substantially) in order to recover the legitimacy lost in the early access-to-medicines controversies, in particular through the South African Treatment Action Campaign of 1997-2001.

The need to shore up the legitimacy of economic globalisation during this period had a dramatic impact on development assistance for health. The new PPPs focused largely on pharmaceuticals, vaccines and specific diseases. As a consequence, millions of people with HIV and TB were able to access treatment, and programs for malaria were boosted. However, the negative consequences, which became increasingly clear over the next decade, included the neglect of health systems, vertical fragmentation, internal brain drain and the overburdening of ministries with separate reporting requirements.

The dominance of the 'national interests' agenda

The national interests agenda has likewise distorted the priorities assigned to both diseases and countries in both development assistance for health (DAH) disbursements and GHG discourse.

The most egregious illustrations of this come from Australia which devotes a significant proportion of its foreign aid budget to paying poor countries (Nauru, Papua New Guinea, Cambodia) to take asylum seekers who have sought refugee status in Australia. Australia initially refused to sanction medical teams going to West Africa to assist with the Ebola crisis because of a perceived risk to its nationals. (Australia and Canada suspended processing of visa applications from Ebola-affected countries on the grounds of national health security.)

The presence of 'national interest' in DAH and GHG is inevitable. However, while low income countries are so dependent on foreign aid, the distortions associated with the 'national interest' agenda are amplified.

The dominance of WHO by the big powers, particularly in their role as donors, is self-evident and to speak about undifferentiated 'member states' as if all member states are equal is not helpful. While Thailand and the US have a formal equality in the governing bodies of the WHO, the threat by the US of trade sanctions in relation to Thailand's pharmaceutical procurement policies illustrates the need to incorporate the geopolitics of imperialism into any analysis of global health governance.

The corporate agenda

Commercial interests have never been very far from GHG; the early sanitary conferences were initiated by the trade ministries wanting to make sure that regulatory action to control communicable disease were 'least trade restrictive' in today's parlance.

With globalisation the global health agenda has widened (medicines, vaccines, food, tobacco, etc) as has the range of commercial stakeholders seeking to prevent the adoption of global health policies which cut across their interests.

WHO has been engaging with big pharma over a range of issues since 1948, including the pharmacopeia, essential medicines, ethical promotion, rational use, drug pricing, TRIPS flexibilities, and R&D. In each case there have been contradictions between the commercial interests of the pharmaceutical industry and the objectives of global health policy.

In some degree the special interests of the pharmaceutical industry have been prosecuted by its nation state sponsors but there is also continuing direct engagement between Secretariat officials and company officials. There are many legitimate and constructive reasons for such direct engagement but it does provide opportunities for influencing the outcomes of contentious policy issues. The risk of such relationships subverting the integrity of WHO are evident in the case of the International Medical Products Anti-Counterfeiting Taskforce [IMPACT, see 12] which involved a number of MSs, working with the pharmaceutical industry and with Secretariat officials on a program which would have had the effect of harnessing the authority of WHO for the commercial purpose of intellectual property protection, with significant implications for access to generic medications and drug affordability.

A rising feature of contemporary global governance is the influence exerted by transnational corporations over nation state policy making and, through foreign policy action, over intergovernmental policy making, including WHO. Tensions between public health and corporate profit are inevitable but managing them is more complicated when corporate interests are promoted, over health policy considerations, by powerful nation states.

Famous cases of MS-mediated corporate influence in WHO policy making and implementation include: WHO's essential medicines program [13], the Code on the Marketing of Breast Milk Substitutes [14], WHO's trade and health resolution [WHA59.26; 15], and attempts by South Pacific countries to keep out cheap fatty meats [16].

Corporate influence over nation state policy making is mediated in different ways: capture of official positions (money politics, revolving doors etc); the manufacture of consent (media moguls); mandated investor privilege through ISDS; big power bullying (trade sanctions, covert destabilisation, war); and 'market sentiment' (share prices, exchange rates, futures contracts, etc).

Declining power of the Enlightenment vision

In ideological terms the wider crisis of GHG reflects the declining power of the Enlightenment vision (of rational policy debate and consensual democratic politics).

The neoliberal prosecution of widening inequality; the denigration of government capability; and the celebration of greed both reflect and have contributed to the progressive loss of leverage of the Enlightenment vision. With disillusion comes the rise of various fundamentalisms, the rejection of human solidarity, a return to violence, and a disregard for environmental responsibility.

It maybe that the rising influence of indigenous spiritualities, including the celebration of mother earth (Pachamama in the Andes), may contribute to the emergence of a new paradigm of human solidarity and environmental custody.

The failures of contemporary GHG arise in part from the disciplines imposed through the structures of global economic governance in order to manage the instabilities of the globalised economy

The resources and technology required to address the global health crisis are available. The fact that they are not being so used is a consequence of the way the global economy works. Rather than addressing stark human needs we face widening inequalities; a scarcity of decent jobs; a huge pool of excluded, marginalised and often alienated people; a shrinking public sector; stalled action on global warming; and the continuing threat of financial crisis.

The kinds of policies which might direct economic capacity to global health run counter to the economic disciplines now being imposed to manage the instabilities of the global economy. This argument is elaborated in more detail below.

GHG is a subdomain of global economic and political governance

It is evident that to treat GHG as an autonomous domain of global governance is quite inadequate. GHG is a subdomain of global economic and political governance.

GHG is commonly described in purely institutional terms, focusing on the institutions which are prominent in global health policy and development assistance for health without regard to geopolitics or the rise of corporate power.

This autonomous, institutionally-defined picture of the global health landscape is useful in thinking through health policy issues such as: food standards, vaccine development, distribution of bed nets, and the provision of advice regarding health care financing.

However, it is a very inadequate picture in trying to make sense of the US threatening India with trade sanctions under Special 301[2] over its TRIPS compliant patent law; the role of ISDS in trade agreements in preventing countries from regulating for public health; or the race to the bottom in terms of taxation, labour rights, and environmental regulation, associated with the auction for foreign investment to create jobs.

2. Section 301 of the US Trade Act authorises the listing of countries which do not provide "adequate and effective" protection of intellectual property rights or "fair and equitable market access to United States persons that rely upon intellectual property rights".

The functions and accountabilities of all of the key institutions in GHG are closely linked to their locus in the political structures and the dynamics through which the global economy is managed. These include big power bullying and the capture of nation state policy making by corporate interests.

The contemporary regime of economic globalisation is economically, financially, socially and environmentally unstable

The global economy is threatened by an imbalance between productive capacity and aggregate demand. With increasingly powerful technologies, and increasingly 'free trade', industries can produce for larger and larger markets with fewer and fewer workers. This means increasing numbers of people are surplus to requirements (and excluded from work). It also means that that workers' wages as a conduit for the flow of enterprise revenue into societal consumption is progressively choked off.

Corporations respond to the sluggish growth in markets by seeking to cut production costs, find new markets and expand market share. Cutting production costs often involves replacing high wage labour with low wage labour and replacing labour with technology both of which further reduce the flow of wages into consumption.

With abundant productive capacity, and reduced opportunities for productive investment, an increasing proportion of aggregate profit flows into speculation, gambling on asset price appreciation. The banks create more credit to support both speculation and household consumption with increased indebtedness in the public, business and household sectors. However, when the bubbles burst the banks are 'too big to fail' and so tax payers are required to foot the bill (with corresponding cuts in public services).

As employment stagnates so the power of the corporations to hold nation states to ransom increases. A continuing auction is in play as the corporations offer the promise of investment (and jobs) in return for low taxes, low environmental standards, low worker protection, and high levels of corporate protection and corporate welfare. This is a race to the bottom.

Free trade is good for the corporations, because it offers them global markets, but it further constricts the flow of wages globally into consumption. The increasing 'efficiency' of global sourcing and global production is based on fewer jobs and lower paid jobs both of which further dampen consumption.

The situation is complicated by those 'emerging economies' who are able to marry capital and technology with under-utilised labour to produce products and services which newly employed consumers want and can now buy. While the larger of the emerging economies are strong enough to protect their own industries (and jobs) and domestic markets they still need to make concessions to the 'free trade' regime in order to find foreign markets for their goods.

The neoliberal program for managing these instabilities, as prosecuted through the structures of global economic governance, yields short term security for the corporations but at the cost of exacerbating the economic, social, environmental and health crises

The prevailing disciplines of global economic governance (GEG) are designed to manage the risks arising from the instabilities of the global economy in the interests of the corporate elite. These disciplines include:

- free trade in goods; expanding the markets accessed by the TNCs, increasing economies of scale; but freezing out local production and jobs;
- free movement of capital; to facilitate speculators' opportunities and reduce their risks but at increased risk and cost to smaller and poorer countries;
- extreme intellectual property protection; providing global monopoly protection for TNCs in information rich industries; increasing prices for medicines;
- restrictions on public interest regulation through ISDS; preventing regulation of food systems, environmental protection;
- tax competition; auctioning investment and jobs; reduced public funding but increased TNC profit; reduced social protection, public health care;
- regulatory harmonisation ('behind the border'); to reduce costs of global production chains;
- privatisation with a view to opening new markets, in particular for big finance;
- deregulation of wages and working conditions; union busting, outsourcing, etc, further reducing consumer demand; and
- deregulation of environmental protection; facilitating the externalisation of production costs to the environment.

These disciplines, implemented to manage global economic instability, also drive:

- unemployment, marginalisation and alienation which contribute to drug use and violence;
- inequality and insecurity which weaken social solidarity and willingness to pool for health, education, urban infrastructure, etc;
- disinvesting in public services and public infrastructure, including health systems;
- continuing ecological destabilisation including global warming and loss of biodiversity.

The disabling of GHG and the hobbling of WHO are necessary parts of this program

These disciplines also shape the parameters within which the policies and structures of GHG are developed and implemented, including the governance, management, financing and operations of WHO.

These disciplines require WHO to accept the global food and beverage corporations as "stakeholders" in the fight against NCDs. They require sanctions against WHO staff who advise countries to make full use of the flexibilities in the TRIPS agreement in writing their IP laws. They require WHO to remain silent while new trade agreements are being negotiated which provide for transit policing, patent linkage, longer protection and stronger enforcement of IP but lower standards of patenting.

A strong independent WHO could be a significant brake on the corporate agenda; it is a necessary principle of global economic governance to choke WHO.

What do we need?

We need vision

Action to address the global health crisis needs to be guided by a vision, clear, inspirational and widely shared; a vision of human rights, fairness, human solidarity and living well (buen vivir); a vision which sees beyond the temple of greed, selfishness and waste, and inspires us to work towards changing the balance of forces, globally and nationally, which at present are taking us to disaster.

We need a new dynamic in global health governance

A new dynamic of GHG will need:

- a new global health architecture with a strong leadership role for WHO and progressive replacement of donor funding with increased funding through assessed contributions;
- replacement of vertical disease focused programming with comprehensive health system strengthening and action on the social determination of health;
- a stronger civil society constituency for global health, independent of the institutional establishment.

For WHO to assume its proper leadership role in GHG will require:

- adequate unconditional funding;
- regional reform, in particular breaking with the dysfunctional regional 'elections';
- clearer recognition of the threats to global health arising from the instabilities in the global economy and the prevailing disciplines of global economic governance;
- strengthened accountability of MS for their custody of this important organisation;
- stronger civil society constituency globally to ensure stronger accountability of WHO (including HQ, GBs, offices and MSs) to the people whose health is a stake.

A new dynamic in global health governance will require redirection of the current trajectory of global economic governance

This will involve:

- wider understanding and discussion of the macro economy and its governance, in relation to the challenges humanity faces, beyond the constraints of the orthodox (neoliberal) narrative;
- stronger and better informed alliances linking social movements intersectorally and linking progressive governments and social movements to resist the neoliberal agenda and to explore different ways of sharing employment, production and consumption around the globe;
- new forms of political action which by pass the censorship and trivialisation of mass media, and which neutralise the power of 'market sentiment' to threaten governments with reprisals;

- a new focus on the conditions for building global solidarity, including around health, tied to action against widening inequality, insecurity and economic exclusion and marginalisation.

Who should do what?

What we, the People's Health Movement, are committed to doing

We are committed to:

- taking action on health issues in ways which also contribute to addressing the global structures and forces which reproduce those health issues;
- researching, analysing, disseminating and teaching about the relations between people's health and the dynamics of the global economy and its governance;
- joining actively in discourses about living well (buen vivir), reducing economic inequality and ensuring social protection;
- working to strengthen the power, reach and effectiveness of WHO in GHG while holding WHO to account (including MSs as well as GBs; ROs as well as HQ);
- joining forces with other social movements who are resisting the encroachments of neoliberal globalisation.

What we urge others to do

WHO governing bodies

We urge the governing bodies to:

- lift the freeze on ACs and double the budget;
- reform the governance of WHO's regions and, in particular, reform the procedures for nominating and appointing RDs;
- strengthen the accountability of individual MS for their implementation WHA resolutions and for the technical quality of their contribution to GB debates.

Ministries of health

We urge ministries of health to:

- take responsibility for strengthening the role of WHO in global health;
- commit to freeing WHO from the donor chokehold and addressing the regional dysfunctions;
- invest in building a stronger domestic civil society constituency (professional and community) for global health.

Professional bodies in public health

We urge professional bodies in public health, including academic programs, to:

- invest in strengthening the macroeconomic literacy of the global health workforce;
- invest in building a wider understanding of the relations between global health and the dynamics of the global economy and its governance;
- stoke the public debate, domestically and internationally, around the donor chokehold and the need for regional reform;

- build a global constituency which can hold MSs accountable for their contribution to and participation in WHO and their implementation of WHA resolutions.

Governments of the Global South

We urge governments of the Global South to:

- resist the onrush of neoliberal globalisation; in particular, trade agreements which lock in foreign investor privileges and extreme IP protection;
- support new financial structures which can support investment and financial stability, independent of the corporate banks and of the Bretton Woods institutions;
- take responsibility for WHO:
  - lift the freeze and increase assessed contributions;
  - look beyond the parochialisms which have repeatedly stymied reform of WHO's regional structures;
  - work collectively to improve the quality of technical and policy input into GB debates.

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PARALLEL SESSION 2.2

ROLE OF NON-STATE ACTORS IN GLOBAL HEALTH GOVERNANCE

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IN GLOBAL HEALTH GOVERNANCE

BACKGROUND

The formal health sector no longer has sole control over health policies and practices. Increasingly, health is influenced by a multitude of people, institutions and political factors. One of the "revolutions" during the last three decades in global, country and community health is the growing role and impact of non-state actors, including people most affected by ill-health and their representatives, in health governance at all levels.
Community networks, private sector (including the pharmaceutical industry, technology and telecommunications), trade institutions, universities and research centers, increasingly impact health policies, priorities and financing rules, including the imperative for greater social justice and ensuring no one is left behind.

The global HIV/AIDS movement is a powerful example of how non-state actors have joined forces to stop and reverse the HIV epidemic. That experience has influenced the way in which the world and communities address other public health issues. For example, Board constituencies in organizations such as UNAIDS, UNITAID, GAVI, the Global Fund and others.

OBJECTIVES

- Review and discuss lessons learnt from the role of non-state actors in the HIV response and health, including research, governance and financing for health
- Discuss guiding principles and recommend concrete actions to ensure systematic involvement of non-state organizations in global health governance and accountability

MODERATOR

Roberta CLARKE
Regional Director for Asia
and the Pacific, UN Women

Thailand

Jan BEAGLE
Assistant Secretary-General
The United Nations

Deputy Executive Director
The Joint United Nations
Programme on HIV/AIDS

Switzerland

Ms Beagle is Assistant Secretary-General of the United Nations and Deputy Executive Director of UNAIDS. She has more than 30 years' experience in the political, development, management and interagency areas of the United Nations.

Ms Beagle leads UNAIDS' work in promoting effective governance of the Joint Programme and provides strategic direction to overarching management functions, in the areas of human resources, finance, budget, information technology and administration, to enhance UNAIDS' capacity to implement its mandate and vision.

Prior to this role, she served as Deputy Director-General of the United Nations Office in Geneva, as Assistant Secretary-General for Human Resources Management, and in senior positions in the Executive Office of the Secretary-General, the Office of the Administrator of UNDP, and the Department of Political and Security Council Affairs. Ms Beagle began her career with the New Zealand Ministry of Foreign Affairs, including as a delegate of New Zealand to the United Nations.

Jeffry ACABA
Education and Research Lead
Youth LEAD (Asia Pacific
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Key Populations)

Thailand

Jeffry Acaba is a Filipino HIV and LGBT rights activist currently based in Bangkok, Thailand. He has a vast experience working on HIV and AIDS advocacy, starting as a volunteer peer educator in 2007 and eventually becoming a monitoring and evaluation coordinator for the principal recipient of the Global Fund to fight AIDS, Tuberculosis, and Malaria (GFATM) in the Philippines. In 2010, he worked as a program coordinator in Action for Health Initiatives (ACHIEVE), Inc., expanding his advocacy to ensure access to justice of Filipinos living with HIV and assist local government units in passing sound and evidence-informed HIV-related policies that support the rights of key populations including people living with HIV and young people.

Jeff co-founded Youth LEAD along with other young people from key populations in Asia Pacific in 2011, and has engaged actively with the network in upholding the rights of young key populations and in leading the movement in the Asia Pacific region. He has facilitated trainings and consultations and has led missions around the Philippines as well as in a number of countries in Asia. He is currently YouthLEAD's Education and Research Lead, coordinating all education and research and advocacy work of the network.

Jeff obtained his Baccalaureate degree in Behavioral Sciences at the University of the Philippines in 2006 and has finished his course work under the Masters of Arts degree in Anthropology from the same university. He practices yoga and enjoys discovering the best milk tea and coffee the world has to offer while listening to indie pop and math rock in his free time. His favorite film is Bernal's 1982 classic, Himala (Miracle).

Goran TOMSON
Professor of International Health Systems Research
Karolinska Institute

Sweden

MD pediatrics PhD Senior Professor in International Health Systems Research Karolinska Institutet, Stockholm. Honorary Guest professor Shandong University, China. Former leader now senior advisor to the Health Systems and Policy (HSP) research group. Vision to contribute to global health through generation of research evidence for universal health coverage with quality care in resource poor settings and in policy dialogues. Contributing to embedding research into health systems development with a people centered approach. Major interest in capacity building, individual and institutional as well as evidence informed policies. Some 200 publications plus reviews and book chapters.

Memberships: Swedish Research Council´s (SRC) Committee for Development Research. Chair Scientific Advisory Committee Alliance Health Policy Systems Research WHO, European Advisory Committee on Health Research WHO Euro. Netherlands Organisation for Scientific Research WOTRO Science for Global Development. Board member GLOBVAC Norwegian Research Council. Senior advisor WHO Evidence Informed Policy Network. Co-founder and senior advisor REACT Network to contain antibioic resistance(ABR). Co-founder International Network for Rational Use of Drugs (INRUD). Board member Peking University China Center Health Development studies. Health Systems Consultant to Dag Hammarskjöld Foundation, EU, Sida, WB and African and Asian ministries.. Supervised 30 PhD students. Ongoing Sida and EU grants plus Sino-Swedish IMPACT Integrated Multisectorial Partnership Containing ABR funded by Swedish Research Council.

Denis Broun
Director of Government
and Public Affairs
CIPLA

India

Denis Broun is the Global Access and Public Affairs Director for Cipla Ltd .

He has worked in the fields of public health and health economics for the past 25 years with extensive relationships with partners in government, civil society, private sector, foundations and international organizations.

Denis is a doctor of medicine from Paris University with a specialization in infectious diseases, parasitology and epidemiology. He also graduated from the Paris Institute of Political Sciences and holds a masters in biomathematics.

He has worked in the field of international health for the past thirty years, first as a health economist with a French engineering company, then as senior health specialist in the World Bank, where he was in charge of the pharmaceutical sector form 1992 to 1996. He was head of the health section of UNICEF until 1998 and joined Geneva as programme manager for the control of tropical diseases and director of resource mobilization in the World Health Organization.

Denis was European director of the American consulting firm "Management Sciences for Health" from 2000 to 2005 and in 2005 joined UNAIDS, first as country coordinator in India (2005-2008), then director of partnerships and finally regional director for Europe and Central Asia. In 2011, he was selected to become executive director of UNITAID, a position he left in January 2014.

INVOLVING NON-STATE ORGANIZATIONS IN GLOBAL HEALTH GOVERNANCE AND ACCOUNTABILITY

Goran TOMSON[1], Zubin SHROFF[2]

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The world faces an increasing number of challenges from climate change to global financial crises to terrorism that both know no national boundaries and that require coordinated action at the global level. Global governance, or 'the capacity within the international system at any given moment to provide government-like services and public goods in the absence of a world government', is thus something that is increasingly important (Weiss et al, 2013, p.6).

Looking more specifically at health, Frenk and Moon (2013) argue that the increased cross national interactions brought about by globalization have led to an intensification of the transmission of health threats across boundaries, including infectious disease and antimicrobial resistance threats and unhealthy lifestyles. They define the global health system 'as the organized social response to health conditions at the global level'; global health governance , refers to the management of this system (Frenk and Moon 2013, pp. 936-7). Below we discuss changes in the area of global governance and global governance for health over the past two decades with reasons for this. We then go on to examine some of the challenges and opportunities resultant from these changes. The final two sections describe some general principles to effectively engage non-state actors in global health governance as well as concrete actions to effect this engagement.

The rise of non-state actors has been central to the changed understanding of governance over the past two decades. At the international level, Weiss et al (2013) argue that this period has seen a profound shift in scholarly understanding of international organizations, away from an exclusive focus on intergovernmental organizations. There is an increasing recognition of the growing role of civil society groups, foundations and transnational corporations in areas that were previously seen as the exclusive domains of governments and member state based international organizations (Weiss et al, 2013). Global Health is no exception. The position of WHO as the 'sole authority on global health' is something of the past, 'today it stands on a crowded stage', a stage it must share with the World Bank and other regional development banks, global health initiatives such as GAVI and the Global Fund, a host of civil society organizations, philanthropic foundations including the Gates Foundation, and transnational corporations (Frenk and Moon, 2013, p. 937).

To quote Fidler, global health governance has shifted from 'a Westphalian to a post-Westphalian context' where non-state actors increasingly, 'shape responses to transnational threats and opportunities' (Fidler, 2007, p.2). Added to this, new forms of supranational public law institutions are emerging which in some areas may supersede nation-state governance while being weak in others; the European Union (including various different forms of new hybrid institutional governance) is certainly the most prominent case but efforts towards supranational coordination and 'institutionalized' collaboration' in healthcare are also gaining currency in Latin America (Brown and Harrison, 2013; ISAGS, 2012).

There are a number of reasons for this emergent plurality. Advances in communications and transportation have greatly eased and reduced the cost of interactions across national boundaries. This has facilitated the spread of information, allowed for the rapid development of issue networks, and served as a catalyst in the establishment and growth of NGOs in particular (Reich, 2002; Weiss et al, 2013).

Perceptions about traditional intergovernmental organizations have also played a significant role. These have been increasingly perceived in some sections as inadequately funded, lacking authority, inefficient and slow to act. On the other hand, newer players such as global health initiatives, have been recognized as more nimble, with governing structures that are looser and thus more conducive to efficiency (Weiss et al, 2013).

Globalization and market reforms in large countries such as China, India and the former East Bloc have also given transnational corporations wider reach than ever before. However, more importantly, corporations themselves have both understood how public health goals fit into their own objectives and through Corporate Social Responsibility initiatives have increasingly recognized their mandate as broader than just their bottom line (Reich, 2000; Weiss et al, 2013).

There is little doubt that the private sector, NGOs, and philanthropic foundations have much to contribute to global health. At the outset, it is important to highlight the significant financial resources they have brought with them. The Gates Foundation is one of the most significant players in Global Health (Weiss et al, 2013). Second, partnering with the private sector has both given UN based organizations credibility in the business world as well as allowed them to tap into skills and management practices from the private sector (Buse and Walt, 2000). Third, non-state actors have played a significant role in bringing particular health related issues on to policy agendas at national and global levels. The work of Civil Society groups on ARVs and the role of Medicines Sans Frontiers in bringing to the fore issues on access to essential medicines are examples of this (Reich, 2000; Buse and Harmer, 2007; Fidler, 2007). Fourth, partnerships with the pharmaceutical industry have both facilitated drug discovery for neglected diseases, such as leishmaniasis (Buse and Harmer, 2007) and enabled improved access to lifesaving medications among impoverished populations, through drug donation programs, including the Mectizan, Malarone and Zithromax donation programs (Buse and Walt, 2000).

The rise of non-state actors however brings with it significant challenges. First, the plurality of actors creates new demand for coordination (Mackey and Bryan, 2013) but also makes coordination of activities and functions increasingly difficult, potentially leading to some issues being neglected, while others get donor attention to an extent that challenges the absorption capacity of the ministries of health of recipient states (Fidler, 2007). This is aggravated by the freedom of non-state actors to respond to specific issues, that need not reflect state priorities (Buse and Walt, 2000; Weiss et al, 2013). There are new questions of legitimacy and representation, and consequently, also on power. The World Health Assembly draws its legitimacy through the inclusion of representatives from all the member states of WHO. There is almost no group of non-state actors that is commensurately representative and that can claim to represent the world. Additionally, critics argue that low-income countries are greatly underrepresented in global health partnerships, including on the boards of these groups (Buse and Walt, 2000, Frenk and Moon, 2013).

Accountability is yet another challenge. Unlike governments, which are held accountable through the electoral process or private companies that are held accountable by their shareholders, the lines of accountability are less clear with both NGOs and global health partnerships. Finally, conflict of interest is a serious issue. As non-state actors assume more significant roles in governance functions through involvement in technical committees, policy-making processes and normative functions, the potential of their interests becoming dominant is a real concern (Buse and Walt, 2000).

While the opportunities discussed above point to the need to stimulate the creative engagement of non-state actors in global health governance, the challenges described underscore the need to codify and strengthen the orchestration role of UN organizations such as WHO (Weiss et al, 2013). This is because, just as at the national level where 'the state is the only institution through which a nation might create consensus among its many autonomous organizations' (Reich, 2002, p.1673), at the global level, it is the UN and its specialized agencies that 'serve as conveners for the states of the world' (Weiss et al, 2013, p.5). Just as a downsized state can potentially hinder its ability to provide public goods at the national level (Reich, 2002), as has been recently tragically demonstrated in the Ebola epidemic in West Africa, a downsized coordinating agency for global health is not something a world increasingly susceptible to transnational health threats can afford. Below we discuss

principles that may be useful in guiding the engagement of non-state actors in global health governance as well as concrete actions that might be taken to implement these principles.

- First, engagements with non-state actors should be initiated on the basis of the engagement unequivocally demonstrating positive effects on public health (WHO, 2014).
- Second, the terms of engagement need to be clearly laid out, this includes a recognition of the central role of national governments and by extension WHO, in the global health architecture, particularly in its normative capacity.
- Third, to be successful, the engagement must be 'transparent, open, inclusive and based on the principle of mutual respect' (WHO, 2014, p.11).

These principles tie in well with Reich's contention about successful partnerships, that he argues have addressed the "seven cs of strategic collaboration". These include, "a) clarity of purpose, b) congruency of mission, strategy and values, c) creation of value, d) connection with purpose and people, e) communication between partners, f) continual learning, g) commitment to the partnership" (Reich, 2000, p. 619).

Buse and Harmer (2007) suggest actions that could be taken to more systematically engage global health partnerships and initiatives in global health governance. We argue that a number of these actions also apply to non-governmental organizations, the larger of which are often influential players in global health. These include

a) bringing non-state actors towards the Paris agenda of 'national ownership, harmonization and alignment' to enable integration of their efforts with national priorities and planning processes,

b) ensuring that governing arrangements of boards of partnerships are representative and balance a variety of stakeholders, thereby enhancing their legitimacy,

c) assessing the relative merits of market based as opposed to state centric approaches to address global health challenges on a case by case basis, so while involving the private sector may be necessary for drug development, it may not be as vital to address service delivery challenges,

d) ensuring transparency in dealing with non-state actors through making publicly available details of all partnerships, systematic rules for declaration of conflicts of interest and clarifying the roles of each organization within a partnership (Buse and Harmer, 2007, p.269).

One mechanism is for partnerships to be created with industry associations, as opposed to individual companies to prevent them being used for corporate gain (Buse and Walt, 2000). WHOs Framework of engagement with non-state actors is a concrete example of a systematic approach to involving these groups in global health governance with a view of maximizing synergies while mitigating risks (WHO, 2014). Others, such as Gostin (2007) have gone further and proposed that the systematic engagement of non-state actors be made an integral component of a proposed framework convention on global health that would serve as a legally binding mechanism to improve global health governance. The political will to do this and feasibility of putting together such a comprehensive treaty, however remains to be seen.

A path forward might be to move beyond the 'either-or' of non-governmental actor involvement in governance and pay greater attention to processes, power, and 'places' of governance (Marks et al., 2010). This also means improving the knowledge base, defining indicators for plurality of actors and governance, and gathering data about how non-governmental governance is exercised, who are the key actors involved, and what are the consequences in relation to quality, efficiency and equality in healthcare. This would also help to further an approach into global health governance as system management (Frenk and Moon 2013) rather than lamenting single factors and de-contextualized governance challenges.

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SECURING AN AIDS-FREE GENERATION: THE CRITICAL ROLE OF YOUNG PEOPLE FROM KEY POPULATIONS COMMUNITIES IN THE GLOBAL AIDS RESPONSE

Jeffry P. ACABA, Youth LEAD

In 2008, the Commission on AIDS in Asia presented a report before the UN Secretary General Ban Ki-moon on the landscape of the increasing HIV cases in the region. The Commission was an independent group formed through Sir Peter Piot's proposal with a mandate to study and assess the impact of AIDS the region, identify the prognosis, and document the realities of HIV in Asian societies. Back then, it was already noted that HIV is taking Asia and the Pacific by storm, blowing up in several countries already among specific population segments, such as among men who have sex with men in Thailand and among injecting drug users in Indonesia. The report also gave a comprehensive picture on the HIV prevalence and country experiences of men who have sex with men, sex workers, and people who inject drugs in the region, including some of the promising national efforts worth replicating. The same report also made a remarkable statement that interventions targeting young people emphasized in reaching young people who are not most at-risk, meaning, they are neither sexually active nor engaged in behaviors or belong to populations that are considered highly vulnerable. While estimates during that time suggest that 95% of new HIV cases will come from "most at-risk" young populations, almost 90% of budget allocation on prevention still remains to target only low-risk youths. Without addressing this gap, we may lose a generation of people to HIV and AIDS. This crack on the wall was where Youth LEAD was born.

In 2010, the AIDS Task Force on AIDS (or ATFOA) of the ASEAN called for a meeting to understand most at-risk young people (MARYP) and most at-risk adolescents (MARA). Invited were representatives from governments as well as of most at-risk populations through partner civil society organizations and national AIDS authorities. In that meeting, it was acknowledged that integral to a successful response targeting both MARYP and MARA is to ensure that they are invited and that they participate in the program and policy development, implementation, and monitoring & evaluation. For this to necessarily happen, however, requires, equitable funding to support youth-led organizations working with and for MARYP and MARA, which was repeatedly demanded at the time.

In 2011, the Coalition of Regional Networks on HIV and AIDS, popularly known as 7Sisters, held a regional consultation of youth activists to further understand the issues and identify the needs of young people who are at-risk. This meeting was pivotal because the youth activists recognized themselves not only as those who are at-risk, but are also key to designing and implementing an effective response that affects their lives, making them key affected populations (KAP). Several issues that were identified by these young key affected populations include: lack of meaningful involvement of young key affected population, lack of funding for programmes targeting young key affected populations, and limited access to health services due to existence of punitive laws and lack of human rights protections to YKAPS who experience stigma and discrimination. For this to be addressed, Youth LEAD, with its first group of focal points, focused on three priority areas: advocacy, capacity building, and networking. With these three focus areas, Youth LEAD aimed to develop youth leadership among young key affected populations; bring young KAP in the region in a common platform where they can share their issues; improve meaningful youth involvement and participation; and form a common advocacy message for YKAP in the Asia Pacific region.

From 2011 until now, Youth LEAD has remained committed to its objectives. Our country focal points have grown from 20 to almost 60 in 20 countries in the region, from Pakistan in the West, to South Korea, Indonesia, and as far as Fiji in the Pacific Islands. With the help of our focal points, we've established national YKP networks in Indonesia and Myanmar, while other countries such as the Philippines, have already convened their youth organizations through the NewGeneration program.

Now, the NewGeneration Leadership program is one of Youth LEAD's flagship programs, with generous support from our UN partners including UNAIDS and the University of Melbourne. It is a leadership training program designed by young key populations for young key populations. It capacitates young people from key populations to effectively and meaningfully participate in their national AIDS responses – from programming to policy development. After 2 regional training of trainers, more than 10 country roll-outs, and more than a dozen roll-outs in their respective countries, we have seen YKAPs organizing themselves and leading the way, "universalizing" the language of YKAP and our issues.

At the regional level, Youth LEAD has been an active member of the Interagency Task Team on YKAP and on Gender, and has actively engaged in different high level meetings and conferences not only in the region but also globally – from ATFOA meetings in the ASEAN, to International AIDS Conferences and the International Congress on AIDS in Asia and the Pacific, to the World Youth Conference, and joining other youth organizations in forming the PACT – a global youth movement to ensure that HIV and sexual and reproductive health and rights continue to be a priority in the post-2015 development agenda. Our recent engagement globally is when we were able to garner to sit as one of the two Asia Pacific delegates in the NGO Delegation to the UNAIDS Programme Coordinating Board: the highest decision-making body of the UNAIDS Joint Programme.

You may ask us, at this point, what then is the critical role of non-state actors, such as Youth LEAD, in global health, particularly in the global AIDS response. It's the greater and meaningful engagement of young key populations in the global AIDS response and in the shortest span of time. In just 4 years, we were able to, universalize the needs of young people from key populations. We brought attention to ourselves and our issues, and highlighted that HIV programming for youth will never be enough if we do not target and allocate our resources strategically to those who are most affected by the disease. We have called on Member States and our partners that in taking issues of young people from key populations, it is imperative to have young people sitting side by side with programmers and planners. More than just saying, "there's nothing about us without us," it is really about not leaving anyone behind, and not leaving any voice unheard and population segment not included.

Youth LEAD has aspired to become the catalysts of change and empowerment for the young key populations in the region. We believe that in order for us to achieve a future that is free from the scare of the AIDS epidemic, the only key towards that future is through us, young people particularly from key populations who have continued to heed our concerns and take the lead in the AIDS response in many levels. Only by ensuring that we are able to carry on that banner, we can only say that we will become successful in securing a generation free from the AIDS pandemic.

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PARALLEL SESSION 2.3

GOVERNANCE BY MARKET FORCES – HOW TO GET THE BEST WHILE AVOIDING THE WORST

PARALLEL SESSION 2.3

GOVERNANCE BY MARKET FORCES – HOW TO GET THE BEST WHILE AVOIDING THE WORST

BACKGROUND

Health has become one of the most important of the world's industries. The last decade alone has seen a doubling of global health spending from 3 to 6.5 trillion USD. Market forces play an increasing role in governing the health sector and behavior of its stakeholders. The intensified inter-relations, connections and mutual dependencies between States, societies and large and small businesses can be viewed as the "commercial determinants of health". The way in which global food, soda and tobacco do their business, and how they interact with national, regional and international bodies can potentially have lasting negative impact on public health. At the other end of the spectrum, business interests of health workers at village level are a potential cause for intractable "last-mile" failure of supply chains (when stock-outs at the public facility drive business to the private chemist shop owned by the health worker's spouse) or market-driven providers may offer low quality or harmful services to non-discriminating health consumers.

On the positive side, the private sector has long solved some of the problems that are cause for chronic concern in the public sector, such as results orientation and accountability, efficient use of resources and fostering ongoing innovation. Here the global public health community should learn from the governance model that has made such success possible in the private sector and use them to re-think public sector governance.

Diagnostic questions to be addressed in the session are

- What role can private corporations and small businesses play in improving global health outcomes?
- How are they held accountable for health outcomes?
- Where does responsibility lie between individuals, states and corporations regarding healthy behaviors?
- How can the private sector contribute to a global vision of better health? To health equity?
- How can market actors be incentivized/cajoled/coerced into better recognition of their responsibilities and roles, and potential contributions to inclusiveness and engagement?
- How best to conform markets to a better vision of health, inclusion and sustainability?

OBJECTIVES

The objective of the session will be to shed light on examples of

- market mechanisms having been used successfully to address health sector challenges, e.g. shared value activities
- market failures with negative health impact having been successfully addressed by "smart regulation" (meaning regulation that allows compliant businesses to remain profitable and economically sustainable, while protecting or furthering public health objectives)
- market failures with negative consequences for health outcomes that have not yet been addressed successfully, trying to come up with ideas how "smart regulation" or other tools for these cases could look like, e.g., consumer m-ratings or m-complaint mechanisms, credible self-regulation to maintain quality standards

MODERATOR

Andreas SEITER
Senior Health Specialist
The World Bank

USA

Andreas Seiter is a Senior Health Specialist and expert for pharmaceutical policy and management at the World Bank's Health, Nutrition and Population Anchor. He joined the Bank in January 2004 and is responsible for analytical and advisory work in all areas of pharmaceutical policy, such as regulation, governance, quality assurance, financing, pharmacy benefit management, supply chain and rational use. He has been working with Bank teams, policy makers and experts on the client side in more than 25 countries in Africa, Eastern Europe, the Middle East, Latin America and South Asia. He leads the Bank's work on medicines regulatory harmonization, priority setting and engagement with the pharmaceutical private sector. In 2010, he published the book "A Practical Approach to Pharmaceutical Policy". Dr. Seiter, a German national, is a physician by training and practiced medicine before joining a multinational pharmaceutical company in 1984. He held various positions in Medical Operations, Product Management, Communications and Stakeholder Relations in the industry prior to joining the Bank.

Patricia MOSER
Lead Health Specialist
Asian Development Bank

Philippines

Patricia Moser is the Lead Health Specialist for the Regional Sustainable Development Department. She provides strategic guidance and oversight to the Asian Development Bank's (ADB) health activities, including management of cross-cutting health portfolio and knowledge activities and support to regional departments for health loans and technical assistance. She is Chair of the Health Community of Practice.

Ms. Moser rejoined the ADB in July 2011, after 5 years as the Health Director for the Millennium Challenge Corporation, a US government institution managing bilateral assistance for developing countries that perform above their peers on key policy indicators. From 1994–2004, she worked at the ADB as Project Economist (Health), Senior Advisor to the Vice President (Operations East), and then Deputy Director of the North American Regional Office (NARO). Prior to joining the ADB, Ms. Moser was a Foreign Service officer with the United States Agency for International Development (USAID) where she managed health activities in Thailand, Jamaica and the Philippines.

Ms. Moser holds a Master's degree in health economics from the University of North Carolina and a BA from Duke University in Durham, North Carolina. She has been an adjunct faculty member at the Johns Hopkins University School for Advanced International Studies (SAIS) and the George Washington University School of Public Health and Health Services (SPHHS).

Olivier BASENYA
Cellule Technique
Nationale FBP
Ministry of Health

Burundi

Dr BASENYA is a medical doctor with a Master degree in health economics. He has a broad experience in health services management and health financing. He used to held positions at all health system level as Director of District Hospitals, Provincial health management teams, Director of Health services and programs at central level and Director General of National Institute of Public health.

Dr BASENYA Olivier has great experience in Results Based Financing design and implementation. He's part of the team who introduced RBF pilot experience in Burundi in 2006 and conduct RBF scaling up integrated to free health care policy for Under five and pregnant women 2010. Other caracteristics are: (i) expertise in health policy and planning; (ii) ability to work in a multicural and multisectorial environment; (iii) experience in health interventions costing including RBF costing; (iv) broad experience in health interventions evaluation; (vi) expertise in strategic and operational planning.

Dr BASENYA Olivier worked as a consultant in many countries (Zimbabwe, Congo Brazzaville, Cameroun, Benin) for the matter of designing, evaluation or costing of RBF interventions. He worked also on health financing strategy in Burundi and health related strategic planning.

Clinton DE SOUZA
Director, Public Health
Imperial Logistics

USA/South Africa

Clinton has twenty years experience in Supply Chain strategy, operations and deployment throughout the African Continent. He has spent much of this time working with the Healthcare, Technology and Consumer Goods sectors where he has developed and deployed Supply Chain solutions in African with both the private and public sectors. He has been a member of the SCMS PMO team since 2011 and currently serves as the Warehousing & Distribution Principle Advisor. Clinton has held director positions in Sales, Organizational Development and Public/Private sector engagement in Supply Chain. He completed his MBA in 2009.

Thulani MBATHA
Technical Advisor
University Research
South Africa

South Africa

Mr. M. Thulani Mbatha is the Public-Private Mix (PPM) Technical Advisor at University Research Co. (URC). In his role, he is tasked with engaging a diverse group of health care providers in the fight against tuberculosis (TB), specifically on the role that private sector can play. He is involved with strengthening the management of TB in the private sector, particularly on addressing the TB in the mines challenge in Southern Africa region through innovative approaches involving the private healthcare sector, business (including the South African mining sector) and traditional health practitioners. For example, Mr. Mbatha provides technical assistance to South African National Department of Health, especially at Provincial and District levels; thus, involving local employers and private general practitioners in fighting TB and TB/HIV management. As a result, he collaborates with private sector to provide a comprehensive approach for systematic involvement of all relevant health care providers in TB control to promote the use of International Standards for TB Care and achieve national and global TB control targets.

He is a graduate of the University of Tennessee in the United States of America, where he obtained a Master's degree in Public Health, with special focus on Planning and Administration, and holds a degree in Economics from Berea College in Kentucky. He has 10 years of public health work experience in Capacity building, Public Private Partnership, Pharmaceutical and Supply Chain Management, strategic planning with extensive fieldwork experience in Bangladesh, Ethiopia, Cameroon, Kenya, Uganda, Nigeria, Malawi and South Africa. He is Co-Founder of Kgololo Academy, a private school in one of the previously disadvantaged community of Alexandra Township in South Africa.

Richard BERGSTROM
Director General
European Federation of
Pharmaceutical Industries
and Associations

Belgium

Richard Bergström has been the Director General of the European Federation of Pharmaceutical Industries and Associations (EFPIA) since April 2011. Previously he served for nine years as the Director-General of LIF, the Swedish Association of the Pharmaceutical Industry, following positions in Switzerland in regulatory affairs at the pharmaceutical companies Roche and Novartis. Mr Bergström was also appointed by the Swedish Government to the Board of the Karolinska Institute. He is a pharmacist by training, receiving his MScPharm degree from the University of Uppsala, Sweden in 1988.

Nathan SIGWORTH
Chief Executive Officer
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USA/India

Nathan Sigworth is the CEO of PharmaSecure, a profitable social enterprise that uses proprietary technology and data to protect the distribution of 1.2 billion medicine packages from counterfeiting while gathering intelligence on the distribution, use and outcomes of patients taking these medicines. Targeting priority diseases like malaria and tuberculosis through partnerships with generic and branded pharmaceutical companies that supply emerging markets, Nathan Sigworth and his team work to increase access to safe and effective medical treatments on a massive scale.

A graduate of Dartmouth College in New Hampshire, Sigworth was recognized by Inc Magazine as one of the 30 top entrepreneurs under the age of 30. He is the winner of a Popular Mechanics Breakthrough Award and is a Poptech and Echoing Green fellow. Nathan and his wife Kimberly live in Mumbai, India.

GOVERNANCE BY MARKET FORCES

by Andreas SEITER

CHARACTERISTICS OF HEALTH MARKETS, MARKET FAILURE

Health has become one of the most important – and fastest growing - of the world's industries. The last decade alone has seen a doubling of global health spending from 3 to 6.5 trillion USD[1]. Market forces play an increasing role in governing the health sector and behavior of its stakeholders. The intensified inter-relations, connections and mutual dependencies between States, societies and large and small businesses can be viewed as the "commercial determinants of health". The way in which global food, soda and tobacco do their business, and how they interact with national, regional and international bodies can potentially have lasting negative impact on public health. At the other end of the spectrum, informal business interests of health workers at village level are a potential cause for intractable "last-mile" failure of supply chains (when stock-outs at the public facility drive business to the private chemist shop owned by the health worker's spouse) or market-driven providers may offer low quality or harmful services to non-discriminating health consumers.

On the positive side, the private sector has long solved some of the problems that are cause for chronic concern in the public sector, such as results orientation and accountability, efficient use of resources and fostering ongoing innovation. Here the global public health community could learn from a governance model that has made such success possible in the private sector and use it to re-think public sector governance.

WHY MARKETS FAIL

Markets fail if there is a lack of balance between buyer and seller. If buyers feel they have no choice other than buying from the only seller available, they may accept a bad price and bad quality and still make the transaction. On the other end of the spectrum, if there is only one buyer and the seller is desperate to sell, the seller may accept make a deal without taking a profit. Both situations are bad from a longer term perspective: in the first case, more buyers will fall into poverty and no longer be able to contribute to the economy through their purchases. In the second, sellers will go out of business and their service or goods will no longer be available if the imbalance is lasting.

In primal, unorganized health markets, buyers are usually individuals without medical knowledge who pay out of pocket. They are sick, meaning they don't have many options to shop around or walk away from a deal, at least in serious cases. Sellers are individuals with expert knowledge and higher status, who are in a position of power over the seller that gives them a great degree of flexibility to package and price their services or goods without being held accountable or measured against rational benchmarks.

This failure of market mechanisms is by no means restricted to the private sector. In many low- and middle income countries, the public sector provides care but the systems are too weak to ensure proper regulation, oversight and enforcement of rules. Public salaries usually are low compared to costs of living and private sector salaries. Doctors, pharmacists and health workers, while on a contract with the ministry, often behave like private entrepreneurs and charge for services that are supposed to be free, try to sell more expensive drugs than rationally needed or try to refer patients into a private practice that they run during most of their official work day in another office a short distance away from the public facility.

Not-for-profit, non-government providers of health care also may show symptoms of market failure. An organization that is set up not to make profit may still overcharge and oversell, but then spend all their revenue through a bloated and inefficient organization, while for-profit organizations

[1]WHO health financing data

have an incentive to stay lean and efficient, at least in a competitive market.

MAKING HEALTH MARKETS WORK

Creating a better balance between buyer and seller in health markets requires an intervention that protects or strengthens the buyer side. Regulation is one way to reign in sellers, but is has its limits in countries with weak systems, human resource and skill shortages or small public budgets that don't allow setting up proper enforcement mechanisms.

Another way of balancing power in health markets is by aggregating patient purchasing power and thereby creating an agency that can engage sellers in a meaningful bargaining process, so that the patient is seen by the seller (service provider) as a member of a community that needs to be served well and at a reasonable prices in order to maintain a positive business relationship with this community. The cleanest form of such a community arrangement would be a "buyers club", with voluntary membership for a small fee that allows the club management to set up a small organization that can then accredit providers and negotiate terms and prices of services. Interestingly, such clubs don't seem to exist in the health sector. Apparently there are barriers that prevent them from being set up, possibly related to our unwillingness to admit that we could become sick one day and therefore should pay a small membership fee during our healthy life so that we can benefit when we need it. Another reason could be that there is an unsurmountable "hen and egg" problem – before a club can be effective and make a difference to its members, it needs to sign up many members and negotiate with many providers, without offering each of them an instant advantage.

What emerged in real life are organizations that pool moneys from private individuals and then pay out in case of need. Small "mutuelles" as they are called in Francophone Africa or District insurance funds as they existed in Ghana prior to the NHIS have traditionally failed to use their purchasing power and just accepted the prices quoted by the providers. This may have to do with the fact that effective bargaining with health professionals requires a level of knowledge that can match and challenge the professionals on their own turf. Obviously, someone who, in a developing country, has acquired this knowledge, would most likely work in the profession rather than switching sides and picking a fight with colleagues.

Only when pooling goes to a larger scale, typically through a national insurance fund, the need to control costs and prevent abuse seems to become large enough so that organizations move from a pure financing function to becoming a true agent on behalf of their members, setting rules for providers and negotiating prices.

As national insurance funds, in growing economies, become larger in scale and better in understanding all the tricks providers are using to increase their income, the pendulum can swing to the other direction, where providers become so dependent on a contract with the health insurance fund that they accept terms that make their own business unattractive until some of them give up, which in the end could lead to a situation in which patients now are underserved. So far, this phenomenon can be observed in some developed countries in form of regional shortages of pediatricians, obstetricians and some other health professionals at the lower end of the income scale or those that have high costs of doing business (for example due to liability insurance costs). Nevertheless, the situation in low and middle income countries is far away from overshooting the power balance, as insurance organizations are still young and often lack the professional qualities needed to engage in effective bargaining and contract enforcement.

Does this mean every country should set up a health insurance fund? This is a controversial question, given the fact that reality in countries having made that step demonstrates that it may come with unintended consequences: markets keep failing, they just do it differently by cheating the insurance fund through fake claims or overtreatment as now the patients' individual purchasing power is no longer a limit. In short, funds that act as a third party payer on behalf of the patient need to set up large and expensive systems and organizations to monitor transactions and enforce rules. Small health budgets in developing economies may not allow for enough headroom for such overhead costs: The Kenyan National Hospital Insurance Fund was heavily criticized when it showed that its overhead costs were 50% of the total budget – now on the way to go below 30% as the scale of operations is growing, which still is a number high enough to challenge the economic sense of adopting such a "northern" approach in countries that have low per-capita

health expenditure. Unfortunately, the internal organization cannot be scaled down to a fixed percentage of total budget in case of health insurance funds. They need a minimum on functioning bureaucracy, IT systems and enforcement tools even if the funds they manage per capita of their membership are only a fraction of their sister organizations in developed countries.

WHICH MARKET FORCES CAN BE UTILIZED TO IMPROVE GOVERNANCE?

Besides the supply/demand power balance, there are other, gentler powers that influence markets. Healthcare has a high rank in the hierarchy of social goods, and therefore it is a prime area for individual and institutional charity, corporate social responsibility programs and not-for-profit operators (example are the faith based provider networks in Africa that provide a significant share of the overall health services provided). All these providers are de-facto competing with the public and the for-profit private health sector and, to the extent that they are targeting the same patients or market segments, provide some sort of benchmark in terms of price and service levels. This competition is far from perfect but it offers room for improvement if providers are organized in networks with data aggregation and sharing, creating more transparency for care seekers or decision makers in financing organizations.

Knowledge and trust are other important elements of a functioning health market. Once patients have confidence that generic drugs are as effective and safe as the branded originals, they can comfortably reduce their out-of-pocket spending on medicines. This trust does not come by itself, it requires investments into a stringent regulatory agency and a sustained education effort to overcome prejudice and generate confidence. Trust can also be fostered through private provider networks setting up voluntary quality systems and making their performance transparent, using the quality image as a differentiator in the marketplace.

HOW DOES TECHNOLOGY PLAY INTO THE EQUATION?

Smart phones or other mobile, connected devices are already used to track goods in supply chains, allow patients to verify the origin of the medicines they are taking or remind them to get a refill, or give nurses in remote villages access to a medical library. In the future, networked devices will change how health care is delivered and paid for. Mobile applications in the hands of doctors or nurses can be used to deliver and manage specific benefits, including functions such as patient identification and enrollment, stepwise guidance through treatment protocols, scanning bar codes of medicines or diagnostic tests used and, once the procedure is completed and verified, immediate provider payment through mobile money. Health workers in remote areas will get guidance from electronic tools with step-by-step decision support algorithms, with a chat connection to a call center on another continent where they can interact with specialists.

End-to-end logistics information systems could be used to give patients visibility of stock levels for example for malaria medicines, so that they do not have to travel on foot for hours only to find out that the health facility is out of stock. Yelp-like services could allow for rating of health service providers from the consumer perspective.

Vision for the future – disruptive change will redefine governance of health markets

The structure of health care markets differs from country to country, which means that future trends will probably not transform markets in a linear way. Nevertheless, given the size of the health sector as part of the economy, the rapid growth rate and the high level of inefficiency linked to bad governance and regulatory capture by insider interest groups, it seems this sector is ripe for disruptive change. Trends like pooling purchasing power, data driven decision making and democratization of expert knowledge through decision support systems, telemedicine and mobile apps have the potential to drive change in the way health services will be delivered, paid for and governed. For those who benefit from the current inefficient systems, such change may be seen as threatening, meaning there will be significant political resistance. Allowing market forces to play out through increased transparency on performance and costs will be a critical factor for health systems in successfully coping with and benefiting from future change.

ROLE OF THE PRIVATE SECTOR IN INCREASING ACCESS TO HEALTH COMMODITIES IN DEVELOPING COUNTRIES

by Clinton DE SOUZA

The private sector can and does provide products and services to all levels of the community within a given country. With regards to the role that the private sector can play in improving health outcomes, there are a number of items to note:

1. The private sector exists and is prepared to step up, provide the goods and services required and make the necessary investments to grow and sustain these services. Our recent experience includes Nigeria and Malawi where we have engaged with, supported and managed extremely high levels of performance on behalf of supply chains for both the Governments of those countries and the donors to assist them. In both cases, on time in full deliveries exceed 95%

2. Through effective management of service level agreements, these partners can be held accountable for delivering the service levels

3. A new skills set needs to be developed within Governments; that of service provider management. Early assessments reveal a lack of these skills with Government

4. Engagement from both sides remains elusive – there is and remains mutual distrust between Government and the private sector.

5. Donors can better support private sector development and long term sustainability by using their donor dollars to procure commodities from local private sector wholesalers and let the private sector make the necessary infrastructure development

LESSONS LEARNT

- Supplier or Partner Development (private sector development) is essential
- Donors play a critical, catalytic role … as a customer, not as an investor
- Contracts must be fair and protect both parties
- Ensure objectives and expectations are clear up front, often vague with inaccurate or no information – as the measures don't exist.
- Effective monitoring and evaluation framework needs to be defined in the contract
- Engagement at all levels, understand the structure and the environment, who is going to be most impacted and ensure buy-in is there – federal government
- Change management needs to be driven – and NOT by the public sector
- Successful pilots often don't progress due to lack of funds or the correct level of approval
- On-going training and continuous improvement is critical

CONCLUSIONS

- Private Sector Engagement can be challenging for both parties
- Leveraging the private sector is essential to achieve the health targets necessary in Africa and helps build sustainable local economies
- Rules and terms of engagement are necessary to forge the differences
- From a private sector perspective, courageous leadership is required to weather the storms and steer the course

GOVERNANCE BY MARKET FORCES: INFLUENCE OF PERFORMANCE BASED FINANCING ON BEHAVIOR OF PUBLIC AND PRIVATE PROVIDERS

by Olivier BASENYA

In Burundi, the General states for Health held in 2004 identified a number of challenges in the health sector, including among others a high burden of morbidity for maternal, newborn and child; lack of health staff; instability and lack of motivation of health personnel; low quality of care; weakness in organization and management of the health system and inefficiency in the health sector financing.

To face these challenges, the Ministry of Public Health and fight against AIDS has undertaken a series of reforms including decentralization of the health system, development of a policy for human resources development, **Performance Based Financing (PBF)**.

PBF, associated with free health care for under 5 and pregnant women has been rolled out in 2010. The various assessments, joint reviews and external analysis showed encouraging results and contribution of PBF in improvement in health services utilization, quality of care and health system strengthening.

The presentation to the ***Prince Mahidol Award Conference, Session 2.3 on Governance by market forces - how to get best while avoiding the worst?***, will be focused on how PBF influences behavior of public and private providers in Burundi.

Major changes observed at provider level, public and private ones are as described below:

- Stimulation of planning culture in health facilities: Before the PBF implementation, no health facility did have an action plan and nor see the need to dispose of. Currently, all health centers and hospitals develop annual and quarterly action plans and all health staff are involved from needs identification to costing;
- Quality of care improvement: health workers globally improved the quality of care and especially hygiene, work environment and patient's reception. Additional efforts are still needed especially on the technical aspects of health care;
- Opening of health centers every day 24H / 24: before the PBF implementation, very few health centers had open during the night and the week end. Currently, due to PBF stimulation, all health centers are open 24 hours/24, 7 days/7;
- Development of entrepreneurship spirit and leadership: to enhance their performance, health centers have developed health promotion activities at the community level. They made investments to improve quality of care including purchasing solar panels, building inpatient rooms, fences, incinerators, buying small medical equipments;
- Improvement of hospitality and friendliness: to stimulate women to give birth in their health centers, they offer to women clothes for their babies, soaps and loincloths;
- Motivation of community health workers: there are community health workers and traditional birth attendants who work in close collaboration with health centers. To stimulate them, incentives are given for traditional birth attendants who accompany women to give birth at health centers. This avoids traditional birth attendants to direct home deliveries.

ON GOVERNANCE BY MARKET FORCES – HOW TO GET THE BEST WHILE AVOIDING THE WORST

by Richard BERGSTROM

There is wide recognition that self-regulation has a role to play in certain domains. There are three areas in particular where self-regulation in pharmaceuticals have proven effective.

1. APPLYING PEER PRESSURE.

The case in point is marketing activities and codes of conduct coupled with complaint mechanisms, independent adjudication and public disclosure of rulings. Experience from Northern Europe (UK, Nordics), Austrialia and Canada is that competitors watch for breaches of marketing standards, such as advertising. In the UK, the regulatory agency MHRA routinely refers complaints to the industry self-regulatory body, PMCPA.

2. INVOLVING BOTH INDUSTRY AND DOCTORS.

It is well-known and a well-accepted fact that pharmaceutical companies support medical education of doctors, such as paying for travel to medical congresses. In Belgium, as an example, the pharmaceutical industry and the medical association have set up a scheme for individual doctors to apply for a permit ("visa") to travel to an international congress with financial support from a company. This involves a review of the scientific standards of the congress in question. Similarly, the association of the pharmaceutical industry in Spain has an inspectorate that carries out un-announced inspections at medical congresses, and operates a website that reviews the appropriateness of differential medical congresses, aiming to avoid social activities etc.

3. TRANSPARENCY.

Europan pharmeceutical industry associations mandate since many years full transparency of financial support for patient organisations. These provisions are now expanded (from 2015/2016) to include all transfers of value to heath care professionals (on an individual level) and health care organisations (such as medical associations). These measures are voluntary by the industry as a whole, but made mandatory by EFPIA, the European industry association, covering more than 90% of companies operating in Europe.

SUPPORTING INTERNAL AND CROSS-BORDER SYSTEM FOR TB AND HIV MANAGEMENT SPECIFIC TO MIGRANT MINEWORKERS:

The Innovative Partnership between Civil Society and Private Companies

by Thulani MBATHA

THE CONTEXT: CROSS BORDER CHALLENGE FOR CONTINUITY OF CARE

Every year, half a million men travel from across the Southern African region (Mozambique, Swaziland and Lesotho) to work in South Africa's mines and, in doing so, contract TB as well HIV and silicosis (a degenerative lung disease linked to exposure to silica dust in gold mines).[1]This pattern of migration-men arriving at the mines to work, becoming infected with TB and returning home again, has created an enormous public health crisis throughout the region.

High TB incidence among the general population; higher still among mineworkers		
Population	**Population TB Incidence Rate/ 100,000**	**TB/HIV Co-Infection (%)**
Lesotho, general	633	77
Mozambique, general	347	66
South Africa, general	948	70
Swaziland, general	1,317	84
South Africa, mineworkers	2,500–3,000 —	

Data Source: World Bank Economic Analysis Report, March 2014 [3]

Migrant mineworkers are highly mobile while undergoing care and treatment. Lack of efficient referrals and monitoring systems between countries and within countries seriously compromises the management of TB and TB/HIV among migrant mineworkers. There are no mechanisms for tracking progress of miners on TB treatment as they move from place to place or for tracing their household or family contacts; and no provision for continuity of care because each country has different guidelines, protocols, registration systems for management of TB patients and none has unique patient identifiers or systems to track patients as they move within and/or between countries

Poor access to health services remains a challenge for migrant mineworkers. On top of that here is additional challenge in terms of the disease burden in the countries that mine works travel to and from:

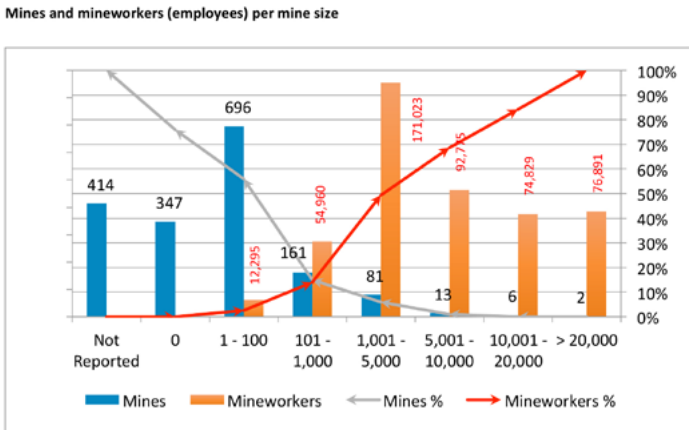
- The four countries of Mozambique, Lesotho, South Africa, and Swaziland, have the highest rates of new TB cases, estimated at 550 per 100,000 compared to the global average of 122 per 100,000; increasing rates of drug resistance; and the highest rates of HIV co-infection in the world.[2]
- There are over 3 million mineworkers in the Southern Africa region (with half a million working in South African mines alone). This group is probably the most vulnerable with an incidence of up to 2500-3000 per 100,000 people and with disproportionate transmission rates to those in the general population. Modelling studies suggest that 30% of TB infections in sub-Saharan Africa can be traced back to infections acquired in the mines, despite the fact that mineworkers constitute a fraction of 1% of the region's population.
- Although few data are publically available, surveys of TB and TB/HIV among mineworkers working in South Africa suggest the high TB incidence of up to 3000 per 100 000 – which exceeds the WHO threshold for TB emergency by 10 times – is attributed to a convergence

of risk factors relating both to social and economic factors.[4] Among the fac¬tors contributing to the higher rates of TB among miners include exposure to silica dust, the prevalence of HIV/AIDS, and the generally poor com¬munal living conditions in the mine residences and in the settlements developing around mining sites.

- Two years of efforts by a health min¬isters from South Africa, Swaziland and Lesotho culminated in a pledge by Southern African heads of state to fight this epidemic in the South African mining industry. The Declaration on TB in the Mining Sector, was signed by 15 heads of state at the Summit Meeting of the Southern African Development Community (SADC) in August 2012. Plation TB Incidence

THE PROCESS: INNOVATIVE PARTNERSHIP TO ADDRESS THE CHALLENGE

The larger mining companies are providing the best medical services to their employees. These mining companies run rigorous Directly Observed Treatment (DOT) program, especially during work hours where TB treatment is provided to every infected miner during the first two months of treatment and are monitored for side effects. Serious loopholes in care provided exist when miners are in their homes, especially in hostels or informal settlements during the weekends. This loophole is even greater when miners are on personal leave or visiting homes during the holiday season. There is anecdotal evidence that that miners do not adhere to their treatment while at home. This is supported by poor sputum smear conversion after 2 months for miners who return to work after their home visit while on TB treatment as reported by the mines. During the holiday season, personal leave and on weekends, the mining companies provide TB, HIV and chronic medications to migrant mineworkers. To further enhance compliance and reduce treatment interruption, the mining companies have partnered with Civil Society Organizations (CSOs), NGOs and the governments of Lesotho, Swaziland, Mozambique, and South Africa to launch interventions aimed at providing the continuity of care for miners who will be traveling home during the Christmas holidays. In December 2014, University Research South Africa (URSA) is launching Operation MOLESWASA (Mozambique, Lesotho, Swaziland, and South Africa). This is a demonstration project aimed at assisting migrant mineworkers with treatment adherence support.



Data Source: University Research South Africa (URSA) mapping of mineworkers and ex-mineworkers in Lesotho, South Africa and Swaziland Report, November 2014

The lessons from this demonstration project will be applied to inform future initiatives aimed at supporting mine workers to complete their TB treatment across the South African borders. Operation MOLESWASA is a collaborative effort and is implemented in partnership with four of the leading South African gold mining companies (Sibanye Gold, Gold Fields, Harmony and Anglo Gold Ashanti), and the National TB Programmes from Swaziland, South Africa, Lesotho, Mozambique, World Bank and local NGOs in the four countries. Here are the key steps in the operationalization of SADC Ministerial declaration:

- Engage the mining companies: Engagement of Medical Officers from the four mines to get buy-in and support for Operation MOLESWASA. Agreements with mining companies, especially to avail staff that will serve as focal persons for obtaining consent forms and data for miners on TB treatment.

- Build regional consensus: A regional consensus meeting with all key stakeholders from the four project countries, including the four mining companies, worker Unions, mining recruitment companies, National TB Control Programmes managers, Non-Governmental Organizations, Ex-miners' associations and the Chamber of Mines. During the workshop, the roles and responsibilities for participation stakeholders were

clarified and agreed upon. Monitoring and evaluation tools were presented and discussed with inputs from all key stakeholders (consent form, enrolment form and pre and post assessment questionnaires were developed).

- Innovative Advocacy, Communication and Social Mobilization (ACSM): Build the capacity of the health teams from the four mining companies to empower mine workers and educate them about the Operation MOLESWASA and the importance of treatment adherence. Equipping migrant mineworkers with information and educational materials on TB and HIV, especially information focusing on TB treatment adherence as well as the dangers of TB and alcohol. Involvement of ex-miners and their associations from Lesotho, Swaziland and Mozambique to use their personal experiences of contracting TB in the mines, and the emphasize on treatment adherence while at home on holidays.

- Recruit miners on TB treatment to enrol into Operation MOLESWASA: Recruitment of TB patients to participate on Operation MoLeSwaSa was proposed to be conducted during each DOT visit at the mine clinics. Every miner will be offered the service and will sign a consent form if they wish to participate. A pre and post assessment questionnaire will be administered to each miner, to ascertain potential barriers to treatment adherence during the festive holidays, adherence to treatment and effectiveness of the project.

- Apply the mHealth technology to ensure continuum of care for miners: Use of mobile phone technology to ensure cross-border and internal migration continuum of care for patients on TB and HIV treatment. Miners under treatment for TB and HIV who have enrolled in the project, will get a reminder to take their medication and the miners will be able to send confirmation by sending back an SMS.

- Integrate incentives: Mobile phone airtime will be provided to miners during interaction with them via SMS when checking and reminding them whether they have taken their medication. Each time a miner responds to the question posed on SMS, the miner will receive free airtime. Additional incentives will include a combination of bus vouchers for migrant miners traveling home and grocery coupons. Each miner on TB treatment will receive a survival kit bag which will include essentials such as food supplement, list of health facilities in their home country, list of phone numbers for MOLESWASA volunteers, information, education and communication (IEC) materials.

EXPECTED RESULTS AND IMPACT

Significance gains have been made in addressing TB in the mines challenge, especially since 2010 about the time when the Minister of Health from South Africa stated that TB in the mines is a regional problem and equated it to a snake, "The head of the TB snake is in South Africa, with its fangs in the country's mines and its tail reaching out to neighbouring countries." Regional intervention strategies for addressing TB are being taken by governments and mining companies. There is a unified civil society response, massive financial and technical boost from regional and international stakeholders, especially from the development partners such as the World Bank, The Global Fund to Fight AIDS, Tuberculosis and Malaria, The Department for International Development (DFID) for TB is essential. There is tremendous momentum to protect workers, their families and communities, and reduce health systems costs for the Southern African Development Community (SADC) region.

There are over 500 mine workers who are on TB treatment, and through Operation MOLWESASA, we aim to reach at least 45% of the miners to ensure they receive optimal support to remain on treatment and also be empowered to complete their TB treatment. At minimum, this project will demonstrate that it is feasible to manage TB and HIV treatment across multiple borders and support migrant mine workers to complete their TB treatment. Operation MOLESWASA is a collaborative effort through innovative partnership of leading South African gold mining companies, National governments/NTPs, donors facilitated by a CSO.

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[1] Stuckler, D. et al. "mining and Risk of Tuberculosis in Sub Saharan Africa', American Journal of Public Health, 2011 Mar, 101 (30:524-30.

[2] (WHO Africa region=43%; Lesotho=75%; Mozambique=58%; South Africa=65%; Swaziland=77%).

[3] Data Source: World Bank Economic Analysis Report, March 2014

[4] The Lancet, Volume 380, Issue 9849, Pages 1217 - 1218, 6 October 2012

PRINCE MAHIDOL AWARD CONFERENCE 2015 | GLOBAL HEALTH POST 2015 ACCELERATING EQUITY

PARALLEL SESSION 2.4

GLOBAL GOVERNANCE FOR HEALTH IN THE POST-2015 ERA

PARALLEL SESSION 2.4

GLOBAL GOVERNANCE FOR HEALTH
IN THE POST-2015 ERA

BACKGROUND

This session will focus on global governance for health, addressing the impact of global governance frameworks outside health on policy space for health. It will provide evidence, present analyses with key governance principles including rights-based approach and participation of non-state actors, and explore innovative approaches to advance global governance for health.

Growing transnational transactions and interactions through globalization provide both threats and opportunities to pursue health equity. They are shaped by global governance standards and systems, or 'global political determinants of health,' which include trade/investment agreements and international laws and institutions including the UN. The Lancet-University of Oslo Commission on Global Governance for Health stresses the need to shift existing global power asymmetry in order to reduce 'unacceptable health inequities'. As the world debates aspirations and priorities for the post-2015 era, new global political solutions and governance systems are required that can better respond to new health challenges posed by the rapidly globalized world.

OBJECTIVES

- To examine how policy space, practices, norms and standards that impact health equity are shaped by global governance frameworks outside the health sector such as trade agreements;
- To discuss the roles of States, civil society, UN institutions, transnational businesses, human rights instruments in global governance for health; and
- To explore key gaps, challenges, opportunities and recommendations for innovations to advance global governance for health in the context of the post-2015 period.

MODERATOR

Ole Petter OTTERSEN
Rector
University of Oslo

Norway

Ole Petter Ottersen MD, PhD is Professor of Medicine and since 2009 the Rector (President) of University of Oslo. He is currently Chair of the Norwegian Association of Higher Education Institutions (UHR) for 2013-2015.

Ottersen was Dean of Science at the Medical Faculty, University of Oslo, from 2000 to 2002. In 2002 he was appointed Director of Centre for Molecular Biology and Neuroscience, http://www.cmbn.no, a Centre of Excellence sponsored by the Research Council of Norway. From 2006 to 2009 Ottersen was Chief Editor of "Neuroscience" – the journal of the International Brain Research Organization (IBRO). Ottersen has received several international awards for his research on brain function and disease. He chaired the Lancet-University of Oslo Commission on Global Governance for Health whose report was launched on February 11, 2014.

Cecilia OH
Programme Manager
Access and Delivery Partnership
United Nations Development Programme

Malaysia

Cecilia Oh is the Programme Advisor with the HIV, Health and Development Group of the United Nations Development Programme, based at the UNDP Bangkok Regional Hub. She is a Malaysian national and a lawyer by training, with a Masters degree in development studies. Her professional experience spans 20 years, during which time she has worked and published on a range of trade and development issues.

Before joining UNDP, Cecilia was an independent consultant on development, trade and intellectual property issues from 2009-2013. During this time, she was also appointed an Adjunct Associate Professor at Duke University's Global Health Institute, where she worked with the Program on Global Health and Technology Access on global health policy issues, with a focus on innovation, technology transfer and intellectual property rights.

She has previously worked with the UNDP Regional Centre in Colombo as a Trade Policy Advisor for the Asia-Pacific region in 2006-2008, and at WHO headquarters from 2003-2006 as a Technical Officer, with WHO's global technical cooperation programme on trade agreements, intellectual property rights and public health. Prior to joining the UN, Cecilia was a Senior Researcher and Legal Advisor of the Third World Network in Geneva, where she worked on international trade, environment and development issues, from 1998-2003.

John-Arne ROTTINGEN
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University of Oslo

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John-Arne Røttingen is the Director of the Division of Infectious Disease Control at the Norwegian Institute of Public Health; Professor of Health Policy at the Department of Health Management and Health Economics, Institute of Health and Society, University of Oslo; Adjunct Professor at the Department of Global Health and Population, Harvard School of Public Health; and Institute Visiting Scholar at the Harvard Global Health Institute. He is Associate Fellow at the Centre on Global Health Security, Chatham House; research associate of the European Observatory on Health Systems and Policies; Chair of the Board of the Alliance for Health Policy and Systems Research; member of the Scientific Oversight Group of the Institute for Health Metrics and Evaluation, University of Washington, Seattle; and member of the International Advisory Committee for the Global Burden of Disease study. He has been Director General of the Norwegian Knowledge Centre for the Health Services; Oxford Scholar at Wadham College; and Fulbright Fellow at Harvard Kennedy School. He received his MD and PhD from the University of Oslo, an MSc from Oxford University and an MPA from Harvard University.

Amit SENGUPTA
Global Co-coordinator
People's Health Movement

India

Dr. Amit Sengupta has trained in medicine. His main interests include issues related to public health, pharmaceuticals policy, and other Science and Technology related policy issues like Intellectual Property Rights.

He has been associated with the Peoples Science Movement in India for the past 30 years, and the Peoples Health Movement in India and at the Global Level for the past 15 years.

Dr.Sengupta has been involved in implementation of a number of action research programmes and research studies in the areas of health, Intellectual Property Rights and on rural industrialization through the Peoples Health Movement and the Centre for Technology and Development, a New Delhi based non-governmental organisation.

He has published a number of papers in peer reviewed journals, including in the Economic and political Weekly, India, the Lancet, The British Medical Journal and the Indian Journal of Medical Ethics. He has also been a co-author and edited a number of books.

Currently Dr.Sengupta is the Associate Global Co-ordinator of the Peoples Health Movement (PHM). He has overall responsibility for co-ordination of the Global Health Watch Programme of the Peoples Health Movement. As part of this responsibility he has co-ordinated and also functioned as the Managing Editor of the two recent editions of the Global Health Watch – Global Health Watch 3 (published in 2011) and Global Health Watch 4 (published in 2014).

Inter alia, he is responsible for co-ordinating PHM's policy engagements and development of policy briefs and position papers and for co-ordinating PHM's engagement and networking with other social movements and networks, including the World Social Forum process.

He is associated with a number of other organisations and networks. He is a former All India General Secretary of the All India Peoples Science Network, is a member of the International Council of the World Social Forum and a member of the Co-ordination Committee of the World Forum on Science and Democracy.

Sigrun MOGEDAL
Former Ambassador
of Norway on Global Health,
Founder of Foreign Policy
and Global Health Initiative

Norway

Dr. Sigrun Møgedal is a medical doctor by training and the former Norwegian Ambassador for Aids and Global Health Initiatives. After retirement from the Norwegian Ministry of Foreign Affairs she has been a Special Adviser associated with the Norwegian Knowledge Centre for the Health Services and served as a Special Advisor to the Executive Director of UNAIDS.

Her main areas of engagement have been in the HIV/AIDS response, health and development policy, strategy and delivery, global partnerships and governance.

Dr Møgedal served as a Commissioner on the UiO-Lancet Commission on Global Governance for Health (2011-2013) and as a lead expert in the Foreign Policy and Global Health Initiative established by Foreign Ministers of seven countries from 2006 and up to retirement. She was a founding member of the Board of the Global Health Workforce Alliance and the Chair of the Board from 2007 to 2010. She is a previous Board member of the Global Fund to fight against AIDS, TB, and Malaria (GFATM), the Global Alliance for Vaccines and Immunization (GAVI), UNITAID and the Global Forum for Health Research.

Dr Møgedal served as the State Secretary for International Development of the Norwegian Ministry of Foreign Affairs from 2000 to 2001. She was the Senior Executive Advisor for Global Initiatives at NORAD, served in research committees of the Norwegian Research Council and as a Moderator for the Ecumenical Council of the Church of Norway. In the period 1970-82 she worked in Primary Health Care Development in Nepal and as the Health Services Director of the United Mission to Nepal.

She is a member of the Independent Monitoring Board for the Polio Eradication Initiative, a Board Member of the Medicines Patent Pool and a Board Member of Norwegian Save the Children.

For her contributions to international health she received the Royal Norwegian Order of St. Olav in 2010.

GLOBAL GOVERNANCE FOR HEALTH IN THE POST-2015 ERA

Background Note, Sigrun MØGEDAL

Proposed main focus:

The focus for this input to panel session 2.4 is the work of the Lancet Commission on Global Governance for Health[1] and its call for governance that respond to the political determinants of health and health inequities, with particular reference to the need for better interconnected, broader and more inclusive governance processes.

What is the justification for a multi sector and multi stakeholder platform which is not controlled by WHO? In what ways can it expand the policy space for health, without undermining the authority and mandate of WHO? How can more structures add value to the already uncoordinated and crowded global governance landscape?

What is the potential for change in inter-governmental collaboration, rule-making and institutional reform that can overcome the structural and institutional barriers to promote healthy lives and well-being within a sustainable development agenda?

GENERAL BACKGROUND

The Commission does not argue that the health sector should have priority above the other sectors with an equally strong case for attention. Rather, the Commission argues for health at a more aggregate level, building the case for action on the broader determinants of health, where many sectors need to contribute.

The health equity that we talk about goes beyond the health sector to become a more aggregate expression of equity of opportunity for health and wellness, human security, education and livelihoods, equality and dignity in society. It requires many building blocks, where the health sector is only one.

In so doing, the Commission aligns itself with the call for broader and more interconnected action on health, that require synergies across sectors in global policymaking and dealing with political, social and structural determinants that maintain health equity. We know this is essential for

- the response to NCDs and the recognition of the limitation of the health sector response
- the strategies for ending AIDS, which will not succeed unless broader policy issues also are dealt with. Finance and medical science and services will not be enough
- the search for understanding health in the context of sustainable development, as an indicator of sustainable society, a universal value and shared social and political objective for all

Many decisions (or lack of decisions) which undermine health and maintain ill-health represent political choices that are far outside the domain of the health sector. They are decisions of national governments, corporate sector and non-state actors that have impact across borders and where global governance does not have institutions, arenas and accountability mechanisms to take corrective and conducive action to safeguard peoples' health.

Within the domain of health, there are many mechanisms concerned with health partnerships, norms, technical cooperation and financing, which could benefit from a more coherent and integrated health architecture. But there are multiple reasons for why it is hard to get there. Reforms in the health architecture is very much dependent on governance reforms in WHO, and in the fragmented architecture for financing health, where donors play a major role. A discussion of how the health architecture can be better fit for purpose and how hard it is to get there is presented in a Working Group report from Chatham House Center on Global Health Security May 2014.[2]

The Commission did not engage in setting out reform proposals for WHO and the health architecture, but focused on the forces and determinants that remain beyond the reach of the structures governing health. Even with progress in WHO reform as a UN specialized UN agency for health, it will only be empowered to deal with a few of the transnational norms, policies and practices that affect health but arise from political interactions across all sectors of global governance (the political determinants of health). There are critical institutional dysfunctions in global governance affecting health, and no current mechanism that deal with and hold actors that control the political determinants accountable for their impact on health.

Responses to the Sustainable Development Agenda post 2015 that is now discussed in the UN General Assembly are likely to bring out needs for institutional reform in the broader global governance architecture, including in the way the UN is structured. A reflection of this is in the discussions about the future role of ECOSOC in relation to the interconnected agenda for environmental social and economic sustainability. This may offer new opportunities in governance for health.

CAN WE MAKE HEALTH A TIPPING POINT FOR SUSTAINABLE DEVELOPMENT?

In the ongoing political discussions on SDGs in New York, the commitment is maintained to bring all the three dimensions of sustainable development together and deal with them in a balanced and interconnected way. The way these sectors and themes interconnect and can drive synergies and coherence now need attention.

How this can be done, given that negotiators also represent diverse and selective positions, priorities and interests is still a big question. We are back to traditional positions on development, including the divide between the responsibilities of donors and recipients. There is fight over priorities and sector rather than search for interconnections. We are stuck in the old stubborn divides. Highly controversial and still unresolved issues continue to block progress to achieve health equity.

Seen in a sustainable development sense, health equity and social justice may be a make or break for what we mean with sustainable social development, as one of the three pillars in the new global agenda for globally sustainable development. Then it is worth going for and fighting for. And it is at the core of responding to the political determinants of health. The Lancet Commission report on Global Governance for Health should be seen in this perspective.

INTERCONNECTED AND INCLUSIVE GLOBAL GOVERNANCE IS NOT JUST ESSENTIAL FOR HEALTH

The broad based processes and consultations for framing the new global sustainable development goals have made loud calls for more interconnected governance, more transparency and accountability and for broader inclusion of non state actors in decision-making. The inter-governmental negotiations of the Open Working Group reporting to the UNSG in 2014 indicated that governance and partnership were among the most challenging themes to sort out. Even so, the recent synthesis report of the UNSG to guide the next steps in the post 2015 process, "The road to dignity by 2030" placed the need for a global, better interconnected development agenda, with more inclusive governance and partnership arrangements between state and non state actors center stage.

Dealing with the political determinants for health, as well as for environment, clearly requires the work and will of political leaders, subjected to intergovernmental negotiation and decision making, in the same way as a national government needs to stand responsible in national governance. But there is also a critical need for broader inclusion of stakeholders in processes leading up to these decisions. Change in favor of health equity and sustainable development will not come by itself, it needs to be demanded and pushed.

Also non-state actors need arenas and processes to stand accountable for decisions and actions in a globalized world where governments are not in control of the rules of the game - in terms of information and resource flows, products and contracts that affect the life and wellbeing of people.

There is a need for putting these cards on top of the table, and rethink the institutions and the governance systems that we have, to make them fit for a new age of sustainable development. The challenges we face are likely to demand

the creation of different tables with different mixes of stakeholders that can help generate visibility of the issues and competing interests, discuss options and demand necessary action to achieve health equity.

This is also an opportunity for innovation and positive change. Probably we need to look for a plurality of institutions, with hubs that provide appropriate linkages and drive mutual accountability, in order to deal with the type of complexity we face.

BRIDGING THE GAP BETWEEN HEALTH GOVERNANCE AND GOVERNANCE FOR HEALTH

The Commission concluded with some indicative steps and proposals to respond in a preliminary way to the institutional dysfunctions that were identified, to stimulate further thinking. The recommendations aim to open up space for new, independent thinking and dialogue by Universities, Human Rights groups, civil society and business, along with governments and agencies, to make global governance better serve health. It calls for a) new mechanisms for convening, informing and monitoring, and b) strengthening and empowering existing mechanisms

Specifically the Commission argues for the establishment of a Multi-stakeholder platform, inclusive of non-state actors and different institutions representing multiple sectors, that can watch and drive enabling policies for health and wellbeing. The platform as envisaged would be able to place policy issues debated in governance processes in different sectors on the table for examining health impact and provide its recommendations to the appropriate governance arenas where decisions are made in full transparency, followed by watch and advocacy functions.

In this way, the platform can be a tool for an evidence informed, interconnected and inclusive debate on political determinants of health and health inequity, in a way that the intergovernmental institutions, including WHO, are not able to do - thereby adding value to and complementing WHO in its role in health governance. The proposal builds on the experience in governance of food security, where a multi-stakeholder committee has been in operation and proved its value, complementing what FAO can do as the UN Special Agency. It can well be adapted to fit other proposals with similar functions as they may arise out of the agreed institutional framework for sustainable development.

So far, seeing health governance in the broader context of the sustainable development goals has, however, gained limited momentum. There are concerns that bringing in the political determinants of health inequities would deviate attention from doable and necessary investments within the health sector, which we know can be counted and will give results. The case for priority investments and clear target for the health sector is important, but should not limit a broader commitment to health that goes beyond health as a single sector and better reflect health as an indicator of interconnected social development.

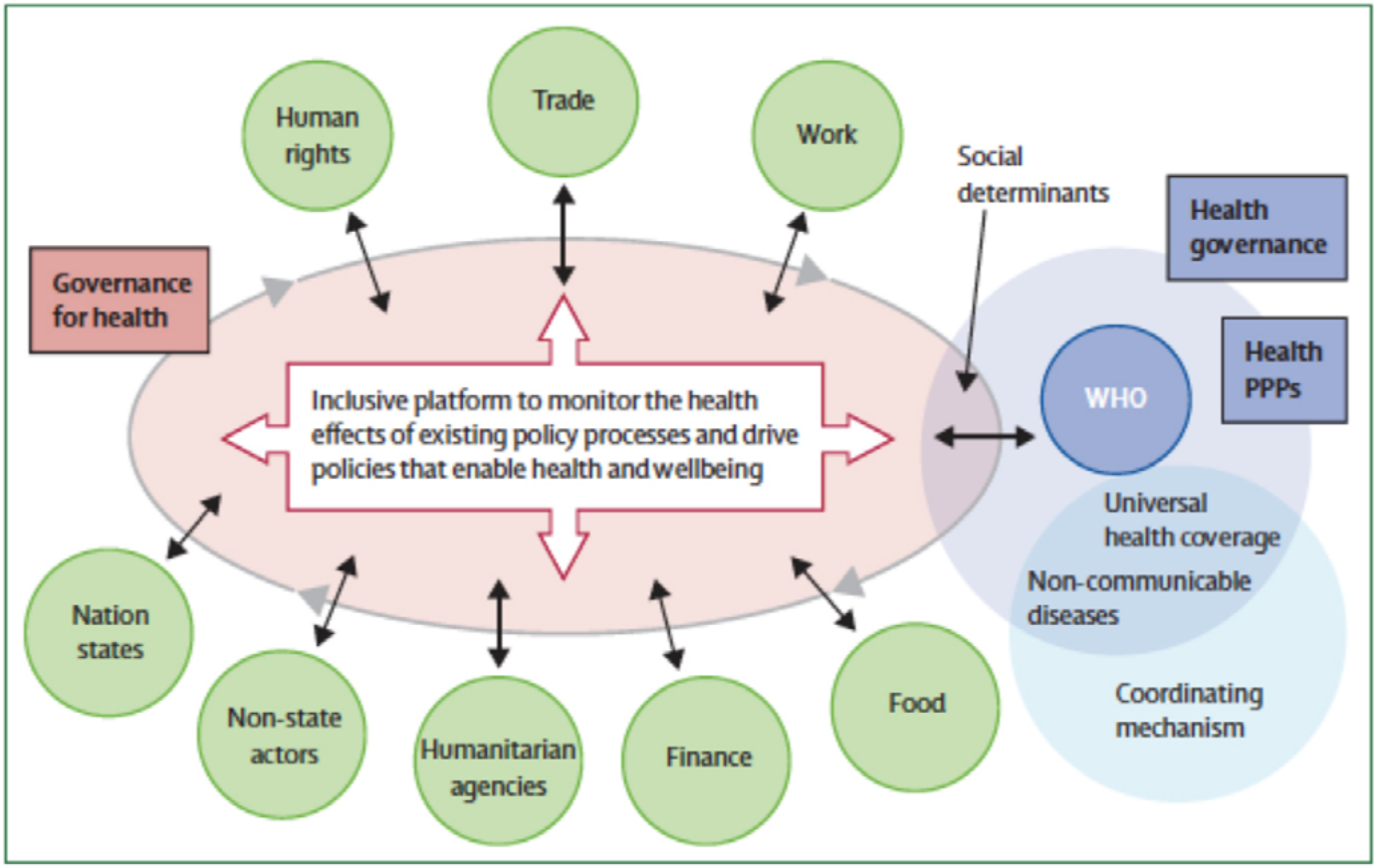
The need to bridge the gap between health governance and governance for health is not new. Neither is the need to go beyond the boundaries controlled by WHO.

The UN Joint Program on AIDS, established by UN Resolution in 1994, was from the start a partnership construction within the UN system, to bring together the necessary policy and technical guidance from the agencies, "including normative activities relating to HIV/AIDS in areas such as social and economic planning, population, culture, education, community development and social mobilization, sexual and reproductive health, and women and adolescents". Among the commitments of Heads of State at the UN in 2001 were to complement Government leadership by the full and active participation of civil society, the business community and the private sector, with a special annual UN reporting mechanism set up. This was unique for its time, and is still a pathfinder for ways to bridge health governance and governance for health.

The new driver for governance models to deal with political determinants that cannot be controlled by health alone is non-communicable diseases. There have been many rounds of negotiations to find the balance between what WHO as an intergovernmental body can control and how non state actors can be included. The WHO leadership and the Member States are reluctant to see NCD governance move out of WHO, like what happened with AIDS.

Similar concerns relate to WHO opening up for civil society and partnerships in health governance. The report of the UNSG to the recent UNGA session on Global Health and Foreign Policy presents a dual position - one that reflect the WHO principles for partnerships and another that pave the way for a new way of engaging with partnerships - in the new era of globally sustainable development.

ILLUSTRATION FROM COMMISSION REPORT:
A MULTISTAKEHOLDER PLATFORM



[1]The Lancet Commission Global Governance for Health The Lancet, Vol. 383, No. 9917, p630–667

[2]Chatham House Report: Charles Clift, What's the World Health Organization for? May 2014

[3]UN GA Document A/69/405

GLOBAL GOVERNANCE FOR HEALTH

Amit SENGUPTA

INTRODUCTION

The, almost universal, application of policies that promote integration of the globe through trade in goods and services and liberalised flow of finances – loosely termed as globalisation – has also necessitated development of fairly elaborate global structures of governance. In the health sector this manifests as global governance for health (GHG), i.e. global structures that attempt to govern issues related to health that transcend national boundaries.

In recent decades, issues under the purview of global health have moved far beyond the physical spread of diseases. Since the early 1980s, the global architecture of governance, trade and economics has come to be informed by globalisation, and consequently national decision making and national policies are often subject to global influences. This is true in the health sector as well[1] and the advent of globalisation marks a shift in institutions and structures that govern health at a global level.

The use of the term global instead of international, when discussing issues of health that go beyond national boundaries, is in itself significant. International health held the connotation that national concerns and policies formed the bedrock of policies about supranational issues, while global health appears to start from the premise that global issues largely supersede national policies, concerns and priorities.

It is possible to identify four major developments in the last three decades that have had profound impact on the structures and processes of global health governance. First: the emergence of the World Bank as a major player in the arena of health governance in the 1980s. Second: the importance of global trade in international relations and its impact on health in different situations across countries, leading to a major role for the World Trade Organisation (WTO) and regional and bilateral trade agreements in global health. Third: the entry of private foundations (such as the Bill and Melinda Gates Foundation) through public private partnerships and other avenues, as a big player in global health issues. Fourth: the demise of the World Health Organisation as the premier organisation in the area of global health governance. While all the four are somehow linked, each have arisen in specific contexts that are analysed below.

THE WORLD BANK AND THE HEALTH SECTOR

The World Bank role in the health sector increased in importance after the global economic crisis in the 1970s. By the 1980s debt ridden countries in the South (Africa, Latin America and Asia) were facing a virtual collapse of their national economic systems. The Bank (along with its Bretton Woods cousin, the International Monetary Fund, stepped in to resurrect these economies through the now infamous Structural Adjustment Programmes (SAPs). These programmes were designed to reduce national debt through the promotion of exports (largely of primary produce) and reduction in Government expenditure on welfare and social sectors, prominently in areas such as health, education and food security.

The Bank's recommendations in the health sector are bundled with its recommendations for the entire economy, and importantly, inextricably link trade and health polices.

WTO: TRADE AND HEALTH LINKED TOGETHER AS NEVER BEFORE

Since 1995 the WTO has become the major international forum for debate and resolution of conflicts, in the area of

major health related policies or policies that impact on health. The WTO's ability to intervene in global health issues is of a much higher order than the WHO as the WTO agreement is a binding agreement with clear commitments made by contracting parties. The dispute settlement mechanism allows members countries to use trade sanctions to enforce rulings against member states that fail to comply with its decisions. In contrast, the WHO does not have mechanisms that can force member countries to abide by decisions it takes.

TRADE AND INVESTMENT AGREEMENTS: BEYOND THE WTO

The failure of the WTO to accommodate interests of all countries and the repeated visible collapse of the Ministerial negotiations has prompted developed countries to look for other channels to promote global trade. Consequently, Regional and Bilateral Trade Agreements are an increasingly important part of trade and health governance. From 1990 to 2007, the number of such agreements notified to the WTO increased from 20 to 159. At present, over 250 regional and bilateral trade agreements govern more than 30% of world trade. In many cases, these agreements do not include the flexibilities and health safeguards available under the TRIPS agreement and can impose onerous terms in other areas as well[2]. Two mega FTAs are now being negotiated (both involving the United States), which are likely to have far reaching effects – the Trans Pacific Agreement (TPPA) and the TTIP (Trans Atlantic Trade and Investment Partnership).

OTHER AREAS OF CONCERN IN FTAS(BEYOND TRIPS)

Government procurement: In a Government Procurement Agreement (GPA) whatever the government of a member country of a FTA procures, all other members have equal right to bid for tenders. This could mean that when tenders are floated to procure medicines for public health facilities, companies based in the EU would have the right to bid for such contracts. Such a situation can also affect the ability of governments to determine how food for public distribution systems (PDS) would be procured.

Appropriation Clause in Investment Chapters: A major area of concern related to investment chapters in most FTAs is that they allow private companies to file cases against governments. So they subject countries to the risk of litigation by corporations from or based in another country. This might be based on a company's objections to the host government's environmental, health, social or economic policies, if these are seen to interfere with the company's 'right' to profit. The biggest issues relate to the provisions for compensation for "expropriation", which can be direct (as in cases of nationalisation) or indirect (policies or actions that impinge on the profitability of the company concerned)[3].

LIBERALISATION OF HEALTH SERVICES

The General Agreement on Trade in Services GATS) under the WTO is negotiated through a system where countries have the option to open areas of their service sector (water services, education, health, banking, insurance, tourism, etc.) based on their own requirements. In this, the GATS agreement is different from other agreements in the WTO, that require similar degrees of compliance from all member countries.

From GATS to the Trade in Services Agreement (TISA): At present those participating in the negotiations (28 countries including the EU and the US and Japan) account for 70% of the global services economy.

TISA not only affects poor countries, it also affects the poor in rich countries. The basic philosophy that drives TISA is that governments should not regulate or provide services. Instead, services should be provided by for-profit private enterprises operating in a global market for services. If markets are to be created for services, then for obvious reasons existing public services need to be privatized.

A global agreement on services would prevent governments from imposing laws and regulations to protect public health (among other areas), and governments would be forced to allow transnational corporations to operate freely, even in situations where they may clearly endanger public health. Countries risk being 'locked' into a regime of private healthcare provision, as those seeking to expand public services would be required to 'compensate' foreign commercial service providers and investors for loss of revenue! TISA would also

impact on polices related to the migration of health workers. Commercial service providers would be free to 'import' health workers (generally as temporary contract labour) from other countries. The availability of 'cheaper' health workers could depress local wages and jeopardize local employment.

GLOBAL PUBLIC PRIVATE PARTNERSHIPS

A new family of global initiatives that have a major impact on global health governance are Global Public Private Initiatives (GPPIs). In the past two decades several hundred such initiatives have been launched, with over a hundred in the health sector alone. GPPIs came to be developed based on an understanding that multilateral co-operation in the present globalised world could no longer adhere to the older principle of multilateralism that primarily involved nation states. Global partnerships were, thus, imbued with a new meaning, that involved not just nation states, but other entities, including prominently, business organisations such as pharmaceutical companies that work through the medium of the market. Partnerships' with the private sector and civil society are thus held up as the way to achieve what governments and the UN cannot manage alone.[4]

GPPIs need to be viewed in the context of an attempt to address the obvious failure of the market to deliver services and goods where most required, i.e. to the income and resource poor, while at the same time staying within the boundaries of neoliberal economic policies. They address what neoliberal economists term as "market failures", but at the same time do not question the fundamental faith in the ability of the market to regulate the global flow of goods and services.

While there have been no systematic evaluation of the impact and viability of GPPIs in the health sector, there have been several evaluations of specific GPPIs. Based on these evaluations some major concerns are beginning to emerge. The gross under-representation of Southern stakeholders in the governance arrangements of GPPIs, coupled with the Northern location of their Secretariats, is reminiscent of imperial approaches to public health. GPPIs are seldom integrated in the health systems of the recipient countries and this has major implications for the sustainability of programmes, after a particular GPPI runs out its course or starts reducing support. GPPIs can allow transnational corporations to exert influence over agenda setting and political decision-making by governments. Some partnerships can distort competition, because they provide the corporations involved with an image advantage, and also support those involved in opening up markets and help them gain access to governments[5].

WORLD HEALTH ORGANIZATION: TIME TO RECLAIM ITS MANDATED ROLE

WHO's leadership in global governance issues has been seriously compromised through the usurpation of its mandate by multiple agencies – the World Bank, the WTO, GPPIs, etc. Increasingly, there is a tendency to characterise the WHO as a 'technical' agency that should concern itself only with issues related to challenges of communicable disease control and the development of biomedical norms and standards.

The WHO faces three key challenges – related to its capacity, legitimacy and resources. The WHO's legitimacy has been seriously compromised because of its inability to secure compliance of its own decisions, which are reflected in the various resolutions passed at the World Health Assembly. As with many other UN organisations, WHO's core funding has remained static because of a virtual freeze in the contributions of member states.[6] Its budget amounts to a tiny fraction of the health spending of high-income member states . In addition, a large proportion of WHO's expenditure (about 80%) comes in the form of conditional, extra-budgetary funds that are earmarked for specific projects by contributing countries.

As a consequence of the above, the WHO is inadequately equipped to reclaim its leadership role in global health governance.

NEED TO REFORM GLOBAL HEALTH GOVERNANCE

Clearly, the terrain of global governance for health is a minefield of contradictions. It is shaped by multiple agencies and by multiple interest groups. In a globalised world this is evidently a cause for concern. While tools designed to

mitigate ill health and disease are now available as never before, access to such tools is a bigger problem than ever before. A nation state driven process, premised on principles of equity, justice and sharing is an urgent requirement if global governance for health is to be restructured to address this problem. Country governments, especially from the South, need to take the lead in rescuing global health governance from the clutches of sectional interest groups.

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[3] Ghosh, Jayati, Treacherous Treaties, Volume 27 - Issue 24 :: Nov. 20-Dec. 03, 2010, Frontline Magazine, India; http://www.frontlineonnet.com/fl2724/stories/20101203272409200.htm

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[5] Buse, K., 2004, Governing Public-Private Infectious Disease Partnerships, Winter/Spring 2004, Volume X, Issue 2, The Brown Journal of World Affairs, London School of Hygiene & Tropical Medicine

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PRINCE MAHIDOL AWARD CONFERENCE 2015 | GLOBAL HEALTH POST 2015 ACCELERATING EQUITY

PARALLEL SESSION 2.5

ACCOUNTABILITY FOR HEALTH IN THE POST-2015 DEVELOPMENT AGENDA

PARALLEL SESSION 2.5

ACCOUNTABILITY FOR HEALTH
IN THE POST-2015 DEVELOPMENT AGENDA

BACKGROUND

The MDGs have contributed to much greater emphasis on tracking progress towards targets and international and national accountability. Poor performance was highlighted with annual monitoring data and UN agencies and governing bodies played a major role.

The commission on accountability for women's and children's health developed a framework for accountability which is used by many countries. In addition, an independent expert review group was established, assessing general progress and advocating for specific issues.

Accountability for health is one of the critical dimensions of the post-2015 development agenda. The health sector needs to review the experiences to-date, take into consideration the experiences of countries, and learn from experiences with accountability in other sectors in order to effectively move into the post-2015 era.

OBJECTIVES

Discuss the importance of accountability for health in the post-2015 development agenda and consider potential mechanisms to facilitate effective accountability in the future implementation of the development agenda.

MODERATOR

Daniel MILLER
Associate Director
PATH

Switzerland

Dr. Miller received his university degree in Bacteriology at the University of California-Davis, and his medical degree with an emphasis on Infectious Diseases at the University of California-San Diego. He completed his clinical training, with emphasis on maternal and child health, and served as Chief Resident in Family Medicine at the University of California-San Francisco. Daniel received his Masters of Public Health degree in Health Services and completed a Preventive Medicine residency/fellowship at the University of Washington. He has also served as Medical Director of a network of primary health care clinics in Seattle that provided comprehensive outpatient and in-hospital medical services to poor and minority communities.

Dr. Miller joined the US Centers for Disease Control and Prevention (CDC) in 1986 and served successively in scientific, management, policy, and leadership positions in cancer epidemiology/statistics, infectious diseases, disease surveillance, and global health. He has extensive field experience in medical and nutritional relief in humanitarian crises during conflict in Somalia and post-conflict environments in Eritrea.

Beginning in 2000, Daniel was assigned to Washington DC in a variety of roles representing CDC as: Senior Technical and Policy Advisor to The World Bank, providing support in project identification, design, implementation, monitoring and evaluation of health projects in Eastern Europe, Central Asia, South Asia, and South East Asia; Liaison for global health to the US Congress with emphasis on polio eradication and malaria; and, Senior Policy Advisor for global health at the US Department of State.

From October 2007 until his retirement from CDC on October 1, 2013, Daniel served as Director of the Office of International Influenza in the Office of the Secretary, US Department of Health and Human Services (HHS), Office of Global Affairs. He coordinated HHS' international activities in influenza preparedness and pandemic response, in emerging infectious diseases, and spearheaded HHS' role in global health security: program development, implementation, and evaluation; global health policy analysis and development; strategic planning; and, health diplomacy.

Dr. Miller currently serves as Associate Director in the Vaccine Access and Delivery Global Program at PATH and is based in Geneva. In addition, on December 1, 2013, he was appointed as Director of the Vaccine Implementation Technical Assistance Consortium (VITAC) funded by GAVI.

Tarek MEGUID
Professor
State University of Zanzibar

Tanzania

Tarek Meguid is Consultant Obstetrician and Gynaecologist in Mnazi Mmoja Hospital and Associate Professor at the State University of Zanzibar (SUZA), School of Health & Medical Sciences, Zanzibar, Tanzania. He is a former Associate Professor and Head of the Department of Obstetrics & Gynaecology at the University of Namibia School of Medicine. Before that he had served as Head of the Department of Obstetrics and Gynaecology at Bwaila Hospital and Kamuzu Central Hospital in Lilongwe, Malawi. As co-founder of the Chitenje Maternity Trust in Malawi, he played a leading role in the planning and construction of two public maternity hospitals where all women can deliver in their own private rooms.

He served as Medical Officer and Obstetrician & Gynaecologist in northern Namibia's Onandjokwe Hospital for ten years before and after Namibia's independence and was visiting professor at the School of Law and Graduate School of Public Health at the University of Pittsburgh, USA. His writings have appeared in numerous peer-reviewed and non-peer-reviewed publications.

Tarek Meguid holds an MD from Maastricht University, the Netherlands; an MPhil in Maternal and Child Health from the University of Cape Town, South Africa; a DTM&H from the London School of Hygiene and Tropical Medicine; an LL.B. from Nottingham Trent University; and a MSt in International Human Rights Law from Oxford University, all in the UK. He is Egyptian and German and the father of one daughter, Lara Meguid, who studies in the Netherlands.

Gorik OOMS
Professor
University of Anterwerp

Belgium

Gorik Ooms is a human rights lawyer and a public health scholar. He graduated as Lic.Jur. from the Catholic University of Leuven in 1989. During most of his professional career he worked with Médecins Sans Frontières Belgium, of which he was the executive director from August 2004 until June 2008. In March 2008, he obtained his Ph.D. in Medical Sciences from the University of Ghent, for a thesis on the subject "The right to health and the sustainability of healthcare: Why a new global health aid paradigm is needed." In August 2008, he joined the Department of Public Health at the Institute of Tropical Medicine, Antwerp.

During the 2009-2010 academic year, with support of a Fulbright scholarship, Gorik Ooms was appointed global justice fellow with the Whitney and Betty MacMillan Center for International and Area Studies at Yale, where he remains corresponding fellow. Since 2010 he is an adjunct professor of law at Georgetown University, and since 2013 a visiting scholar at the Faculty of Law of the University of Antwerp.

Carmen BARROSO
Regional Director
of International Planned
Parenthood Federation iERG /
International Planned
Parenthood Federation

USA

Dr. Carmen Barroso is a member of the Independent Expert Review Group of the Global Strategy on Women and Children's Health, appointed by the Secretary General of the UN and is a member of a new Lancet Commission on Adolescent Health. Last year she was also a member of the UN Secretary-General Independent Expert Advisory Group on the Data Revolution for Sustainable Development.

A native of Brazil, Dr. Carmen Barroso was a professor of sociology at the University of Sao Paulo, Brazil, and a senior researcher with the Carlos Chagas Foundation, where she created Brazil's first and foremost women's studies center. She was a Presidential appointee to the National Council on Women's Rights and wrote a regular op-ed column in one of the major Brazilian newspapers.

In 1991 Dr. Barroso became the first non-American woman to be appointed as director in a major US foundation. She was the Director of the MacArthur Foundation's Population and Reproductive Health program until 2003. Under her leadership, the program funded hundreds of local organizations in Africa, Asia, and Latin America, and helped bring the voices and experiences of women from the Global South to international policy fora. In particular, Dr. Barroso has been recognized by the media and academics for the influential role she played in making sexual and reproductive health and rights central to development policy at the landmark 1994 International Conference on Population and Development.

Since 2003, Dr. Barroso has served as the Regional Director of International Planned Parenthood Federation/Western Hemisphere Region. Through its 41 Member Associations in the Americas and the Caribbean, IPPF/WHR provides nearly 33 million services annually. As the director of one of the most dynamic regions of IPPF, and as a member of the IPPF global senior team, Dr. Barroso has been a leader in innovation both in advocacy and services, especially for young women.

She has served on several boards and international commissions, including the Millennium Project Task Force on MDG 3, and the Brazilian Commission on Reproductive Health, a pioneer effort for engaging multiple stakeholders in accountability for women's health policies.

Dr. Barroso holds a PhD from Columbia University in Social Psychology. She was a Visiting Scholar at the Population Department of Cornell University and received numerous academic and public service awards and honors, including Ford Foundation and Fulbright Scholarships. Most recently she was named one of the 21 women leaders of the 21st Century by Women's eNews. Dr. Barroso has published numerous articles in professional journals and popular media in Brazil and internationally, and has consulted for many international and intergovernmental agencies.

Hani SERAG
Coordinator
International People's Health University

Egypt

An Egyptian physician and public health activist obtained my M.B.B.Ch from the Faculty of Medicine, Ain Shams University, Cairo. He has completed a number of training courses in fields of health system research, health care finance, biostatistics, quantitative and qualitative research methods, and primary health care.

He worked as a primary health care physician in poor urban settings in Cairo for several years. Since 1994, He volunteered as a public health research assistant in a civil society organization; named the Association for Health and Environmental Development (AHED) and promoted overtime till being the director of its health policy program in 2000.

In mid 2006, he was assigned as the global coordinator of the People's Health Movement (PHM) till mid 2009 when he continued to serve as an associate coordinator of the movement. His current tasks include the coordination of the PHM's International People's Health University (IPHU) and the PHM's initiative on 'Democratizing Global Health Governance' which is focusing currently on watching the World Health Organization (WHO).

Najeeb AL-SHORBAJI
Director
Department of Knowledge
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Has been working as Director, Department of Knowledge, Ethics and Research at the World Health Organization Headquarters (WHO/HQ) in Geneva since November 2013. Prior to that he worked as Director of the Department of Knowledge Management and Sharing between 1 September 2008 and 31 October 2013. Between 1 February 1988 and 31 August 2008, he held the posts of Information Scientist, Regional Advisor for Health Information Management and Telecommunication and Coordinator for Knowledge Management and Sharing at the WHO Eastern Mediterranean Regional Office in Amman, Alexandria and Cairo. He is from Jordan, married and holds a PhD in Information Sciences since 1986.

Dr Al-Shorbaji's current portfolio covers WHO publishing activities and programmes, library and information services, knowledge networks, eHealth, research and public health ethics, research and knowledge translation and WHO Collaborating Centres.

Through his career he initiated, lead and managed a number of regional and global projects related to access to health information, networking, capacity building, use of information and communication technology for health. He published over 100 research articles, book chapters, conference papers and presentations. He is a member of a number of national and international professional associations.

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PARALLEL SESSION 2.6

GLOBAL HEALTH TREATIES - DO WE NEED MORE?

PARALLEL SESSION 2.6

GLOBAL HEALTH TREATIES - DO WE NEED MORE?

BACKGROUND

There are many international legal instruments, both hard laws and soft laws, that have direct and indirect implications on Global Health, including WHO constitution, FCTC, IHR, environment related conventions/ protocols, WTO agreements and FTAs, UNGA and WHO resolutions, global goals/declarations/statements/calls for actions. In the midst of global health governance dialogues, it would be important to learn how much these international legal instruments, especially treaties, really affect the changes in health systems and even health at the country, region and global level, and the factors that govern their effectiveness. In the past decade, there have also been new proposals for global legal instruments on health, e.g., Framework Convention on GH, R&D treaty, alcohol, diet, AMR, etc. It would be necessary to revisit the issue of how we can have a better concept and principle re the role of the global legal instruments to really improve health and what would be the criteria for successful global health treaties.

OBJECTIVES

- Review and discuss the lessons learnt from the current legal instruments including the factors for successful implementation, especially treaties, related to Global health, both direct and indirect.
- Discuss and recommends concrete principle and criteria to ensure the effective use of global legal instruments, especially treaties, to improve health systems and health.

MODERATOR

James LOVE
Director
Keionline

USA

James Love is the Director of Knowledge Ecology International (KEI), a nonprofit focused on access to medicines and knowledge resources with offices in Washington, DC and Geneva, Switzerland. Mr. Love is an advisor to a number of UN agencies, national governments, international and regional intergovernmental organizations and public health NGOs. He is also the United States co-chair of the Trans-Atlantic Consumer Dialogue (TACD) Working Group on Intellectual Property, the Chairman of Essential Inventions, a member of the MSF working group on Intellectual Property, and the UNITAID Patent Pool Expert Group.

Mr. Love was previously Senior Economist for the Frank Russell Company, a lecturer at Rutgers University, and a researcher on international finance at Princeton University. He holds a Masters of Public Administration from Harvard University's Kennedy School of Government and a Masters in Public Affairs from Princeton's Woodrow Wilson School of Public and International Affairs. In 2013, Mr. Love was awarded the Electronic Frontier Foundation's Pioneer Award alongside Glenn Greenwald and Laura Poitras, and Aaron Swartz.

Steven HOFFMAN
Assistant Professor
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Canada

Steven Hoffman is an Assistant Professor of Law and Director of the Global Strategy Lab at the University of Ottawa with courtesy appointments as an Assistant Professor of Clinical Epidemiology & Biostatistics (Part-Time) at McMaster University, Adjunct Faculty with the McMaster Health Forum, and Visiting Assistant Professor of Global Health at Harvard University. He is an international lawyer licensed in both Ontario and New York who specializes in global health law, global governance and institutional design. His research integrates analytical, empirical and big data approaches to craft global regulatory strategies that better address transnational health threats, social inequalities and human rights challenges. Past studies have focused on access to medicines, antimicrobial resistance, development assistance, health misinformation, maternal health, pandemics and tobacco. Currently he is co-principal investigator of a large $4.6 million CAD research consortium on "Strengthening International Collaboration for Capitalizing on Cost-Effective and Life-Saving Commodities (i4C)" with John-Arne Røttingen at the Norwegian Institute of Public Health. He is a regular columnist with Vox and writes the Burden of Proof column with journalist Julia Belluz.

Steven previously worked as a Project Manager for the World Health Organization in Geneva, Switzerland, and as a Fellow in the Executive Office of United Nations Secretary-General Ban Ki-moon in New York City, where he offered strategic and technical input on a range of global health issues. He also previously worked for a Toronto law firm specializing in cross-border intellectual property litigation, health product regulation, and government relations, as well as Incentives for Global Health – a Yale University-based NGO devoted to improving global access to medicines – where he was responsible for international advocacy and strategic planning. Steven recently advised the World Health Organization on development of a global strategy for health systems research and was lead author on the background paper that provided the strategy's conceptual underpinnings. For three years he convened an academic advisory committee on science reporting for Canada's only national weekly current affairs magazine.

Thiruk BALASUBRAMANIAN
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Thiru Balasubramaniam is the Managing Director of Knowledge Ecology International Europe (KEI Europe) and Geneva representative of Knowledge Ecology International (KEI). Mr. Balasubramaniam has represented KEI in various multilateral fora including the World Intellectual Property Organization (WIPO), the Internet Governance Forum, the World Health Organization (WHO) and the World Trade Organization (WTO).

Prior to his post, Thiru worked at Health Action International in Colombo and at the World Health Organization in Geneva as a technical officer in the Department of Essential Drugs and Medicines Policy, dealing with access to medicines and intellectual property. During his first year at the WHO, Mr. Balasubramaniam was a Global Health Leadership Fellow, supported by the Rockefeller Foundation and the United Nations Foundation. He began his career with KEI working on issues related to health and intellectual property. Mr. Balasubramaniam holds a B.A. in Economics with a Minor in European History from the University of Pennsylvania.

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Dr. Carlos Maria Correa is Special Advisor on Intellectual Property and Trade of the South Centre and Director of the Center for Interdisciplinary Studies on Industrial Property and at the Law Faculty, University of Buenos. He has been a visiting professor in post-graduate courses of several universities and consultant to UNCTAD, UNIDO, UNDP, WHO, FAO, IDB, INTAL, World Bank, SELA, ECLA, UNDP, and other regional and international organizations. He has advised several governments on intellectual property, innovation policy and public health. He was a member of the UK Commission on Intellectual Property, of the Commission on Intellectual Property, Innovation and Public Health established by the World Health Assembly and of the FAO Panel of Eminent Experts on Ethics in Food and Agriculture. He is the author of several books and numerous articles on intellectual property and public health, technology transfer and investment.

GOVERNMENT, LAW, AND PUBLIC HEALTH PRACTICE

Legal Remedies Far and Near

Assessing the Expected Impact of Global Health Treaties: Evidence From 90 Quantitative Evaluations

Steven J. Hoffman, BHSc, MA, JD, and John-Arne Røttingen, MD, PhD, MSc, MPA

We assessed what impact can be expected from global health treaties on the basis of 90 quantitative evaluations of existing treaties on trade, finance, human rights, conflict, and the environment.

It appears treaties consistently succeed in shaping economic matters and consistently fail in achieving social progress. There are at least 3 differences between these domains that point to design characteristics that new global health treaties can incorporate to achieve positive impact: (1) incentives for those with power to act on them; (2) institutions designed to bring edicts into effect; and (3) interests advocating their negotiation, adoption, ratification, and domestic implementation.

Experimental and quasiexperimental evaluations of treaties would provide more information about what can be expected from this type of global intervention. (*Am J Public Health*. Published online ahead of print November 13, 2014: e1–e14. doi:10.2105/AJPH.2014.302085)

THERE HAVE BEEN MANY calls over the past few years for new international treaties addressing health issues, including alcohol,[1] chronic diseases,[2] falsified/substandard medicines,[3] health system corruption,[4] impact evaluations,[5] nutrition,[6] obesity,[7] research and development,[8] and global health broadly.[9] These calls follow the perceived success of past global health treaties—most notably the Framework Convention on Tobacco Control (2002) and the revised International Health Regulations (2005)—and perceived potential for future impact.[10] The World Health Organization's unusually expansive yet largely dormant powers for making new international treaties under its constitution's articles 19 and 21 are also cited as a reason for using them.[11–13] Although few multilateral institutions are empowered to enact new treaties, in the World Health Organization's case, with just a majority vote of its governing assembly, new regulations can automatically enter into force for all member states on communicable disease control, medical nomenclature, diagnostic standards, health product safety, labeling, and advertising unless states specifically opt out (article 21). Treaties in other health areas can be adopted by a two thirds vote of the World Health Organization's membership, with nonaccepting states legally required to take the unusual step of justifying their nonacceptance (article 19).[14]

The effect that can be expected from any new global health treaty, however, is as yet largely unknown. Negotiation, adoption, ratification, and even domestic implementation of treaties do not guarantee achievement of the results that are sought. Contemporary history has shown how some states comply with international treaties whereas others neglect their responsibilities. Even those states that mostly comply with their international legal obligations do not necessary comply with all of them. Citizens in the most prosperous and powerful countries may be surprised by the extent to which their own governments break international law and skirt responsibilities—which is well beyond what may be commonly assumed. Often states are even quite open about acknowledging their noncompliance, whether in statements to the media or in formal reports to international institutions.[15] Perhaps most concerning is that even if we assume all international treaties cause at least some effects, there is no reason to believe these effects will all be intended and desirable. States can strategically use international treaty making to buy time before needing to act, placate domestic constituencies without changing domestic policies, provide a distraction from dissatisfaction, hide more pressing challenges, and justify unsavory expenditures. Ratifying international treaties can even provide political cover for engaging in behaviors—such as state-sponsored torture—that are more harmful than what was done or may have been acceptable before.[15,16] In this way, advocates of new global health treaties cannot be sure whether they are successfully promoting their goals or unintentionally helping states undermine the very objectives they so earnestly seek to be fulfilled.

The most obvious starting point to assess what impact can be expected from global health treaties would be evaluations of existing global health treaties—those that were adopted primarily to promote human health. These include the International Sanitary Conventions (1892, 1893, 1894, 1897, 1903, 1912, 1926, 1938, 1944, 1944, 1946), Brussels Agreement for Free Treatment of Venereal Disease in Merchant

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Seamen (1924), International Convention for Mutual Protection Against Dengue Fever (1934), International Sanitary Convention for Aerial Navigation (1933, 1944), Constitution of the World Health Organization (1946), International Sanitary Regulations (1951), International Health Regulations (1969), Biological Weapons Convention (1972), Basel Convention on Transboundary Movements of Hazardous Wastes and Their Disposal (1989), Chemical Weapons Convention (1993), World Trade Organization Agreement on the Application of Sanitary and Phytosanitary Measures (1994), Convention on the Prohibition of Anti-Personnel Mines and Their Destruction (1997), Rotterdam Convention on Hazardous Chemicals and Pesticides in International Trade (1998), Cartagena Protocol on Biosafety to the Convention on Biological Diversity (2000), Stockholm Convention on Persistent Organic Pollutants (2001), World Health Organization Framework Convention on Tobacco Control (2003), International Health Regulations (2005), and Minamata Convention on Mercury (2013).

However, few studies to date have empirically measured the real-world effect of these global health treaties across countries.[17-19] Three studies modeled the Framework Convention on Tobacco Control's influence on national policies, finding that the treaty and its negotiation process were associated with certain countries adopting stronger tobacco control measures faster.[20-22] Although it is not a treaty, there is a study that qualitatively evaluated the perceived effectiveness of the World Health Organization's Global Code of Practice on the International Recruitment of Health Personnel, finding it had no effect on 93% of key informants surveyed.[23]

The evidence of international treaties' effects in other policy areas is rapidly expanding and can be used to inform judgments about what impact can be expected from existing and proposed global health treaties. The precise effects of international treaties, their causal pathways, and the conditions under which these pathways function is currently among the most heavily debated issues and contested puzzles in the fields of international law and international relations.[17,18] This includes at least 90 quantitative studies evaluating the effect of international trade treaties,[24–32] international financial treaties,[33–67] international human rights treaties,[68–98] international humanitarian treaties,[99–105] and international environmental treaties.[106–115]

ASSESSING IMPACT BY POLICY AREA

As with any complex regulatory intervention, the effect of international treaties will vary greatly depending on the problems being addressed and the contexts in which they operate.[18] Looking at their impact by policy area is particularly important for drawing insights about global health treaties because the latter are so diverse, with some proposals most reminiscent of international human rights treaties that promote norms (e.g., proposed health research and development treaty), international humanitarian treaties that constrain state behavior (e.g., proposed global health corruption protocol), international environmental treaties that impose regulatory obligations (e.g., proposed framework convention on alcohol control), and international trade treaties that regulate cross-border interactions (e.g., proposed falsified/substandard medicines treaty).

Evaluations of international trade treaties have overwhelmingly found they encourage liberal trade policies and increase trade flows among participating states as intended. International financial treaties have similarly been found to reduce financial transaction restrictions and increase financial flows. Less evident is the impact of human rights treaties. These treaties have been found to improve respect for civil and political rights but only in countries with particular domestic institutions such as democracy,[71] civil society,[116,117] and judicial independence.[118] International criminal treaties appear even more contested and uncertain. Some scholars have found war crime prosecutions to have no effect on violations[119]—some even claim it can worsen matters by lowering losing parties' incentives to make peace[120]—whereas others have found it improves postconflict reconstruction efforts by facilitating transitional justice.[85] International environmental treaties' effects are similarly debated. Some argue they can improve environmental protection,[106] especially by incentivizing private sector action,[121] and others contend they merely codify existing practices, preferring incremental approaches that use nontreaty political mechanisms.[122]

When categorizing each of the 90 quantitative evaluations according to whether they found positive, negative, or no effects—defined on the basis of the treaties' own stated purposes as found in the preamble text—it appears that trade and finance is where international treaties have been most "successful" (Figure 1a). The 9 studies evaluating international trade treaties overall found them to reduce trade volatility and increase trade flows,[31] particularly among member states of the General Agreement on Tariffs and Trade and the World Trade Organization[28] but also among nonmember participants.[29] Preferential trade agreements conditional on human rights standards were associated with less repression than were preferential trade agreements without them.[27] However, some studies suggest that international trade treaties do not guarantee increased trade flows[25] and that any increases may be limited to industrialized states and liberalized economic sectors.[26,28] The 33 studies evaluating international financial treaties mostly found they increase foreign investment among participating states,[33-37,40,41,43,44,46–48,50,53,56,57,59,60,62-67] although some found they had no impact in certain circumstances,[38,39,42,45,49,51,52,55,57,59,61,62] and others concluded they sometimes diminished investment (Table 1).[49,50,54,55,58,65]

ASSESSING IMPACT BY TYPE OF OBJECTIVE

The effect of international treaties will also vary according to

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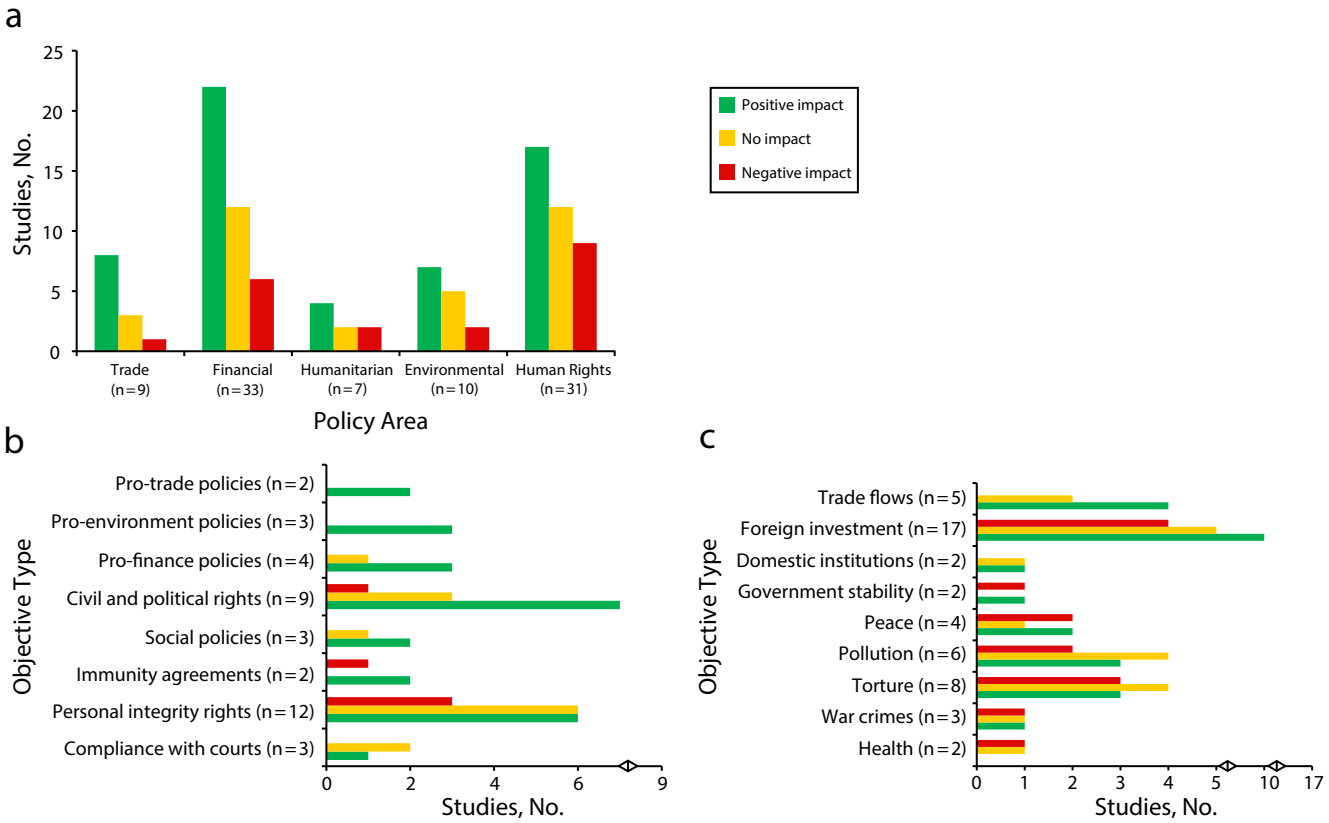

Note. Outcomes were deemed either "positive" or "negative" on the basis of whether they aligned or contradicted treaties' own stated goals as found in their preamble text. We coded studies that drew both positive and negative conclusions twice in the bar chart coloring but only once in the tally of studies presented beside each label. This explains why there are 2 studies evaluating the impact of international law on immunity agreements for international crimes although the bar chart coloring indicates that 66% of studies found a positive impact and 33% found a negative impact. This also explains why there are 4 studies evaluating the impact of international law on peace yet the bar chart coloring indicates that 2 studies found a positive impact, 2 found a negative impact, and 1 found no impact. The figure does not show the impact of international laws on derogation from rights, economic sanctions, public support, and water levels because these 4 outcome measures were only evaluated in a single study each.

FIGURE 1—Number of studies showing positive, negative, and no impact on (a) any outcome measure by policy area, (b) government policies by type of objective, and (c) people, places, and products by type of objective.

the type of objective sought. This insight is important for global health treaties because each proposal has different goals, from changing national government policies to regulating people, places, or products.

The good news is that most studies evaluating changes in national government policies found treaties had a positive effect in the direction drafters desired (Figure 1b). For example, World Trade Organization and General Agreement on Tariffs and Trade membership increased trade liberalization[24,30] just as the International Monetary Fund's Articles of Agreement successfully reduced restrictions on financial transactions.[34–36,46,60] International environmental treaties promoted desired changes in national environmental policies,[110,113,115] International Labor Organization conventions increased the length of maternity leave,[89] and the Rome Statute of the International Criminal Court has succeeded in preventing immunity agreements for international crimes by state parties.[102,104]

The bad news is that treaties' influence on government policies did not always translate into positive changes for people, places, or products—with "positive" defined on the basis of treaties' own stated goals in their preamble text (Figure 1c). Most studies that evaluated real-world outcomes found treaties had either no effect or the opposite effect than what was intended. For example, environmental agreements did not always reduce pollution,[106–112] international humanitarian treaties did not reduce intentional civilian

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TABLE 1—Impact of Different Areas of Laws on Any Outcome Measure

Area of Law	Negative Impact	No Impact	Positive Impact
International human rights law (n = 31)	69	68	71
	70	73,a	73,a
	72	74	78
	81,b	75	79
	84,a	76,b	80
	86,a	77	82
	87	83,b	84,a
	92,a	91	85
	97,a	93,a	86,a
		95,a	88
		96,a	89
		97,a	90,b
			92,a
			93,a
			95,a
			96,a
			98,b
			94
International humanitarian law (n = 7)	100	99,b	102,b
	104,a,b	101	103
			105,b
			104,a,b
International environmental law (n = 10)	106,a,b	107	106,a,b
	108,a	109,a,b	108,a
		111,b	109,a,b
		112	110,b
		114,a,b	113,b
			114,a,b
			115,b
International trade law (n = 9)	32,a	25	24
		26,a	26,a
		27,a	27,a
			28
			29
			30
			31
			32,a

Continued

fatalities during wartime,[101] human rights treaties did not improve life expectancy or infant mortality,[76] and structural adjustment agreements actually diminished these health indicators along with basic literacy rates and government stability.[72] Eight studies are split on whether the Convention Against Torture improved, had no effect, or worsened torture practices.[69,75,77,84,87,89,93,96]

Like the earlier analysis by policy area, a common trend here is that international treaties seem to be most successful in attaining economic objectives. This analysis additionally emphasizes how treaties seem to be least successful in realizing social goals. Although nearly all studies that evaluated these outcomes found treaties increased liberal economic policies, trade flows, and foreign investment, few studies reported improvements in government stability, peace, pollution, torture, war crimes, or health. More studies concluded that treaties had negative effects in these noneconomic areas than either positive or no effects (Table 2; individual summaries of the 90 quantitative evaluations are available as a supplement to the online version of this article at http://www.ajph.org).

IMPORTANCE OF INCENTIVES, INSTITUTIONS, AND INTERESTS

What impact can be expected from global health treaties? According to our analysis, not very much. International treaties have consistently succeeded in shaping economic matters just as they have consistently failed in achieving social progress (including improved health status).

But global health treaties are not necessarily destined to fail. Although there may be intrinsic differences between economic and social domains, there are at least 3 differences in how treaties are characteristically designed between these areas that suggest ways new global health treaties could be constructed to achieve positive effect.

First, international economic treaties tend to provide immediate benefits to states and governing elites such that action aligns with their short-term self-interests. International treaties on social issues rarely offer immediate benefits and usually impose costs on those in charge. This suggests new global health treaties can have greater impact if they too include incentives for those with power to act on them. This hypothesis aligns with neorealist theories from political science and international relations and game theory from economics that emphasize the role of incentives in shaping national agendas and the priorities of elites.[79,123,124]

Second, international economic treaties tend to incorporate institutional mechanisms for promoting compliance, dispute resolution, and accountability that are typically absent from socially focused treaties that must instead rely on the "naming and shaming" efforts of progressive states and civil society. Examples of institutional mechanisms include automatic penalties, sanctions, mandatory arbitration, regular reporting requirements, and compliance

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TABLE 1—*Continued*

International financial law (n = 33)	49,a	38	33,b
	50,a,b	39	34–36
	54	42	37
	55,a	45	40
	58,b	49,a	41
	65,a	51	43
		52	44
		55,a	46
		57,a	47,b
		59,a	48
		61,b	50,a,b
		62,a	53
			56
			57,a
			59,a
			60
			62,a
			63
			64
			65,a
			66
			67
No. of studies	20	34	59

Note. The citations to studies within each cell are listed in chronological order.
[a]These 23 studies are listed more than once, as they featured multiple conclusions about the impact of international law on measured outcomes.
[b]These 23 studies used time-series analysis (n = 3),[33,99,114] cross-sectional analysis (n = 6),[33,61,76,90,102,111] Cox proportionate hazard models (n = 4),[34–36,80,104,105] generalized method of moments analysis (n = 1),[47] quantile treatment effect distributional analysis (n = 1),[50] formal model analysis (n = 1),[109] descriptive statistics (n = 6),[81,83,106,110,113,115] survey experiments (n = 1),[98] and difference-in-difference analysis (n = 1).[58] One of these studies used both time-series analysis and cross-sectional analysis.[33] The other 67 studies[24–32,37–46,48,49,51–57,59,60,62–75,77–79,82,84–89,91–97,100,101,103,107,108,112] and 2 of the studies with Cox proportionate hazard modeling[34–36,80] used time-series cross-sectional analysis.

assessments. This suggests that new global health treaties can have greater effect if they include institutions specifically designed to bring edicts into effect. This hypothesis aligns with institutionalist theories that emphasize the role of implicit or explicit structures in defining expectations, constraining decisions, distributing power, and incentivizing behavior[125,126] as well as international legal process theories that view treaties as organizing devices and constraints on diplomatic practice.[127]

Third, international economic treaties tend to have the support of powerful interest groups who advocate their full implementation and few strong opponents who can advocate against them. This most notably includes those industry groups and multinational corporations with extremely generous lobbying budgets, worldwide affiliates, and access to sophisticated advocacy professionals, which are resources not typically used by industry to address social challenges. Progressive civil society organizations are comparatively underfunded. This suggests that new global health treaties can have greater impact either if their aims match those of powerful interests or if supporters can build sufficiently strong coalitions of their own. This hypothesis aligns with institutionalist theories that stress how treaties serve as focal points for social mobilization and provide resources for political movements,[79,124] critical legal theories that view treaties as offering language with which actors assert claims,[128,129] and network theories that emphasize the role of transnational advocacy networks and networked governmental authorities in shaping domestic political decision making.[130,131]

Less important, this analysis suggests, is for new global health treaties to (1) allow individuals to bring claims against their own governments (e.g., domestic human rights litigation), (2) address an urgent imperative requiring immediate action (e.g., climate change), or (3) promote ideals of an ethical world (e.g., peace). These features are typically absent from the seemingly effective international economic treaties and characteristic of the seemingly less effective treaties addressing social problems. This hypothesis is in opposition to legal theories supporting individual litigation,[132] cosmopolitanism's ideal of shared morality,[133,134] and constructivist theories that emphasize ideas, norms, language, and the power of treaty-making processes.[22,135–138]

EXPERIMENTAL AND QUASIEXPERIMENTAL METHODS

Our analysis of 90 quantitative evaluations is a start in assessing what impact can be expected from global health treaties and in identifying design characteristics of treaties that have historically achieved greater effect. But global health decision makers need stronger and more specific conclusions than existing research can offer. This is a matter not just of needing more research but also of needing a greater diversity of methodological approaches.

All but 2 of the 90 quantitative evaluations relied on observational study designs that by themselves do not facilitate causal inferences. The vast majority employed time-series cross-sectional analysis (n = 69), with the remaining studies using time-series analysis (n = 3),[33,99,114] cross-sectional analysis (n = 6),[33,61,76,90,102,111] Cox proportionate hazard models (n = 4),[34–36,80,104,105] generalized method of moments analysis (n = 1),[47] quantile treatment effect distribution analysis (n = 1),[50] formal model analysis (n = 1),[109] and descriptive statistics (n = 7).[81,83,106,110,113,115]

This is not all bad news. Time-series cross-sectional analysis is a relatively strong design that increases the number of and variation across observations by incorporating both the temporal (e.g., year) and spatial (e.g., country)

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TABLE 2—Impact of International Treaties

Outcome	Study Conclusions	Impact	Conditions
	Impact on government policies		
Civil and political rights (n = 12)	Keith found ratifying the ICCPR did not improve civil rights practices.[68]	None	
	Hathaway found ratifying the ICCPR did not improve civil liberties and did not increase fairness of trials, and ratifying the UN Covenant on the Political Rights of Women did not improve women's ability to take part in government.[69]	None	
	Neumayer found ratifying human rights treaties improved civil rights practices in democratic states or states with strong engagement in global civil society.[71]	Positive	Democracy Civil society
	Abouharb and Cingraelli found SAAs promoted an institutionalized democracy, freedom of assembly and association, freedom of speech, and free and fair elections.[72]	Positive	
	Cardenas found international and domestic human rights pressures did not improve civil rights practices but increased ratification of human rights treaties in countries without a national security threat, in which norm violations would threaten the elites' economic interests and prohuman rights groups have public support.[73]	None and positive	Security Elite interests Human rights groups
	Simmons found ratifying the ICCPR slightly improved civil liberties after 5 years, reduced government restrictions on religious freedoms most strongly in states transitioning between autocracy and democracy, and improved the fairness of trials only in countries transitioning between autocracy and democracy.[78]	Positive	Transitional state
	Simmons found ratifying 6 international human rights treaties (e.g., ICCPR, ICESCR, CERD, CEDAW, CAT, and CRC) improved civil and political rights practices in states transitioning between autocracy and democracy.[79]	Positive	Transitional state
	Simmons found ratifying the ICCPR's optional protocol slightly improved civil liberties.[80]	Positive	
	Hill found ratifying the CEDAW improved women's political rights practices.[84]	Positive	
	Cole found due process and personal liberty claims filed under the ICCPR's Optional Protocol were more successful than were suffrage and family rights claims in HRC rulings.[86]	Both	Claim type
	Lupu found ratifying the ICCPR improved government respect for freedoms of speech, association, assembly, and religion.[95]	Positive	
	Lupu found ratifying CEDAW improved respect for women's political rights.[96]	Positive	
Compliance with court rulings (n = 3)	Basch et al. found high noncompliance with remedies adopted by the IASHPR, with total compliance observed only after a long time.[81]	None	
	Hawkins and Jacoby found only partial compliance with rulings of the IACHR and ECtHR.[83]	None	
	Staton and Romero found high compliance with IACHR rulings that were clearly expressed.[90]	Positive	Ruling clarity
Derogation from rights (n = 1)	Neumayer found that among ICCPR signatory states in declared states of emergency, democracies did not increase violations, whereas autocracies and some anocracies increased violations of both derogable and nonderogable rights.[97]	Both	Regime type
Economic sanctions (n = 1)	Hafner-Burton and Montgomery found PTAs did not affect the likelihood of sanctions, but the likelihood was increased when the initiator had high centrality in the PTA network.[49]	None and negative	Initiator centrality
Environment policies (n = 3)	Miles et al. found international environmental laws promoted positive behavioral changes by states and, to a lesser degree, improved the state of the environment.[110]	Positive	
	Breitmeier et al. found international environmental laws promoted significant compliance behavior by signatory states and sometimes improved the state of the environment, with knowledge of the problem, member states' interests, and decision rule being key factors.[113,115]	Positive	Knowledge Interests Decision rule

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TABLE 2—*Continued*

Financial transactions restrictions (n = 4)	Simmons found states that ratified Article VIII of the IMF's Articles of Agreement were less likely to impose restrictions on their accounts.[34–36]	Positive	
	von Stein[34–36] found the positive effect in Simmons[45] was not because of Article VIII itself but the IMF's informal conditions for selecting and pressuring states to ratify Article VIII.	None	
	Simmons and Hopkins found ratifying IMF Article VIII reduced account restrictions, even after accounting for selection effects.[46]	Positive	
	Grieco et al. found states that ratified IMF Article VIII were less likely to impose account restrictions, even if their political orientation shifted away from monetary openness.[60]	Positive	
Immunity agreements for international crimes (n = 2)	Kelley found states that valued the ICC and respected the rule of law were more likely to reject a nonsurrender agreement with the United States that would violate Article 86 of the Rome Statute.[102]	Positive	
	Nooruddin and Payton found states that entered the ICC, especially those with high rule of law, had high GDP, had defense pacts with the United States or were sanctioned by the United States and took longer to sign a BIA with the United States, whereas states that traded heavily with the United States signed more quickly.[104]	Both	ICC membership US relations
Personal integrity rights (n = 12)	Keith found ratifying the ICCPR did not improve personal integrity rights practices.[68]	None	
	Hafner-Burton found PTAs requiring member states to improve their human rights practices were more effective than were HRAs in improving personal integrity rights practices.[27]	Positive and none	
	Hafner-Burton and Tsutsui found ratifying human rights treaties did not improve personal integrity rights practices, but participation in global civil society activities did.[70]	None	
	Neumayer found ratifying human rights treaties improved personal integrity rights practices in democratic states or states with strong engagement in global civil society.[71]	Positive	Democracy Civil society
	Abouharb and Cingranelli found SAAs worsened personal integrity rights practices.[72]	Negative	
	Hafner-Burton and Tsutsui found ratifying the CAT or ICCPR did not improve personal integrity rights practices of highly repressive states even long into the future, regardless of democracy and civil society.[74]	None	
	Greenhill found membership in IGOs whose member states have strong human rights records improved personal integrity rights practices.[82]	Positive	
	Hill found ratifying the ICCPR worsened personal integrity rights practices.[84]	Negative	
	Kim and Sikkink found domestic and international prosecutions of human rights violations and truth commissions reduced repressions of personal integrity rights.[85]	Positive	
	Cole found ratifying the ICESCR worsened labor rights laws but improved labor rights practices.[92]	Both	
	Lupu found ratifying the ICCPR did not improve personal integrity rights practices.[95]	None	
	Lupu found ratifying the CEDAW improved respect for women's economic and social rights and ratifying the ICCPR did not improve personal integrity rights.[96]	Positive and none	
Social policies (n = 3)	Linos found the promulgation of global norms (through ratifying International Labor Organization conventions and large presence of INGOs) increased length of maternity leave.[89]	Positive	
	Kim and Boyle found SAAs did not increase education spending but citizen engagement in global civil society did.[91]	None	
	Helfer and Voeten found ECtHR rulings on LGBT issues increased the likelihood that states under the ECtHR's jurisdiction that had not yet adopted a pro-LGBT policy would do so.[94]	Positive	

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TABLE 2—*Continued*

Trade policies (n = 2)	Bown found commitment to trade liberalization following WTO or GATT trade disputes was greater if the trading partner had the ability to retaliate.[24]	Positive	Ability to retaliate
	Kucik and Reinhardt found WTO member states that could take advantage of the WTO's antidumping flexibility provision agreed to tighter tariff bindings and applied lower tariffs.[30]	Positive	Flexibility provision
	Impact on people, places, or products		
Domestic institutions (n = 2)	Ginsburg found BITs did not improve and in some cases worsened domestic institutions.[42]	None	
	Busse et al. found BITs promoted institutional development and may thus substitute for domestic measures to improve political governance.[66]	Positive	
Foreign investment (n = 27)	UNCTAD found BITs slightly increased FDI to developing countries.[33]	Positive	
	Banga found BITs with developed countries increased FDI inflows to developing countries.[37]	Positive	
	Davies found renegotiations on BTTs involving the United States did not increase FDI stocks and affiliate sales in the United States.[38]	None	
	Hallward-Driemeier found BITs did not increase FDI inflows to developing countries.[39]	None	
	Egger and Pfaffermayr found BITs increased outward FDI stocks but only if they have been fully implemented.[40]	Positive	Fully implemented
	di Giovanni found BTTs and bilateral service agreements increased M&A flows.[41]	Positive	
	Grosse and Trevino found BITs signed by states in Central and Eastern Europe increased FDI inflows to the region.[43]	Positive	
	Neumayer and Spess found BITs with developed countries increased FDI inflows to developing countries.[44]	Positive	
	Egger and Merlo (2007) found BITs increased outward FDI stocks to host countries, with their long-term impact being greater than was their short-term impact.[47]	Positive	Time
	Büthe and Milner found WTO or GATT membership, PTAs, and BITs increased FDI inflows to developing countries.[48,56]	Positive	
	Millimet and Kumas found BTTs increased inbound and outbound US FDI activity (i.e., flows, stocks, and affiliate sales) in countries with low FDI activity and decreased inbound and outbound US FDI activity in countries with high FDI activity.[50]	Both	Base FDI activity
	Yackee found BITs, even the formally strongest ones with international arbitration provisions, did not increase FDI inflows to developing countries.[51]	None	
	Aisbett found that although BITs seemingly increased FDI outflows, the measured effect was simply because of the endogeneity of BIT adoption.[52]	None	
	Barthel et al. found DTTs increased FDI stocks between partner countries.[53]	Positive	
	Blonigen and Davies found recently formed BTTs decreased outbound FDI stocks and flows to partner countries.[54]	Negative	
	Blonigen and Davies found BTTs involving the United States decreased outbound FDI stocks and affiliate sales from the United States and did not affect inbound FDI stocks and affiliate sales to the United States.[55]	None and negative	
	Coupé et al. found BITs, but not DTTs, increased FDI inflows to countries undergoing economic transition.[57]	Positive and none	Economic transition
	Egger et al. found BTTs decreased outward FDI stocks to host countries.[58]	Negative	
	Gallagher and Birch found BITs with the United States did not increase FDI inflows from the United States to Latin American and Mesoamerican states, whereas BITs with all countries increased total FDI inflows to Latin American states.[59]	None and positive	

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TABLE 2—*Continued*

	Louie and Rousslang found BTTs with the United States did not affect the rates of return that US companies required on their FDI.[61]	None	
	Millimet and Kumas found BTTs increased time-lagged inbound FDI stocks and flows but did not affect inbound affiliate sales and outbound FDI stocks, flows, and affiliate sales.[62]	Positive and none	
	Neumayer found DTTs with the United States increased outbound FDI stocks from the United States, whereas DTTs with all countries increased general inbound FDI stocks and FDI inflows but only in middle-income countries.[63]	Positive	Economic status
	Salacuse and Sullivan found BITs with the United States increased FDI inflows to developing countries, both generally from other countries and specifically from the United States.[64]	Positive	
	Yackee found BITs decreased FDI inflows to developing countries, whereas those signed with countries at low political risk increased FDI inflows.[65]	Both	Political risk
	Busse et al. found BITs increased FDI inflows to developing countries.[66]	Positive	
	Tobin and Rose-Ackerman found BITs increased FDI inflows to developing countries that had a suitable political–economic environment.[67]	Positive	Investment environment
Government stability (n = 2)	Abouharb and Cingranelli found SAAs increased the probability and prevalence of antigovernment rebellion.[72]	Negative	
	Hollyer and Rosendorff found autocracies that ratified the CAT had longer tenures in office and experienced less oppositional activities.[88]	Positive	
Health and well-being (n = 2)	Abouharb and Cingranelli found SAAs led to worse quality of life as measured by basic literacy rate, infant mortality, and life expectancy at aged 1 year.[72]	Negative	
	Palmer et al. found ratifying human rights treaties did not improve life expectancy, infant mortality, maternal mortality, or child mortality.[76]	None	
Peace (n = 4)	Meernik found judicial actions of the ICTY did not improve societal peace in Bosnia.[99]	None	
	Simmons and Danner found the ICC terminated civil conflicts and promoted engagement in peace agreements in nondemocratic and low rule-of-law member states.[105]	Positive	Nondemocracy
	Hafner-Burton and Montgomery found membership in IGOs increased the likelihood of participation in militarized international disputes.[100]	Negative	
	Hafner-Burton and Montgomery found membership in trade institutions decreased the likelihood of militarized disputes between states with relatively equal economic positions and increased the likelihood of militarized disputes between states with unequal positions.[32]	Both	Economic status
Pollution (n = 6)	Mitchell found a treaty mandating tankers to install pollution-reduction equipment was more effective than was a treaty that set a legal limit to tanker oil discharges.[106]	Both	
	Murdoch and Sandler found the Montreal Protocol did not reduce CFC emissions but rather codified previous voluntary reductions by member states.[107]	None	
	Murdoch et al. found the Helsinki Protocol reduced sulfur emissions but the Sofia Protocol did not reduce nitrogen oxides emissions in European states because of differences in the source and spread of each pollutant.[108]	Both	
	Helm and Sprinz found the Helsinki Protocol reduced sulfur dioxide emissions and the Oslo Protocol reduced nitrogen dioxide emissions but fell short of the calculated optimum levels.[109]	Positive and none	
	Finus and Tjøtta found the sulfur emission reduction targets set by the Oslo Protocol were lower than were those expected without an international agreement.[111]	None	
	Ringquist and Kostadinova found the Helsinki Protocol did not reduce sulfur emissions in Europe.[112]	None	

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TABLE 2—*Continued*

Public support (n = 1)	Putnam and Shapiro found public support for government action against Myanmar increased when respondents were informed that Myanmar's forced labor practices violated international law.[98]	Positive	
Torture (n = 8)	Hathaway found ratifying the CAT led to worse torture practices, whereas additionally ratifying Article 21 of the CAT (which allows state to state complaints) did not change them.[69]	None and negative	
	Gilligan and Nesbitt found ratifying the CAT did not improve torture practices.[75]	None	
	Powell and Staton found ratifying the CAT improved torture practices in states with strong domestic systems of legal enforcement.[77]	Positive	Legal enforcement
	Hill found ratifying the CAT led to worse torture practices.[84]	Negative	
	Hollyer and Rosendorff found autocracies that ratified the CAT continued their torture practices but at slightly lower levels.[88]	Positive	
	Conrad and Ritter found ratifying the CAT improved torture practices in dictatorships with politically secure leaders but did not change practices in those with politically insecure leaders.[93]	Positive and none	Leader security
	Lupu found ratifying the CAT was not associated with lower torture rates.[96]	None	
	Conrad found ratifying the CAT increased the likelihood of torture in dictatorships with power sharing but only when judicial effectiveness was high.[87]	Negative	Judicial effectiveness
Trade flows (n = 5)	Rose found WTO or GATT membership did not increase trade.[25]	None	
	Gowa and Kim found GATT membership increased trade between Canada, France, Germany, United Kingdom, and United States but did not affect trade between other member states.[26]	Positive and none	
	Subramanian and Wei found WTO or GATT membership increased trade for industrial states, especially when trading partners were also WTO or GATT members.[28]	Positive	Industrialized partners
	Tomz et al. found WTO or GATT participation, formally or as a nonmember, increased trade.[29]	Positive	
	Mansfield and Reinhardt found membership in the WTO or GATT and PTAs reduced export volatility and thereby increased export levels.[31]	Positive	
War crimes and genocide (n = 3)	Hathaway found ratifying the UN Convention on the Prevention and Punishment of the Crime of Genocide led to worse genocide practices.[69]	Negative	
	Valentino et al. found international humanitarian law did not reduce intentional civilian fatalities during wartime, regardless of regime type and identity of enemy combatants.[101]	None	
	Morrow found democracies had fewer violations of international humanitarian laws during wartime, and joint ratification of laws promoted reciprocity between warring states.[103]	Positive	Democracy
Water levels (n = 1)	Bernauer and Siegfried found water release from the Toktogul reservoir after the 1998 Naryn/Syr Darya basin agreement met mandated levels, but was significantly higher than the calculated optimum levels.[114]	Positive and none	

Note. BIA = Bilateral Immunity Agreement; BIT = Bilateral Investment Treaty; BTT = Bilateral Tax Treaty; CAT = Convention Against Torture; CEDAW = Convention to Eliminate All Forms of Discrimination Against Women; CERD = Committee on the Elimination of Racial Discrimination; CFC = chlorofluorocarbon; CRC = Convention on the Rights of the Child; DTT = Double Taxation Treaty; ECtHR = European Court of Human Rights; FDI = foreign direct investment; GATT = General Agreement on Tariffs and Trade; HRC = Human Rights Committee; IACHR = Inter-American Court of Human Rights; IASHRP = Inter-American System of Human Rights Protection; ICC = International Criminal Court; ICCPR = International Covenant on Civil and Political Rights; ICESCR = International Covenant on Economic, Social, and Cultural Rights; ICTY = International Criminal Tribunal for the Former Yugoslavia; IGO = intergovernmental organization; IMF = International Monetary Fund; INGO = international nongovernmental organization; LGBT = lesbian, gay, bisexual, and transgender; M&A = merger and acquisition; PTA = Preferential Trade Agreement; SAA = Structural Adjustment Agreement; UN = United Nations; WTO = World Trade Organization.

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dimensions of data. This makes parameter estimates more robust and allows the testing of variables that would display negligible variability when examined across either time or space alone.[139,140] But like most models of observational data, causal inferences from time-series cross-sectional analyses are undermined by the possibility of confounding, reverse causation and the nonrandom distribution of interventions (i.e., international treaties) that may be linked to the outcomes measured.[141,142]

Unfortunately we found only 2 experimental or quasiexperimental evaluations of specific international treaties for any policy area, despite these representing stronger methodological designs for measuring effects. The single experiment we found was a survey of 2724 American adults testing public reaction to Myanmar's forced labor practices, which found that respondents who were told that Myanmar's actions violated an international law were more likely to support sanctions than were uninformed respondents.[98] The quasiexperiment was a difference-in-difference analysis of bilateral tax treaties' effect on foreign investment.[58] Quasiexperimental methods have been used extensively to evaluate the effects of legislation, policies, and regulations in domestic contexts,[143–146] but they do not appear to be popular in the study of international instruments thus far.

CONCLUSIONS

States have increasingly relied on international treaties to manage the harmful effects of globalization and reap its potential benefits. Sometimes they seek to mitigate a threat or resolve a collective action problem; other times they hope to promote a specific norm, signal intentions, or encourage the production of global public goods. Motivating such international treaty making is the idea that states are willing to constrain their behavior or accept positive obligations if other states do the same. This type of international cooperation is viewed by many as essential for progress across many policy areas, including for health, because of how risks now travel between states irrespective of national boundaries (e.g., pandemics), and where attaining rewards often requires coordinated action or resources on a scale beyond any single country's willingness to pay (e.g., research and development for neglected diseases).

But evidence of international treaties' effects on health is scant, making it difficult to draw reasonable inferences on what impact can be expected from new treaties that either regulate health matters or aim to promote better health outcomes. The only 2 studies that evaluated health outcomes found that human rights treaties had no impact on a variety of health indicators[76] and that structural adjustment agreements had a negative effect on them.[72]

As long as the evidence remains unclear, we should not assume new global health treaties will achieve positive outcomes. Their inconsistent effects undermine the oft-cited claim that treaties can have a greater effect on people, places, products, or policies than do other instruments, such as political declarations, codes of practice, or resolutions.[147] The precise mechanism through which states make commitments to each other seems less important than does the content of the commitment, the regime complexes it joins,[148,149] financial allocations,[150] dispute resolution procedures,[151] processes for promoting accountability,[152] and the support of states and other stakeholders to see commitments fully implemented.[153] Arguments about "hard law" versus "soft law" and "binding" versus "nonbinding" seem less important than do strategic conversations about incentivizing elites, institutionalizing compliance mechanisms, and activating interest groups. Without such conversations, new global health treaties will have less chance of achieving their intended impact, or, worse, they could even cause harm as some treaties may already have done. ■

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Contributors

S. J. Hoffman originated the study and wrote the first draft of the article. J.-A. Røttingen contributed to the analysis and revised successive drafts of the article for important intellectual content.

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No protocol approval was necessary because no human participants were involved.

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PARALLEL SESSION 2.7

GOVERNANCE BY PARTNERSHIP – AN ANSWER FOR POST 2015?

PARALLEL SESSION 2.7

GOVERNANCE BY PARTNERSHIP –
AN ANSWER FOR POST 2015?

BACKGROUND

Global Health Governance was in transition from states and multilateral organizations such as World Health Organization to the involvement of non-states and global health initiative organizations. With the rising of new actors in global health has diminished the important role of WHO and other health related UN organizations. Global Health initiatives such as Global Fund and GAVI have different model of partnership with participation of private sector, civil society and non-health sectors. Partnership is a main strategy of Global Fund since its inception in 2002 and was in every level of Global Fund model. Civil society and non-health sectors are also important parts of global health successful program such as Gates Foundation; Task Force for Child Survival; Bangladesh Rural Advancement Committee; Carter Center; Clark etc. Participation by NGOs and CSOs give voice from people and also make the health issues relevant to people on the ground. At the country level, participation in public policy development through National Health Assembly is implemented in some countries to provide public forum for policy dialogue. This In this respect, partnership can be an answer to the global health governance in these complex health problems.

OBJECTIVES

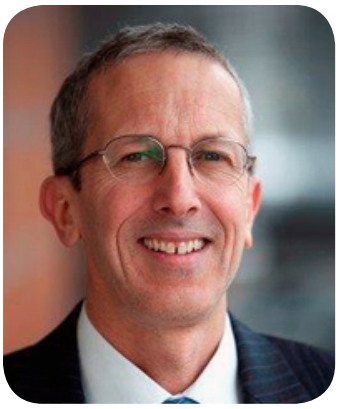
- To discuss on different model of partnership for participation from different sector both public and non-public sector
- To discuss on benefits and limitations of partnership models
- To provide recommendations on partnership models that are relevant to changing globalhealth landscape

MODERATOR

Thein Thein HTAY
Deputy Minister
Ministry of Health

Myanmar

Dr. Thein Thein Htay is a Deputy Minister for Health and currently her main responsibility for the medical education, health services delivery and medical research in Myanmar. Dr. Thein is also an adjunct faculty member as well as an honorary Professor to the University of Public Health in Myanmar. She obtained her Master of Health Science in population development and reproductive health from the John Hopkins Bloomberg University of Public Health in 2000. She earned a range of certificates on MCH/Family Planning including from UCLA and BKKBN in early 1990s. She received her Master of Public Health from the University of Medicine (1), Yangon in 1987. She also holds a medical degree from the University of Medicine (2), Yangon since 1977. Her career focused originally on maternal, newborn and child health, and then extends to reproductive health since 1996. Dr. Thein was one of the founding members of family planning program in Myanmar. In this capacity, she leads the public health division of the DOH, with main thrust on meeting MDGs 4 & 5. She is also volunteering as a technical consultant to the one of key national NGOs, Myanmar Maternal and Child Welfare Association since 2003. She has been a research consultant to many UN funded RH projects. She also served as a member of Gender Advisory Panel, WHO-HQ from 1999 to 2004. Also served as a regional steering committee member for the Lancet series of South East Asia Region's health issues and also a country lead for Lancet Myanmar Series. Currently, she is a member of International Steering Committee of 8th Asia Pacific Conference on Sexual & Reproductive Health and Rights. She is keen in integrating HIV and FP services since decades ago and have participated in every effort to make it happened at country level. Her keen interest and vast experience in medical education has been instrumental in advocating decision makers for the reform towards new paradigm of medical education system in Myanmar. Currently, she is an advocate as well as the key player in the health sector reform with main focus on building infrastructure through governance, transparency and accountability. She has also taken much effort in realizing Universal Health Coverage, Health System Strengthening and Global Supply Chain and Management System in Myanmar. She is also a member of Myanmar Help Poverty Committee and the Committee on the Myanmar Provident Fund.



Robert NEWMAN
Managing Director
Policy & Performance
Global Alliance for Vaccines and Immunization (GAVI)

Switzerland

Dr Robert D. Newman is a pediatrician and is currently the Managing Director for Policy and Performance at the Gavi, the Vaccine Alliance, in Geneva, Switzerland. In that role, he oversees organizational strategy setting, market shaping, policy development, business planning, and monitoring & evaluation.

Before joining Gavi, Dr. Newman was Director of the Global Malaria Programme at the World Health Organization (WHO) in Geneva from 2009 to 2014. Prior to that, he spent 9 years at the Centers for Disease Control and Prevention in Atlanta in the Malaria Branch, where he also served as the CDC team lead for the US Presidents Malaria Initiative from 2006 to 2009. He has also spent time in the field, first studying Cryptosporidium in a favela in Brasil in the early 1990s, and then as Country Coordinator of Health Alliance International in Mozambique in the late 1990s supporting the government in its efforts to improve maternal and child health.

Dr. Newman received his BA in English Literature from Williams College, his MD from Johns Hopkins University, and his MPH from the University of Washington. He completed his residency in Pediatrics at the University of Washington--Seattle Children's Hospital in 1996, and stayed on to complete a National Research Service Award fellowship in General Pediatrics in 1998. He has published more than 60 peer-reviewed articles on malaria and other infectious diseases.

Mushtaque CHOWDHURY
Vice Chair
BRAC

Bangladesh

Mushtaque Chowdhury is the Vice Chair of BRAC, the world's largest non-governmental organization. Previously, he was its Deputy Executive Director, founding Director of the Research and Evaluation Division and founding Dean of the James P. Grant School of Public Health.

Dr Chowdhury is also a Professor of Population and Family Health at the Mailman School of Public Health of Columbia University in New York. During 2009-12, he worked as the Senior Adviser to the Rockefeller Foundation, based in Bangkok, Thailand. He also served as a MacArthur Fellow at Harvard University. Dr. Chowdhury holds a PhD from the London School of Hygiene and Tropical Medicine, an MSc from the London School of Economics and a BA (Hon's.) from the University of Dhaka.

Dr. Chowdhury was a coordinator of the UN Millennium Task Force on Child Health and Maternal Health, set up by the former Secretary General Kofi Annan. He is a co-recipient of the 'Innovator of the Year 2006' award from the Marriott Business School of Brigham Young University in USA and in 2008 he received the PESON oration medal from the Perinatal Society of Nepal. He has wide interest in development, particularly in the areas of education, public health, poverty eradication and environment. Dr. Chowdhury has published over 150 articles in peer-reviewed international journals including the International Journal on Education, the Lancet, the Social Science & Medicine, The Scientific American and the New England Journal of Medicine. One of his recent books is From One to Many: Scaling Up Health Programs in Low Income Countries (co-edited with Richard Cash et al.), published in 2011. He co-ordinated the recently launched Lancet Series on Bangladesh (http://www.thelancet.com/series/bangladesh). The Lancet also published a 'profile' celebrating his contributions to Global Health.

Dr Chowdhury is a founder of the Bangladesh Education Watch and Bangladesh Health Watch, two civil society watch-dogs on education and health respectively. He is on the board and committees of several organizations and initiatives, including: Board of Trustees of BRAC University in Bangladesh, and International Advisory Board of the Centre for Sustainable International Development at the University of Aberdeen in UK.

Amphon JINDAWATTANA
Secretary General
National Health Commission Office

Thailand

Dr. Amphon Jindawatthana currently serves as the Secretary General of Thailand's National Health Commission chaired by the Prime Minister. He has 37 years of experience in health systems reform and healthy public policy development. His remarkable work is to develop and advance the National Health Act enacted in March 2007 and drive the process of participatory healthy public policy into action nationwide.

In addition to health systems reform, he also contributes his expertise and experience to the national development as a whole. He is an executive board member of the Political Development Fund for Civil Sector of King Prajadhipok's Institute, a board member of the Governmental Pharmaceutical Organization, a council member of the Learning Institute for Everyone, and a senior advisor to the National Community Organization Council. Recently in 2014, he is appointed to be a member of the National Reform Council

He had joined the Ministry of Public Health from 1977 – 2000 and served several roles and positions such as Director of Community Hospital in 2 provinces, Director of Provincial Public Health Office in 3 provinces and Director of Praboromarajchanok Institute of Health Workforce Development. His previous engagement included the Director of the National Health System Reform Office from 2000 to 2007, the secretary to the Minister of Public Health from 2006 to 2007 and a member of the National Legislative Assembly from 2006 to 2008.

Dr. Jindawatthana obtained his Honorary Phd. in Thai Traditional Medicine from Chiangrai Rajabhat University, Thailand, his master degrees in public health from Mahidol University, Thailand and in health development from Leopold Institute of Tropical Medicine, Antwerp, Belgium, and a medical degree from Mahidol University.

Pasakorn AKARASEWI
Senior Advisor
Bureau of Epidemiology
Department of Disease Control,
Ministry Of Public Health

Thailand

Dr. Pasakorn Akarasewi graduated from Faculty of Medicine, Chiangmai University in 1983. He, afterward, worked as a director of a community hospital, as well as public health doctor, in lower northern part of Thailand. While working in a rural district, he implemented the initiative of primary health care, community training for village health volunteer and control of infectious diseases such as tuberculosis, malaria, parasitic and diarrheal diseases. In 1989, he was an active member of Thailand epidemiologist to set up National HIV/AIDS Surveillance which became the foundation of the AIDS surveillance up to present time. He was trained in HIV epidemiology and Virology at the University of California at Los Angeles in 1990 and Advance Tuberculosis Training Course in Japan in 1991. He served as the director of Bureau of Epidemiology from 2009 –2013. During this period, Dr. Pasakorn Akarasewi was also served as Thailand Focal Point for International Health Regulation. He had gained valuable experience in dealing with major outbreaks of pandemic Influenza 2009, Chikungunya Outbreak, Dengue Outbreak and public Health crisis during the major floods in Thailand 2011. Dr. Pasakorn Akarasewi is working as senior epidemiologist and public health consultant (Department of Disease Control, MoPH) in response to Public Health Emergency such as to plan and implement strategic response to H7N9, Middle East Severe Respiratory Syndrome (MERS CoV) and at present dealing with Ebola response for Thailand.

GOVERNANCE BY PARTNERSHIP – AN ANSWER FOR POST 2015

DR AMPHON JINDAWATTHANA
SECRETARY-GENERAL OF NATIONAL HEALTH COMMISSION, THAILAND

The primary health care concept formulated in Alma-Ata in 1978 emphasizes public participation in health services. In 1986, the health promotion concept by the Ottawa Charter underlines five strategies to connect health services with communities, the environment and public policies.

Thailand has been adapting such concepts to develop its health systems.

In 1992, the Health Systems Research Institute was established to develop systematic knowledge to support health systems reform which will replace the bio-medical oriented health systems that focus on professionals providing health services in the governance-by-state manner with bio-social oriented health systems that allow multiple sectors/actors to provide and take charge of health services in the governance-by-partnership fashion.

In 2000, the Public Health Commission of the Senate publicized the National Health System Report which recommended the "prevention is better than cure" direction for health systems reform and encouraged all parties in the society to take part in health-related work. It proposed the reform of subsystems of the national health system to suit the multicultural society and the health situation in which health problems grow from conventional illnesses to diseases resulting from germs, health threats and social pathologies that are increasing.

In the same year the Thai government formed the National Health System Reform Committee chaired by the prime minister. The committee was tasked with studying and pushing for the formulation of a national health law to be the master law that will guide and realize health systems reform.

In 2002, the National Security Act was passed to reform health financing system to realize the universal coverage of health service provision. A law was introduced to establish the National Health Promotion Fund in 2001. Parts of liquor and cigarette taxes are spent on comprehensive and widespread health promotion. All parties including the government, the private sector, the civil sector and local communities are allowed to participate in health promotion.

In 2007, the National Health Act defined health as the state of human being which is perfect in physical, mental, spiritual and social aspects, all of which are holistic in balance. Health systems mean overall relations in connection with health. Health becomes closer to well-being and the coverage of health systems greatly expands. All sectors in the society become owners, partners and actors in pluralistic health systems.

The National Health Commission was formed and chaired by the prime minister so that it can really mobilize all sectors to do health-related tasks. The commission equally represents the government sector, the sector of academics and professionals, and the civil sector. Representatives of the three sectors have officially supervised and supported the development and implementation of healthy public policies.

Key instruments are the National Health Assembly, area-based health assemblies, issue-based health assemblies and health impact assessment (HIA). Besides, the law requires the Statute on the National Health Systems to guide the development of national and local health systems. The idea has been applied to create local area health statutes nationwide.

The official development and implementation of participatory healthy public policies through the National Health Assembly has continued for seven years and there have been 65 healthy public policies. Some important policies call for the asbestos-free Thai society, Thai people's universal access to medicines, solutions to obesity and overweight, illegal advertisement bans on drugs and health products, solutions to premature pregnancy, the promotion of everyday cycling and strategies for the health of people with disabilities.

Over 200 healthy public policies have been formulated and implemented on the issue base and at the area base. They include policies on food safety systems, solutions to liver flukes, strategies for good death and health education reform.

Besides, there has been support for the application of HIA to develop healthy public policies at the levels of development plans, projects and community HIA. For example, HIA was conducted to cope with the health impacts of the Map Ta Phut Industrial Estate, the impacts of mining, the impacts of coal-fired and biomass power plants and the impacts of Thai-EU free trade on access to medicines.

The functions of the abovementioned pluralistic health systems of Thailand are unique. Many laws have been created. Many mechanisms have been developed to facilitate the functions. All sectors have been clearly welcomed as actors. This complies with the "Health in All Policy" concept and the "All for Health for Health for All" direction. There have been many developments as follows.

1. Health and health systems have more meanings than medical and public health affairs.
2. There are concrete and official systems and mechanisms to continuously apply the above idea.
3. There have been intersectoral collaborations among partners and networks and they are automatically the exercises of participatory democracy.
4. There have been new knowledge and interactive learning through actions.
5. People have chances to take part in work for the public interest systematically and continuously and this consequently strengthens the society.
6. Complicated health issues have been discussed in public. People in many sectors have conducted academic work and brainstorming to find solutions. Therefore, solutions to such problems are likelier to succeed.

The abovementioned health systems development reflects the governance by partnership/network which is complementary to the governance by government. However, there are many challenges as follows.

1. Academic work is not strong enough to support the development and implementation of healthy public policies.
2. The quality of participatory healthy public policy processes must be improved continuously.
3. Unfamiliarity with the totally participatory approach, that replaces orders or the government-styled service management, delays full participation of governmental organizations at the levels of policy formulation and implementation. This requires gradual understanding and learning.
4. Unfamiliarity with the broaden scope of work beyond medical aspects and the multi-stakeholder collaboration discourages health personnel from fully taking up this kind of work. This requires gradual understanding and learning
5. The process of governance by partnership/network is time-consuming and requires the development of trust, discussions and negotiation. Command cannot be exercised in the process. Therefore, work progresses slowly and is not accomplished as fast as expected.

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PLENARY 3

GLOBAL HEALTH FINANCING – WHAT LIES AHEAD?

PLENARY 3

GLOBAL HEALTH FINANCING
– WHAT LIES AHEAD?

BACKGROUND

The session will provide an overview of current and future scenario in health care management, service delivery and financing summarized from the preceding sessions in the sub-theme. These sessions will highlight analytical trends discussed by the keynote speaker as well as the seven parallel sessions that jointly covered universal health coverage, resource mobilization, innovative approaches and related challenges. The focus will be on sufficiency, equity and sustainability with a call for collective action from national governments and the international community including the private sector.

OBJECTIVES

The session will address the following objectives:

- Take stock of the increase in health care costs, the capacity and efforts made to strengthen systems and mobilize funds externally and by countries;
- Discuss innovative approaches, their outcomes on equity and health outcomes, and review how countries are addressing the move towards universal health coverage;
- Promote wider understanding of the required steps to improve access, reduce inequities and assure sustainable financing.

MODERATOR

Ariel PABLOS-MENDEZ
Assistant Administrator,
Bureau for Global Health
The United States Agency for
International Development

USA

Dr. Ariel Pablos-Méndez, physician, scholar, diplomat and a creative leader in global health, was appointed in 2011 by President Barack Obama and Secretary of State Hillary Clinton, with the consent of the U.S. Senate, to lead the Global Health program of USAID, the premier agency in international development. USAID's vision, guided by the U.S. Global Health Initiative, aims to end preventable child and maternal deaths, and to catalyze an AIDS-free generation with approaches such as empowering women, fostering country ownership and strengthening health systems in low-income countries.

Dr. Pablos-Méndez began his public health career at Columbia University working on the emergence of multi-drug resistant tuberculosis in New York City in 1991; in 1997 he led the Global Surveillance Project on Anti-Tuberculosis Drug Resistance at the World Health Organization (WHO). In both instances, his research and publications brought about significant and successful policy changes in the field. He also served as Director of Knowledge Management at WHO in Geneva, 2004-2007, revamping WHO's flagship publications, working to bridge the know-do gap in public health and promoting e-Health in the developing world.

In 2007, he returned to the Rockefeller Foundation as Managing Director, where he was a program officer from 1998 to 2004 spearheading public-private partnerships in R&D for diseases of poverty (e.g. the Global Alliance for TB Drug Development), the Foundation's strategy on AIDS treatment in Africa (2001), and the Joint Learning Initiative on Human Resources for Health. From 2007-2011 he developed and led the Foundation's initiative on the transformation of health systems towards universal health coverage.

Dr. Pablos-Méndez received his M.D. from the University of Guadalajara (Mexico) and his M.P.H from Columbia University (New York), where he was a Professor of Clinical Medicine and Public Health. He has over 100 publications and has served in various boards and international commissions.

Timothy EVANS
Director
Health Nutrition and Population
The World Bank

USA

Tim Evans is the Senior Director of Health, Nutrition and Population at the World Bank Group.

From 2010 to 2013, Tim was Dean of the James P. Grant School of Public Health at BRAC University in Dhaka, Bangladesh, and Senior Advisor to the BRAC Health Program. From 2003 to 2010, he was Assistant Director General at the World Health Organization (WHO). Prior to this, he served as Director of the Health Equity Theme at the Rockefeller Foundation. Earlier in his career he was an attending physician of internal medicine at Brigham and Women's Hospital in Boston and was Assistant Professor in International Health Economics at the Harvard School of Public Health. He is a board member of a number of international health alliances.

Tim has been at the forefront of advancing global health equity and strengthening health systems delivery for more than 20 years. At WHO, he led the Commission on Social Determinants of Health and oversaw the production of the annual World Health Report. He has been a co-founder of many partnerships including the Global Alliance on Vaccines and Immunization (GAVI) as well as efforts to increase access to HIV treatment for mothers and innovative approaches to training community-based midwives in Bangladesh.

Tim received his Medical Degree from McMaster University in Canada and was a Research and internal Medicine Resident at Brigham and Women's Hospital. He earned a D.Phil. in Agricultural Economics from University of Oxford, where he was a Rhodes Scholar.

Mai Oanh TRAN
Director
Health Strategy
and Policy Institute

Viet Nam

Dr. Tran Thi Mai Oanh is the Director of Health Strategy and Policy Institute (HSPI). As being the Director of Vietnam's leading research institution, she has been officially tasked to provide evidence for policy development in health. She has experience in generating robust evidence for policy making and has worked extensively with policy makers to make most efficient use of evidence in policy making. Working at HSPI for over 23 years, she has been called upon to lead and support major transformational health initiatives including: health structure operational reviews, health service provision, development and implementation of health manpower strategies, public hospital governance, public private partnership. In the area of health financing, she takes a leading role as principle investigator in conducting policy reasearches on health insurance, user fees, hospital autonomy, designing and implementation of health financing mechanisms including provider payment methods.

Dr. Oanh was trained as a General Practitioner at the Hanoi Medical University. She obtained her Master Degree in Public Health at Karolinska Institute, Sweden and her PhD degree in public health at National Institute of Hygiene and Epidemiology (NIHE), Viet Nam.

Dean JAMISON
Professor Emeritus
Global Health
University of Washington

USA

Dean Jamison is the Lead Editor for Disease Control Priorities, 3rd edition and a Co-editor of DCP3's volumes on Essential Surgery and on Child and Adolescent Development. He is a Senior Fellow in Global Health Sciences at University of California, San Francisco, and an Emeritus Professor of Global Health at the University of Washington. In 2006-2008 he served as the T. & G. Angelopoulos Visiting Professor of Public Health and International Development in the Harvard Kennedy School and the Harvard School of Public Health. Previously, Dean had been at University of California, Los Angeles (1988-2006) and at the World Bank (1976-1988). His last position at the World Bank was Director, World Development Report Office and lead author for the Bank's 1993 World Development Report, Investing in Health. His publications are in the areas of economic theory, public health and education.

Jamison studied at Stanford (M.S., Engineering Science) and at Harvard (Ph.D., Economics, under K.J. Arrow). In 1994 he was elected to membership in the Institute of Medicine of the U.S. National Academy of Sciences. Jamison was recently co-first author with Lawrence Summers of 'Global Health 2035', the report of the Lancet Commission on Investing in Health (The Lancet, December 2013). His publications are in the areas of economic theory, public health and education.

Kiyoshi KUROKAWA
Professor
National Graduate Institute
for Policy Studies

Japan

Dr. Kurokawa, Professor Emeritus of the University of Tokyo, is Adjunct Professor of National Graduate In-stitute for Policy Studies (2014.11-); Chairman, Health and Global Policy Institute (2005-); Commissioner on the WHO Commission for Social Determinants of Health (2005-2008); Chair, Global Health Innovative Technology Fund (2013-); Adjunct Senior Research Scientist of the Earth Institute of Columbia University (2011-); Distinguished Research Affiliate, the MIT Media Lab (2011-).

Dr. Kurokawa received a MD degree from the University of Tokyo. Following clinical training in internal medicine, then in nephrology at the Department of Medicine of the University of Tokyo, Faculty of Medicine, he spent 15 years in USA; professor of medicine, Department of Medicine, UCLA School of Medicine (1979-84). After returning from USA; he was professor of medicine of the University of Tokyo, Faculty of Medicine (1989-96); Dean and Professor of Tokai University School of Medicine and Director of the Institute of Medical Sciences (1996-2002), Research Institute of Science and Technology (2002-04), Tokai University; Adjunct Professor, the Research Center for Advanced Science and Technology, the University of Tokyo (2003-06).

Dr. Kurokawa has served as president and/or executive officer to many prestigious national and international professional societies in medicine, nephrology, science academies and science policy organizations. He is Master of the American College of Physicians, and Founding Governor of the Japan Chapter of American College of Physicians (2004-2011). He is an elected member of many prestigious professional societies including Science Council of Japan (President, 2003-06), Member of InterAcademy Panel (2001-06), and InterAcademy Council (2001- 06), Association of American Physicians, the Institute of Medicine of the National Academies of the USA and World Dementia Council (2014.4.30-). He is also Board Member of Bioblioth eca Alexandria, Egypt (2006-2010), Khalifa University of Science and Technology of Abu Dhabi Government (2008-) , Okinawa Institute of Science Technology Graduate University and Advisory Board to the Prime Minister of Malaysia.

Dr. Kurokawa, Special Advisor to the Cabinet (2006-08), has served and serves many committees of the Ministries and Cabinet Office of Japan, eg, Committee for Science and Technology Policy and as Science Advisor for the Ministry of Education, Science and Culture, Chairperson of the Hideyo Noguchi Africa Prize Committee, and He chaired the Fukushima Nuclear Accident Independent Investigation Commission by the National Diet of Japan (NAIIC)(2011.12-2012.7).

He is a recipient of Order of Purple from the Government of Japan for Excellence in Academic Achievements (1999), Order Legiion de Honour of the Government of France (2009), Person of the Year of the American Chamber of Commerce of Japan (2010), the Order of the Rising Sun, Gold and Silver Star (2011 Spring), "Scientific Freedom and Responsibility Award" of AAAS (2012) and of "100 Top Global Thinkers 2012" of 'Foreign Policy'.

His website: **http://www.kiyoshikurokawa.com/en**

PRINCE MAHIDOL AWARD CONFERENCE 2015 | GLOBAL HEALTH POST 2015 ACCELERATING EQUITY

PARALLEL SESSION 3.1

FISCAL SPACE FOR HEALTH:
MOBILIZING AND EFFICIENTLY USING DOMESTIC FUNDS

PARALLEL SESSION 3.1

FISCAL SPACE FOR HEALTH:
MOBILIZING AND EFFICIENTLY USING DOMESTIC FUNDS

BACKGROUND

Adequacy of domestic health resources and the issue of fiscal space for health is a key health financing challenge in many low and middle-income countries. Improved fiscal space through domestic action can be realized only if there is an increase in government revenues or more public borrowing. However, even if fiscal space increases and overall government expenditure rises, without re-prioritization there is no guarantee that this will lead to an increase in government spending specifically for health. Fiscal space for health spending can be constrained if the health sector does not demonstrate efficiency in use of public funds.

OBJECTIVES

The objectives of this session will be to: review recent experience with mobilizing domestic public resources for health, including increasing overall fiscal space and re-prioritization; debate the pros and cons of earmarking revenue for health; and explore the importance of the purchasing function of health financing in promoting efficiency as a source of fiscal space for health.

MODERATOR

Kara HANSON
Reader in Health System Economics
London School of Hygiene and Tropical Medicine

United Kingdom

Kara Hanson is Professor of Health System Economics at the London School of Hygiene and Tropical Medicine. Her research focuses on the economics of health system financing and organisation in low-and middle-income countries and has included work on health financing arrangements, the role of the private sector in health systems, and the economics of delivering malaria interventions. She is co-Research Director of RESYST – Resilient and Responsive Health Systems, a health policy and systems research consortium.

Jane DOHERTY
Senior researcher
University of the Witwatersrand

South Africa

Jane Doherty (BVSc (Pretoria), M.Phil (Cantab), DHSM (Wits)) is a South African health systems and policy researcher with twenty-five years' experience. She specialises in issues affecting the equity and effectiveness of the South African public health sector.

Between 1989 and 2001 Jane worked at the Centre for Health Policy at the University of the Witwatersrand (South Africa) where she eventually became Deputy Director. Since 2001 she has worked independently but remains a part-time lecturer in the School of Public Health and at the Centre for Rural Health at the University of the Witwatersrand.

Jane's research interests include health financing policy, hospital planning and management, district health systems, human resource planning and production, the public-private mix and methodological issues in policy research. She has written 45 reports, 12 book chapters and 20 journal articles, amongst other outputs such as policy briefs. She also acts as a reviewer for a number of international journals.

Beyond her research interests, Jane is committed to developing capacity for health systems and policy research in low- and middle-income countries. She has considerable experience in designing post-graduate courses, adult learning techniques and mentoring. She also acts as an external examiner for Master's students and conducts research on effective capacity-building approaches.

Lara BREARLEY
Senior Health Policy
& Research Adviser
Save the Children UK

United Kingdom

Lara Brearley is a Senior Health Policy & Research Adviser at Save the Children UK. She has been leading the organisation's advocacy on universal health coverage and health in post-2015, and has authored various reports, briefings and articles. Lara participates in various global technical working groups, including the Countdown to 2015 health financing and health systems and policies working groups. She also provides technical support to Save the Children country programmes on health financing advocacy and broader RMNCH policy engagement. Lara is currently on secondment to the 3MDG Fund in Myanmar, working as a Technical Specialist on Health System Strengthening. Lara has an MSc in Health Policy, Planning and Financing from the London School of Economics and the London School of Hygiene and Tropical Medicine, and a first class MA(Hons) in History from Edinburgh University. Lara has previously worked for research institutes, NGOs, and the UN in Africa and Asia.

Jeremias PAUL JR.
Undersecretary Philippines
Department of Finance

Philippines

Jeremias N. Paul, Jr. is a seasoned government official, having held various positions in the Department of Finance since 1990. In more than two decades now, he has practically done the rounds of all the units in the Department, including being Assistant Secretary of the International Finance Group and being Undersecretary of the Corporate Affairs Group. Jun Paul now heads the Domestic Finance Group, standing at the helm of government initiatives to reform the country's fiscal and tax systems, including the "Sin Tax Reform" law" which restructures the decades-old Philippine excise tax system for alcohol and tobacco products.

Jun Paul is also an internationally recognized expert in corporate governance and energy and water sector reforms, frequently invited to speak at various fora. In 2005-2006, he served as Alternate Executive Director of the World Bank Group in Washington D.C. and spearheaded governance reforms in G-24 when the Philippines was Chair.

Jun Paul holds a Master's degree in International Affairs (Major in Economic Policy Management) from Columbia University in New York and a Master of Science in Industrial Economics and Bachelor of Science in Industrial Engineering degrees from top universities in the Philippines.

Mawuli GADDAH
Ministry of Finance

Ghana

Mawuli Gaddah, PhD, is an Economist in Ghana's Ministry of Finance, with over eight years of experience in policy analysis and economic policy management, having served in various capacities/divisions in the Ministry, including, Head of the Agriculture and Agribusiness Unit in the Real Sector Division and Policy Analyst in the then Economic Planning Division. He is currently the Head of Special Studies Unit in the Economic Research and Forecasting Division, responsible for initiating and coordinating research activities.

Dr. Gaddah has played key roles in salary administration reforms and in the preparation and implementation of the national budget. He has served on several technical committees and working groups including economic policy coordinating committee, fiscal commitment technical committee and the macro-sector working group.

Prior to joining the Ministry of Finance, Dr. Gaddah worked as a Research Officer at the University of Cape Coast and a Statistician at the Ghana Statistical Service.

Dr. Gaddah holds a Ph.D in Development Economics and an M.A in Public Policy from the National Graduate Institute for Policy Studies, Japan, an MPhil in Economics from the University of Ghana, and a B.A. in Economics from the University of Cape Coast, Ghana. His current research interests include fiscal space analysis and incidence of public subsidies to health and education in Ghana.

Samrit SRITHAMRONGSAWAT
Deputy Secretary General
National Health Security Office

Thailand

Dr. Samrit Srithamrongsawat, MD. PhD. is now the Deputy Secretary General of National Health Security Office (NHSO), Thailand. He got his MD from Chulalongkorn University, Thailand, in 1984, MPH from Mahidol University, Thailand, in 1989, MSc. in Health Service Management from London School of Hygiene and Tropical Medicine (LSHTM) in 1995, and PhD in Health Policy and Financing from LSHTM in 2005. He got experiences public health insurance systems more than 20 years and has been substantially doing research and development of health insurance systems. He was the former director of Health Insurance System Research Office (HISRO which is a network of the Health System Research Institute (HSRI), Thailand. He was a leader in conducting research on assessment of a decade of Thai Universal Coverage Scheme.

Caryn Bredenkamp
Senior Health Economist
The World Bank

Philippines

Caryn Bredenkamp is a Senior Economist in the World Bank Health Nutrition and Population Global Practice. She specializes in health care financing, and the promotion and measurement of health system equity. Having previously worked in the World Bank's European and South Asian regions, she now splits her time equally between assignments in the Philippines and Myanmar. A South African citizen, Caryn currently lives in Manila.

Caryn holds a PhD in Public Policy (Health Economics), a Master's degree in Economics and, before joining the World Bank Group, spent several years lecturing Economics in South Africa and the Netherlands. When not working, she can be found practicing yoga or training her rescue dogs in agility sport.

Increasing the fiscal space for Health: The experience of Kenya, South Africa and Lagos state (Nigeria)

J Doherty[1], D Kirigia[2], H Ichoku[3], D McIntyre[4], K Hanson[5], J Chuma[2]

[1]School of Public Health, University of the Witwatersrand, South Africa, [2]KEMRI-Welcome Trust, Kenya, [3]Department of Economics, University of Nigeria, Nigeria, [4]Health Economics Unit, University of Cape Town, South Africa [5]London School of Hygiene and Tropical Medicine, United Kingdom

Introduction

How can African countries fund universal health coverage when
- user fees are inequitable
- donor funding is unsustainable
- health insurance schemes struggle to extend coverage?

What about increasing public financing of health care through
- improved tax collection and
- expanded government budgets for Health?

Objective

This study explores whether dramatic improvements over the past 15 years in the tax collection capacity of Kenya, Lagos State and South Africa created more 'fiscal space' for Health.

For a government to have ***"fiscal space for Health"*** it must have the capacity to provide the public health sector with an increased budget without compromising its financial sustainability.

Methods

Country research teams developed a common data collection and analytical approach. Mixed methods were used in each country based on:
- document reviews
- trend analyses of quantitative data on government revenue and expenditure
- semi-structured interviews with key stakeholders

Results

How did countries increase tax revenue?

Tax revenue in the study countries increased 2 to 6-fold over the study period.

These dramatic increases are explained by the range of factors in Table 1.

Arguably, the economic and political climate - and changes to tax policy - were as important as the internal transformation of the tax collection agencies.

Interestingly, Lagos State was particularly successful in reaching the informal sector (see Box 1).

Box 1: Increasing tax collection from the informal sector in Lagos State

- engaged with informal trade associations
- transformed the membership bases of these associations into a tax base
- brought large sections of the informal sector onto the state's tax register
- employed women in the tax agency to promote dialogue with women's associations

Table 1: Factors explaining improved tax collection capacity

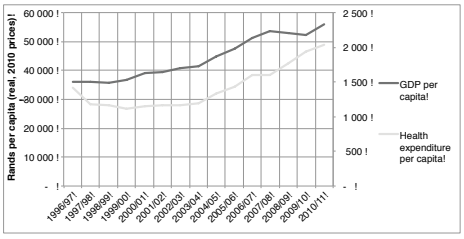
FACTORS	Kenya	Lagos State	South Africa
External environment			
political transition to democracy and government legitimacy	✓	✓	✓
strong economic growth, at least during key periods	✓	✓	✓
The public sector institutional environment			
political support from powerful politicians	✓	✓	✓
continuity of strong leadership in both government and tax collection agency	✓	✓	✓
tax policy reform that rationalised tax rates and expanded the tax base	✓	✓	✓
administrative autonomy for the tax collection agency which enabled operational efficiency and recruitment of highly skilled staff	✓	✓	✓
adequate funding of tax collection agency	✓	✓	✓
The task network for tax collection			
strategic use of external consultants	✓	✓	✓
cooperation between tax collection agency, government departments and private entities (especially banks) to build coherent tax information system	✓	✓	✓
The organisational capacity of the tax collection agency			
a transformation strategy for tax collection agency that • was founded on a clear vision, shared values and good governance • created a streamlined organisational structure and new culture • invested in the recruitment and development of skilled staff • invested in computerisation • coalesced activities around integrated teams • dealt swiftly with corruption	✓	✓	✓
prioritisation of tax collection activities and easier tax filing systems	✓	✓	✓
multiple strategies to promote tax compliance, including positive public perceptions		✓	✓
strong tax enforcement strategies, including public shaming of tax defaulters	✓	✓	✓
Human resource capacity			
increased numbers of adequately skilled staff	✓	✓	✓
active retention of skilled staff	✓	✓	✓
appropriate deployment of staff according to skills	✓	✓	✓
strategic use of positive and negative incentives to motivate staff (including training and performance-based remuneration)	✓	✓	✓

Did the public health sector benefit from increased tax revenue?

In all three countries, economic growth and increased government revenue did not translate into greater per capita spending on Health.

On the contrary, all three countries saw periods of disinvestment in Health. This was the case for South Africa, for example, where health spending was effectively de-prioritised for the decade after 1996.

Figure 1: Trends in real GDP and health expenditure per capita, South Africa



Why was this so, when all countries demonstrated political support for improving health systems?

The answer seems to lie in the complex interplay between economic, political and administrative issues:
- macroeconomic policy reined in public expenditure, required rapid debt servicing or prioritised other sectors
- Ministries of Health did not always have the political clout or technical capacity to argue for larger allocations for Health
- opaque and fluid Health budget development processes undermined Health allocations
- Treasury did not support allocations to Health because it distrusted Health's ability to deliver (see Box 2)

Box 2: The impediment posed by poor performance by Health

"Increasing [the] health budget is important but will the higher funding translate into better performance in the health sector? What we need is to demonstrate that resources allocated to health are distributed efficiently to achieve the desired health outcomes" (Kenyan interviewee)

Conclusions and recommendations

1. With commitment and creativity it is possible to raise additional domestic resources through expanding the tax base and improving the efficiency of tax collection.
2. Fiscal space for Health is constrained by many factors, even in the context of economic growth, increased tax collection and strong political support for Health.
3. Macro-economic policy influences the size of the government health budget.
4. Ministries of Health and others working on health policy need to engage with debates on appropriate macro-economic choices. The trade-offs between developing public health services and growing the economy must be made explicit.
5. Ministers of Health must strengthen their ability to negotiate with Cabinet colleagues for larger allocations, including demonstrating the economic and social benefits of Health investments and the debilitating effects of underfunding.
6. Ministries of Health will strengthen these arguments, and win the trust of colleagues from Cabinet and Treasury, if they are able to demonstrate improved performance and achievements in service delivery.
7. In managing these challenges it is important for Ministries of Health to have clear strategies for presenting and defending budgets, and adequate technical and analytical capacity to support these strategies.

References

Individual country reports on which this study is based (still in press)

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Thanks are due to the interviewees who gave of their time and expertise to contribute to this study. This collaborative study involved partners from the international research consortium RESYST (Resilient and Responsive Health Systems) funded by UKaid from the Department for International Development.

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PRINCE MAHIDOL AWARD CONFERENCE 2015 | GLOBAL HEALTH POST 2015 ACCELERATING EQUITY

PARALLEL SESSION 3.2

RESULTS-BASED FINANCING IN THE HEALTH SECTOR AND EQUITY IN ACCESS TO QUALITY CARE

PARALLEL SESSION 3.2

RESULTS-BASED FINANCING IN THE HEALTH SECTOR
AND EQUITY IN ACCESS TO QUALITY CARE

BACKGROUND

Provide a brief background or overview of the session, including a statement specifying the exact nature of the issues under discussion and current situation of the topic, including trends, scope of discussion, key issues, stakeholders, etc. (approximately 100 words).

Results Based Financing (RBF) by linking financing to results in terms of quantity and quality of health care provides the ability to intervene on a number of fronts including provider motivation, strengthened supervision, facility autonomy and robust monitoring. This session will focus on the impact of RBF on health provider's motivation, quality of care and equity in access to care. It will compare RBF with other interventions including demand-based subsidies such as equity funds in terms of whether a) they have reduced out of pocket expenditures and b) had any long-term sustained impact on equity. It will also cover demand side approaches to improve health care usage.

OBJECTIVES

The session will provide an overview of current initiatives and recent results from rigorous evaluations aimed at increasing access to quality health care by using incentives such as results- based financing, demand incentives or equity funds.

Damien De WALQUE
Senior Economist
The World Bank

USA

Damien de Walque is a Senior Economist in the Development Research Group (Human Development and Public Services Team) at the World Bank. He received his Ph.D.in Economics from the University of Chicago in 2003. His research interests include health and education and the interactions between them. His current work is focused on evaluating the impact of financial incentives on health and education outcomes. He is currently evaluating the education and health outcomes of conditional cash transfers linked to school attendance and health center visits in Burkina Faso.

He is also working on evaluating the impact of HIV/AIDS interventions and policies in several African countries. He is leading two evaluations of the impact of short-term financial incentives on the prevention of HIV/AIDS and other sexually transmitted infections (STIs): individuals who test negatively for a set of STIs receive regular cash payment in Tanzania, while in Lesotho they receive lottery tickets. On the supply side of health services, he is managing a large portfolio of impact evaluations of results-based financing in the health sector. He has also edited a book on risky behaviors for health (smoking, drugs, alcohol, obesity, risky sex) in the developing world.

Olivier BASENYA
Cellule Technique
Nationale FBP
Ministry of Health

Burundi

Dr BASENYA is a medical doctor with a Master degree in health economics. He has a broad experience in health services management and health financing. He used to held positions at all health system level as Director of District Hospitals, Provincial health management teams, Director of Health services and programs at central level and Director General of National Institute of Public health.

Dr BASENYA Olivier has great experience in Results Based Financing design and implementation. He's part of the team who introduced RBF pilot experience in Burundi in 2006 and conduct RBF scaling up integrated to free health care policy for Under five and pregnant women 2010. Other caracteristics are: (i) expertise in health policy and planning; (ii) ability to work in a multicural and multisectorial environment; (iii) experience in health interventions costing including RBF costing; (iv) broad experience in health interventions evaluation; (vi) expertise in strategic and operational planning.

Dr BASENYA Olivier worked as a consultant in many countries (Zimbabwe, Congo Brazzaville, Cameroun, Benin) for the matter of designing, evaluation or costing of RBF interventions. He worked also on health financing strategy in Burundi and health related strategic planning.

Hossain ISHRATH ADIB
Programme Head
Healthcare Financing
Health Nutrition and Population Programme
BRAC

Bangladesh

Mr. Hossain Ishrath Adib started his career with BRAC in the year 2000 as a Program Organizer (field officer) of Microfinance in Bangladesh. Over the years he gained experiences in designing and implementing various development programmes with BRAC in Bangladesh and abroad. Mr. Adib spent most of his professional career in the field of community based development interventions, particularly in access to financial services. Internationally, he was instrumental in designing and implementing BRAC development initiatives in Uganda, Tanzania and Aceh (Indonesia). Mr. Adib served as Country Programme Manager of BRAC Tanzania for two years where he headed the BRAC mission with a portfolio of over 100 branch offices, around 1,200 staff and over 1.5 million beneficiaries through community based interventions in the fields of Microfinance, Health, Agriculture, Livestock and Youth Development.

Since year 2011, Mr. Adib has been leading the implementation of a number of healthcare financing projects in several districts of Bangladesh as a Programme Head of BRAC Health, Nutrition and Population Programme. The projects primarily focus on improving access to reliable healthcare services through innovative financing mechanisms such as pre-payment, credit for low income households and application of mobile phones in financial transactions. The other key components entail quality of service, navigation and referral to the higher levels of care. In year 2012, Mr. Adib actively took part in the design exercise of Bangladesh Healthcare Financing Strategy (2012 - 2032), a task led by Health Economics Unit under The Ministry of Health and Family Welfare in Bangladesh. He also participates in working groups and task forces on implementation of Bangladesh Healthcare Financing Strategy. His other responsibilities entail overseeing the administration of several brac clinics and the expansion of "Vision Bangladesh" (elimination of cataract blindness) project of brac in partnership with Ministry of Health and Family Welfare of Bangladesh and Sightsavers.

Mr. Adib is also a part-time faculty member at the Department of Economics at East West University where he teaches courses covering the fields of Development Economics.

Mr. Hossain Ishrath Adib attained his Bachelor of Science in Economics from North South University Dhaka, Bangladesh and Masters Degree in Economics of Development from The Australian National University (ANU), Canberra, Australia.

RESULTS BASED FINANCING IN THE HEALTH SECTOR AND EQUITY IN ACCESS TO QUALITY CARE

by Olivier BASENYA

In order to accelerate the achievement of the health-related MDGs by 2015, the Burundi Ministry of Health and fight against AIDS undertook a series of reforms to strengthen the health system including decentralization through establishment of Health Districts, free health care policy for under 5 and pregnant women, Performance Based Financing (PBF).

The implementation of Performance Based Financing started in 2006 by pilot experiences and was rolled out nationwide in 2010, associated with free health care for under 5 and pregnant women. The PBF objectives are to: (i) improve the use of health services and quality of care, (ii) strengthen the health system, (iii) motivate health staff, (iv) enhance community participation in the management of health problems.

Several results were obtained: (i) health services utilization increased from 0.38 to 1.62 new contacts per inhabitant per year from 2005 to 2013; (ii) skilled births attended rate increased from 22% in 2005 to 72% in 2013 ; (iii) quality score raised from 48% in 2005 to 82% in 2013 at health center level; and from 56% to 86% at hospital level during the same period; (iv) community health workers are more involved in health population issues.

The PBF implementation in Burundi has an equity component. Indeed, the unit rates for contracted indicators vary from one province to another depending on the poverty score of the province (interprovincial equity). Moreover, in the same Province, unit rates are higher in health centers that treat more poor, are far from purchasing supply points or suffer from lack of human and material resources. The extra funds received help them to treat poor without loss, recruit additional staff or buy equipment to further improve their performance.

PBF in Burundi is associated with free health care for under 5 and pregnant women. Indeed, the health services of these target populations are reimbursed through PBF mechanisms.

For under 5, the outpatient consultations has increased up to 3 new contacts per inhabitant per year after free care policy adopted in 2006. From 2010 to 2013, with the association of PBF and free health care, use of health services by under 5 increased from 3 to 5 new contacts per inhabitant per year. A study conducted in 2014 on equity[1] shows that the prevalence of pathological conditions among under 5 decreased from 2009 to 2012, mainly due to the contribution of PBF and free health care, and no difference in health status was found between better off and poor. However, in terms of malnutrition, it is noted a higher concentration of malnutrition among the poor.

The same study notes, however, that the use of prenatal services and births attended by skilled personnel still show inequalities in favor of the rich. Efforts are still to be conducted despite the free services.

In a study regarding effects of PBF on maternal and child services[2] published in 2014, Bonfrer and al noted that the PBF led to a significant increase of 4 percentage points in the probability of a child being fully vaccinated, with more pronounced effects among poor.

Rural areas have a higher proportion of consultations than urban areas, which can be explained in part by reduction barriers to access to care, especially for under 5 and pregnant women; and by the fact that the urban population are more self-medicated. Moreover, there is no difference on health services utilization by sex and the vaccination rate is not different between urban and rural areas[1].

The use of health centers is more concentrated among the poor while hospital use is more concentrated among the rich, confirming the fact that health centers are more close to population in rural area where most of the poor are concentrated. Regarding PBF implementation; 62% of the PBF Budget at health facility level is used at health centers level against 38% for Hospitals; allowing to have more funds at the most peripheral level where most poor are located. Indeed, the equity study mentioned above indicates that spending in health centers are pro-poor. In addition, 85% of all PBF budget is directed to facilities, making the PBF Budget more oriented towards operational level and poor population.

Efforts are still to be done in order to reduce catastrophic spending for the poor. According to the household survey data conducted in 2012, although the catastrophic health expenses decreased from 7% to 0.4%, the impact of these catastrophic payments is higher among the poorest (14.4 %) than the richest (0.4%). The Government is about to introduce in January 2018 mandatory universal health coverage with subsidy for the poor, under 5 and pregnant women; cross subsidies from the informal to the formal sector. This system will further reduce the inequalities that still persist to the detriment of the poor.

[1] Etude sur l'équité en santé au Burundi, Banque Mondiale, 2014

[2] The effects of performance incentives on the utilization and quality of maternal and child care in Burundi, Social science and Medicine 123 (2014)96-104

MEDICAL TREATMENT LOAN – An Inter-Sectoral Approach for Improving Access to Healthcare for the Poor as An Innovative Financing Mechanism in Bangladesh.

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Key terms: Healthcare financing, access to healthcare services, catastrophic health expenditure, loans for health, Bangladesh, BRAC

BACKGROUND

Forty years since independence, Bangladesh is now in a position to make a credible claim that it has experienced a health revolution. Such achievements have been termed as "The Bangladesh Paradox" due to its exceptional health achievements, particularly in health related targets set through Millennium Development Goal despite poverty (Lancet, 2013). However, despite remarkable achievements in a number of primary health indicators, equitable access to comprehensive health services from reliable providers remains to be a critical public health challenge for Bangladesh. At the same time, rising proportion of aging population and growing burden of chronic, non-communicable diseases and injuries is creating more pressure on the limited budgetary allocation for health.About two-third of total health expenditure in Bangladesh isprivately financed through out-of-pocket payments and around 15% of total householdsface catastrophic health expenditure without effective coping mechanisms against health related shocks (MOHFW, 2012). High cost of treatment for emerging non-communicable diseases and health emergencies often induce low-income households to liquidate family and business assets. With a fast growing expenditure in health, and a large informal economy the traditional tax-based financing or social health insurance for universal health coverage (UHC) are not realistic in the near future. Community based approaches like micro-health insurance are yet to show any credible evidence as an effective alternative solution with adequate depth of coverage, scalability and sustainability.

In the absence of adequately functioning health facilities with comprehensive access to care, especially at the periphery, the patients have to travel to bigger cities and often all the way to tertiary facilities. The associated cost of non-medical expenditure and inconvenience of traveling as well as dependency on attendants create additional barriers to timely access to medical treatment from appropriate providers. As a result, informal providers turn out to be the initial and often the only point of care for the low-income households. Such phenomenon presents inequity and discrimination in access to quality health services in Bangladesh.

INTRODUCING MEDICAL TREATMENT LOAN (MTL)

Historical contexts in Bangladesh suggest that while state-led healthcare financing policy and delivery mechanisms retains its due importance, there are significant potentials for alternative health financing through multi-sectoral engagement. In view of such circumstances, BRAC, a leading non-state development organization in Bangladesh took the initiative ofdevelopinginnovative approaches and policy options. It was designed to diminish catastrophic payments, to improve access and quality of careand to create a set of interventions with a scope for integration into a universal coverage strategy.At the same time, as a pioneer of microfinance and one of the largest microfinance institutions in Bangladesh, BRAC assessed that healthshocksare often the cause of micro-credit default. Income shock resulting from medical emergencies is one of the primary reasons for families to fall deeper into poverty. Such realization led to a collaborative effort between Microfinance Programme and Health Nutrition and Population Programme of BRAC in designing and launching"Medical Treatment Loan" (MTL) scheme. This facility is primarily available for microfinance clients and their family members in 3 districts of Bangladesh with thefollowing objectives:

i. Improve timely access to reliable healthcare services for low-income households.
ii. Reduce financial constraints for seeking healthcare for low-income households.
iii. Minimize incidents of asset depletion and adverse indebtedness on account of catastrophic health events

This innovative low-interest loans approach aims to protect the poor from the vulnerability associated with catastrophic health expenditures and to assist them with effective referral and navigation support at the facilities. MTL offers opportunities for individuals/households affected by such payments to cushion or buffer the impact of catastrophic expenditures. Moreover, by securing institutional credit to pay back the expenditures over a reasonable period of time. This innovative post-payment mechanism is expected to spread the financial risk of health events over a long period into the future, making the required payments affordable.

PERFORMANCE OF MTL DURING THE PILOT PHASE OF YEAR 1

BRAC microfinance programme provides small loans to low income households, with a special focus on womenwho invest the money in their small businesses. MTL serves as a top-up loan to meet the treatment and associated costs incurred by the respective clients or their family members. Within six months of launching in October 2013, MTL was gradually made available for nearly 200,000 microfinance households located in 26 sub-districts under 3 districts of Bangladesh. In an event of illness within the family, a current microfinance member can apply for this loan. To avail the loan, borrowers are required to collect a referral slip from BRAC office, which entitles the client with a special discount from a list of empanelled local providers. Upon consultation, the doctor writes a medical advice with an estimated treatment cost. The microfinance team at the respective branch office then carries out a quick financial appraisal to determine the loan amount and duration before disbursing the loan. The client repays the loan along with his/her other loans through weekly/monthly installments (as applicable).The size of MTL ranges from USD 38 to USD 640. The repayment period varies between 6 to 24 months.

In a year, a total number of 1,467 clientsreceived MTLto finance the treatment cost for themselves/their family members. The primary purpose of the first year of operation was to set up the institutional structure, establishing the providers' network and design navigation support for the clients while seeking medical care. From the very beginning,one of the key activitiesof the project is to undergocontinuous evaluation to observe its performance in terms of achieving the three major objectives stated above. Periodic results from this continuous evaluation exercise will provide the managements with critical feedback for fine-tuning of the design and operational modalities of the scheme and its expansion strategies.

During the first phase of evaluation, the monitoring team collected information from 168 randomly selected households that received MTL. Data was collected on medical conditions of households who borrowed from BRAC, time required to get the loan, cost of treatment, sources of financing in case the loan was not adequate and utilization of loan. Simultaneously, health events in the last 12 months were also collected from the same household regarding, their

healthcare seeking behavior and means of financing before MTL was available. The following table shows a breakdown of health conditions from the sample in broad categories for which the treatments were financed by MTL:

Type of disease/health condition	% of MTL borrowers
I. Pregnancy and gynecological complications: e.g. Uterine prolapse, fibroid, PID	19%
II. Surgical Conditions: e.g. Appendicitis, cholelithiasis, tonsillitis, TURP, piles	18%
II. Injury: e.g. Femur, Hip joint, Implant remove, cut injury, RTA	4%
III. Internal Medicine: e.g. Asthma, PUD, vertigo, generalized weakness. Rheumatoid arthritis, LBP, Cervical spondylitis, Osteomyelitis, CKD, skin	49%
IV. Non communicable diseases (DM, HTN, cancer)	5%
V. Eye diseases	5%

Following is some of the basic information that was collected during the first phase of evaluation:

Average loan size	USD 96
Average amount from the loan utilized for treatment	USD 81
Average cost of treatment	USD 185
Average days needed to mobilize fund with MTL	7.31
Average days needed to mobilize fund without MTL	10.68

It has been observed that the loans that are disbursed on average, covers 52% of the treatment cost (including transportation, drugs, diagnostics, medical consultation, hospitalization if needed and costs incurred by the attendants). The key reason for incomplete financing for health expenditure through MTL was to avoid over-indebtedness through financial appraisal and assessment of the debt capacity of the borrower. Another finding was that on average, MTL borrowers could mobilize necessary resources three days earlier than the households without this scheme.

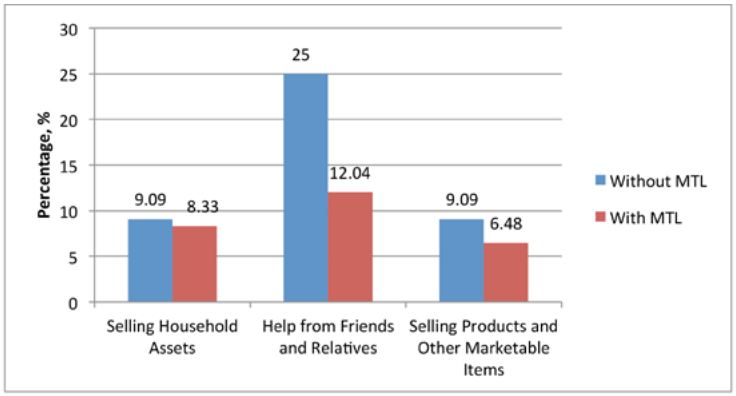
The following table gives a comparison between a subset of MTL borrowers in terms of how long it took them to mobilize financing for treatment and other associated costs:

Number of Days *	Without MTL	With MTL
1 to 3 days	0%	34%
4 to 7 days	40%	26%
7 to 10 days	16%	15%
More than 10 days	44%	25%

*Number of days required to arrange financing in the absence of adequate income and savings – i.e. the household will have to rely entirely on external support to address a health shock

In the absence of MTL, during health shock, households without minimum income or savings had to wait for more than 3 days to mobilize resources for treatment. On the other hand, with MTL, 60% of households mobilized resources within 7 days to initiate treatment, thus avoiding critical delay in seeking healthcare.

The following diagram shows a comparison in terms of coping mechanisms during health events:



The above diagram shows a slight improvement in the trend of asset retention and dependency on others for meeting health related expenses in the presence of MTL.

IS MTL ABLE TO ATTAIN THE KEY OBJECTIVES?

In order to assess the performance of MTL with respect to attaining its key objectives, there is a need for in depth research and trend analysis. Based on some early observations generated by monitoring and evaluation exercise, some early indications can be derived about the scope for MTL as an innovative and complementing health financing mechanism. As far as 'access' is concerned, BRAC has taken the strategy of creating incentives and providing the households with the choice of seeking treatment from a list of qualified practitioners with discount. The loan component has created a strong incentive for the households to receive treatment from qualified practitioner without delay, as this is a pre-condition for their proposal for MTL to be processed. Such incentive has been found to have clear implications in reducing delay when it comes to taking a decision on when and which provider to visit.

With respect to reduction in financial constraints in seeking healthcare, minimizing the incidence of asset

depletion andadverse indebtedness-the early evidencesare indicatingsome positive results of MTL. As mentioned earlier, 52% of average treatment costs are being financed by MTL. It has also been observed that average number of days required for mobilizing resources to cover treatment costs has reduced by more than 3 days when MTL became available. In terms of dependency on extended family members, relatives and friends to finance health expenditure there is more than 50% decline in such borrowing with the introduction of MTL.Finally, with the availability of MTL, there is a considerable decline in the selling off of marketable items such as crops, where the transactions often take place below market price due to distress selling.

FUTURE PERSPECTIVES

Considering the early nature of the scheme, initial findings from the research and evaluation exercises should be carefully interpreted before deriving final conclusions. Still, some of the key indicators related to operational performance and financial projections are showing strong potentials for MTL to be scaled up across the nation. The project has an impressive loan recovery rate of over 99.5% despite high risk of default on account of illness and death. Financial projections show that the programme will attain its break even at a scale of 1.5 million households havingaccess to this facility within 3 years. Such prospects for improving access to quality health services for the poor without relying on subsidies have encouraged BRAC to scale up this facility all over Bangladesh within five years. Accordingly, BRAC has already initiated the mainstreaming of MTL for all its microfinance clientele that consists of 4.63 million borrowers/ households.

The experience of MTL during its first year of operation indicates its strong potentials in getting integrated with the national health financing strategy in addressing the limitations of conventional mechanisms. One such mechanism is insurance in any form having limitations in terms of providing a comprehensive coverage without exclusion. Typical insurance schemes are also constrained by annual claim limits due to which the coverage does not finance the entire cost of treatment when the expenses exceed such limit. A supplementary financial instrument like MTL can address such limitations for both formal and informal mechanisms by virtue of its credible institutional method and strong presence at the grass-root level through microfinance institutions. As of 2013, microfinance sector in Bangladesh was supporting 33 million registered clients, most of whom represent low-income households (MRA 2014). The successful trend of community basedinitiativeswith credible institutional platforms in Bangladesh presents a strong platform for innovative approacheslike MTL to improve access to comprehensive health services for the poor - supporting the nation's journey towards Universal Health Coverage.

[1.] Chowdhury, AMR, Bhuiya, A, Chowdhury, ME, Rasheed, S, Hussain, Z & Chen, LC 2013, 'The Bangladesh paradox: exceptional health achievement despite economic poverty', The Lancet.

[2.] Microcredit Regulatory Authority (MRA) 2014, Microcredit in Bangladesh. Available from: http://www.mra.gov.bd/images/mra_files/Publications/microcredit%20in%20bd14072014.pdf

[3.] Health Economics Unit, Ministry of Health and Family Welfare 2012, Expanding Social Protection for Health Towards Universal Coverage - Health Care Financing Strategy 2012-2032, MOHFW, Dhaka

EQUITY IN ACCESS TO CARE AND RESULTS-BASED FINANCING: RESULTS FROM RECENT IMPACT EVALUATIONS.

Damien de WALQUE (The World Bank)

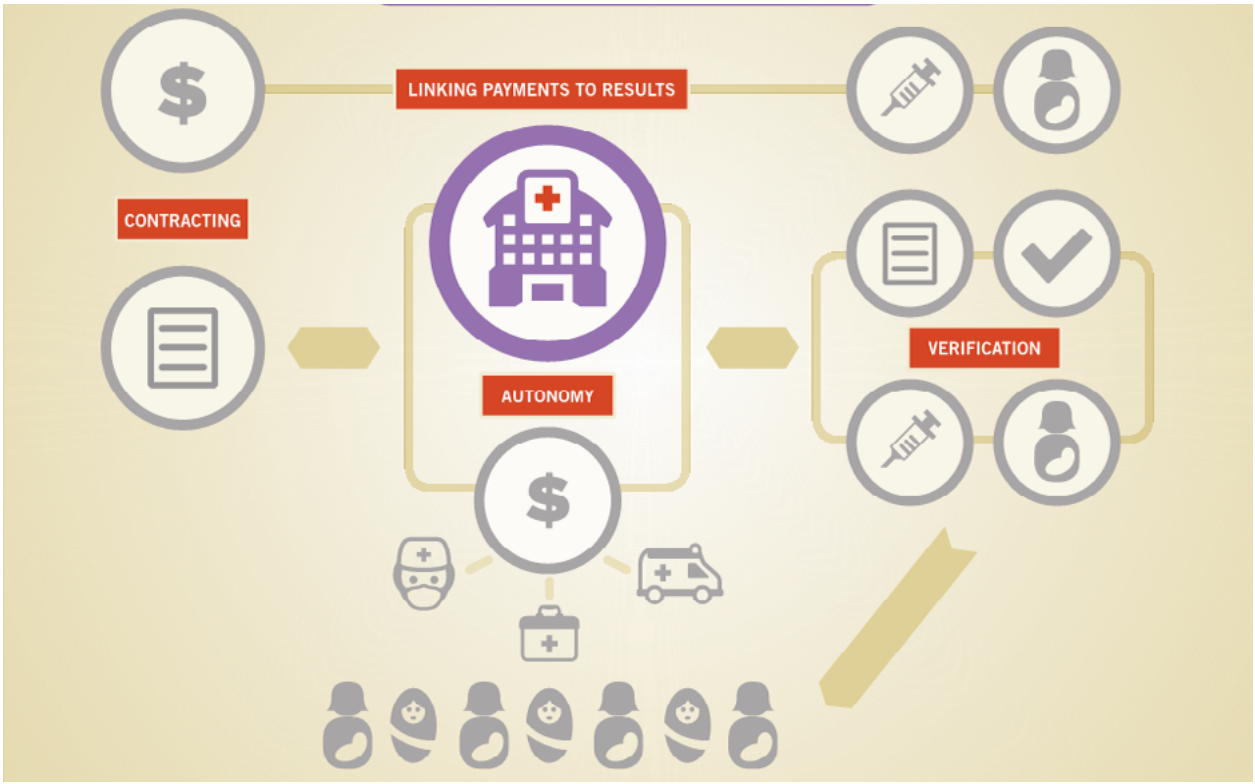
What is Results-Based Financing?

Results-Based Financing is defined as a cash payment or nonmonetary transfer made to a national or sub-national government, manager, provider, payer or consumer of health services after predefined results have been attained and verified. RBF is an umbrella term that encompasses various types of interventions that target beneficiaries (for example, conditional cash transfers), providers (for example, performance-based financing), and country governments (for example, cash on delivery).

These programs usually include incentives at the health facility and district/provincial level. However, more and more countries are including community and/or demand-side components.

Other countries have added demand-side incentives to initially supply-side focused RBF programs, either by providing in-kind incentives—like an umbrella distributed to women delivering in the health facility in Rwanda or the use of vouchers for the urban poor in Zimbabwe RBF program.

Figure 1: RBF is a health systems intervention

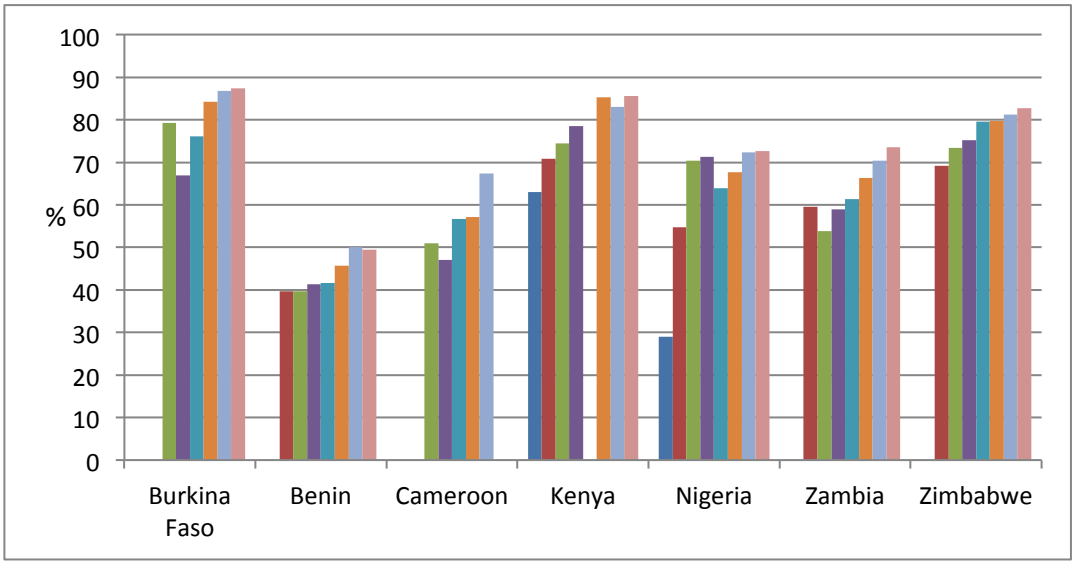


The RBF approach enables a results-oriented focus through: (i) linking payment to results (whether demand- or supply-side) based on context-specific health priorities (ii) a contract or agreement to clarify the respective responsibilities of all stakeholders; (iii) autonomy for those contracted to be able to use RBF funds to attain the pre-agreed results; (iv) verification of the results to ensure they are accurate; and (v) enabling the use of data for planning purposes and for those contracted to enhance the results.

RBF programs collect and use operational data to provide information on the coverage, quality and equity of service delivery, with the added advantage that data are available real time. This gives facility managers and providers the opportunity and capacity to monitor their results and develop solutions of their own in order to improve the quantity and quality of maternal, newborn and child health services delivered.

Figure 2 illustrates how the overall quality score (a composite measure of an objective score based on technical and process competence and a subjective score based on patient perception) for seven countries has improved under RBF.

Figure 2: Overall quality of care in health centers and hospitals



Note: Each bar represents a quarter of implementation

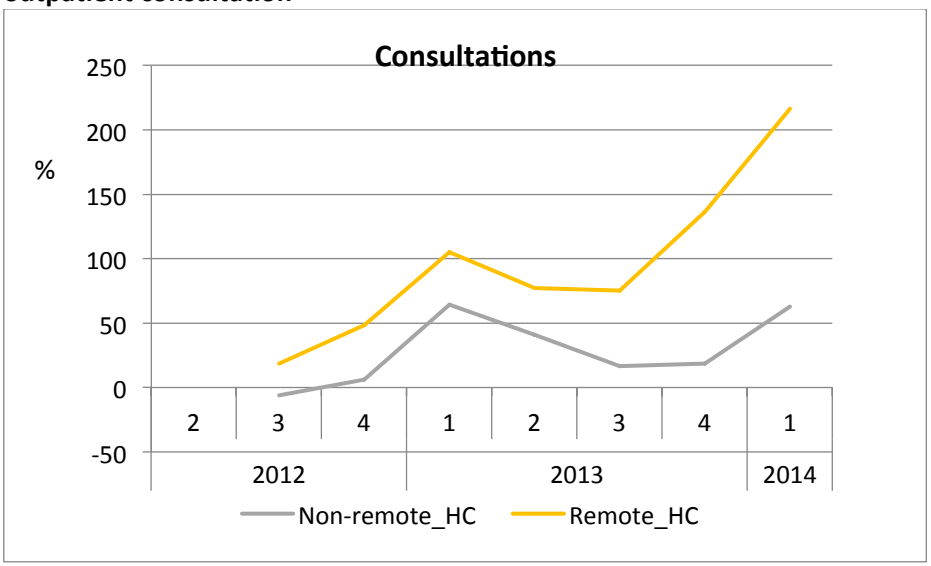
For governments looking for a way to use limited resources more efficiently and to meet the obligation to provide essential services to its most vulnerable citizens, RBF mechanisms can serve to clearly signal health priorities to all levels of the health system, particularly at the service delivery level. This approach can also help ministries of health to focus efforts on producing tangible results on the ground, and monitoring them stringently, while at the same time empowering those closest to the communities they serve to set priorities according to local needs.

RBF and equity in access to care

Beyond **quantity** and **quality**, RBF programs can also promote **equity** of service utilization in a variety of ways to ensure that women and children have the access they need to MCH services. One way is to pay facilities an equity bonus that is based on an assessment of their operational context—for instance, if facilities are located in remote and rural areas or if they serve a particularly vulnerable population.

Operational data suggest that these equity bonuses have benefited the most vulnerable and typically underserved populations. RBF in Zambia, for example, has made great general progress throughout the country. This progress has been observed in both remote and non-remote areas, and it is much stronger in the former (Figure 3).

Figure 3: Change compared to first quarter by remote category in health centers in Zambia--outpatient consultation



Examples of RBF designs with an emphasis on equity in access to care

1) RBF and equity in the Republic of Congo (Brazzaville)

The overall research question of this impact evaluation is " Does performance-based financing improve outcomes related to the utilization and quality of maternal and child health services in Republic of Congo?" The primary research questions for the impact evaluation are the following:

Improved financial access through integrating PBF and social safety nets

- Does PBF improve financial access to and utilization of quality health services for vulnerable populations without demand-side interventions that aim to improve financial access for the poor?

- Does the combination of PBF and pro-poor targeting mechanisms improve financial access to and utilization of quality health services for vulnerable populations more than PBF alone?

Interventions that will be introduced to answer the IE research questions

To answer the above mentioned research questions, the intervention and its impact evaluation will introduce different packages of PBF linked or not to improving access for the poor:

- ***Intervention 1:*** *Performance-based financing:* PBF performance agreements concluded between the MOH and the health center will define the package of basic services to be provided, and the indicators and targets to be reached in delivering these services. The results achieved against these targets will then be assessed by external reviewers through monthly quantity verification (by the contract management and verification agent), and once per quarter quality verification by a different entity (the regulator). Based on these verified results, each facility under a PBF contract will receive payments in partial reimbursement for the services delivered. The payments will be based on unit prices developed under the PBF model, based on a number of factors designed to achieve the desired results, including basic cost of the inputs required (and not financed elsewhere) for services to be rendered, adjusted for quality of the service. As part of the supply-side PBF intervention in the Republic of Congo, this intervention group will allow for up to 20% of total services delivered at each health facility to be provided free of charge to poor and vulnerable households through a post-identification method at the point of service delivery (*implicit* or *passive* targeting), meaning that identification will be at the discretion of health care providers when patients arrive at health facilities for care. PBF unit prices will be higher for these services provided free of charge than for services where user fees are charged.

- ***Intervention 2:*** *Performance-based financing + community-based targeting (CBT) and subsidization of the poor (safety net):* Intervention 2 will use the institutional framework of Intervention 1 (Supply-side PBF) but will also include implementation of the CBT method to identify households through pre-identification at the community-level (*explicit* or *active* targeting) that meet enrollment criteria for the safety net program and register poor households that meet inclusion criteria for the safety net program. Households that are identified and enrolled in the program will receive free health care cards ("carte d'indigence") and will be guaranteed access to a pre-defined package of health services free of charge at health facilities under PBF. The community-based targeting process will be implemented just prior to the implementation of the supply-side PBF intervention in order to ensure that both demand and supply-side interventions begin at the same point in time. Specifically:

a) PBF contract management and verification agents will work with district health teams, health facility management committees (COSA) and Government Social Protection agents to identify households that meet inclusion criteria for the CBT safety net program. Basic information will be collected on each household in each community in the health facility catchment area, complied and analyzed using the LISUNGI criteria for poverty classification (10-20% poorest households).
b) Patients who meet the enrollment criteria will be enrolled into the program, receive the "carte d'indigence" and benefit from the free services as defined by the PBF intervention, after verification that the households meets the criteria through follow-up visits to the households by SP agents.
c) As in intervention 1, the PBF price schedule for services provided free of charge to safety net enrollees will be higher than for services where user fees are charged, meaning that health facilities will receive higher PBF payments for these services to cover the potential lost due to user fee waivers for the poor.
d) Subsidization of health services for the poor through post-identification at the point of service will still be an option for health care providers in this intervention group.

- ***Control:*** The performance-based financing intervention introduced in the Republic of Congo that includes multiple components such as additional financial resources, payment linked to achieved results, and enhanced monitoring, supervision and verification. In order to control for the PBF attribute of providing additional financial resources at the health service delivery level, Control (C) facilities will receive a *fixed per capita budgetary supplement that matches the per capita budgetary allocation for T1 facilities*, based on the population of the health facility catchment area. However, the additional financial resources provided will be lump-sum and not be linked to performance. C1 facilities will not receive enhanced supervision and monitoring and managerial autonomy over the budgetary supplement received as in the PBF groups. Control facility managers will not have the autonomy to hire/ fire staff or financial autonomy. Introducing a control group that allows for budget neutrality between groups will allow for the impact evaluation and Government of the Republic of Congo to generate scientific evidence on the effect of the PBF intervention and linking payments to results on outcomes of interest *conditional* on providing additional resources to health facilities.

2) RBF and equity in Burkina Faso

The overall objective of the impact evaluation is to scientifically evaluate the impact of the PBF intervention on maternal and child health outcomes such as quality of care and health service utilization. The impact evaluation has a specific focus on the role of PBF, in combination with various demand-side interventions, in improving equity in health outcomes across socio-economic groups.

Based on the different interventions which will be implemented, five study groups will be introduced to answer the impact evaluation research questions.

T1: PBF	**T2:** PBF + systematic targeting and subsidization for the poor
T3: PBF + systematic targeting and subsidization for the poor + providers motivation for poor consultations	**T4:** PBF + Community Base Insurance (CBI) + systematic targeting and subsidization for the poor
C: Control - Health facilities and populations within this study group would not receive any of the interventions	

Figure 5. *Different interventions tested in PBF context*

3) Embedded lab-in-the-field experiment in Burkina Faso: Testing PBF incentives and equity outcomes in a lab setting

We propose to introduce "lab-in-the-field experiments" at baseline to test the different types of incentives that will be included in the RBF operation in Burkina Faso and how these incentives affect outcomes related to health service delivery and equity in coverage across varying socio-economic groups. Lab-in-the field experiments replicate real world incentives experienced by the target population with simple tasks performed in a laboratory environment.

We created a computerized real effort task, based on video vignettes, designed to efficiently measure health worker ability, and paired it with behavioral games to measure motivation. We describe the task and protocol for assessing ability and motivation. We then worked with 1,000 health workers in Burkina Faso to to find out whether performance-based pay affects the effort and care that the subjects invested in watching and analyzing the video vignettes.

The tool consists of 20 medical cases, presented in the form of an actress relaying her or her child's symptoms to a doctor, and followed by four multiple choice questions designed by independent health experts. The cases focus on child and maternal health, and contain a range of possible health conditions. The tool has been used to assess health worker knowledge in Burkina Faso and Cameroon and for a "lab-in-the-field" study supporting a Results Based Financing Impact Evaluation in Burkina Faso.

By tying subject payments to behavior, and varying the types of payment schemes, we show how performance pay impacts effort among a sample of health workers in Burkina Faso. Results

indicate that motivated health workers perform better on the task; that performance on the task is remarkably sensitive in distinguishing health worker ability; and that difference in compensation schemes affects health worker performance. For example, health workers respond to "pay for performance" incentives by (a) increasing their output (as measured by number of patients seen), and (b) decreasing the quality of care (as measured by accuracy of responses). We also find that performance incentives are likely to attract high ability, but less motivated workers.

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PARALLEL SESSION 3.3

HEALTH SYSTEMS RESPONSIVENESS: HEALTH SERVICE DELIVERY ENSURES THE DIGNITY, CONFIDENTIALITY, AUTONOMY AND PROMPTNESS IN EMPOWERING THE POOR AND MARGINALIZED

PARALLEL SESSION 3.3

HEALTH SYSTEMS RESPONSIVENESS:
HEALTH SERVICE DELIVERY ENSURES THE DIGNITY, CONFIDENTIALITY, AUTONOMY AND PROMPTNESS IN EMPOWERING THE POOR AND MARGINALIZED

BACKGROUND

One of the health systems' goals is "responsiveness", in which how the health systems can respond to the expectations of the population. Regardless of the types of health systems, people have medical and non-medical expectations and satisfactions in terms of how the institution responds to their real needs in their health seeking behaviors. However in many countries, health systems fail to perform effectively and efficiently, especially in needs of vulnerable and marginalized people including the indigents, women and children, elderlies, disabilities and ethnic minorities.

In the era of Post 2015 Development Agenda, health systems responsiveness becomes more and more significant. It aims to assess and raise awareness of how people are treated and the environment in which they are treated when seeking health care under all social systems. The analytical process of the legitimate expectations of populations regarding how they are treated is recognized as an important part of health systems performance. To explore this concept, we have to pay serious attention to dignity, equity, autonomy, confidentiality, clear communication, prompt attention, access to social support networks, quality of basic amenity, choice of healthcare provider and other determinants.

In the session, we explore the cases and overview of health systems' response to the people's needs to ensure the quality and other determinants in the health systems. And then, we prospect with the panel and floor to enhance equity and performance in health service provision towards achieving Universal Health Coverage from the perspectives of consumers as well as providers of health services.

OBJECTIVES

The session objective is to revisit practices and challenges in ensuring equity and performance in health systems from the perspectives of vulnerable and marginalized people.

MODERATOR

Tomohiko SUGISHITA
Senior Advisor
Japan International
Cooperation Agency

Japan

Tomohiko Sugishita MD, MPH is a health systems specialist, currently working for Japan International Cooperation Agency (JICA) as Senior Advisor to JICA HQs. He holds a Doctor of Medicine from Tohoku University, Master of Public Health from Harvard School of Public Health and Mater of Arts in Medical Anthropology from University of London. He is specialized in general and cardiovascular surgery and served in Malawi as a Chief Surgeon from 1995 to 1998 as a Japan Overseas Cooperation Volunteers (JOCV). Since then, he has been extensively working in more than 25 countries in Africa, such as Tanzania, Uganda, Ghana, Zambia, Senegal, Niger, Sierra Leone, Sudan and Somalia. He was recently dedicated in working for the Ministry of Health in Kenya and running a Health Systems Management Program in Kenya and other neighboring countries until 2013. He is currently working for JICA Headquarters in Tokyo responsible for Health Systems Strengthening and Universal Health Coverage mainly Africa region.

Miriam WERE
Chancellor
Moi University

Kenya

Miriam K. Were is a Medical doctor who qualified from the Faculty of Medicine of the University of Nairobi, Kenya. Subsequently she specialized in Public Health at the Johns Hopkins University School of Public Health in USA and received both the Masters and Doctor of Public Health degrees. Miriam has felt a personal responsibility for improving health in African communities where most people live. Thus her career focus has been on improving Community Health from the basic realisation that IN AFRICA, IF IT DOESN'T HAPPEN IN THE COMMUNITY, IT DOESN'T HAPPEN. WHEN IT HAPPENS IN THE COMMUNITY, IT HAPPENS IN THE NATION.

MamaMiriam's career life includes Working as a Medical Officer for Kenya's Ministry of Health 1973-74; Teaching in the Department of Community Health of the Faculty of Medicine, University of Nairobi: 1974-1985; working for the UN agencies UNICEF, WHO and UNFPAT in the period 1985-2000.

After retirement from the UN in 2000, she has held senior positions including Chair of Kenya's National AIDS Control Council & African Medical and Research Foundation, AMREF. She continues to be on various national and international Committees and boards of service, research and academic Institutions. Among responsibilities she holds currently are being on the UN Secretary General's independent Expert Review Group (iERG) for Women's and Children's Health, Community Health Strategy Goodwill Ambassador, Co-Founder of UZIMA Foundation and by Presidential appointment she is the Chancellor of Moi University

MamaMiriam has been honoured with many awards, honorary degrees and prizes. This includes several national honours including Community Health Strategy Goodwill Ambassador of Kenya; HIDEYO NOGUCHI AFRICA PRIZE by Japan; The Queen Elizabeth II Gold Medal for Public Health; Knight in the Legion of Honour in the French National Order for distinguished service in promoting Mothers' and Children's health; The World Young Women Christian Association (YWCA) Trail Blazer award as a woman leading change. She has received Honorary Doctor of Science from Moi University in Kenya; Honorary doctorate from Ochanomizu University in Japan, and Doctor of Humane Letters by DePaul University, USA.

MamaMiriam's personal values are underpinned by respect for human life and its dignity as well as responsibility of the human family for well-being of planet earth.

Hitoshi MURAKAMI
Senior Expert
Bureau of International Medical Cooperation
National Center for Global Health and Medicine

Japan

As a senior expert of the National Center for Global Health and Medicine (NCGM), Japan, Hitoshi Murakami, MD, MPH, PhD is now conducting a comparative research on health financing in Viet Nam, Lao PDR and Cambodia. The objectives of this study are to identify the degree of the expansion of non out-of-pocket health financing schemes (i.e. compulsory and voluntary health insurance, health equity fund for the poor and payment exemptions) and their impacts on care-seeking and expenditures of health care clients in these three countries.

He worked as a regional coordinating officer in the Asia-Pacific Hub of the United Nations System for Influenza Coordination (UNSIC), the multi-sectoral and multi-agency coordinative body of the UN in taking actions against avian and human influenza. From 1996 to 2007, he worked for Expanded Programme on Immunization (EPI) in Lao PDR, China (as an expert of Japan International Cooperation Agency) and Viet Nam (as a medical officer of the World Health Organization).

His major areas of interest include community health, community-based health service delivery and costing and financing of community health programmes.

He has obtained PhD degree from the School of International Community Health, the University of Tokyo in 2003, MPH degree from Harvard School of Public Health in 1993 and MD degree from the University of Tsukuba, Japan in 1987.

Alex ERGO
Senior Health Economist
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Myanmar

Alex Ergo is a health economist with more than 20 years of experience in health systems strengthening in numerous countries, from middle-income countries to fragile states. Alex is Lead Health Economist with Broad Branch Associates. He is currently based in Yangon, Myanmar. His professional expertise includes the elaboration of risk pooling mechanisms, such as social health insurance, the development of more efficient and equitable approaches to resource allocation, and the design of innovative provider payment mechanisms. Alex has tackled health systems challenges from different perspectives and positions, namely service delivery NGOs, Ministries of Health, local health authorities, bilateral donor agencies such as Danida and DFID, and multilateral institutions such as WHO and the World Bank. In his current position, Alex is the technical lead on health systems strengthening within MCHIP, the USAID flagship program for maternal, neonatal and child health. He also provides technical assistance to several low-income countries that are in the process of designing or implementing performance-based financing schemes, and contributes to global knowledge through his research, analytical work and publication in the areas of health equity, health financing and aid effectiveness. Alex received his masters in Health Economics from University of York in the UK and his PhD from the Johns Hopkins Bloomberg School of Public Health.

Jinpeng XU
Senior Health Officer
Office of Deepening
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China

Mr Xu Jinpeng is a senior technical officer in the reform and development commission, Shaanxi province, China. In 1983, he began his career as a health officer in the office of Shaanxi provincial government leading group for control of endemic diseases and was responsible for prevention to Kashin-Beck disease, Keshan disease, endemic fluorosis, Brucellosis, leprosy, and plague. He worked as a senior program officer in the foreign loan office, Shaanxi provincial health department and was responsible for health projects in Shaanxi province related to loan from World Bank and foreign governments between 1999 and 2002. At the same time, he played the role of the coordinator for health component of Belgium-China Integrated Social-Economic development program for poverty- alleviation (10 million USD aid from Belgium), which focused on tuberculosis control and covered a population of 1.2 million in six national level poverty counties in Shaanxi province, China.

From 2002 to 2007, he was appointed as the chief operations manager in Australia-China Xianyang integrated rural health project (10 million USD aid from Australia), which focused on increasing service capacity and access to basic medical service and covered one million people in five national level poverty counties in Shaanxi province, China.

In 2008, he temporally worked as deputy division chief, department of Chinese medical team management, center of international exchange and cooperation, health ministry, China. He temporally worked as a technical officer in the western pacific region office of World Health Organisation from 2009 to 2010. In 2011, he served as a technical officer in the office of provincial leading group in deepening the health care system reform and was responsible for basic health service reform and statistics related to health reform. One year later, he was despatched to the office of state counsel leading group in deepening the health care system reform as deputy division chief.

He studied Public Health in Shanxi Medical College, Taiyuan, China, from 1978 to 1983 and got his bachelor degree. He had his master degree study of Health Administration in Xi'an Medical University, Xi'an, China, from 1989 to 1992. He studied Primary Health Care Management in Mahidol University, Bangkok, Thailand, from 1992 to 1993. He did master study on Medical & Pharmaceutical Research in Free University Brussels (VUB), Brussels, Belgium, from 1995 to 1997.

Jetsada MINGSAMORN
President
National Health Assembly
Organizing Committee

Thailand

After graduation at the Business School of Rajabhat Chacheongsao University, he has had a determination to devote his knowledge and capacity for benefit of civil society and to build collaboration with the government sector, so that the people sector's plans can be implemented and eventually achieved.

With his determination, he as a civil society involved in drafting the Constitution of the Kingdom of Thailand, B.E. 2540 (1997) and the National Health Act, B.E. 2550 (2007). At present, he has been a member of National Health Commission which has a four year term from 2011 - 2015. The commission, chaired by the Prime Minister, has a role to give advices on healthy public policies to the cabinet, as stipulated in the National Health Act.

He has also involved in organizing National Health Assembly since beginning. Currently, he is appointed to be the President of the National Health Assembly Organizing Committee from 2014 – 2015, although he doesn't come from the health field.

In addition to collaboration with the health organizations, he has worked with the Prime Minister's Office, Ministry of Interior, Ministry of Social Development and Human Security, and Community Organizations Development Institute in order to strengthen capacity and self-reliance of the community.

He has worked at the national and provincial level, especially in Chacheongsao province, his hometown. In Chacheongsao province, he is the vice chairman of committee on the strategic social development and human security at the provincial level, the resource person for the committee on community welfare, the committee member on the provincial health security, the committee member on the provincial administrative office's development and the member of the basic education commission office (region 2)

In 2011, he received an insignia of merit contributing to the country, the religion and the public

THE SILVER STANDARD
A SIMPLER APPROACH TO MONITORING HOW WELL HEALTH PROGRAMS REACH THE POOR

Davidson R. Gwatkin & Alex Ergo

While basic information about overall inequalities in health service coverage is readily available, at least for maternal and child health in most countries, such is rarely the case for specific health programs or initiatives. One reason for this is the perceived complexity and cost of collecting the data needed, especially for a full and careful program evaluation like that represented by a randomized field trial that is currently considered the "gold standard" in the field.

But there is a far simpler and less expensive way to provide the basic information that program administrators need to track how well their initiatives are serving disadvantaged economic groups. While the approach involved provides less complete findings than a randomized field trial, it can yield the key information that policy makers need at far less cost and in far less time.

The presentation will introduce the approach involved, to be called the "silver standard;" explain how it works; and provide illustrations of its application.

In brief, the silver standard approach involves developing 4-5 minute asset questionnaire using the same questions as in a representative national household survey, such as the DHS, and administering it to a small random sample of service users. The wealth of each service user is assessed, weighting each response using the weights derived from an assessment of the national population. The resulting wealth scores of service users are then compared with those of people in the country as a whole, producing a frequency distribution of users' wealth status by economic quintile (or other division) of the national population.

EFFECTIVENESS OF HEALTH INSURANCE ON EXPENDITURE AND CARE-SEEKING OF DELIVERED MOTHERS IN A RURAL AREA IN VIET NAM

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BACKGROUND

Financial barrier to accessing health care is an important issue in ensuring health systems equity and responsiveness to the needs of vulnerable and marginalized population. Health financing, as rightly addressed in the 8th PMAC in 2012, is an essential dimension of universal health coverage (UHC).

Viet Nam has been vigorously pursuing expansion of health insurance (HI) since its first installation in 1992, and there are reviews, community surveys and statistical data analysis already conducted on the scheme. Ekman et al reviewed the Vietnamese HI in 2008 and analysed that the Health Care Funds for the Poor (HCFP), which was incorporated into general compulsory HI (CHI), represented a significant and judicious attempt by the government to provide the poor and ethnic minorities with financial health protection (1). Regarding the impact of HI on household expenditures, an analysis of 1993 and 1998 data of the Vietnam Living Standard Survey (VLSS) showed that the HI reduced out-of-pocket (OOP) expenditure by 16-18% and the reduction was more prominent among the poor (2). Also, a household survey in three different locations in 1999 showed the OOP reduction by 200% with more prominent reduction among the poor (3). Regarding the impact of health insurance on care-seeking, household surveys conducted in Hai Duong and Bac Giang provinces both showed increased outpatient and inpatient utilization rate per population among residents who were covered by HI compared with those who were not covered (4).

The purpose of the present research was to elaborate the effectiveness of the HI on expenditure and care-seeking of delivered women, particularly the poor and ethnic minorities, in a rural district of Hoa Binh province, Viet Nam in 2013.

METHODS

The research was conducted in Luong Son district, Hoa Binh province, which held the total population of 97,446, in January 2014. Two data collection methods were applied. Initially, a series of in-depth interviews were conducted with officers in charge of HI at local Viet Nam Social Security (VSS) offices and hospital/health centre managers to elaborate the current institutional design of the HI in Hoa Binh province. Then, a stratified cluster-sampled survey of mothers who delivered their last child in 2013 was conducted to reveal the HI coverage and its impact on medical expenditure and care-seeking and during pregnancy and delivery.

Stratified single-step cluster sampling was applied for the mothers' survey in which villages was specified as clusters. All 322 villages in Luong Son were stratified into three groups: villages located close to the district hospital, located within the sub-district where district hospital was located (group 1); villages located close to commune (sub-district) health centres (CHC), thus having CHC within (group 2); and villages that were far from both the district hospital and commune health centres (group 3). From each group, seven villages were selected in accordance with their population size using probability proportionate to size (PPS) sampling.

In 21 villages selected, all mothers who delivered in 2013 were targeted. Altogether, 316 mothers were interviewed. In parametric data analysis, the sampling design applied was taken into account: standard error (SE) was adjusted by reflecting intra-class correlation and samples were weighed in accordance with their selection probability.

RESULTS

The HI in Hoa Binh province vis-à-vis Viet Nam comprised CHI and voluntary HI (VHI). The former primarily targeted civil servants and formal sector employees, but also incorporated tax-based enrolment of the poor, near-poor, ethnic minorities, children aged <6 years and students. The latter targeted self-employed, informal sector workers and dependents of CHI members. From the point of view of the vulnerable and marginalized population, the CHI, particularly its tax-based enrolment of the poor, near-poor, ethnic minorities and children aged <6 years, played a critical role in ensuring their HI coverage. The coverage of these vulnerable groups, most of whom were the subjects of the VHI if they were classified by their employment status, were not left to their voluntary participation but rather the VSS automatically covered them on the basis of their vulnerability status.

Table 1 summarizes the basic characteristics of the mothers interviewed. Average age was 27.1 years and median household income was 60 million Viet Nam dong (equivalent to US$ 2,874). Majority of them were either ethnic Kin (national majority) or Muong (minority). High school was the most common educational level and farmer was the most common occupation they had.

Table 1: Basic characteristics of mothers interviewed in Luong Son district, Hoa Binh province, Viet Nam (n=316)

Basic characteristics	Categories	% age: mean value, income: median value
Age	(Mean)	27.1 years
Household annual income	(Median)	60,000,000VND*
Ethnicity	Muong	56.1%
	Kin (Viet)	43.4%
	Giao	0.1%
	Others	0.4%
Education level	Primary school	7.3%
	Secondary school	26.9%
	High school	41.6%
	College	23.2%
	Others	1.0%
Occupation of household head	Agriculture	57.1%
	Industry/office workers	16.6%
	Self-employed	13.7%
	Civil servants	12.6%

VND: Viet Nam dong.

Table 2 shows the HI coverage (by either CHI or VHI) by different household income quartile and ethnicity (Kin majority versus minorities). There was no significant difference in coverage between different income quartile: the poorest quartile had as high coverage of 67% as other quartiles. For ethnicity, ethnic minorities group had significantly higher coverage (90%) than Kin majority (42%) due to compulsory enrolment of ethnic minorities living outside urban areas.

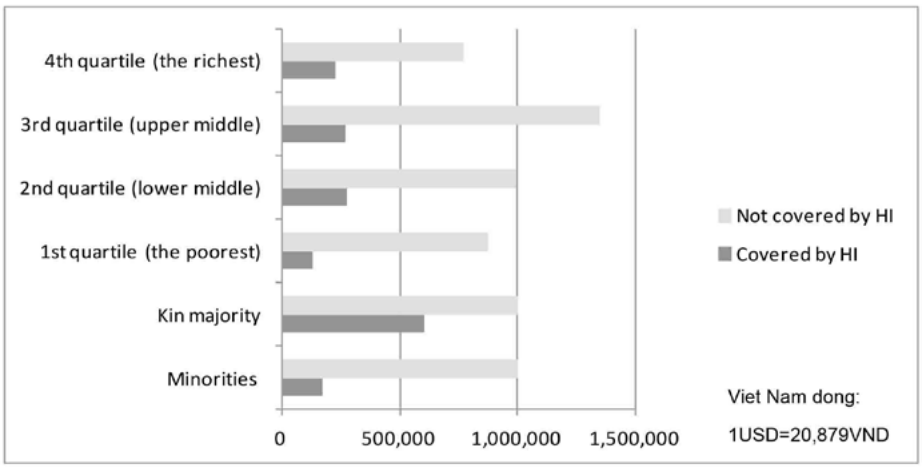
Table 2: Health insurance coverage among mothers who delivered in Luong Son district, Hoa Binh province, Viet Nam in 2013 by household income quartile and ethnicity (n=316)

Household income quartile	
Richest	79.7 (95%CI: 62.3-90.3)
Upper middle	63.5 (95%CI: 37.8-83.3)
Lower middle	67.6 (95%CI: 33.8-89.6)
Poorest	67.3 (95%CI: 30.4-90.6)
Ethnicity*	
Kin majority	42.3 (95%CI: 21.5-66.3)
Minorities	89.5(95%CI: 77.6-95.5)

*Chi^2 test: P<0.01. CI: confidence interval

Examining the impact of the HI on medical expenditures at delivery, in both normal delivery and caesarean section, the median expenditure was significantly less among those who were covered by HI than among those who were not covered. Therefore, the HI demonstrated a significant suppressive effect on medical expenditure at child delivery. Such reduction in expenditure was demonstrated across all four household income quartile and both ethnic majority and minorities (Fig. 1, 2).

Fig. 1: Median payment to health facility for normal delivery among mothers who delivered in Luong Son district, Hoa Binh province, Viet Nam in 2013 (n=241)



Analyzing the relation between the HI coverage and mothers' care-seeking, all mothers surveyed delivered their baby in health facility, thus the institutional delivery rate was 100% regardless of mothers' HI coverage status.

For antenatal care (ANC), among all mothers surveyed and even among those covered by the HI, there was a tendency that those in higher income quartile had higher proportion of mothers who had 4 times or more of ANC as recommended by the health authority (Fig. 1). Regarding the ethnicity, Kin majority had higher proportion of ANC ⍰4 times than ethnic minorities (Fig. 1). A logistic regression model was constructed in which ANC ⍰4 was dependent variable and household income quartile, ethnicity, insurance coverage, mode of delivery (normal trans-vaginal or caesarean), education and occupation were independent variables. Only the income quartile (between the 1st and the 3rd quartile) showed significant association with ANC ⍰4 after adjusting for other independent variables ($p<0.05$). HI coverage did not show significant association with the ANC ⍰4 status. Ethnicity was not associated with the ANC status either.

Fig. 2: Median payment to health facility for caesarean section among mothers who delivered in Luong Son district, Hoa Binh province, Viet Nam in 2013 (n=70)

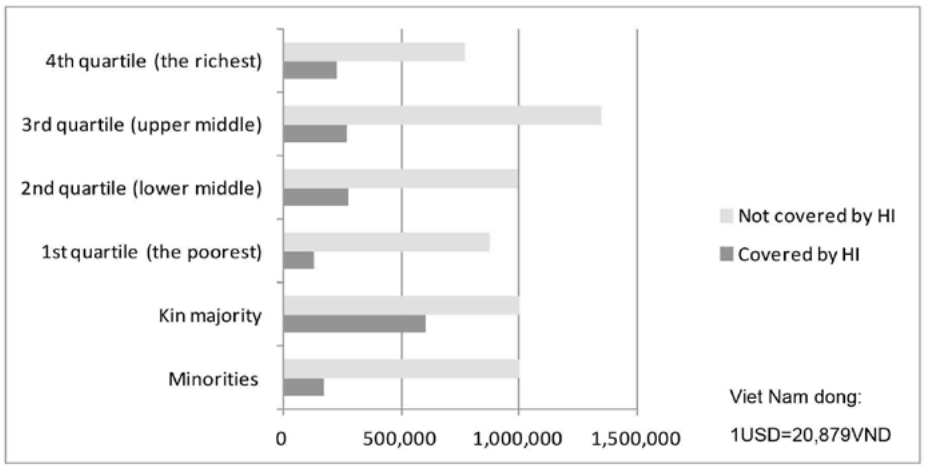
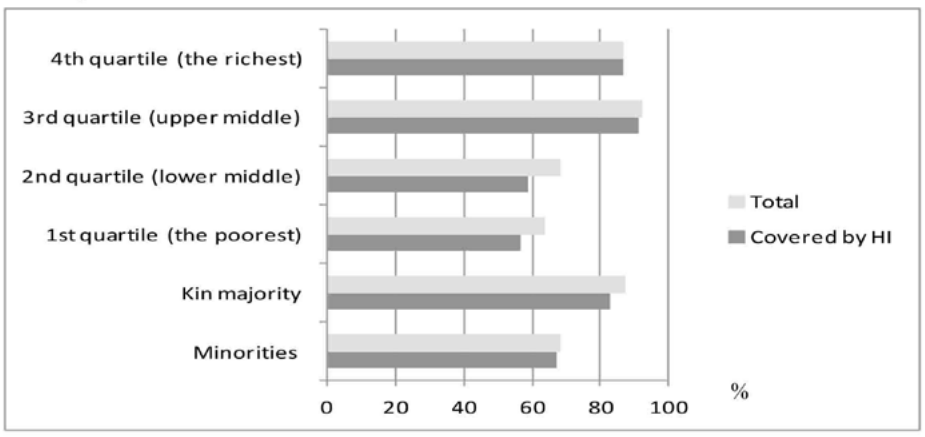


Fig.3: Proportion (%) of mothers who received antenatal care (ANC) 4 times or more in the last pregnancy among mothers with different household income quartile and ethnicity



DISCUSSION AND CONCLUSIONS

The present research showed that the HI coverage among poor and ethnic minority mothers who delivered in 2013 were comparable and even better than richer and Kin majority mothers, respectively, in Luong Son district. Such equitable coverage contributed to less amount of OOP payment to health facility for normal delivery and caesarean section across all income quartile and different ethnicity. The OOP reduction result was concordant with previous studies conducted in Viet Nam (2, 3).

For care-seeking, maternal health service utilization was not significantly associated with HI coverage. The institutional delivery rate was 100% regardless of the HI status due mainly to the strong promotion of such delivery and against home delivery by the health authority. The proportion of ANC4 was lower among poorer mothers despite the HI coverage. Dissociation between HI coverage and the number of ANC visits can partly be explained by the role of private clinics. On average, mothers covered by HI attended to ANC 5.97 times whereas those not covered attended 6.18 times. Among these visits, 2.90 times of those who were covered by HI and 3.76 times of those who were not covered were the visits to private clinics. These clinics were in most cases not contracted with the HI. However, analyzing the provincial outpatient and inpatient statistics, as demonstrated by Liu et al (2), outpatient and inpatient utilization rate per population among residents with HI were higher than those among residents without HI in Hoa Binh province in 2009-2011.

The study derived the following three main conclusions:

1. The HI in Luong Son district, Hoa Binh province, Viet Nam ensured coverage among poor and ethnic minority mothers who delivered in 2013 through tax-based enrolment of the poor, near-poor, ethnic minorities and children aged <6 years to CHI;
2. Such equitable coverage contributed to less amount of OOP payment to health facility for normal delivery and caesarean section across all income quartile and different ethnicity;
3. For care-seeking, maternal health service utilization was not significantly associated with HI coverage. There were other determinants such as promotion of institutional delivery, existence of private clinics without HI contract and household income.

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HEALTH SYSTEMS RESPONSE TO THE CUSTOMER'S PERSPECTIVE EXPERIENCE FROM THAILAND

Mr. Jetsada MINGSAMORN

President of National Health Assembly Organizing Committee

When talking about health or health system, it is very important to look at it in the holistic view. Health simply means well-being. And the health system is a part of the social system and a part of the national security system. If focusing the health system at health service delivery only, the health system cannot be responsive to the expectation of customers or people as a whole.

In addition, building health systems responsiveness from the government sector and health professionals' side only is not adequate. Thailand has worked it in parallel at people's side with an attempt to change people mindset on two critical aspects.

1. People have rights and duties in respect to health. Health is not relationship between doctors and patients or service providers and service users/customers. Hence people should not wait to receive health services, but rather stand up to create their desirable health systems. Good health is a shared responsibility of every one.
2. People have rights to determine their life and voice out their needs and concerns. They also have rights to participate the policy development process as the way participatory democracy should be.

These mindsets of people have gradually changed over time through the movement of the health system reform in Thailand. Followings are factors to strengthen health system responsiveness in Thailand.

1. LEGISLATION

1.1 The National Health Act in 2007

The Act provides the rights to health and the rights to take part in the policy development process including tools – health statute and health assembly - to materialize these rights.

- The Statute of National Health Systems is a framework and direction of the national health systems. It is collectively developed by the government sector, academia/professions and people sector . The participatory development of the health statute is to assure that the 9 sub-health systems are responsive to the need of all sectors particularly people sector. The idea of developing the health statute has expanded from the national level to the local level, so that the local health systems are fit to the local context. Currently, 77 health statutes has been publicized and 200 health statutes are in the process of development.
- National health assembly (NHA) is a process and a platform where 3 keys power of the society – authoritative power which is represented by government sector, knowledge power which is represented by academia/ professions, and social power which is represented by people sector such as civil society, NGOs and private sector - collectively develop public policies. The exchange of knowledge and evidence is as important as

the participatory process to make resolutions of health assembly responsive and implementable. The consensus-based NHA resolutions are submitted to the National Health Commission chaired by the Prime Minister and further submitted to the Cabinet for acknowledgement.

The agenda at NHA, proposed by organizations/networks throughout the country, is wide-ranging from health, social, to environmental and economic development. Some resolutions give specific attention to access to health care for vulnerable and marginalized groups such as the resolution on informal workers (the 1st NHA in 2008), the resolution on equal access to basic public health services (the 1st NHA in 2008), the resolution on sexual health (the 1st NHA in 2008), the resolution on dependent elderly people (the 2nd NHA in 2009), the resolution on people living with difficulties (the 3rd NHA in 2010 and the 5th NHA in 2012), and the resolution on occupational health and safety of workers in the service and industry sectors (the 4th NHA in 2011).

These are examples to demonstrate how Thai people can determine their health system in response to their specific needs. The process of development of health statute and policy dialogue at health assembly assists in empowering people, especially the poor and the marginalized.

1.2 The National Health Security Act in 2002

The Act provides universal access to essential health care and reduces catastrophic illnesses from out-of pocket payments by establishing a tax-based financing system and paying providers on a capitation basis. In additional to health care delivery, the Act gives importance to the voice of people/customers over the quality, expenditure and development of health service delivery. Health Assembly is also used as one of the tools for public hearing on overall development of health service delivery.

2. GOVERNANCE BY NETWORK

One of the results of the health system reform is the new health landscape. More actors come to play in the health field including non-health sector and non-government agency. This is because health is redefined as well-being covering physical, mental, social and spiritual dimensions.

Hence the governance on health has gradually changed from governance by state to governance by network. This can be witnessed in the commissions of many new health organizations such as the National Health Commission and National Health Security Board. The structure of both boards applies the same strategy that is "Triangle that Moves the Mountain". As a result, the board members consist of government sector, academia/professional sector and people sector. Voice of people can influence the decision making on healthy public policies and health security.

In addition to the national level, Ministry of Public Health has recently initiated the district health system (DHS). DHS is aimed to use a district as a management unit to develop and manage responsive primary health care in response to the need of local people. Apart from working together, organizations at the district level, such as district health office, community hospital, sub-district health promotion hospital, local government, temple, school, civil society organization and private sector, also share resources and knowledge.

In conclusion, the heart of strengthening health system responsiveness is public participation in setting direction, implementation, collaboration, sharing resources and exchanging knowledge. General public is not possible to take part in the mentioned activities, if a governance system, a working structure, legislation and tools do not pave the way for meaningful participation. On top of that, the mindset of individuals from all walks of life should be aware of their rights and duties to health.

IMPROVING HEALTH EQUITY IN CHINA THROUGH DEEPENING THE HEALTH CARE SYSTEM REFORM BASED ON PHC VALUES

Xu Jinpeng

As the economic and social development in China accelerated very fast, people's health care demands ever increased. The issue of "difficult and costly access to health care services" became the prominent issue in maintaining social fairness and justice in early 2000's. The gap was increasing in utilization of health care service among different regions, especially between rural and urban residents. There was a consensus that the basic health care system should be available as public goods provided to the entire population and the prominent issue to which people strongly react should be emphatically resolve. To deepen the health care system reform and quicken the development of health care sector is an inevitable requirement of constructing a harmonious and stable society.

"Opinions of the CPC Central Committee and the State Council on Deepening the Health Care System Reform" (hereinafter referred as "the Opinions") was finalised in 2009, which symbolised a new health reform in China. As deepening the health care system reform (DHCSR) involved multi-sectoral action and health in all policies, an inclusive body of leadership named as the leading group of DHCSR was set up in the state council at national level, which consisted of all relevant commissions and ministries besides health ministry. The similar DHCSR leading groups were formed at each level government (province□city□county and township) to implement health care system reforms on the basis of their actual conditions.

1. CHALLENGES FOR DHCSR

Difficult access to basic health care service was increasing health inequity, which was found to be mainly relevant to the following: 1) health resource allocation was unreasonable and health care undertakings were developing unevenly between urban and rural areas and among different regions. 2) the work of public health as well as rural and community health care was comparatively weak. 3) the medical insurance system was incomplete. 4) pharmaceutical production and circulation order was not well regulated. 5) hospital managerial system and operational mechanism were imperfect. 6) government investment in health was insufficient.

The above issues also contributed to soaring medical cost and heavy individual burden, which lead to costly accesses to basic health care services.

DHCSR would be a difficult and long term social systemic project due to the large population, low per capita income, significant urban-rural and regional disparities. It needed specified directions and framework to rebuild a robust health care system in line with the country's actual national conditions.

2. THE AIMS OF DHCSR

2.1. The overall goal of DHCSR is to establish and improve the basic health care system covering urban and rural residents, and to provide all people with secure, efficient, convenient and affordable health care services.

2.2. The long term goal by 2020 is that everyone shall have access to the basic health care services, the multi-layer demands of the people for health care services shall be met preliminarily, and the health level of the people shall be further enhanced.

2.3. The short term goal and priorities

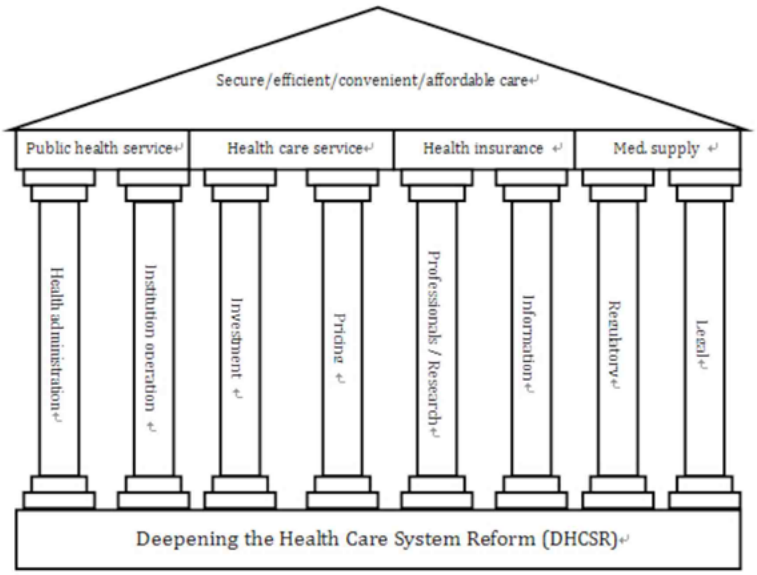
The short term goal by 2011 is that the accessibility to the basic health care services shall have been improved markedly, residents' burden of medical costs shall be effectively reduced, and the situation of "difficult and costly access to health care services" shall have been remarkably relieved.

The priorities of DHCSR from 2009 to 2011 were: 1) to accelerate the establishment of the basic medical security system, 2) to set up the national essential medicine system, 3) to improve the grass-roots health care services system, 4) to promote equalization of basic public health services, 5) push forward pilot projects for public hospital reform. DHCSR started from improving basic health care service provision at grass-roots level in a systematic way.

3. THE FRAMEWORK OF DHCSR

The strategy of DHCSR is to renovate systems of public health service, health care service, health insurance, and supply of pharmaceuticals. The framework of DHCSR was called"four-beam and eight-column"(figure 1), which would be constructed in conjunction with each other, supplement each other and develop in a coordinated way.

Figure 1: Four-beam and eight-column framework of DHCSR



3.1. The composition of four beams

3.1.1. Beam of the public health service
It includes diseases prevention and control, health education, maternity and child care, mental health, emergency treatment, blood collection and supply, hygiene supervision, family planning, health promotion; The network should have the capacity to deal with public health emergencies, and make equalized basic public health services gradually available to urban and rural residents.

3.1.2. Beam of the basic health care service
It should be established by adhering to the operational principle of taking the non-profit health care institutions as the main body, for-profit health care institutions as the supplement. The rural health care service network is designed with county-level hospitals as the bellwether, township health centers and village clinics as the basis. Urban community health centers should be the main body of basic health care service and their service functions need to be upgraded to provide citizens with public health services. All the health centers and clinics would gradually assume the responsibility and duties of the "gate-keeper" for rural and urban residents' health.

3.1.3. Beam of the medical security
The basic medical security system shall be jointly composed of urban employees' basic medical insurance, urban residents' basic medical insurance, New Rural Cooperative Medical Scheme and urban-rural medical assistance system, covering urban employees, urban non-employees, rural population, and urban and rural economically strained residents, respectively. The basic medical security plays as the main body, and other diversified supplemental medical insurance and commercial health insurance as the supplement.

3.1.4. Beam of pharmaceutical supply
A secured pharmaceutical supply system on the basis of the national essential medicines system will be established, which should ensure medicine safety for the people. The central government shall unitarily formulate and issue national essential medicines list, and rationally determine the categories and quantities of medicines in line with China's medication characteristics and with reference to international experience.

3.2. The composition of eight-column

The eight-column was designed to support the health care systems of the four beams, which would operate in an effective and regulated way. They are: 1) column of a coordinated and unified health care administration; 2) column of an efficient and well regulated operation mechanism for health care institutions; 3) column of a multi-source health investment mechanism with the government playing the dominant role; 4) column of a sound health care pricing mechanism; 5) column of a rigorous and effective health care regulatory mechanism; 6) column of a sustainable development mechanism for scientific and technological innovation and a secured mechanism for professionals in the health sector, 7) column of a practical and shared health care information system, 8) column of a profound health care legal system.

4. MAIN ACHIEVEMENTS CONCERNING HEALTH EQUITY IN THE FIRST PHASE OF DHCSR

The health equity issue was the priority in the first phase of DHCSR to guarantee the essential demands of the people for basic health care services. The urban workers' health insurance, the urban residents' health insurance, and rural cooperative medical scheme extended their coverage to 95% of the total population. There were 172 million newly participants in the three basic health insurance schemes and most of them belonged to the disadvantaged. The per capita subsidy from central government to urban and rural residents tripled. The inpatient reimbursement rates increased to 70%, which were 54% for the urban and 48% for the rural respectively before DHCSR. 35,000 health facilities were renovated, which covered 2,200 county hospitals, 33,000 primary health care institutions at township and village level. Those health facilities provide basic health care service on an equal basis. The outpatient utilization of grassroots health services was increased.

National essential drug list was implemented in all government run township hospitals and community health centers in 2011. Shaanxi province adopted strong administrative interventions in procurement and unified distribution, as well as using in 93% of village clinics besides township level. The soaring medical price got controlled and the average price for essential drugs decreased by 30%. 10 categories of public health service programmes were provided free of charges to urban and rural residents. Mega public health programmes were implemented. The maternal mortality rate dropped from 342 per million in 2008 to 261 per million in 2011; the infant mortality rate declined from 14.9 per thousand in 2008 to 12.1 per thousand in 2011.

5. PRIMARY HEALTH CARE (PHC) VALUES IN DHCSR

the Declaration of Alma-Ata (1978) defined PHC as essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and determination. The Sixty-second World Health Assembly□2009□reaffirmed that the values and principles of primary health care, including equity, solidarity, social justice, universal access to services, multisectoral action, decentralization and community participation as the basis for strengthening health systems.

A good health system should be able to deliver quality services to all people, which contains a robust financing mechanism, a well-trained and adequately paid workforce, reliable information on which to base decisions and policies, well maintained facilities and logistics to deliver quality medicines and technologies. WHO proposed an effective integrated health system based on PHC value, which consists of six building blocks such as health service delivery, health systems financing, health workforce, medicines, national leadership and health policies (figure 2).

The DHCSR framework of four-beam and eight-column (figure 1) contains all the elements of the six building blocks frame proposed by WHO besides the similar outcomes towards PHC values. The four beams of public health service, basic health care service, pharmaceutical supply and medical security play building block's role of service delivery. The eight columns have the function of other five blocks and support the four beams to service the people.

Figure 2: The health system framework based on PHC values

The primary strategy of DHCSR was to improve the accessibility to the basic health care services and to reduce residents' burden of medical costs by strengthening an inclusive health system. The aim for 2020 is that all Chinese people have access to the basic health care services and different advanced demands of the people for health care services will be met preliminarily. The overall objective is to establish a robust health care system, which shall provide all urban and rural residents with secure, efficient, convenient and affordable health care services.

The future health care service system based on PHC values must be accessible by all people, regardless of factors such as socio-economic background, race or sexuality.

Comparing DHCSR with the consensus on PHC, it is clear to read that the aims of DHCSR are fully in line with PHC values.

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HEARING THE PEOPLE'S VOICES: HEALTH SYSTEM RESPONSE IN THE COMMUNITY PERSPECTIVE

BY MIRIAM K. WERE

AN OVERVIEW OF THE PRESENTATION:

The presentation starts off by making the point that for most rural people, health facilities are far away –as far as 50 km away--and out of reach. This is one reason Community Health Services need to be in place in order to improve physical access of the people to health services. Further, the point is made that both for rural populations and those who live in urban slums, living in poverty and in marginalized circumstances pushes people into states of helplessness and lethargy that keeps them from seeking services. And even when they are forced by dire circumstance to make it to a health facility, the "foreignness" of the environment makes them feel harassed especially since most health workers do not treat them with dignity. Community Health Services then also become an important psychosocial bridge between the people and health services. This is particularly important for MCH Services.

The presentation then gives examples of a few countries where Community Health Services are established as part of the National Health System. In these countries the Community level health workforce includes both trained Community health workers on the payroll of ministries of health and Community Health Volunteers who are the contact people with a few households which take part in selecting them. These Community Health Volunteers are given basic orientation which includes communication skills as well as ideas on health promotion and disease-prevention so that as they interact with the household, they pass this to the house hold and thus are in synergy with the trained health worker within the Community Health Services.

The paper then states the importance of Community Health Services being globally recognised in the Post-2015 period as the approach towards making Universal Health Coverage a reality especially in countries where health coverage is less than 70%.

PRINCE MAHIDOL AWARD CONFERENCE 2015 | GLOBAL HEALTH POST 2015 ACCELERATING EQUITY

PARALLEL SESSION 3.4

NEW TRENDS AND INNOVATIVE STRATEGIES FOR GLOBAL HEALTH FINANCING

PARALLEL SESSION 3.4

NEW TRENDS AND INNOVATIVE STRATEGIES FOR GLOBAL HEALTH FINANCING

BACKGROUND

Traditionally, "global health financing" has been understood as the almost $30 billion that donors provide to health programs in low- and middle income countries. This has been channeled through the traditional bilateral aid-agencies, multilateral institutions or increasingly through public-private partnerships such as the Global Fund to Fight AIDs, TB an Malaria or the GAVI Alliance. However, if we broaden the way we think about "global health" to refer to the health of the world population at large, then the concept of global health financing can be expanded to take into account all actors' contributions to financing improved public health.

A high-level working group at Chatham House has taken this holistic approach to global health financing and has recently launched (May 2014) their final report, "Shared responsibilities for health. A coherent global framework for health financing". The session will focus on how the current development aid paradigm will need to change and what new approaches and policies may be needed to build a sustainable, fair and adequate system for financing health for all.

Speakers and discussants are selected from the abstracts, from members of the Chatham House Working group, representatives of major institutions and opinion leaders.

OBJECTIVES

The session will:

- Describe critiques towards the current models of development aid for health
- Discuss how the challenges of middle income countries illustrate the general problems of the current system
- Explain how the Chatham House global health financing framework can address some of these concerns
- Discuss how taxation policies, the financing system and macroeconomic system may be leveraged to promote health and development
- Discuss novel approaches for implementing a new global financing framework, including reforming or creating new institutions and applying a human rights framework.

MODERATOR

John-Arne ROTTINGEN
Professor
University of Oslo

Adjunct Professor
Harvard University

Norway

John-Arne Røttingen is the Director of the Division of Infectious Disease Control at the Norwegian Institute of Public Health; Professor of Health Policy at the Department of Health Management and Health Economics, Institute of Health and Society, University of Oslo; Adjunct Professor at the Department of Global Health and Population, Harvard School of Public Health; and Institute Visiting Scholar at the Harvard Global Health Institute. He is Associate Fellow at the Centre on Global Health Security, Chatham House; research associate of the European Observatory on Health Systems and Policies; Chair of the Board of the Alliance for Health Policy and Systems Research; member of the Scientific Oversight Group of the Institute for Health Metrics and Evaluation, University of Washington, Seattle; and member of the International Advisory Committee for the Global Burden of Disease study. He has been Director General of the Norwegian Knowledge Centre for the Health Services; Oxford Scholar at Wadham College; and Fulbright Fellow at Harvard Kennedy School. He received his MD and PhD from the University of Oslo, an MSc from Oxford University and an MPA from Harvard University.

Trygve OTTERSEN
Researcher
Department of Global Public Health and Primary Care
University of Bergen

Norway

Trygve Ottersen, BSc, MD, PhD, is a postdoctoral fellow at the Department of Global Public Health and Primary Care at the University of Bergen and at the Department of International Public Health at the Norwegian Institute of Public Health. His research interests span the fields of health economics, distributive justice, health systems research, development assistance, and global governance. Alongside research, Trygve has over the last year worked with the WHO Consultative Group on Equity and Universal Health Coverage, the Centre on Global Health Security at the Chatham House, and the Norwegian Committee on Priority Setting in the Health Sector. He currently concentrates on projects related to global health priorities and to strategies for global collective action for health.

Rachael LE MESURIER
Executive Director
Oxfam

New Zealand

Oxfam New Zealand is a member of Oxfam International, a global network of 17 organisations. At the core of the Oxfam Confederation are the principles of a human rights-based approach to development and the belief that each and every one of us can play a role in ending poverty and injustice.

Our aim is to mobilise all parts of society to achieve a more just and sustainable world. For Oxfam New Zealand, we focus on our neighbourhood – supporting marginalised and vulnerable people, particularly women and girls, in the Pacific to improve their wellbeing, realise their human rights, access essential services and determine their future.

As the Executive Director of Oxfam New Zealand, Rachael brings a range of relevant skills and experience to this role. She has worked in leadership roles in the UK, New Zealand and in the Pacific for over 24 years primarily amongst community based NGO providers (national and international). Her areas of expertise in service delivery and CSO led advocacy include: access to social welfare, health and legal services; protection of human rights - particularly in sexual and reproductive health, HIV, disability and gender. Underpinning all of these roles has been the personal drive to promote human rights for those who are marginalised, disenfranchised and disadvantaged (e.g. sex workers, IDUs, women and girls, sexual minorities and transgender people, people with disabilities, victims of gender based violence and migrants/refugees)

She has also worked as a technical consultant in the Pacific (regional CSOs, UN Women, UNAIDS, IPPF, SPC, Australian Aid Programme and NZ Aid Programme). She has been invited by: civil society organisations to represent their perspectives to regional and global committees (e.g. ICAAP, ASAP, APA); NZ government to join government delegations to international fora (e.g. UN General Assembly Special Sessions, UNAIDS Programme Co-ordinating Board, WHO Regional Meetings); and by the NZ Aid programme personnel to assist with engaging civil society groups in the Asia and Pacific region.

Oxfam's areas of interest are:

- Inequality and essential services - Wealth inequality and tax avoidance
- Sustainable food and livelihoods, particularly for women
- Gender justice - Gender equality with a focus on economic independence and GBV
- Active citizenship - Civil society's voice in holding their governments and companies accountable.
- Climate change adaptation and resilience.
- Saving Lives - Humanitarian response, rights in crisis and DRR in the context of increased climate change events
- Natural resources – land rights, pollution and extractive industries
- Long term development support - tackling the causes of poverty by a combination of hands on know-how, financial investment and education.

Lisa FORMAN
Assistant Professor
Director of Comparative Program
on Health and Society
University of Toronto

Canada

Lisa Forman is a South African human rights lawyer and international human rights law scholar whose research explores the contribution of the right to health in international law to remediating global health inequities. Her current research focuses on the strengthening of the concept of the minimum core concept within the international human right to health, and the development of post-2015 rights-based health development goals. Past research foci has included trade-related intellectual property rights, human rights impact assessment and South African constitutional law related to health. Lisa is the Lupina assistant professor in global health and human rights at the Dalla Lana School of Public Health, and director of the Comparative Program on Health and Society at the Munk School of Global Affairs, both at the University of Toronto. She qualified as an attorney of the High Court of South Africa, with a BA and LLB from the University of the Witwatersrand. Lisa's graduate studies include a Masters in Human Rights Studies from Columbia University and a Doctorate in Juridical Science from the University of Toronto's Faculty of Law. Lisa's doctoral research explored the contribution of the right to health in international human rights law to increasing access to AIDS treatment, focusing on the case-study of South Africa. Her postdoctoral training investigated the theoretical and practical relevance of international human rights law to medicines access in low and middle-income countries. Lisa has collaborated with a range of organizations, including the Canadian HIV/AIDS Legal Network, the Zambian AIDS Research and Advocacy Network, the US Centre for Economic and Social Rights, Care Peru, the World Health Organization, the United Nations Office of the High Commission for Human Rights and the United Nations Special Rapporteur on the Right to Health.

Gorik OOMS
Professor
University of Anterwerp

Belgium

Gorik Ooms is a human rights lawyer and a public health scholar. He graduated as Lic.Jur. from the Catholic University of Leuven in 1989. During most of his professional career he worked with Médecins Sans Frontières Belgium, of which he was the executive director from August 2004 until June 2008. In March 2008, he obtained his Ph.D. in Medical Sciences from the University of Ghent, for a thesis on the subject "The right to health and the sustainability of healthcare: Why a new global health aid paradigm is needed." In August 2008, he joined the Department of Public Health at the Institute of Tropical Medicine, Antwerp.

During the 2009-2010 academic year, with support of a Fulbright scholarship, Gorik Ooms was appointed global justice fellow with the Whitney and Betty MacMillan Center for International and Area Studies at Yale, where he remains corresponding fellow. Since 2010 he is an adjunct professor of law at Georgetown University, and since 2013 a visiting scholar at the Faculty of Law of the University of Antwerp.

Timothy EVANS
Director
Health Nutrition and Population
The World Bank

USA

Tim Evans is the Senior Director of Health, Nutrition and Population at the World Bank Group.

From 2010 to 2013, Tim was Dean of the James P. Grant School of Public Health at BRAC University in Dhaka, Bangladesh, and Senior Advisor to the BRAC Health Program. From 2003 to 2010, he was Assistant Director General at the World Health Organization (WHO). Prior to this, he served as Director of the Health Equity Theme at the Rockefeller Foundation. Earlier in his career he was an attending physician of internal medicine at Brigham and Women's Hospital in Boston and was Assistant Professor in International Health Economics at the Harvard School of Public Health. He is a board member of a number of international health alliances.

Tim has been at the forefront of advancing global health equity and strengthening health systems delivery for more than 20 years. At WHO, he led the Commission on Social Determinants of Health and oversaw the production of the annual World Health Report. He has been a co-founder of many partnerships including the Global Alliance on Vaccines and Immunization (GAVI) as well as efforts to increase access to HIV treatment for mothers and innovative approaches to training community-based midwives in Bangladesh.

Tim received his Medical Degree from McMaster University in Canada and was a Research and internal Medicine Resident at Brigham and Women's Hospital. He earned a D.Phil. in Agricultural Economics from University of Oxford, where he was a Rhodes Scholar.

Osamu KUNII
Head, Strategy, Investment
and Impact Division (SIID)
The Global Fund to Fight AIDS,
Tuberculosis and Malaria

Switzerland

Osamu Kunii, M.D., M.P.H., Ph.D. has more than 25 years of experience in global health and development. After working in two hospitals, he had served for two years as physician in a clinic of a remote village deep in the mountains in Tochigi, Japan. He engaged in emergency medical relief in several countries as co-founder and deputy representative of international medical NGO called AMDA.

In International Cooperation Bureau, International Medical Centre of Japan (currently called National Centre of Global Health and Medicine), he served for emergency relief, project planning, implementation, evaluation and research in the fields of infectious diseases control, primary health care, maternal and child health, and health system strengthening, especially through Japan International Cooperation Agency (JICA). In particular, he was involved in field research of Ebola outbreaks in Gabon, Cote d'Ivoire and Philippines.

After serving as Assistant Professor in the University of Tokyo, Graduate School of Medicine, he joined the Ministry of Foreign Affair as Deputy Director of Aid Planning Division and special policy advisor. After 3 years of policy and strategy related work, he moved to the Nagasaki University, Research Institute of Tropical Medicine serving as Professor of Global Health.

Moving to UNICEF headquarters in New York as Senior Health Strategy Advisor, he engaged in maternal and child health policy and strategy development at global level, and then worked for three years in Myanmar as Chief of Health and Nutrition Programme of UNICEF Country Office, and for another three years as Chief of Child Survival and Development of UNICEF Somalia Support Centre at Nairobi, Kenya. In those capacities of UNICEF, he had engaged in emergency relief in Saffron revolution and Cyclone Nargis and infectious diseases control including HIV and malaria in Myanmar; and civil war, famine and outbreak response including cholera and measles in Somalia.

Since March 2013, he has served as Head of Strategy, Investment and Impact Division (SIID), The Global Fund to fight AIDS, Tuberculosis and Malaria, taking the lead of five departments and team (Access to Funding; Strategic Information; Technical Advice and Partnership; Community, Rights and Gender; Technical Evaluation and Reference Group Support team).

He received his medical degree from Jichi Medical University, master of public health from Harvard School of Public Health, and doctoral degree from the University of Tokyo.

Fran BAUM
Director
Southgate Institute for Health,
Society and Equity
Flinders University

Australia

Fran Baum is Matthew Flinders Distinguished Professor of Public Health and Foundation Director of the Southgate Institute for Health, Society and Equity at Flinders University, Adelaide, Australia. From 2009-2014 she held a prestigious Australia Research Council Federation Fellow. She is a member and past Chair of the Global Steering Council of the People's Health Movement – a global network of health activist (www.phmovement.org).She also served as a Commissioner on the World Health Organisation's Commission on the Social Determinants of Health from 2005-08. She is a Fellow of the Academy of the Social Sciences in Australia and of the Australian Health Promotion Association. She is a past National President and Life Member of the Public Health Association of Australia.

Fran Baum is one of Australia's leading researchers on the social and economic determinants of health. She holds grants from the National Health & Medical Research Council and the Australia Research Council which are considering a wide range of aspects of health inequities and social determinants of health including an evaluation of the South Australian Health in All Policies initiative, assessment of population health planning for primary health care and review of Australian health policies. In 2014 she won a $2.5 million grant to establish a Centre for Research Excellence on Policies for Health Equity which she will co-Director with Prof. Sharon Friel (ANU). Her book, The New Public Health (3rd edition 2008 4th Edition 2015 Oxford University Press), is widely cited and used as a public health text in many public health courses.

Walaiporn PATCHARANARUMOL
Senior Researcher
International Health
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Thailand

Dr. Walaiporn Patcharanarumol is the Director of Capacity Building for Universal Health Coverage program (CapUHC) and a senior researcher for the International Health Policy Program (IHPP), Ministry of Public Health Thailand. A former hospital pharmacist, Dr. Walaiporn's main research areas include health systems and health insurance, with extensive knowledge and 18 years of experience in healthcare financing.

Dr. Walaiporn completed her master's thesis on unit cost of outpatient and inpatient services at Khon Kaen Hospital in 1996, and provided technical support for the health insurance annual report from 1996-1999. At Maharat Nakorn Ratchasima Hospital she conducted unit cost estimation and worked with hospital staff on health insurance reimbursement of Social Health Insurance beneficiaries and hospital financing from 1999 to 2000.

Since joining IHPP in 2001, her research perspective has broadened from the hospital level to the national and regional level. Awarded the Dorothy Hodgkin Postgraduate Award in 2004, Dr. Walaiporn attended the London School of Hygiene and Tropical Medicine, University of London and received her PhD in Public Health and Policy 2008. Since returning to Thailand she has worked extensively on the National Health Account, National Drug Account, National AIDS Spending Assessment, long-term projection of national health expenditure, health care financing for the poor and capitation rate estimation for the public health insurance scheme. Her work has been published in The Lancet, PLOS Medicine and BMC Public Health among other international and national journals.

Through her work as the Director of CapUHC, Dr. Walaiporn provides capacity strengthening to a number of countries in the region, such as Maldives, Vietnam and Lao PDR. She frequently represents IHPP as a speaker at international and national conferences. Since 2012, Dr. Walaiporn has been the Rapporteur Coordinator for the Prince Mahidol Award Conference held each year in Bangkok.

HOW CAN TAXATION FINANCING RESOURCE UNIVERSAL HEALTH COVERAGE?

Rachael Le Mesurier, Executive Director - Oxfam New Zealand

ABSTRACT:

The concept of universal health coverage (UHC) has risen to the top of the global health agenda and been described by the Director-General of the World Health Organization (WHO), Margaret Chan, as 'the most powerful concept that public health has to offer'. At its core, UHC is about the right to health. Whether rich or poor, everyoneshould get the health care they need without suffering financial hardship. For Oxfam, realising UHC would see everyone recieve the same financial protection and access to the same range of high quality health services, regardless of their employment status or ability to pay.

WHO has been explicit that countries should prioritize four key actions to finance UHC: reduce direct payments, maximize mandatory pre-payment, establish large risk pools, and use general government revenue to cover those who cannot afford to contribute. In too many cases these guiding principles are being ignored. User fees for health care still exist in the majority of developing countries and 150 million people worldwide face catastrophic health-care costs annually because of direct payments. Moreover, 100 million are pushed into poverty – the equivalent of three people every second.

In the name of UHC, many governments and donors are promoting and implementing voluntary private and community-based health insurance schemes. These have low coverage, are costly to administer, and exclude the poor and no country in the world has achieved anything close to UHC using voluntary insurance.

At the same time, a growing number of countries are building universal and equitable financing systems that are working to advance UHC. Rather than charging user fees or collecting insurance premiums from people who are too poor to pay, these countries have prioritized spending on health from general taxation. In Thailand for example, the decision from the government to finance UHC from general tax revenues managed to reduce the proportion of the population without health coverage from 33% in 2002 to less than 4% in 2012. Infant and maternal mortality rates plummeted. There is an opportunity to use the lessons from these countries and build on them.

Although tax financing has played a dominant role in all UHC success stories, the crucial question of how to generate more tax revenues for health has been largely overlooked. Developing countries can increase domestic revenue for health by improving tax collection, adjusting tax bases and rates, fighting tax dodging by the richest individuals and large companies and introducing new progressive taxes

The countries making most progress towards UHC have prioritized spending on health from general taxation. Developing countries can increase domestic revenue for health by improving tax collection, adjusting tax rates, and introducing new progressive taxes.

However raising additional tax revenues alone is not enough to advance progress towards equitable UHC. Governments must also demonstrate their political commitment by increasing and protecting allocations to the health sector and moving quickly to address inefficiencies, improve quality, and ensure effective, accountable, and safe patient care. Without these three pillars – progressive tax collection, adequate allocation to health budgets, and effective monitoring, there will not be the fiscal justice necessary to achieve UHC and reduce inequality.

COUNTRY CAPACITY VERSUS PEOPLE'S NEEDS: THE CHALLENGE OF MIDDLE-INCOME COUNTRIES TO DEVELOPMENT ASSISTANCE FOR HEALTH

Trygve Ottersen,[1,2] Suerie Moon,[3] John-Arne Røttingen[2,3,4]

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ABSTRACT:

Recent developments have transformed the role and characteristics of middle-income countries (MICs). Many now question the proper role of MICs in development assistance for health (DAH), and key actors have already recast their approach to these countries. The pressing question is whether MICs should be recipients, donors, both, or none. The answer has deep implications for individual countries as well as for the DAH system as a whole. In this paper, we describe the fundamental issues involved and emphasise a special feature of many MICs: mid-level gross national income per capita (GNIpc) combined with substantial health needs and large inequalities. We discuss the trade-off between concerns for capacity and need and illustrate a capacity-based approach to setting the level of a GNIpc eligibility threshold. We also consider the use of such a threshold together with needs-based exceptions and incentive-preserving instruments. Against that background, we suggest what could be the proper role of MICs in various circumstances. We conclude that major players in the DAH system should reconsider their criteria for allocating DAH among countries and their norms for which countries should contribute and how much.

NEW TRENDS AND INNOVATIVE STRATEGIES FOR GLOBAL HEALTH FINANCING: Why We Need a Political Definition of Health as A Global Public Good

Gorik Ooms, Ilona Kickbusch

The new trend in global health financing is, in our opinion, the one described by Andy Sumner and Richard Mallet in their book on 'The Future of Foreign Aid: Development Cooperation and the New Geography of Global Poverty'.[1] Health is no exception to the trend of focusing aid on so-called 'least developed countries' and 'fragile states', while other developing countries are expected to solve their own domestic health issues. All countries, however, will be involved or invited to partake in international cooperation for global public goods – including goods that contribute to people's health, like infectious disease control. The financial transfers involved in this international cooperation for global public goods may give the impression that it is a form of altruistic aid, but our opinion, this is fundamentally different from 'aid as we used to know it'.

Is this a 'healthy' trend? Allow us to borrow Raphaël Lencucha's grid of "ethical frames" underlying foreign policy for health, to explain my mixed feelings about this.[2] In simplified terms, Lencucha argues there are four normative frames for international financing of health efforts (or not):[3]

- "Isolationism" – states have no responsibility whatsoever to assist other states in improving health;
- "Charity" – states can help other states, if they want, for as long as they want, and according to their own priorities;
- "Security" – states should help other states address health issues that are of common concern;
- "Cosmopolitanism" – humanity has a moral responsibility towards humanity, and therefore states should assist each other (or people should assist each other, across borders, using states as instruments).

If Sumner and Mallet are right – and we believe they are – we will see global health financing given as a form of charity being concentrated in least developed countries and fragile states, and global health financing to the majority of developing countries transforming from charity into cooperation for the sake of addressing health issues that transcend national borders: health as 'security', in Lencucha's grid.

The advantage of this trend is that international financial transfers 'given' for the sake of addressing common concerns are in many ways superior to financial transfers given as charity: the new "international public finance", as John Glennie calls it,[4] is likely to be more important in volume and better in quality – more reliable, governed in partnerships – than charity was.

The disadvantage of this trend is that international financial transfers to address common concerns are not necessarily leading to the most equitable health outcomes. 'Equity' is a word we use with caution; allow us to refer to the definition of the World Health Organization of 'equity': the "Principle of being fair to all persons, with reference to a defined and recognized set of values."[5] The 'defined and recognized set

of values' we would use is international human rights law, and the right to health does not distinguish between health issues that transcend national borders, and health issues that do not—in Lencucha's grid, equity points at 'cosmopolitanism', not 'security'. Furthermore, international financial transfers that are focused on global health concerns may lead to a double standard of health care in developing countries: a higher standard for communicable disease treatment than for non-communicable disease treatment, for example.

But at the end of the day, cooperation is always better than charity. Furthermore, we should not forget that at the national level as well, the relatively generous social protection mechanisms we have in most so-called developed countries started from addressing common concerns. As Abram de Swaan explains it: "[t]he rich were ready to shoulder the care for the poor only if they believed they could pacify those who might otherwise constitute a threat to them or if the continued presence of the poor in their midst held some opportunities for them".[6]

We believe it is time to revisit the meaning of 'the continued presence of the poor in their midst' in the context of globalization.[7] The people of today's high income countries can continue to build fences around their territories, trying to keep the world's poor out of their midst. As Branko Milanovic found: [8]

> *…if you classify countries, by their [Gross Domestic Product (GDP)] per capita level, into four "worlds", going from the rich world of advanced nations, with GDPs per capita of over $20,000 per year, to the poorest, fourth, world with incomes under $1,000 per year, there are 7 points in the world where rich and poor countries are geographically closest to each other, whether it is because they share a border, or because the sea distance between them is minimal. You would not be surprised to find out that all these 7 points have mines, boat patrols, walls and fences to prevent free movement of people. The rich world is fencing itself in, or fencing others out.*

But if the people of today's high income countries can continue to keep the global poor out of their midst, they cannot prevent the poor from sharing the same planet – from belonging to a single global society that increasingly faces problems that neither single high income countries, nor all high-income countries acting collectively can solve. It makes no sense to expect global cooperation, based on global shared responsibility, in the area of climate change, terrorism, or narcotics control, in the absence of global cooperation, based on global shared responsibility, on health, education, and other essential social rights that define whether people are truly included in or rather excluded from the single global society that is unstoppably taking shape.

So we can live with global health financing of health as a global public good, if and only if we manage to develop a political definition of global public goods – and of health as a global public good in particular. As Inge Kaul wrote (in 2001!):[9]

> *The analysis in this paper suggests that the present standard definition of public goods is of limited analytical, and therefore also, limited practical-political value. This is not a new insight. In effect, an extensive literature exists critiquing the standard definition of public goods. But so far, no revised definition has emerged.*

According to its standard – economic – definition, a public good is a good that is both 'non-rivalrous' and 'non-excludable'. In health, the eradication of polio is an example of a (global) public good: once the eradication is or would be achieved, all people enjoy it without depleting it – the good of an environment without polio creates no rivalry – and nobody can be excluded from enjoying the good. Health care itself is not a public good, however: health care is a rival good (the time of a health worker 'consumed' by a person cannot be consumed by another person); and health care is an excludable good (as too many people find out too often). But the benefits of decent, population-wide health care can be global public goods, as the example of polio eradication illustrates. It is precisely this (narrow/standard) definition of global public goods that makes us concerned that global financing for global public health goods will focus on infectious disease control, at the detriment of other health issues.

But let's have a look at Kaul's proposal of a broader, political definition of public goods:[9]

First, we need a positive – not just a negative – definition of publicness in consumption. Second, since many PGs are a social construct, and since we live in a world of inequity and disparity, "public involvement in the design of [Public Goods (PGs)]" should be among their defining characteristics. And third, publicness in consumption should be linked with publicness of benefits.

A decent level of essential health care, truly accessible to all – we could call it 'Universal Health Coverage'[UHC) – would fit Kaul's definition of publicness in consumption. The health services provided would be adapted to each country's particular needs and priorities, in a participatory and transparent manner. And the benefits of UHC would be public in many ways – the way we're interested here is that no human being would feel excluded from the essential benefits of global progress in health science.

In terms of international health financing transfers, the c ost would be fairly limited. According to the Working Group on Health Financing of the Chatham House's Centre on Global Health Security, 0.1 to 0.15% of the GDP of high-income and some upper middle income countries would be sufficient.[10] That is a fairly modest cost, if it lays the foundations for international cooperation on other issues. We think it will be a prerequisite for international cooperation on other issues.

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A COHERENT GLOBAL FRAMEWORK FOR HEALTH FINANCING - BRIEF INTRODUCTION

John-Arne Røttingen

Executive summary and Recommendations from

Røttingen JA, Ottersen T, Ablo A, Arhin-Tenkorang D, Benn C, Elovainio R, Evans DB, Fonseca LE, Frenk J, McCoy D, McIntyre D, Moon S, Ooms G, Palu T, Rao S, Sridhar D, Vega J, Wibulpolprasert S, Wright S, Yang BM. Shared Responsibilities for Health. A Coherent Global Framework for Health Financing. Final Report of the Centre on Global Health Security Working Group on Health Financing. London: Chatham House, May 2014

Financing is at the centre of efforts to improve health and health systems. It is only when resources are adequately mobilized, pooled and spent that people can enjoy robust health systems and sustained progress towards universal health coverage – that is, all people receiving high-quality health services that meet their needs without exposing them to financial hardship in paying for the services.

This report, which presents the findings and recommendations of the Working Group on Health Financing in the Centre on Global Health Security at Chatham House, shows how common challenges put such progress at risk in countries across the world, and particularly in low- and middle-income countries. These challenges are common not only because they happen to be present throughout these countries, but also because globalization means the underlying causes and transitions know no borders. This calls for collective action on a global scale. Specifically, the report calls for an agreed coherent global framework for health financing capable of securing sufficient and sustainable funding and of both mobilizing and using these funds efficiently and equitably.

Progress towards such a framework can be made by revising the current approach to health financing in three areas: the domestic financing of national health systems, the joint financing of global public goods for health, and the external financing of national health systems where domestic capacity is inadequate. Progress in these areas can be achieved through a set of policy responses which can be encapsulated in 20 recommendations.

TO STRENGTHEN DOMESTIC FINANCING OF NATIONAL HEALTH SYSTEMS, WE CONCLUDE THAT:

1. Every government should meet its primary responsibility for securing the health of its own people. This involves a responsibility to oversee domestic financing for health and ensure that it is sufficient, efficient, equitable and sustainable.
2. Every government should commit to spend at least 5 per cent of gross domestic product (GDP) on health and move progressively towards this target, and every government should ensure government health expenditures per capita of at least $86 whenever possible. Most middle-income countries should be able to reach both targets without external support.
3. Every government should ensure that catastrophic and impoverishing OOPPs are minimized. Specifically, governments should commit to the targets of OOPPs representing less than 20 per cent of total health expenditures (THE) and no OOPPs for priority services or for the poor.

4. Every government should improve revenue generation and achieve reduction of OOPPs through effective, equitable and sustainable ways of increasing mandatory prepaid pooled funds for health services. Individual contributions to the pool(s) should primarily be based on capacity to pay and be progressive with respect to income.
5. Every government should consider improved and innovative taxation as a means to raise funds for health. Promising policies include the introduction or strengthening of excise taxes related to tobacco, alcohol, sugar and carbon emissions, and these should be combined with measures to increase tax compliance, reduce illicit flows and curb tax competition among countries. Other sources of government revenue, particularly in countries rich in natural resources, should also be explored.
6. Every government should ensure that mandatory prepaid pooled funds are used with the aim of making progress towards UHC – that is, affordable access for everyone. Specifically, every government should seek to ensure a universal health system with full population coverage of comprehensive primary health care, high-priority specialized care and public health measures, and should not prioritize expanding coverage of a more comprehensive set of services for only some privileged groups in society.
7. Every government, in collaboration with civil society, should formalize systematic and transparent processes for priority-setting and for defining a comprehensive set of entitlements based on clear, well-founded criteria. Potential criteria include those related to cost-effectiveness, severity and financial risk protection. The processes can build on the methods of health technology assessment and multicriteria decision analysis, which can help translate evidence and explicit values into policy decisions.
8. Every government and other actor involved in the financing or provision of health care must continuously strive to improve efficiency. In particular, this will require action on corruption and strategic purchasing, with continuous assessment and active management of which services are purchased and what providers and payment mechanisms are used.

TO STRENGTHEN JOINT FINANCING OF GLOBAL PUBLIC GOODS FOR HEALTH (GPGHS), WE CONCLUDE THAT:

1. Every government should meet its key responsibility for the co-financing of GPGHs and take the necessary steps to correct the current undersupply of such goods. Among key GPGHs are health information and surveillance systems, and research and development for new technologies that specifically meet the needs of the poor. Public funding for the latter purpose should be at least doubled compared with the current level.
2. Every government should increase its support for new and existing institutions charged with the financing or provision of GPGHs. In particular, the World Health Organization's capacity to provide GPGHs should be enhanced and adequate funds provided on a sustainable basis for that purpose.
3. Every government, international organization, corporation and other key actor should promote a global environment that enables all countries to pursue government-revenue policies that can sufficiently finance their social sectors, including health, education and welfare. This requires action on illicit financial flows, tax havens, harmful tax competition and overexploitation of natural resources.

TO STRENGTHEN EXTERNAL FINANCING FOR NATIONAL HEALTH SYSTEMS, WE CONCLUDE THAT:

1. Every country with sufficient capacity should contribute with external financing for health. Determination of capacity should partly depend on GDP per capita. Net contributing countries should include all high-income countries and most upper middle-income countries and not only member countries of the OECD's Development Assistance Committee (OECD-DAC).
2. High-income countries should commit to provide external financing for health equivalent to at least 0.15 per cent of GDP. Most upper-middle-income countries should commit to progress towards the same contribution rate.

3. Every provider of external financing for health, including contributing countries and international organizations, should establish clear, well-founded and publicly available criteria to guide the allocation of resources. These should be the outcome of broad, deliberative processes with input from key stakeholders, including civil society in contributing and recipient countries.
4. Every provider of external financing for health should align its support with recipient-country government priorities to the greatest extent possible. This calls for strong adherence to the Paris Declaration on Aid Effectiveness and the Accra Agenda for Action. In particular, providers of external financing for health should encourage and comply with national plans and strategies, improve transparency and monitoring of disbursements and results, and help to build domestic governance and institutional capacity.
5. All providers of external financing for health should strive to strengthen coordination among themselves and with each recipient country, in order to improve efficiency as well as equity. In particular, they should encourage and comply with country-led division of labour, harmonize procedures, increase the use of joint and shared arrangements, and improve information sharing.
6. Every government should actively assess the existing mechanisms for pooling of external funds for health – including the Global Fund to Fight AIDS, Tuberculosis and Malaria, the GAVI Alliance, and the World Bank's health trust funds – and consider the feasibility of broader mandates, mergers and increased global pooling with the aim of improving efficiency and equity.

STRONG ACCOUNTABILITY MECHANISMS AND GLOBAL AGREEMENT ON RESPONSIBILITIES, TARGETS AND STRATEGIES WILL FACILITATE THE IMPLEMENTATION OF THE NEEDED POLICY RESPONSES AND A COHERENT GLOBAL FRAMEWORK. WE CONCLUDE THAT:

1. Every government and other actor involved in domestic or external financing or in the provision of health services should seek to strengthen accountability at global, national and local levels. This should be done by improving transparency about decisions, resource use and results, by improving monitoring and data collection and by ensuring critical evaluation of information with effective feedback into policy-making. Accountability should also be strengthened through active monitoring by civil society and by ensuring the broad participation of stakeholders throughout the policy process.
2. Every government and other key actor should seek to ensure that health and universal health coverage are central goals and yardsticks in the post-2015 development agenda. These actors should also seek to ensure that the responsibilities, targets and strategies of a coherent global framework for health financing are integrated to the fullest extent possible. Moreover, the agenda should make clear that health is important both for its own sake and for the sake of other goals, including poverty eradication, economic growth, better education and sustainability.
3. All stakeholders should enter into a process of seeking global agreement on key responsibilities, targets and strategies for health financing – including on the mechanisms for monitoring and enforcement – in order to expedite the implementation of a coherent global financing framework. In the short term, consultation on the post-2015 development agenda is one useful arena for building consensus, and the agenda itself can be a valuable commitment device. In the longer term, a more specific process should be devised in one or more relevant forums, such as the UN General Assembly, the World Health Assembly, World Bank/International Monetary Fund, or a highlevel stand-alone meeting.

With successful agreements, the great potential of health system strengthening and proven high-impact interventions can eventually be unleashed.

CHANGES IN DOMESTIC AND GLOBAL TAXATION POLICIES AS A MEANS TO IMPROVE GLOBAL HEALTH FINANCING

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INTRODUCTION

..the resurgence of inequality after 1980 is due largely to the political shifts of the past several decades….the history of inequality is shaped by the way economic, social and political actors view what is just and what is not, as well as by the relative power of those actors and the collective choices that result. (Piketty, 2014: 20)

Global health financing concerns both the provision of adequate public health systems and funding to improve the social determinants of health (Baum, 2015, Commission on Social Determinants of Health, 2008). Global health financing has to be considered in the context of the current global political and economic arrangements. Inadequate financing for public health is just one expression of a grossly unfair system. The provision of adequate financing requires attention to global inequities and the devising of mechanisms to share global wealth more equally and to do this through fair mechanisms of public financing.

The extent and growing inequity is now well-known (Oxfam, 2014, Piketty, 2014):

- Almost half of the world's wealth is now owned by just one percent of the population.
- The wealth of the one percent richest people in the world amounts to $110 trillion. That's 65 times the total wealth of the bottom half of the world's population.
- The bottom half of the world's population owns the same as the richest 85 people in the world.
- Seven out of ten people live in countries where economic inequality has increased in the last 30 years.
- The richest one percent increased their share of income in 24 out of 26 countries for which we have data between 1980 and 2012.
- In the US, the wealthiest one percent captured 95 percent of post-financial crisis growth since 2009, while the bottom 90 percent became poorer.

Despite the rapid increase in wealth accumulation in the past two decades this period has also seen a decrease in taxation income in many OECD countries and the failure to establish effective global and national institutions and practices which would enable adequate public financing for the provision of public goods, which enhance health and equity.

GLOBAL ECONOMY CHARACTERISED BY UNFAIRNESS

Fair trade better than aid

Foreign aid establishes a relationship of charity which is inevitably an unequal relationship despite a rhetoric of empowerment. Foreign aid exists in an unfair economic world. This world particularly benefits Trans-national Corporations (TNCs). For example, Esidene and Hafsat (2012) note that the incursion of TNCs into Nigeria has worsened poverty in the country. They note that some multinational companies

have sold products that have been proven to cause health problems in the population (they cite example of skin lightening cream containing mercury). They also note that inappropriate consumption patterns have been encouraged where people swap to more expensive foreign products that are often not as healthy as the traditional products. For example, many Nigerians are now eating processed breakfast cereal instead of porridge made from local grains. They note that the TNCs together with the domestic elite class "connive to siphon the nation's resources abroad for metropolitan developments" (Esidene and Hafsat, 2012:p. 4). There are no international or national trade rules which make such practices illegal.

Low taxation regimes

Very rich people and TNCs pay low rates of taxation and have developed a series of measures to avoid paying their fair share of tax (Tax Justice Network, 2013). Also governments compete to offer TNCs favourable conditions to attract investment which includes very low taxation rates (Stiglitz, 2007). Around the world taxation rates have either been cut in the face of neo-liberal public policies or those countries which didn't have effective taxation have been urged to keep that status quo.

"Free market" is subject to gross distortion

There are many ways in which TNCs are able to manipulate "free markets". Big Pharma provides an example. These companies have massive wealth (it is calculated that the combined worth of the five top drug companies is twice the combined GNP of all Sub-Saharan Africa) and work directly with the US government and European Commission to shape international rules on patents (Drahos and Braithwaite, 2004). Labonte et al. (2011) note that that trade and investment treaties appear to be eroding the policy space for governments to intervene through restrictions on advertising, points of sale, taxation, and other measures likely to reduce the adverse health impact of unhealthy products such as tobacco, alcohol and ultra-processed foods.

Privatising assets and socialising debt

While there have been some measures to reduce the burden of debt in recent years debt remains an issue. Where debt relief has been enacted more resources are available for health and social spending. Economic growth in some heavily indebted countries has meant that they can now service debt more easily. Debt has been compounded by illegal and commercial capital flight, which results in net resource transfers away from low income countries. Henry (2012, p. 5) calculates that since the 1970s "with eager (and often aggressive and illegal) assistance from the international private banking industry" the group of 139 countries he considers it appears that private elites accumulated $7.3 to $9.3 trillion of unrecorded offshore wealth in 2010. This was while structural adjustment packages were being imposed and governments urged to cut public spending and sell off assets having very adverse impacts on poor people and the general public infrastructures of the countries. Basically, assets of many countries have been privatised and the debt socialised. Henry (2012, p. 6) says "in terms of tackling poverty it is hard to imagine a more pressing global issue to address".

Wealth growth outstrips any poverty reduction

Poverty rates in Sub-Saharan Africa fell only very slightly over period 1980-2010, and failed completely to keep pace with population growth as there was a continuing rise in number of poor. Globally, there were only modest gains in decreasing poverty at the two-dollar-a-day level, and a substantial rise in the number subsisting between the $1.25 and $2/day rates, which the World Bank notes "points to the fact that a great many people remain vulnerable" (Chen and Ravallion, 2012: 3). These data mean that the not very ambitious Millennium Development Goal of halving the number of people living in extreme poverty ($1 or $1.25/day) between 1981 and 2015 has been achieved. But Labonté et al. (2015) note that the value of the global economy more than quadrupled during this same time period – from US$18 trillion in 1980 to US$80 trillion in 2011, suggesting that that very little 'trickle down' of the benefits of that growth reached the 'bottom billion' (Collier, 2007). They further point out that halving these rates says nothing about the adequacy of the poverty lines themselves. An ethical poverty line of $3/day increases the number of global poor by 1.3 billion to around 3.7 billion, or roughly half the planet's total population. This is the situation at a time when the accumulation of wealth by the richest people on the planet is increasing dramatically (Oxfam, 2014; Piketty, 2014) and some redistribution of power and

resources could realise the ethical poverty line. Analysis by the South Centre (Oritz and Cummins, 2013) comes to the conclusion that the recent policy prescriptions from the IMF to contract government spending has resulted in the most vulnerable households bearing the brunt of these austerity measures.

SOLUTIONS

It is very evident from the above analysis that the global community has more than enough resources to reduce health inequities if there was political will to redistribute the currently very uneven distribution of wealth. Key measures that would help are detailed below.

Global Governance Regime

The Lancet-University of Oslo Commission on Global Governance for Health reviewed the system of global governance in light of health concerns and determined that the system was dysfunctional and that certain actors and institutions control too much power and that power needs to be redistributed. The analysis of this Commission and that of O'Keefe (2000) and Stiglitz (2002) suggest the following measures would provide a sound global governance regime:

1. Much greater democracy with participation and representation of civil society, health experts, and marginalised groups in decision-making processes.
2. Stronger accountability mechanisms to constrain power and increase transparency in order to hold institutions to account for their actions.
3. Mechanism to ensure adequate public financing and reduce taxation evasion.

Public financing regimes that benefit people rather than profits

'With taxes we buy civilisation' Oliver Wendell Holmes

The following measures would enable a redistribution of wealth and ensure that nation states have funds to invest in public goods including health, education and welfare (Baum, 2015).

1. Establish an international agreement regulating international corporations and finance. Currently international agreements under the World Trade Organization (WTO) maintain an international trading regime that permits TNCs to operate with very few controls on their activities and to appeal to the WTO if there are restrictions that impede their profit-taking. This item would use international agreements to control the TNCs and hold them accountable to the public good.
2. Eliminate corporate welfare. TNCs receive considerable direct public subsidies and tax breaks. They also externalise a range of costs like pollution, worker health and safety, and dangerous and defective products. Steps to internalise the costs of their operation would include eliminating direct public subsidies and tax breaks, charging environmental-use fees for the full cost of natural resource extraction and the release of pollutants into the environment and estimating and charging for other indirect subsidies. These include the costs to society when corporations fail to provide a living wage adequate to support a family, health insurance, pension contributions and safe working conditions for their workers.
3. Institute a system of effective global regulation of taxation on TNCs so that tax havens and other tax avoidance schemes are eliminated. Piketty (2014: 515) argues that a progressive global tax on capital coupled with a very high level of international financial transparency is required "to avoid an endless inegalitarian spiral and to control the worrisome dynamics of global capital concentration" (. Revenue is vital to development and this is most pressing for poor countries who lack the public infrastructures richer countries have established. This position is no longer just that of the progressive left. The G20 meeting in Sydney in 2014 included on its agenda ways of instituting measures to ensure corporations pay their fair share of taxes. National governments need to be supported to strengthen the efficiency of tax collection methods and overall compliance, including fighting tax evasion.
4. Use fiscal and central bank foreign exchange reserves (Oritz and Cummins, 2013): This includes drawing down fiscal savings and other state revenues stored in special funds, such as sovereign wealth funds, and/or using excess foreign exchange reserves in the central bank

for domestic and regional development; for instance, a country like Timor-Leste, where the share of people living in poverty increased from 36% to 50% between 2001-07, has an estimated US$6.3 billion stored in a Sovereign Wealth Fund invested overseas. Or

5. Adopt a more accommodating macroeconomic framework (Oritz and Cummins, 2013): This entails allowing for higher budget deficit paths and higher levels of inflation without jeopardizing macroeconomic stability (e.g. quantitative easing in the United States).

6. Curtail illicit financial flows (IFFs) (Oritz and Cummins, 2013): which could also free up additional resources for economic and social investments. IFFs involve capital that is illegally earned, transferred or utilised and include, inter alia, traded goods that are mispriced to avoid higher tariffs, wealth funnelled to offshore accounts to evade income taxes and unreported movements of cash. In 2009, it is estimated that US$1.3 trillion in IFFs moved out of developing countries, mostly through trade mispricing, with nearly two-thirds ending up in developed countries; this amounts to more than ten times the total aid received by developing countries.

Civil Society: voice for tax justice

There is an increasingly vocal civil society arguing for increased taxation. The Tax Justice Network leads the pack and its website (http://www.taxjustice.net/) contains a lot of information on how tax can become much fairer. The South Australian Council on Social Services (SACOSS, 2013) provides a local example of a campaign run in conjunction with a State election which argued for increased taxation which used the slogan "Without taxes vital services disappear".

CONCLUSION

The issue of financing improved public health cannot be discussed outside the context of the global political economic system. This system is unfair and stacked in favour of TNCs. Financing for global health requires governments to have sufficient public financing so that they can both provide public health services and also address the social determinants of health. This requires radical reform to global systems of trade, governance and taxation.

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PRINCE MAHIDOL AWARD CONFERENCE 2015 | GLOBAL HEALTH POST 2015 ACCELERATING EQUITY

PARALLEL SESSION 3.5

UNIVERSAL HEALTH COVERAGE: POLITICAL COMMITMENT AND FINANCING FOR COMPLEX PUBLIC HEALTH NEEDS IN THE NEXT TWO DECADES

PARALLEL SESSION 3.5

UNIVERSAL HEALTH COVERAGE: POLITICAL COMMITMENT AND FINANCING FOR COMPLEX PUBLIC HEALTH NEEDS IN THE NEXT TWO DECADES

BACKGROUND

The concept of Universal Health Coverage (UHC) has been recognized regionally and globally as a way forward to accelerating health equity for all the people. The ASEAN-plus-Three have put out a statement that the ASEAN countries will strive to attain UHC in the future. In Africa, Minsters of Health have acknowledged the critical role of UHC in the Luanda Declaration. Over the past years, there has been an increasing momentum to prepare and expand the coverage of essential health packages to their citizens, crossing over social, physical, and financial barriers, in countries that have not yet attained UHC. Some countries have made further strides by creating public health insurance mechanisms, which require high political commitments as well as financial sustainability.

UHC can provide a powerful solution that could work as a global goal to further decrease mortality and morbidity by extending health services holistically to all the people, disregard of where they live or where they are from, at an affordable cost.

This session will focus on how to finance emerging and challenging public health needs as the world undergoes economic growth as well as changes in demography and diseases structure, and faces political instability and migration issues. It firstly provides an overview of the latest status and efforts made by some Low- and Middle-Income Countries regarding UHC, highlighting the role of institutions, including the Ministry of Health, and health financing options that they have sought. With that overview, it secondly looks into concrete examples in the cases of the Philippines, Kenya and Japan, to learn from those countries both validity and new challenges in realizing health equity. The presentations cover the political economy, legal framework, effectiveness of measures to achieve UHC, financial struggles and possible solutions. Thirdly, it focuses on who is left out and how to reach them: the case for migrant health care provision and coverage for other hard-to-reach populations. It deals with strategies for social protection, working with non-health sectors and coverage for those who fall through the cracks.

OBJECTIVES

The objective of the session is to (1) learn from country experiences ways to secure financing toward the achievement of UHC; and (2)discuss what sort of political commitments and effective financing are required to achieve and sustain UHC as the world faces emerging public health needs in the next two decades.

MODERATOR

Naoyuki KOBAYASHI
Deputy Director-General
(Human Dev. Dept.)
Japan International
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Japan

Naoyuki Kobayashi oversees JICA's official development assistance programs in the health sector for the Asia-Pacific region as deputy director-general at JICA's Human Development Department. His responsibility includes JICA's strategies in the areas of health workforce and MCNH, and also developing aid programs to support partner countries in the region. Previously, he served as director for the Maternal and Child Health Division and led his team to execute JICA's MNCH and reproductive health programs for all regions. As for his overseas assignment, he served as a deputy resident representative at the JICA Afghanistan Office and as an assistant resident representative in Egypt. He worked also for UNDP as program adviser to increase collaboration between the UN and Japan.

Inke MATHAUER
Health Systems Development Specialist
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Switzerland

Inke Mathauer is a health systems development and health financing specialist, holding a MSc and PhD from the London School of Economics, with 16 years of work experience.

Inke joined the World Health Organization in 2007 where she is working in the Department of Health Systems Governance and Financing in Geneva. Her work focuses on health financing system reviews, country health financing policy advice as well as conceptual work based on synthesising country evidence of what works and what doesn't for universal health coverage. She publishes on a range of health financing related aspects. One of these included an analysis of DRG-based hospital payment systems in low- and middle-income countries and their implementation experiences and challenges.

Her current interests lie particularly in the institutional design features of state budget subsidization for poor and vulnerable groups to be covered in health insurance type schemes. Also, at the moment, she is guiding a number of country studies in Africa that explore the feasibility and potential of additional resource mobilization through new revenue raising mechanisms (or „innovative financing mechanisms").

Inke has developed the so-called OASIS approach (Institutional and Organizational ASsessment for Improving and Strengthening Health Financing), which is an analytical guide for a comprehensive and systematic assessment of a health financing system to explore institutional design aspects and organizational practice and how they contribute or don't to moving towards universal health coverage. The approach has been applied in numerous countries, both low- and middle-income as well as high-income, providing a basis for health financing reform discussions and health financing strategy development processes.

Prior to joining WHO, she worked for over 5 years for the German International Cooperation (GIZ). At GIZ Headquarters / Health and Social Protection Department, her work in health systems development included country advisory work with a particular focus on decentralization in the health sector, community participation, social health insurance and public-private partnerships. She also led a multi-country study on non-financial incentives for motivating health workers. In Kenya, she headed the GIZ supported quality management and health financing program division and provided policy and technical advice to the Ministry of Health and the National Hospital Insurance Fund. Inke has also undertaken several institutional analysis consultancies for the World Bank in the field of health and social protection. Her career started 20 years ago in Benin and later Uganda, where she lived at district level for several years and worked on service delivery issues and public-private partnerships.

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Dr. Francisco Soria, Jr. is a physician with over a decade of public service that spans the frontline local government unit health operations to central policy and program development work in public health and social health insurance in the Department of Health and the Philippine Health Insurance Corporation (PhilHealth).

For the past three years until recently, he supervised in an ad hoc capacity the development of new benefits and provider payment policies as well as expansion/enhancement of existing ones as the officer-in-charge of health finance policy office of PhilHealth. He was also in charge of PhilHealth's provider engagement policy- setting accreditation and provider performance standards, designing provider performance monitoring program and accreditation policy. Since December 2014, he assumed his new position as Vice-President for quality assurance, at the same time overseeing the development of primary care and MDG-related benefits.

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Ministry of Health
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DR John is a chief consultant surgeon by profession, with postgraduate training in Health Systems management (HSM) from the Galillee College, Israel and Public Policy formulation, Analysis and Implementation form the Kenya School of Government. I have been offering leadership in the development of the Kenya Health Policy, 2014-2030, the Health Sector strategic Plan, 2014-2018 and the road map to Universal health Coverage in Kenya.

Bounfeng PHOUMMALAYSITH
Deputy Chief of Cabinet
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Lao PDR

Dr. Bounfeng Phoummalaysith, a Deputy Director General of the Cabinet, Ministry of Health, Lao People's Democratic Republic. He began his career as pharmacist in Food and Drug Department, Ministry of Health, Lao PDR. He graduated Master of Sciences in Almaty Medical University, Kazakstan (1989) and Master of Medical Administration in Nagoya University, Japan (2004). Presently, he has got a scholarship of PhD on Transnational Doctoral Programs for

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At present, he serves as administrator in the Cabinet, Ministry of Health. He is in charge of a health legislation, information and technology and advancement women promotion. A part from these responsibilities, he has been assigned as technical focal point of the health system reform in the Ministry of Health, Lao PDR and the committee member of natural disaster and emergency protection and control.

Publications:

- Building the national drug policy on evidence- a cross sectional study on assessing implementation in Lao PDR;
- Health Policy Evolution in Lao PDR: context, processes and agency; Lao Health Information System: Review and Assessment;
- Impact of Health System Reform and Community Health Insurance in Districts of Lao PDR.

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Naoki Ikegami is Professor and Chair of the Department of Health Policy and Management at the Keio School of Medicine, from which he received his MD and PhD. He also received a Master of Arts degree in health services studies with Distinction from Leeds University (United Kingdom). During 1990-1991, he was a visiting professor at the University of Pennsylvania's Wharton School and Medical School, and has continued to be a Senior Fellow at Wharton. He is a founding member of interRAI (a non-profit international consortium of researchers and clinicians focused on care planning instruments), and served as a consultant to the WHO and the World Bank. He has been President of the Japan Society of Healthcare Administration and of the Japan Health Economics Association. He has sat on various national and state government committees, including the Chair of the Investigative Specialist Sub-committee on Case-mix Based Reimbursement for Chronic Inpatient Care and member of the Reforming Elder Healthcare Council and of the End-of-Life Health Care Council. His research areas are health policy, long-term care and pharmacoeconomics. His publications include "The Art of Balance in Health Policy - Maintaining Japan's Low-Cost Egalitarian System" (Cambridge University Press, 1998) with John C. Campbell, "Japanese universal health coverage: evolution, achievement, and challenges" lead author (Lancet, 2011), "Universal Coverage for Inclusive and Sustainable Development: Lessons from Japan" (World Bank, 2014).

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Takashi Fukuda is Research Managing Director at National Institute of Public Health. He received his PhD degree from the Graduate School of Medicine, The University of Tokyo, majored in Health Sciences. After his career as an Assistant Professor of Health Administration at the Graduate School of Medicine, The University of Tokyo during 1995-2000, he worked as an Associate Professor of Pharmacoeconomics at the Graduate School of Pharmaceutical Sciences, The University of Tokyo during 2001-2006. In 2007 as the School of Public Health was opened, he became an Associate Professor of the Department of Health Economics and Epidemiology Research, the School of Public Health , The University of Tokyo. From November, 2011, he moved to the National Institute of Public Health, which is the governmental research institute. From April 2014, he has the current position. His major research areas are health care economics, health care administration, and pharmacoeconomics.

STATE BUDGET SUBSIDIZATION OF POOR AND VULNERABLE POPULATION GROUPS IN HEALTH INSURANCE TYPE SCHEMES IN LOW- AND MIDDLE-INCOME COUNTRIES: A global overview and trends in institutional design patterns

By Inke MATHAUER

KEY MESSAGES

- State budget subsidization of poor and vulnerable groups in health insurance type schemes delink or weaken the link between contributions and entitlement to an explicit benefit package for identified, affiliated and enrolled beneficiaries.
- Evidence shows that subsidization helped to increase enrolment and population coverage of poor and vulnerable population groups.
- Effective UHC extension is contingent upon the careful design and effective implementation of critical institutional design features, which include the targeting mechanism for high targeting effectiveness, a high degree of subsidization, integrated pooling of the subsidized and contributors, harmonized benefit package and reduced co-payment rates for the subsidized.
- Core policy questions are: How to improve coverage of informal sector workers and their families? How to merge separate schemes to create an integrated system with no-opt out options for the better off?

BACKGROUND AND PURPOSE OF THE PAPER

Universal, fully budget funded, population-based health care system ("National Health Service"-type) have not successfully materialized in many low- and middle-income countries (LMIC), as funding shortages often translated into non-availability of care, while high out-of-pocket (OOP) expenditure and user fees led to financial barriers. Likewise, "traditional" contributory social health insurance (SHI) for formal sector employees has proven challenging for moving towards universal health coverage (UHC), because the informal worker population and the poor remain excluded.

There are various ways to extend UHC extension. Non-contributory approaches include user fee exemption for specific groups and free health care policies for selected health services and/or selected population groups. A common feature of these approaches is that they are usually not based on affiliation and enrolment of entitled individuals. An alternative approach is to fully or partially subsidize health insurance type contributions for economically and medically vulnerable population groups from general government revenues. This approach, being a mix of contributory and non-contributory, typically requires affiliation and enrolment of beneficiaries identified as eligible. The aim is to enhance equity in coverage extension, financing and access to care, by putting the poor, vulnerable or otherwise uninsured people at the centre.

This paper focuses on such state budget subsidization arrangements, with the objective to provide a global overview of this health financing option in LMICs. The purpose is to reveal those critical institutional design aspects that are conducive to progress towards UHC. This could offer lessons to other LMICs, which explore the introduction of subsidization schemes.

As a starting point, based on a literature review, an assessment of LMICs with state budget subsidization arrangements was undertaken for each WHO region (European, African, Eastern-Mediterranean, South East Asia & Western Pacific region and Pan-American region) to capture the growing body of country evidence with a regional perspective. This global overview paper (Mathauer et al. 2015) is a synthesis of these regional studies.

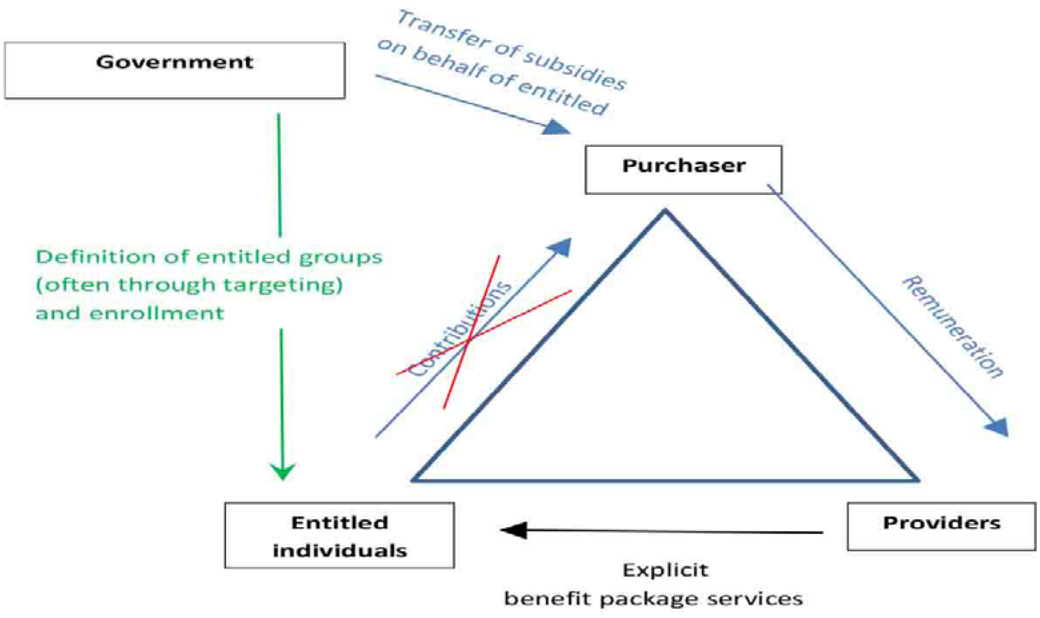
Country experiences are assessed along the following institutional design features: enrolment and eligibility rules, targeting mechanism, pooling arrangements, financing arrangements, purchasing

mechanisms and benefit package design. For this matter, UHC progress is captured as increased total population coverage and coverage of the subsidized, improved financial risk protection (lower OOP burden of the subsidized, lower incidence of catastrophic and impoverishing expenditure), and improvements in utilization as a proxy for access to health services.

CONCEPTUAL UNDERPINNINGS

While such subsidization schemes often show a number of health insurance characteristics, general government revenues are an equally important source of funding. The resulting hybrid financing overcomes the dichotomous thinking of a "Bismarckian" versus "Beveridge" system. From a Health Accounts perspective, such schemes may fall in the category of a government program or a SHI, ultimately depending on how explicit subsidization of contributions on behalf of the subsidized is. As Figure 1 depicts, subsidization implies delinking or weakening the link between contributions and entitlements, in that subsidies may cover the full or a part of the contribution. Many of such schemes have a separate third-party payer as a purchasing agency, although this is not a defining feature. Table 1 below outlines the policy choices related to the institutional design of such schemes.

Figure 1: Weakening the link between contributions and entitlement



Source: Mathauer (2014)

State budget subsidization of health insurance type schemes contribute to improving coverage along the three UHC dimensions. They increase population coverage by enrolling population groups that previously had insufficient financial risk protection, and often focus in particular on those most in need, i.e. the economically and medically vulnerable. The package of services covered is made explicit and thus usually larger than what these population groups could access prior to being enrolled in such schemes, hence expanding service coverage. Cost coverage and financial risk protection may improve, in particular if eligible groups no longer face the full cost-sharing rates.

Table 1: Key institutional design features and related policy choices of subsidization schemes

Function	Institutional design aspects	Policy choices
Revenue collection	Eligible groups	Large variety in eligibility definitions
	Targeting rules for the subsidized	Direct targeting is based on a threshold income or poverty lines; indirect targeting focuses primarily on socio-demographic, socio-economic and geographic characteristics; a universalistic approach considers everybody outside a formal sector scheme as eligible
	Source of funding for subsidies	Central budget revenues, sometimes earmarked; social security funds for specific population groups (e.g. the unemployed); also local government budgets and charity funds
	Degree of subsidization	Full subsidization or partial subsidization (semi-contributory)
	Calculation of state budget subsidies	Calculated on a per capita basis using average contribution rates, average wage or minimum wage as a reference point; based on a share of the government budget, or negotiated
Pooling	Nature of pool	The pool of the subsidized can be integrated with the pool for formal sector employees, or remain separate with no potential for cross-subsidization
	Type of membership	Voluntary or mandatory
Purchasing	Purchasing arrangement	Separate purchasing agency, with explicit purchaser-provider split, or MOH as purchaser and provider
	Provider payment	In separate schemes: same or different provider payment mechanisms
Benefit package	Scope of services covered	Clearly defined (positive list or negative list); range from being more limited (outpatient care or only inpatient care) to more comprehensive packages, including drugs

Source: Mathauer (2014)

GLOBAL EVIDENCE

Trends and patterns in institutional design

The global synthesis paper (Mathauer et al. 2015) shows that by 2014, over 40 LMICs across the globe have introduced state subsidization of poor and vulnerable groups (four of which moved into the group of high-income countries since 2012). Despite many commonalities, there is also considerable variation in institutional design and performance. Moreover, an increasing number of countries is exploring and preparing the introduction of such schemes.

Meanwhile, 25 LMICs operate an integrated scheme, i.e. a single pool that allows for cross-subsidization from within. LMICs in the WHO European region avoided fragmentation by establishing right from its start a health insurance type scheme that pools both contributors and the subsidized as a way to maximize risk pooling and redistributive capacity. More and more countries explore how to merge their different schemes into one. It is found that integrated schemes usually offer the same benefit package to both the contributors and the subsidized, sometimes even a larger one to the latter. In about 15 countries, the subsidized are enrolled in separate schemes resulting in a multiple pool setup. Most of the separate schemes provide a smaller benefit package than that for formal sector employees, with some few exceptions only.

Effects on population coverage, access to health services and financial risk protection

Subsidization schemes helped to strongly increase enrolment and population coverage in a relatively equitable way as they focus on poor and vulnerable population groups. Population coverage rates turn out to be highest in countries with a "universalistic" targeting approach, but only a few countries have a universalistic approach in place. Coverage rates are somewhat lower when indirect targeting is applied, and again lower with direct targeting. Most countries in fact apply a mix of direct and indirect targeting.

Full subsidization via general government revenues has allowed to cover a substantial share of the population and a range of different vulnerable and otherwise uninsured population groups outside the formal sector. In contrast, partial subsidization has in general not succeeded as much in increasing enrolment rates, although China and Rwanda did so due to a combination of institutional design features and their particular context.. Challenges remain: Inclusion and exclusion errors

relating to the targeting process are still significant in a number of countries and result in leakage and under-coverage, thus resulting in inequitable population coverage.

Few subsidization programs have undergone a systematic and comprehensive evaluation, but evidence, while scarce for several countries, suggests that in their majority, financial risk protection and access to services improved for the subsidized. In several countries, co-payment rates are differentiated and thus lower for the subsidized as a way to reduce the burden of OOP expenditure. Nonetheless, lower income quintiles frequently continue facing a heavier burden of OOPs.

In separate schemes with smaller benefit packages for the subsidized, inequities in access and financial protection continue to prevail. But even in integrated schemes, differences in utilization remain and may not be easily removed completely (Mathauer et al. 2015).

CONCLUSION AND POLICY RECOMMENDATIONS

In conclusion, among the financing options for UHC extension, state budget subsidization of health insurance type schemes can be an effective mechanism to move towards UHC and cover poor and vulnerable people or otherwise uninsured population groups. But state budget subsidization is no magic bullet and only contributes to UHC progress, if critical institutional design features are well designed and effectively implemented. This includes the targeting mechanism for high targeting effectiveness, a high degree of subsidization, harmonized benefit package and reduced co-payment rates for the subsidized. It also requires explicit funding for the provision of an explicit benefit package. The most important institutional design feature for enhancing equity is the integration of the subsidized in the same pool as the contributors, which facilitates the provision of a uniform benefit package and more equal access to health services.

However, challenges remain: Coverage of the poor and vulnerable population groups needs to deepen through improved institutional design. And a comprehensive benefit package on paper is not enough as long as supply side constraints and gaps in health service quality prevail. The core policy question is how to improve coverage of informal sector workers and their families. The other key policy issue relates to countries with separated schemes and how these can eventually merge to create an integrated system with no-opting out for the better off. In the short and medium term, the aim should be to harmonize different benefit packages.

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Regional studies:
http://www.who.int/health_financing/documents/other_mechanisms/en/

Ministry of Health

A Model for Health Financing Reforms in Kenya
"Government will for achieving Equity"

Prepared by:

DR JOHN MASASABI WEKESA

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SECTION 1.0: BACKGROUND AND CONTEXT

Globally, there is a growing focus on the goal of universal coverage in health systems. The 58th World Health Assembly of 2005 (WHA, 2005) encouraged member countries to aim at providing affordable universal coverage and access for all citizens on the basis of equity and solidarity. Following this declaration, many countries including Kenya are currently considering how to reform their Health Financing Systems (HFS) with the aim of achieving Universal Health Coverage (UHC[1]).

The Constitution of Kenya, 2010, through the Bill of Rights puts a heavy responsibility on the health sector to ensure realization of the right to health by the Citizen's , particularly the right to the highest attainable standards of health including Reproductive Health and Emergency Treatment . The goal of Kenya's Vision 2030 and that for the health sector is to provide equitable and affordable health care of the highest standards to Kenyas. The Government recognizes that access to health care not only entails the physical availability of services, but also the protection of its citizens from financial hardship. It is against this background that this Concept Paper was developed to provide recommendations on key Health Financing Reforms (HFR[2]) required to accelerate the movement towards Universal Health Coverage.

This Concept paper is on the preferred model for health financing reforms for accelerating the movement towards UHC in Kenya. The paper has been informed by various studies and relevant background papers on UHC and consolidated into an "Options for Kenya's Health Financing System" by the Providers for Health (P4H) group[3].

The recommendations for health financing reforms contained in this Concept paper pay attention to the role of County Governments in a devolved system of Governance, equity in access, efficiency in service delivery and quality assurance and improvement.

SECTION 2.0: HEALTH FINANCING SITUATION IN KENYA

2.1 UHC related indicators on health sector performance

Kenya has strived to build a health system that can effectively deliver quality health services to its population. Among the key health indicators, the overall under-five child mortality rate remains high at 74 per 1000 live births and

[1] UHC requires that financing systems be specifically designed to provide all people with access to needed health services of sufficient quality to be effective and ensure that the use of these services does not expose the user to financial hardship (WHO report, 2010)

[3] The global initiative "Providing for Health (P4H)" is a network supported by various partners such as USAID, WB, WHO, GDC, France and others and seeks to organize discussions around UHC and to support partner countries like Kenya, Tanzania and others in developing their Healthcare Financing Strategies

maternal mortality ratio stands at 488 deaths per 100,000 live births (KDHS 2008/09).

Access to health care varies widely throughout the country and major disparities exist between rural and urban communities and between the rich and poor. According to NHA 2009/10, individuals carry a huge burden of health care expenditures at 24% in form of direct out of pocket payments (OOP). Other sources of funds for health comprise of government 29%, Donors 35% and other private sources accounting for 13% of the Total Health Expenditure(THE). The per capita health spending was estimated at USD 42.2 against the recommended WHO requirement of USD 60, indicating a general underfunding of about 30 percent. In addition, long distance to health facilities, unavailability of services and shortage of health workers are major factors that hinder access to health services. There is therefore need for a revamped health financing structure that can increase funding to the health sector and reduce direct OOP spending on health.

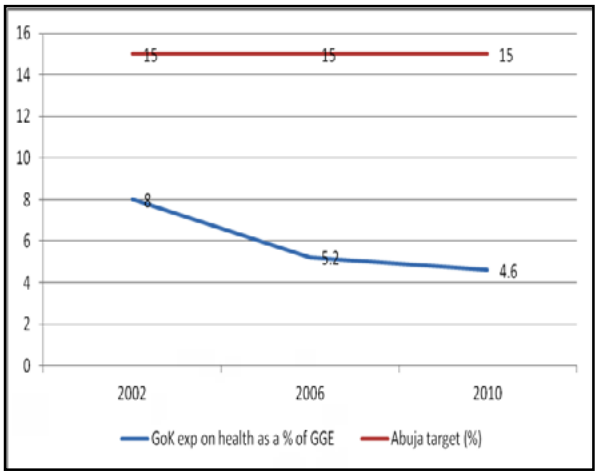
The key health policy concerns are not whether the government uses general revenues or payroll taxes, but whether the actual amounts of revenues raised are sufficient and being used in an efficient, equitable and sustainable manner.

2.2 Key issues in health financing in Kenya

2.2.1 Raising funds for health spending

The health sector is generally underfunded with only 70% of expected funding available from all sources. This is inclusive of direct out of pocket payment (OOP). In 2010, health resources from domestic public health expenditures accounted for only 29% (or approximately USD 12 per capita) of THE (NHA 2010). This amounted to about 5% of the total Government budget which is way below the Abuja target of 15% (see figure 1, above, on trends). This figure has not been estimated in the devolved system of governance. In addition, Private sources accounted for 37% of which 67% was direct out of pocket spending.

It is estimated that nearly 15% of Kenyans spend more than 40% of non-food expenditure on health care. This is a major source of financial distress in a context of high poverty levels, and leads to catastrophic health expenditures.



2.2.2 Financial Risk Pooling

Financial Risk Pooling of resources is the accumulation and management of funds contributed by individuals or households and possibly by employers, government and others, in a way that insures the individual contributor or defined beneficiary, against the risk of having to pay the full cost of care out of pocket in the event of illness. Tax based health financing and health insurance both involve pooling, while fee for service user payments do not involve pooling.

Currently, within the domestic sources the main financing pools are government budgetary allocations (29%), health insurance (6 %), and small community based prepayment schemes. These pools are isolated and not connected through financial risk equalization mechanisms. The generally low insurance coverage is largely limited to formal sector employees (mandatory) and a small number of informal sector voluntary contributors. In all, about 20% of Kenya's population is insured.

The two main pools are characterized by further fragmentation. For example, within the government budgetary allocation pool, access to services for individuals and households is fragmented by coverage schemes which include general budget lines for GOK subsidized services, Free Maternity Initiative, Free Primary Health care , health insurance for the elderly who are currently on the Government cash transfer programme. Devolution adds to the complexity in pooling, as Counties are purchasing health services from their block grant allocation of general tax revenue. This further fragments the system and therefore hinders equal access to care for all.

2.2.3 Purchasing of healthcare services

In practice, purchasing of health services is done by public or private agencies that spend money either to provide services directly or to purchase services for their beneficiaries. In many cases, the purchaser of health services is also the agent that pools the financial resources. In Kenya, the main purchasers of health services are the government through the Ministry of Health, other government departments and agencies, County governments, National Hospital Insurance Fund (NHIF), Private Health Insurance and households.

Purchasing from both government allocation and NHIF pools is mainly passive and dependent on a pre-determined budget as opposed to strategic purchasing which requires deliberate approaches to seeking better quality services at low cost via selective contracting of providers and their services while reviewing the actual performance of the contracted providers. In Kenya, passive purchasing is associated with high levels of wastage due to inefficiencies as demonstrated by the 50 – 60% wastage levels in public hospitals, 10 – 20% for health centers and 20 – 50% for dispensaries. This implies that the facilities are using more inputs than required and could potentially reduce their current input endowments while leaving their output levels constant. For NHIF, administrative/operating costs account for over 30% of total expenditures thus, denying resources for actual service provision.

2.2.4 Provider payment mechanisms

Pooled funding in Kenya is predominantly from general tax, and mainly benefits public providers and restricts the emergence of internal markets. The payment mechanism is largely effected through input based line item budgets (for e.g. salaries, supplies, equipment, infrastructure development and other investments). This mechanism provides no incentive for increasing efficiency and productivity.

In addition, input based financing provides incentives for unnecessary referrals if costs can be avoided by referring patients to another “budget”. For example, County facilities may refer patients to tertiary hospitals since these are not financed by the County, but by the MOH. Varying payment mechanisms may compound this issue. The more fragmented the financing pool, the more difficult it is to avoid negative effects. In addition, the flow of health information

is often inhibited where different funding sources are involved in data collection. This can have obvious negative impacts on reporting of health outcomes and on the financial and general governance of the health sector.

SECTION 3.0: CONCLUSIONS AND IMPLICATIONS

Kenya's' health financing system like for other low income countries is facing numerous challenges. Key among them include inter-alia high dependency on external sources, persistent under funding , low insurance coverage, and inefficiencies in the use of available limited resources. **Over fragmented** pools without adequate regulatory framework offer limited risk pooling **with negative** consequences on cross **subsidization** and benefit package design.

Despite these challenges the Government is committed to achieve UHC by 2030. However, this calls for key reforms to be made in the health financing system. The particular reforms should focus on resource mobilization, pooling, strategic purchasing from public and private providers, provider payment mechanisms. Other key reform areas include but not limited to strengthening of institutional capacity for health financing, oversight and general governance of the sector, accompanied by suitable regulatory measures to create a cost-effective system.

SECTION 4: PROPOSED MODEL FOR HEALTH FINANCING REFORMS IN KENYA

The goal of this financing model is to ensure financial risk protection, quality services with resultant improvement in the health status of Kenya's population. The intermediate objectives are to ensure equitable access to quality and affordable health care for the population. The proposed preferred health financing model is characterized by the following salient features:

4.1. Raising funds for health spending

It is suggested that the model will optimize on the mixed sources of funding from both general tax revenues and health insurance premiums. This in turn implies strengthening of inclusive pre-paid risk-pooling schemes with the overall target of increasing total public funding available to the sector as well as a reduction of direct out of pocket payments for services. Only when the healthy and wealthy contribute via taxes or premiums according to their economic ability, can the sick and poor benefit according to their need. Against this background, the proposed strategies for consideration include:

a) Maximize on efficiency gains by reducing wastage at all levels of the health system;
b) Increasing government funding from the current 4.6 percent of General Government Expenditure (GGE) to a minimum of 15 percent (Abuja target);
c) Expanding pre-paid insurance funding from the current 6 percent to about 40 percent of THE by mobilizing mandatory contributions from the informal sector, but excluding indigents and the vulnerable groups;
d) Mobilizing additional resources from external sources while at the same time paying attention to the objects of the Paris declaration on Aid effectiveness;
e) Allocating additional funds to the health sector from the County level locally raised revenues and;
f) Co-payments of up to 10 percent of THE to counteract consumer moral hazard.

4.2 Financial risk pooling

The pooling objective is to minimize the fragmentation of the existing pools by progressively consolidating towards a single pool from which all the inputs into the health system will be financed. It is preferred that the government budgetary allocation to health be consolidated and pooled at National level, to be administered by a single agency that is independent of both MOH and Counties. The fragmentation within insurance pools will be eliminated to allow for cross-subsidization and uniformity of the Benefit Package.

4.3. Purchasing arrangements

There is need to change from passive to strategic purchasing of health services. This calls for creation of internal markets characterized by purchaser-provider split, defining interventions to be purchased in response to population needs and national health priorities, how they should be purchased and from whom and in which volumes to purchase.

4.3. Provider payment mechanisms

A payment mechanism that provides incentives for efficiency and productivity is recommended. Towards this end, several methods on provider payment mechanisms are proposed. Such mechanisms advocate for progressive movement away from line-item budget mechanism towards a fee-for-service (FFS) system, including capitation-based budgets, Global budgets and Diagnostic related Groups (DRG). Payments based on fee-for-service are administratively cumbersome and carry an "inborn" incentive for provider moral hazard. However, it is useful in low-productivity settings and provides incentives for providers to report additional performance data to be used for e.g. quality assurance and financial and health services planning. The possible additional administrative burden can be reduced when lumping together commonly used interventions for specific health conditions in distinct cases into a DRG payment system.

On the other hand, a capitation budget can be used, where calculating the expected average expenses of a provider for a disease episode will allow for determining the budget needed for e.g. 3 months and advance it to the health facilities. This way, the health care provider has a guaranteed income, which allows organizing health services efficiently. Such a system of capitation-based advanced budgets needs to be accompanied by a system of quality control, litigation and complaint management.

SECTION 5.0: OTHER REQUIRED REFORMS FOR THE MODEL

5.1. Definition of a benefit packages:

Due to limitation of resources, universal health coverage can only be progressively achieved through incremental financing of defined health services packages moving from a minimum package of essential health care to a more comprehensive package. The defined package should benefit all. Additional services are included, as funds become available while individuals remain free to enroll in duplicative, supplementary or complementary private insurance. It should be kept in mind, that fragmentation of the population into too many target groups, leads to inequality and higher administrative costs.

The three key steps of implementation should be 1) Define the minimum package of essential health care for all the three levels of care. 2) Determine the

criteria for referral and other conditions for access to care. 3) Estimate the cost of providing this minimum package of essential health care services. 4) Biennial review of benefit expenditures to possibly adjust the package and/or its funding level.

5.2. Standardized quality assurance system

Services will only be purchased from accredited providers. Accreditation[4] standards need to be defined by the Ministry of Health for all public and private service providers at all service levels. Standards, review processes and quality improvement activities will be developed via a participatory approach with both levels of government, health insurance agencies and service providers.

5.3. Legal and Regulatory Framework

There will be need for reforms as the MOH embarks on the movement towards UHC. Among key targets for legal reforms include:

i. Legislation of laws that support earmarking funds for health at the National and County Governments;
ii. Operational autonomy and governance structures for all public health facilities;
iii. Establishment of a health tariffs forums or body, which includes representatives of key stakeholders;
iv. Strengthen Insurance Regulatory Authority (IRA) in order to support and oversee the proposed health-financing model including NHIF reforms and;
v. Establishment of a health facilities accreditation body for external quality assessment and continuous quality improvement

5.4. Managerial Considerations

Success of this complex reform process depends on political will and the right management approach. The strategies and management principles recommended include:

a) Advocacy for the importance of the reform and its implications;
b) Analyzing the interests of the main stakeholders;
c) Informing all stakeholders and actors on the proposed reforms for ownership;
d) Developing a 5-year implementation plan based on a logical framework with a solid component for internal and external monitoring, as part of the UHC roadmap;
e) Avoid fragmentation of the approach by accommodating donors and external experts with preferences to specific target groups and strategies and;
f) Give the process time to grow organically with full support from all stakeholders while staying the course towards UHC

[4] Accreditation can be defined as *"A self-assessment and external peer assessment process used by health care organisations to accurately assess their level of performance in relation to established standards and to implement ways to continuously improve". It can be voluntary or mandatory, implemented by MOH, an independent government agency or a private body recongnized by purchasers as authority of which the review results and accreditation status is used in their contracting policies.*

UNIVERSAL HEALTH COVERAGE: POLITICAL COMMITMENT AND FINANCING FOR COMPLEX PUBLIC HEALTH NEEDS IN THE NEXT TWO DECADES

Professor Naoki IKEGAMI

KEY POINTS

To achieve equity in access, resources must be rationed. However, first, physicians oppose rationing, ostensibly because, according to their professional ethic, the best care must be delivered, with organ transplants and triaging in emergency being perhaps the only exceptions allowed. They also oppose because rationing would directly impact on their income. Therefore, governments must manage the expectations of physicians on the "appropriate" levels of services and income. Second, the rich must not only be satisfied with the same level of services as the rest, but also pay for the services provided to the poor. Such altruism is probably unrealistic, especially as physicians are more than willing to provide the "best" at their price. Thus, surmounting these barriers would be a formidable task. However, Japan has gradually succeeded by subsidizing insurance plans that enroll the poor, and establishing and revising a nationally uniform fee schedule.

FINANCIAL COMMITMENT AND IMPLEMENTATION FOR THE EFFECTIVE COVERAGE OF HEALTH CARE

Francisco SORIA

I. ACHIEVING UNIVERSAL HEALTH CARE THROUGH THE AQUINO HEALTH AGENDA

The thrust to achieve universal health care (UHC) in the Philippines can be traced back to the establishment of the country's national health insurance program (NHIP) in 1995, which aims to cover all sectors of the society. Over succeeding leadership changes, this thrust was sustained through different brands of continuing health reforms. When the current political leadership took office in 2010, it espoused universal health care through the Aquino Health Agenda and devised new ways to mobilize resources for health. The Aquino Health Agenda is built around three strategic thrusts:[i]

1. Financial risk protection through expansion in NHIP enrollment and benefit delivery- the population, especially the poor, will be protected from the financial impact of health care use by improving the benefit delivery ratio of NHIP;

2. Improved access to quality hospitals and health care facilities- upgrading of government-owned health care facilities will be undertaken in order to expand capacity and provide quality services to help attain MDGs, attend to traumatic injuries and other types of emergencies, and manage non-communicable diseases and their complications; and

3. Attainment of the health-related MDGs- public health programs will be focused on reducing maternal and child mortality, morbidity and mortality from TB and malaria, and the prevalence of HIV/AIDS, in addition to being prepared for emerging disease trends, and prevention and control of non-communicable diseases.

II. EXPANDING THE COVERAGE OF THE NATIONAL HEALTH INSURANCE PROGRAM

At the centerpiece of this health reform is the NHIP, which requires mandatory coverage for all sectors, and was established in 1995 by law.[ii] Under the original law, the local government units (LGU) would enroll the poor in the program and share their premium with the national government, depending on the LGU income class. The formal sector members, both public and private, share the burden of paying their premiums equally with their employer. The informal sector members had to pay for their own premiums. Operationally, the coverage of the informal sector and the poor met many challenges in implementation, notable among which were adverse selection in the former and leakages in the identification of the latter. An amendment to the law in 2013 streamlined the enrolment of the poor through the national social welfare agency (Department of Social Welfare and Development or DSWD); strengthened the coverage of persons with disabilities (PWDs), women and children; mandated retention of PhilHealth payments to government health facilities so that more funds would be made available for health care; shifted the role of LGUs towards health care provision rather than enrolment of the poor.

III. MOBILIZING ADDITIONAL RESOURCES THROUGH SIN TAX

The shift in strategy in covering the poor, the informal and other marginalized sectors received a big boost with the implementation of the "sin tax law" earlier in 2013, which

increased the taxes on tobacco and liquor.[iii] This law provides that after the 15% share of the tobacco and barley-producing provinces has been deducted from the incremental lrevenue, 80% of the remaining incremental revenues will be allocated for the universal health care under the National Health Insurance Program and twenty percent (20%) will be allocated nationwide for medical assistance and enhancement of health facilities. Beginning 2015, the senior citizens (those at least 60 years old)[iv] and LGU volunteer staff[v] were included among those that will benefit from the sin tax through their enrollment in PhilHealth. In order to mop up the remaining un-enrolled poor, PhilHealth also implemented point-of-care enrollment when patients seek care in government hospitals, with the hospitals paying the initial one-year premium.[vi] All these mechanisms contributed to the increase in PhilHealth membership coverage to the current 82% of the estimated 100 million population. The added revenue from sin tax provided additional fiscal space, enabling the Department of Health to increase its budget since 2013.

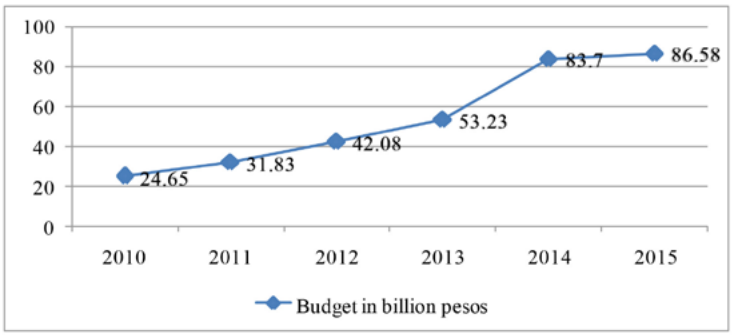


Figure 1. Department of Health budget, 2010-2015[vii]

This additional budget enabled the enrollment of 5.2 million and 14.7 million poor families in the NHIP in 2013 and 2014, respectively.[viii] Likewise, 2,685 barangay health centers, 3,395 rural health units and 831 district, provincial and DOH hospitals were enhanced. On the health human resource side, additional 324 doctors, 63,932 nurses and 9,137 rural midwives were deployed to far flung communities to complement the existing personnel and provide necessary health care.[ix] The additional funds did not only expand PhilHealth coverage but also allowed the increase of benefit rates for catastrophic conditions and allowed the expansion of services covered by the primary care benefit being enjoyed by the poor. As a result, benefit payments went up to P55.6 billion in 2013, an increase of 16% over the 2012 payments, and projected to have approached P70 billion in 2014.[x]

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PRINCE MAHIDOL AWARD CONFERENCE 2015 | GLOBAL HEALTH POST 2015 ACCELERATING EQUITY

PARALLEL SESSION 3.6

THE ROLE OF EMERGING ECONOMIES AND PRIVATE SECTOR IN GLOBAL HEALTH FINANCING

PARALLEL SESSION 3.6

THE ROLE OF EMERGING ECONOMIES
AND PRIVATE SECTOR IN GLOBAL HEALTH FINANCING

BACKGROUND

The session will review how some of the BRICS countries and their counterparts in the private sector have been contributing to global health financing. This will also be an opportunity to have an exchange on the challenges and opportunities to build partnerships on global health issues in the post-2015 agenda.

OBJECTIVES

The session will address the following objectives:

- Review current efforts made by countries who have recently reached upper middle income status to contribute as emerging donors to global and regional health concerns;
- Describe the growing trend of large scale private sector and philanthropic organizations in these countries who are now providing assistance to health development, their preferred areas for support, and modalities in financing;
- Discuss opportunities for creative partnerships and the range of issues that influence equity and sustainability.

MODERATOR

Aye Aye THWIN
Senior Health Technical Advisor
to the office of Health System
Global Health Bureau
The United States Agency for
International Development

USA

Aye Aye Thwin is a physician with a doctorate in public health economics. Since 1986, she has been working internationally in health policy and financing reform, reproductive health, child survival and control of infectious diseases. From 1991-1995, Aye Aye served in Dhaka, Bangladesh with the German Agency for Technical Cooperation (GTZ) as an Adviser to the National Institute of Population Research and Training, Ministry of Health and Family Welfare. In 1995, she was a faculty member at the Department of International Health, Bloomberg School of Public Health, Johns Hopkins University seconded as Senior Technical Adviser to the International Centre for Diarrhea Disease Research, Bangladesh. For the next four years, she led Hopkins' research program in Bangladesh on various aspects of health financing, analysis of health and population policy and urban poverty. She also served as an ad hoc advisor to the Ministry and the donor community on specific structural and organizational reforms. In 1999, she joined the World Health Organization as Health Economist and Sector Management Advisor to the Ministry of Health, Cambodia. She entered USAID in 2003, served for one year at the Bureau of Global Health at headquarters, and was later assigned to the Philippines as the Chief of the Office of Health from 2004-2009. In 2009, she moved to USAID's Regional Development Mission for Asia as the Director of the Office of Public Health in charge of the Agency's assistance portfolio to address regional and transnational health threats. In August 2014, Aye Aye was assigned as Senior Health Advisor at USAID HQs in Washington DC focusing on a range of strategic initiatives on health systems and financing. Aye Aye has a medical degree from the Institute of Medicine in Rangoon, Burma, a Masters in Public Health from Mahidol University and a Doctorate in health economics from the Bloomberg School of Public Health, Johns Hopkins University.

Peilong LIU
Senior Adviser
Ministry of Health

China

Liu Peilong currently is the Director of the Department of Global Health, School of Public Health, Peking University. Liu Peilong started his career in 1968 in the Ministry of Health (MoH), China. He participated in China's medical assistance programmed in Africa from 1969 to 1972. After returning to his home country in 1972, he worked as programme officer in the Department of International Cooperation of the MoH for 10 years and was in charge first of Chinese development cooperation for health with Africa and then of multilateral health cooperation with UN agencies. He was transferred to the Foreign Loan Office (FLO) of the MoH in 1983 and work there for 15 years. He became the Director General of the FLO and chief counterpart to the World Bank in all its health activities in China, including health investment projects and sector studies. From 1998 to 2003, he was the Director-General of the Department of International Cooperation of the MoH and acted as the focal point of the government to World Health Organization (WHO) and other multilateral and bilateral organizations in the field of health cooperation. In 2003, he was appointed Assistant Director-General level Adviser to the Director-General of WHO and worked in WHO headquarters in Geneva till 2007. Liu Peilong served as a member of Executive Board of WHO, a member of the Global Health Advisory Board of the World Economic Forum in 2010 and 2011, a member of WHO Consultative Expert Working Group on research and Development: Financing and Coordination in 2011, and was also a member of Chatham House Global Health Security Working Group on Health Governance. Liu Peilong studied at the Department of Human Sciences and Literature at the University of Rennes in France and earned a Master's degree in Public Health at the School of Public Health, Johns Hopkins University in the United States.

Mmathari MATSAU

Deputy Director-General
for Health in South Africa

South Africa

Ms. Mmathari Matsau is the Deputy Director-General for Health in South Africa, responsible for International Relations.

Ms. Matsau has worked for almost all her life in the field of public health policy, as Director for Health Planning in Lesotho, a consultant for the World Bank and the African Development Bank. She has been working for the National Department of Health since June 1995, in Pretoria. As Chief Director for Operational and Technical Policy at the Department of Health in South Africa until the year 2000 she was responsible for: Policy and Planning, the National Health Information Systems, Quality Assurance, Health Systems Research and Epidemiology.

She was appointed Deputy Director-General for Strategic Programmes in 2000, responsible for key programmes in Communicable and Non-communicable Diseases, MCH, Pharmaceutical Services as well as Drug Policy. From 2006 to date, she has been the Deputy Director-General for International Health Development and Support, with main focus areas as:

Mainstreaming health in South Africa's bilateral and multilateral initiatives

- Building of strategies, alliances and partnerships with global health partners
- Monitoring of international health trends for domestication
- Promotion of South Africa's health priorities
- Mobilization of international resources to support national, regional and international policy objectives.

Srinath Reddy

President,
Public Health Foundation of India
World Heart Federation

India

Prof.Reddy is the president of Public Health Foundation of India.He chaired the High Level Expert Group on Universal Health Coverage, set up by the Planning Commission of India.He also serves as the President of the National Board of Examinations which deals with post-graduate medical education in India.He is the first Bernard Lown Visiting Professor of Cardiovascular Health at the Harvard School of Public Health.Earlier, Dr.Reddy served as the head of the cardiology department at the All India Institute of Medical Sciences.Prof. Reddy is a global leader in preventive cardiology and has provided instrumental direction to strengthening training, research and policy development in the area of Public Health.

http://en.wikipedia.org/wiki/K._Srinath_Reddy

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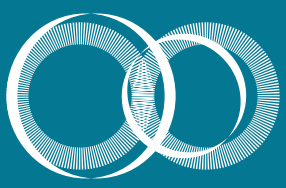

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