THE Last Generation

Health Care and Security
BY CANADIAN FOREIGN AFFAIRS MINISTER JOHN BAIRD

Time to Let Women Decide
BY UK SECRETARY OF STATE FOR INTERNATIONAL DEVELOPMENT ANDREW MITCHELL

Child Survival: Call to Action
BY USAID ADMINISTRATOR DR. RAJ SHAH

Malawi’s Transition
BY PRESIDENT OF MALAWI H.E. JOYCE BANDA

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The Last Generation. Without addressing global health challenges, many of the world’s communities are faced with diseases that threaten the very existence of their populations. Traditional killers including malaria, TB and HIV remain very real threats. Too many children lose the battle against preventable illnesses such as diarrhea and pneumonia. Many mothers do not live to see their children’s first smile.

Children represent one of our world’s most vulnerable populations. They also represent our future. That is why this issue of Global Health and Diplomacy is shining a spotlight on children’s health issues. Our feature articles discuss a myriad of opportunities to improve child survival rates in developing countries, including the use of vaccinations to prevent disease, the use of nutritional supplements to reduce morbidity and collaborative efforts to address malnutrition.

Children are most vulnerable in the first years of life. Research has clearly demonstrated the importance of maternal survival in the survival of children. Our authors point out that the world can no longer afford to shy away from discussions on women’s health due to traditional taboos, but rather, we need to develop a comprehensive approach to women’s health before, during and after pregnancy. What would the near death of Malawi’s new president in childbirth have meant not only to her own children, but also to her country as a whole?

The authors of this issue represent a diverse cross-section of experts in medicine, public health, politics and diplomacy. Our experts acknowledge the challenges that currently exist in the field of global health, but look to the opportunities to bring real change to the health of many populations throughout the world. Success in these endeavors would mean this is the Last Generation that would need to suffer from these threats.

Advances in technology provide new hope and treatments for centuries old diseases. Research in molecular biology is giving us hope for new biologic agents to treat resistant strains of malaria. Progress in information technology and informatics is providing us with robust statistics that allow for more rapid recognition of potential public health disasters and better data for monitoring the outcomes of our interventions. Ultimately, it is this data that allows us to make progress and meet the next challenge.

Global health issues are too broad for any one doctor, health care worker, world leader or lab to address alone. Only through partnership can we achieve success. Our authors discuss strategies of cooperation to address mortality from infectious and non-infectious diseases including cervical and breast cancer. Proposals for global networks linking developed countries and countries with high burdens of neonatal mortality through collaborative training programs are put forward. In these articles, the emergence of young leaders playing an active role in the global health agenda is brought to the forefront.

Challenges will always be present, but this issue highlights many of the figures in public health and diplomacy that are making measurable progress in the fight to ensure the health of the next generation.

— Joanne Manrique
Global Health Challenges

Malaria, HIV/AIDS, TB, Maternal and Child Health, Security and NCDs
Sustain Gains, Save Lives: R&D Leads the Way

BY DR. DAVID REDDY
CEO, Medicines for Malaria Venture

We have come a long way since the first Global Malarial Eradication Program was launched in 1955. Over the last 60 years, and particularly in the last decade, hundreds of millions of lives have been saved through a combination of preventive actions (such as indoor residual spraying initiatives and the distribution of bed nets) and effective medical treatments. In the latter category, our progress has been particularly striking: with the development of artemisinin-based combination therapies (ACTs), we have been able to better target the parasite and make it easier for patients to complete their treatment course. We have also recently succeeded in mapping the complex biology of the malaria parasite through its lifecycle, enabling us to develop medicines that will ultimately block the transmission of the disease.

However, these recent gains are fragile and reversible. Over 650,000 people still die each year from malaria. Complacency, or even simply a failure to address one of the many challenges posed by this constantly evolving disease, could cost us dearly.

GROWING TREATMENT RESISTANCE

Over the last 60 years, the effectiveness of the medicines used to treat malaria, such as chloroquine and sulfadoxine-pyrimethamine, has decreased substantially. Chloroquine resistance first emerged in western Cambodia in 1962 and spread across south-east Asia into Africa resulting in millions of cases. Over 650,000 people still die each year from malaria.

Complacency, or even simply a failure to address one of the many challenges posed by this constantly evolving disease, could cost us dearly.

- Once injected through the mosquito's saliva, parasites are taken up into the cells of the liver, and become schizonts, multiply and go on to invade red blood cells. In Plasmodium vivax and Plasmodium ovale, a proportion of the liver-stage parasites, known as hypnozoites, can remain dormant and reactivate triggering a new infection any time between 3 weeks and several years after the initial infection.
- In the blood stage, the parasite becomes a merozoite and replicates asexually in an exponential fashion. Each emerging merozoite goes on to multiply and destroy the blood cells they infect, leading to the clinical symptoms of malaria.
- A small percentage of merozoites, differentiate into male and female gametocytes, which are taken up by the mosquito in her blood meal. Within the mosquito these male and female forms fuse sexually and pass through a series of further forms, eventually becoming sporozoites. These sporozoites are then transmitted to man the next time the mosquito takes a blood meal, allowing the cycle of transmission to continue.

The Lifecycle of a Malaria Parasite
of additional deaths. Today, with a cure rate of over 99 percent, ACTs have become the gold standard treatment and have successfully treated millions of people infected with the disease. The spectre of resistance, however, still looms. From 2008 to 2009, scientists reported the emergence of a resistance to artemisinin in western Cambodia.1 The ACT drug regimens were taking longer than anticipated to treat the disease. Signs of resistance have also been detected in western Thailand,800 km away. If resistance were to spread beyond Southeast Asia, with no other drugs ready for deployment, the costs in human lives would be significant.

In spite of these challenges, there are reasons to be hopeful. Over the last decade, the medical and scientific communities have consistently proven their ability to adapt to the challenges created by the parasite. Medicines for Malaria Venture (MMV), a not-for-profit product development partnership, currently has over 60 promising antimalarial research teams from across the world, MMV has helped to reproduce, in the laboratory, the complex biology of the malaria parasite throughout the stages of its life cycle.2 This research could potentially multiply the number of treatment options able to be developed and refined to treat malaria, including at the sexual stage when the parasite is transmitted to humans. The continuation of this work will ensure that only the most effective next-generation molecules are progress into clinical development.

CONCLUSION

Malaria, like time, does not stand still. Time and again, the malaria parasite has developed resistance to the mainstays of treatment, targeting the most vulnerable populations. It constantly threatens to resurface in regions from where it has been eradicated. Just last year, for example, 40 cases of P. vivax were reported in southern Greece, which had previously been malaria-free since 1974.3,4

Our success in eradicating malaria will largely be determined by global commitment to sustained investment in the development of new treatments, ensuring that the potential seen in the lab is then later realized in the field. We must ensure that these new medicines can be developed, approved and distributed to patients as quickly and effectively as possible. Only then will we win this interminable fight.

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Saving Lives at Home:
CIDA-Funded Community Health Program Lifts Health Care Burden from Families in Africa

BY MANDY MOORE
American Song Writer, Actress and PSI Ambassador

For millions of parents in the developing world, waking up in the middle of the night to find that one of their children is ill with a life-threatening fever is a common reality. I have witnessed these parents’ struggle as they carry their children by foot to the nearest health center (which often can be one or two days away) only to find that they cannot afford the treatment.

Three years ago, the Canadian International Development Agency (CIDA) launched a unique pilot program in several countries in Africa. Last summer, I traveled to Cameroon with the global health organization PSI—to see the program firsthand.

We set out for the small village of Ebanga, where I met a reserved grandmother named Madame Ngono. We sat together in her mud hut. She held her grandson close. He squirmed and wiggled and wanted to escape her grasp to join his friends who were playing outside. She gave him the sign, and off he ran.

After her grandson left, Madame Ngono told me about each time he had fallen ill and about her other grandchildren who had been sick with malaria. I could tell that a lot of pain—and tenderness—lay beneath her strong exterior. I asked her about her dream for her grandson. She responded that she hoped only for him to be healthy.

She then walked me through the village and introduced me to Atangana Manga. In 2009, Atangana became a community health worker under the CIDA program. Along with 2,142 other volunteers from across Cameroon, Atangana received training from Cameroon’s Ministry of Public Health and PSI’s local affiliate, ACMS, to administer timely, WHO-approved treatment for early cases of malaria and diarrhea to children in Ebanga.

We sat down with Atangana to learn more about community health work. A proud man, he spoke with great eloquence. In another life, Atangana could have been a stage actor, a preacher or a motivational speaker. He had us enraptured with his explanation of his work. I could see why he was so effective.

Atangana explained that he was a volunteer. He made his living as a farmer and people came to his home at all hours of the day and night for help—sometimes to the chagrin of his wife. Nevertheless, he served them with great pride.

Later that afternoon, I visited a district health clinic where doctors and nurses told me that they rarely saw severe cases of malaria and diarrhea anymore, thanks to the timely treatment and advice provided by Atangana and other community health workers in surrounding villages.

Not only did I leave Cameroon deeply affected by what I saw in Ebanga, but I remain in awe of the impact that the program has had. Within the Cameroonian communities where the program has been piloted, twice as many mothers have received antimalarial treatment for their children and more than 57 percent of children with fevers have been successfully treated. For diarrhea cases, 60 percent of children have received oral rehydration salts, compared to 7 percent in non-pilot communities.

Imagine if these statistics were applied to every country and every disease in Africa—and around the world?

I love this program and applaud CIDA for its initiative to improve the lives of the families I met in Ebanga as well as those in other Cameroonian communities.

I promised Madame Ngono I would pass along a message: Please continue this work, she’d like to see her dream realized.
The HIV/AIDS Epidemic in Mexico and Its Response

BY DR. JOSÉ ANTONIO IZAZOLA-LICEA
Director General of the Center for HIV/AIDS Prevention and Control in Mexico

The first case of the Acquired Immune Deficiency Syndrome (AIDS) in Mexico was diagnosed in 1983. AIDS peaked in 1999 when 8,859 cases were reported, reaching an incidence of 9 cases per 100,000 inhabitants. From that year on there were more than 8,000 cases per year for almost a decade, then a steady decline to 3,438 cases in 2011. The cumulative number of AIDS cases up to December 31, 2011 was 152,390. Almost 102,000 of them have died.

In 1996 the introduction of Highly Active Anti-Retroviral Therapy (HAART) revolutionized HIV management resulting in dramatic decreases in mortality. Approximately, 75,000 people receive HAART in the public sector while less than 500 receive it privately. Given the segmentation of the health system, 60 percent (44,000 persons) receive HAART through the Ministry of Health (federal and state levels), 5 percent receive it through the “Seguro Popular” program, and 36 percent receive it from the social security systems for public and private employees.

Historically, the social security institutions were the main providers of HAART until 2003, when the “Seguro Popular” program was implemented. “Seguro Popular” allowed the Universal Access Policy for HAART to become a reality with its goals: no waiting lists, universal access to HAART for patients reaching medical facilities, no out of pocket payments and infrequent instances of drug shortages. We have surpassed the second target of the HIV-MDG since our latest estimate indicated 85 percent HAART coverage by the end of 2011. The main reason that limits the HAART coverage is late diagnosis for some of the poorest populations, particularly domestic migrants who lack access to health services and only return to their hometown when ill.

Programs improving access to HAART in Mexico have been highly successful. 71 percent of the patients in the Ministry of Health have reached undetectable viral load levels after six months of treatment. While there are still opportunities to improve the quality of care and patient compliance to treatment, there might be positive externalities in diminishing HIV transmission by those who are under effective HAART control. The quality of care has also improved over the past three years. In 2008 7 percent of those receiving HAART died within 12 months while in 2011 only 3 percent died and in some places less than 1 percent.

The cost of HAART in Mexico is one of the highest in low- and middle-income countries and it is financed completely with domestic resources. 80 percent of patients are in first line treatment regimen, which cost US$2,076 per person per year, 15 percent of patients are in second line treatments, which costs US$4,770 per patient annually, and 5 percent are in salvage therapy with a cost of US$30,000 per patient, per year.

Sustainability of the publicly-funded universal HAART access policy depends on lowering of costs. It is using almost 40 percent of the specific fund to pay for “financial catastrophic diseases”. This fund in the Ministry of Health is responsible for paying for 65 catastrophic diseases out of a list of more than 100. Mexico is struggling to control the costs of the provision of HAART. There are different forces driving the costs of treatment including resistance to restrictions on physician prescription choices even while lower costs and non-inferior drugs may be used.

In order to limit the unit cost of antiretrovirals, there have been negotiations with pharmaceutical companies since the International AIDS Conference in 2008. The cumulative reduction of prices resulted in the saving of approximately US$100 million for the 2012 country-purchase.

The recent strengthening of the strategy to eliminate vertical transmission of HIV resulted in less than 50 newborns getting HIV in 2011 from 1,300 pregnant women screened for and living with HIV, down from an annual average of 140 for the five previous years. The target in 2012 is 28 children per year.

The mortality associated to HIV/AIDS has a different pattern than that observed in many countries where there has been a consistent decrease since the description of the HAART in 1996. In Mexico, there was a slight decrease from 1996 to 2003 and then a slow increase since 2004 despite the expansion of HAART for the uninsured (through the “Seguro Popular”) reaching a high of 4.9 deaths for 100,000 inhabitants in 2008.

The expenditure in projects executed by community-based organizations for MSM and IDUs include US$44 million from the Mexican Federal Government and a grant from the Global Fund for AIDS, Tuberculosis and Malaria (GFATM) for 2011-12.

The national response is strongly committed to respecting human rights as well as seeking the elimination and prevention of discrimination, including homophobia and trans-phobia. These types of discrimination serve only as barriers to care, treatment and prevention within the health sector and elsewhere.

Mexico is committed to the universal access to treatment, care and prevention to reach the HIV-MDG in 2015 and beyond.
Q: What are your thoughts about the transition from Vice President to President?
A: I am proud that Malawi had a peaceful and smooth transition of power after President Mutharika's death. The Constitution was very clear, and I had no question that my job was to uphold the Constitution. This is a great opportunity to create positive change for the people of Malawi. I am confident that together we will make Malawi strong. As President, I believe it is a moral imperative to do all I can to improve the health, education and economic status of all Malawi's citizens.

Q: What are your priorities for the first 6 months?
A: As the first woman Vice President of Malawi and now the first woman President of Malawi, I want to make sure that this is a time of hope and transformation for all our citizens, but especially for women. In my life, I have always fought for women, and as president that will not change. However, every person in Malawi needs the government to be strong and to work to build a more equitable future for all. From my earliest days, I have fought for the rights of women and girls—organizing rural women and women entrepreneurs, fighting for access to education, jobs and health services. I think the government should be a transformational force for good. Since 2004, when I joined the government as Minister of Gender, Child Welfare and Community Services, I have used the government to improve the lives of women. I fought hard to draft and pass the first legislation in Malawi on domestic violence. I used the legislative process to address this sensitive topic, and helped make it possible for women to get the help they needed to leave abusive relationships. As Minister of Foreign Affairs and as Vice President in 2009, I have remained a voice for women and for all people.

Q: What can Malawi's youth expect from you as President?
A: As President, I think I have a special and critical responsibility for the youth of Malawi. Young people are our future and our hope, and all political leaders should look at their young citizens and ask if we are making decisions that will provide a sound basis for a healthy and prosperous future for this generation. We must help them dream of a future where all people have great economic opportunities and share in a new global economy. I know that as President, my decisions and the decisions of my cabinet will have a long-lasting impact on today's youth.

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Q: What can the international community do to support you?
A: Donors should know that under my presidency, I will make accountability and transparency a cornerstone of our government. Strategic partnerships that are driven by my government and based in mutual respect will be very much welcomed. It is a new day for all the people of Malawi, and I welcome the opportunity to renew relationships and explore the ways in which we can create a healthy and more prosperous nation together.
Prevention is Key: New Tuberculosis Vaccines Needed to End Global Health Emergency

BY JIM CONNOLLY
Aeras President and CEO

Nearly 20 years after the World Health Organization declared tuberculosis “a global health emergency,” the situation remains grim. Even with mortality rates slowly declining, tuberculosis is an unrivalled killer, claiming the lives of more people than any other infectious disease except HIV. In 2009 alone, TB orphaned 9.7 million children. Despite the unwavering efforts of countless health workers and officials, TB continues to spread at an alarming rate.

It is impossible to see this epidemic firsthand and not feel a strong sense of urgency to change the situation, as well as frustration that it has been so dire for so long. On a recent trip to the Western Cape in South Africa, which has some of the highest TB and HIV rates in the world, I saw dedicated health workers doing the best they could with current methods to fight TB, but our tools are outdated and quickly becoming obsolete. We need new drugs, diagnostics and vaccines, and we need them now.

The bleak reality is that TB research has not been granted the urgent global action it deserves. Treatment for drug-susceptible TB requires taking four drugs for six to nine months. For TB that is resistant to first-line drugs (known as MDR-TB), treatment takes up to two years and can have debilitating side effects including hearing loss and dementia. In some cases, TB cannot be cured. Countless TB patients are forced to quit their jobs, face stigma from their communities, and make daily decisions about whether to buy food for their children or bus fare to reach the clinic.

Developing countries often have high rates of TB, which threatens progress in these emerging economies. However, everyone who breathes is susceptible. Many were astounded by the findings of a recent report that outlined Eastern Europe as having an extremely high frequency of MDR-TB. Additionally, London has been dubbed the TB capital of Europe after a 2010 report showed that tuberculosis cases jumped 50 percent there in the last decade.

While drug-susceptible TB treatment is fairly affordable for those with access and sufficient resources, drugs for MDR-TB are up to 200 times more expensive. The cost to treat one person in a high burden country is usually more than 100 percent of the gross national income per capita, about $2,000 to $4,000 per patient. In the United States, just one case of MDR-TB costs $100,000 to $300,000 to treat. This puts a huge burden on health systems.

Vaccines are considered the most cost-effective public health intervention. The widely administered TB vaccine, Bacille-Calmette Guerin (BCG), is 90 years old. While BCG prevents severe forms of TB in children, it is largely ineffective in preventing adult pulmonary TB (the most common and contagious form) and it has failed to halt TB's spread despite decades of widespread global use. If we must the will to accelerate our efforts and invest additional resources, we can one day declare victory over this persistent enemy. On my recent trip, I was deeply encouraged by the South Africans I met—from the researchers who tirelessly analyzed clinical trial data, to the mothers who diligently brought their infants to appointment after appointment for TB vaccine studies. Their desire to find real, long-lasting solutions showed me that there is hope.

Twelve new TB vaccine candidates have succeeded in early testing and reached clinical trials. We are at a turning point for TB vaccine research and development, as the field is collaborating in new and exciting ways. In recognition of this year’s World TB Day, a new road map was published: “Tuberculosis Vaccines: A Strategic Blueprint for the Next Decade”–which outlines the way forward for TB research and addresses critical questions. We are on the verge of exciting new scientific advances that will have an enormous public health impact. However, at this moment, where we see the most promise, we also see the most roadblocks. Late-stage clinical trials require thousands of participants, and funding needs are high.

We cannot allow current progress in the field to lead to complacency. The challenges and costs will undoubtedly grow as we come closer to success. Once a vaccine candidate shows positive results in mid-stage clinical trials (results from a pivotal proof-of-concept trial are expected next year), it will be imperative that we move into late-stage Phase III licensure trials as quickly as possible so as not to delay when a new vaccine is within reach. However, we have neither the resources nor the infrastructure for these late-stage trials. We must create a new paradigm to support this effort by building partnerships and creating innovative financing mechanisms to bridge this gap.

If we muster the will to accelerate our efforts and invest additional resources, we can one day declare victory over this persistent enemy. On my recent trip, I was deeply encouraged by the South Africans I met—from the researchers who tirelessly analyzed clinical trial data, to the mothers who diligently brought their infants to appointment after appointment for TB vaccine studies. Their desire to find real, long-lasting solutions showed me that there is hope.

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About four people die every day from a disease that is largely overlooked by those with the power to make a change. After years of sustained control efforts have failed to overcome TB, we need a new means to a new end. Insanity has been described as doing the same thing over and over again, but expecting different results. We need to stop the insanity surrounding TB research and invest in new vaccines to get the results we so desperately need.
India’s Commitment to Women’s Health

BY DR. KOKI AGARWAL

Director, U.S. Agency for International Development's Maternal Child Health Integrated Program (MCHIP)

India’s Commitment to Women’s Health

Sabiya Kumari lost her first baby within days of her due date. When she became pregnant again, soon after, she and her husband, Jitendra Kumar, decided they would go to their local hospital in Patna, India, to give birth this time. They didn’t want to take any chances.

While at the Patna Medical College and Hospital, the young couple learned that Sabiya needed a Caesarean section (C-section). But they also received information and counseling that would give this soon-to-be new mother, baby, and young family a healthy start. Sabiya and Jitendra learned about healthy pregnancy spacing, and the benefits to mother and newborn of waiting at least two years before getting pregnant again. They were told about the range of appropriate family planning methods available to them for spacing their next birth, including an intrauterine contraceptive device (IUCD) that prevents unwanted pregnancies for up to 10 years. Convinced that adopting a long-lasting but reversible contraceptive method prevents unintended pregnancies for up to 10 years. Convinced that adopting a long-lasting but reversible contraceptive method would be best for his wife and family, Jitendra joined Sabiya in deciding that she should get a postpartum IUCD inserted right after her C-section. It’s a choice thousands of couples and families are making throughout India today, as part of the government’s decision to both reinvigorate and increase access to postpartum family planning services in many of the country’s populous states. The Indian family planning program has long been dominated by the use of permanent methods like tubal ligation and vasectomy. The interest and need in India reflects what’s happening throughout the developing world. Data from 27 countries confirms that 65 percent of women who are 0-12 months postpartum want to avoid a pregnancy in the next 12 months but are not using contraception (Ross and Winfrey 2005). According to an article in The Lancet medical journal titled “Sexual and Reproductive Health: A Matter of Life and Death,” as many as 120 million couples worldwide lack access to family planning services. In India, with support from the U.S. Agency for International Development's Maternal Child Health Integrated Program (MCHIP), Jhpiego and other global health partners, family planning is undergoing a renaissance as government leaders, health providers and families recognize its impact on maternal and newborn survival.

For women throughout the developing world, delaying pregnancy as well as preventing unintended pregnancies through contraceptive use safeguards the health of mother, newborn and other children in a family. A healthy mother is able to care for herself and properly nurture her children. According to a 2009 study by the Population Reference Bureau, choosing to wait two years before becoming pregnant again and avoiding unintended pregnancies could prevent as many as one in every three maternal deaths and more than two million infant and child deaths. Husbands who are engaged in these discussions realize what’s at stake. Jitendra Kumar, a carpenter who lives with his wife in a Patna slum, certainly understood why spacing their next child was important both for his wife and their newborn baby. “My wife had to undergo a C-section and so needs to be extra careful about her health,” he said. “We all have to make sure that she eats well and gets time to recover. Only when she will stay healthy and happy will she be able to look after the baby. I am very happy that we chose a family planning method as now we will only have the next baby when we want, after a few years. Today, I feel that this is a really good method of family planning” The government of India’s commitment to revitalizing family planning is evident across most of the states. Initiatives are underway in educational institutions and hospitals, among health care providers and professionals associations, and with the support of partners such as USAID, the Bill and Melinda Gates Foundation, the Norway India Partnership Initiative, the David and Lucile Packard Foundation and others. Doctors who were skeptics have become IUCD advocates, championing use of this family planning method with staff and patients. Women who have chosen this method have encouraged friends and families to do the same. Husbands are joining the conversation and explaining the importance of healthy birth spacing to their families with life-saving results.

During India’s recent celebration of National Safe Motherhood Day (April 11, 2012), government leaders talked about the progress made in maternal and newborn survival and reducing total fertility, and how much more remains to be done. A key component in promoting safe motherhood is family planning, especially healthy birth spacing. At MCHIP, we are proponents of integrating family planning counseling and services into routine maternal and child health care. That way mothers are receiving the vital information they need to stay healthy and alive—all in one place. If all women who wanted contraception had access to it, unintended pregnancies would drop by over 70 percent, 100,000 maternal deaths would be avoided every year, and more than half a million newborns wouldn’t die from complications in their first month of life. Women shouldn’t have to die giving birth. Nor should they lack the information or services they need to plan their families, especially in that first year after giving birth, a vulnerable time for both mother and baby.

Women getting counseled on Family Planning

Patna Medical College and Hospital

Jitendra and Sabiya with their child

GLOBAL HEALTH CHALLENGES
Saving the Lives of Women and Children

By Jill Sheffield
CEO of Women Deliver

One of the drawbacks of the UN Millennium Development Goals (MDGs) is that health and girls’ and women’s issues are siloed. Within the MDGs framework, family planning is squarely under MDG 5, which aims to improve maternal health and achieve universal access to reproductive health. But in truth, family planning equally belongs under MDG 4, which targets child mortality.

A key factor that affects newborn mortality is the spacing between births. Every year, two million infants could be saved by preventing closely-spaced births. And when families space births three years apart, the child can receive the additional benefit of breastfeeding. Breastfeeding protects infants and babies from illness and helps them keep on the road to physical and mental growth and development, reducing the risk of stunting.

Delaying childbearing just a few years can save hundreds of thousands of lives, newborns, young children, and their young mothers. Unplanned pregnancies often happen to young women who, in too many areas of the globe, have little access to family planning information or services. Not only are young women at higher risk of maternal mortality, but the infants of young mothers under the age of 23 are more likely to die before their first birthday than are the infants of older mothers. For mothers 18 years or younger, the numbers are even more stark: Their babies are 80 percent more likely to die than a baby born to a mother older than 19 years.

The benefits of family planning to children go beyond the strict definition of health. Family planning brings great social and economic dividends. Eliminating unmet need would increase educational attainment and reduce poverty. In Bangladesh, for example, researchers found that the government saved $615 in expenditures in social services for every $62 spent to prevent an unwanted birth—nearly a ten-to-one return. And the effects are multi-generational: Women who delay childbearing until age 20 not only remain in school longer, but their children have higher educational attainment and are healthier than children born to mothers under 20 years.

At Women Deliver 2013, which will be held May 28-May 30, 2013 in Kuala Lumpur, Malaysia, a key theme will be meeting unmet need for family planning. We will reach out beyond the maternal and sexual and reproductive health communities because family planning is a solution that affects the other MDGs, especially MDG 4. The case is strong, and frankly, advocacy on a collective basis across sectors is needed more than ever: We have the technology. We just need strong leaders to stand up for these basic rights. The return on investment will be nothing short of remarkable. GHD

Although there is substantial evidence of the wide-reaching benefits that access to family planning can have on not only the health of women and children but also on local economies through demographic dividends, development aid in related products and services fell dramatically in the last decade. Simply put, both the funding process and the investments themselves meant to ensure adequate supplies of contraceptives are available are not doing enough to ensure that women have reliable access to the methods that are best for them. According to a 2008 Brookings Institution analysis, as much as 28 cents of every dollar of overseas development assistance in health is lost due to inefficiencies in the flow of aid. This leaves an enormous unmet need: With regards to family planning, 215 million women do not have access to modern forms of contraceptives, which contributes to the fact that of all Millennium Development Goals, MDG 5.a Maternal Mortality lags the furthest behind.

The Pledge Guarantee for Health (PGH), housed at the United Nations Foundation, works to meet this challenge in a unique way: It provides bridge financing to grant recipients on the basis of pending aid commitments. By leveraging both Letters of Credit and Supplier Credit through bank guarantees, PGH ensures that health supplies can be shipped without waiting for the normal processes of transferring donor funding for a particular commodity to be put in place. Since 2009, PGH has provided an opportunity for not only family planning programmers in governments, donor agencies and private sector funders, but the international development community as a whole (including Malaria, HIV, Polio and TB programs) to consider new ways of doing business to not only make aid have impact faster but overall increase the value of donor dollars through enhanced aid effectiveness. GHD
The Hope and Challenge of Immunization
Preventing Death and Transforming Lives

BY DR. SETH BERKLEY
CEO of the GAVI Alliance

In 1985, a measles epidemic blew through a group of Sudanese refugee camps where I was working, quickly killing scores of malnourished children and leaving a scar in my memory. More than a quarter century later, some 1.5 million children still die every year from a handful of vaccine-preventable diseases, but the discourse of death—how many children die from which disease—has shifted to a message of hope.

New partnerships, new country commitments and new donor ambition means that more vaccines are reaching more children than ever before and child mortality rates are falling throughout the world. In 30 years of work as a doctor and scientist, I am more profoundly optimistic than ever about the future of vaccines and immunization.

Immunization’s enormous strength is not just that it prevents death and is one of the most cost-effective ways to do so, but that it also prevents disease and disability. Vaccines help healthy people remain healthy, and in doing so, they remove a major obstacle to human development. In a world protected by immunization, parents can concentrate on productive work while their children go to school and live up to their full potential.

Since its establishment in 2000, the GAVI Alliance (formerly the Global Alliance for Vaccines and Immunization) has supported developing countries to immunize an additional 325 million children, resulting in the prevention of more than five and a half million deaths.

This progress is both wonderful and relentless. Supporting an ambitious roll out of relatively new vaccines against pneumonia and diarrhea (the two largest killers of children) since June 2011, we have supported immunization...
systems to reach more children than ever before. The rollout of these pneumococcal and rotavirus vaccines to some 50 countries by 2015 has started. We have also added measles-rubella and human papillomavirus (HPV) vaccines to our portfolio and worked with vaccine manufacturers to lower prices on critical vaccines.

Our 2011 to 2015 programme aims to prevent another four million vaccine-preventable deaths by supporting the immunization of an additional 240 million children in some of the world’s most marginalized populations.

This April, I visited Ghana for celebrations to mark the introduction of the pneumococcal and rotavirus vaccines that will help protect Ghanaian children from the leading causes of pneumonia and diarrhea, two diseases which together account for 20 percent of Ghana’s child mortality. Introducing even one new vaccine is a heavy lift for any country—one that includes careful planning, training and the upgrading of complex logistical and cold chain systems. Yet, through speeches, music and dancing in the sweltering west African heat, Ghana launched two vaccines and made one very cool, calm calculation: vaccines are a cost-effective intervention for reducing child mortality.

Children in Ghana and other developing countries have been dying from pneumonia and diarrhea for centuries, of course, but the pneumococcal and rotavirus vaccines only became available to them in the last two years. Why? Vaccine development and production has high fixed costs and before the GAVI Alliance, manufacturers did not see value in producing new products for developing countries where markets were small or unstable. When the WHO, UNICEF, World Bank, Bill & Melinda Gates Foundation, vaccine manufacturers, donors, developing countries and others came together to form the GAVI Alliance, they were able to create large and predictable markets, raise money for immunization in the developing world and aggregate vaccine demand across many countries.

The GAVI Alliance spends the money it raises in the most strategic way to achieve the best results. We work to support the use of new and under-used vaccines in the 73 lowest income countries, strengthen health and immunization delivery systems, increase the sustainability of vaccine financing and help shape vaccine markets. By purchasing and procuring for 75 countries, our alliance can negotiate hard for the best deal possible. Knowing that GAVI provides large, long-term and stable markets, vaccine manufacturers can afford to drop their prices and produce new vaccines for developing countries. This public-private partnership pays dividends for the poorest children and—for the first time—provides manufacturers with extra incentive to produce more vaccines that are appropriate and affordable for the developing world. By offering such predictability, for example, GAVI’s Advance Market Commitment led to private sector investment and accelerated the production of pneumococcal vaccines for developing countries.

This terribly unequal access to markets had little to do with demand, by the way:

My wife, who until recently worked as a doctor in New York, has never seen, let alone treated a single case of measles or tetanus. In that vain, there are parents in Europe and North America who fail to realize the danger of these diseases and make the decision not to immunize their children. By contrast, in developing countries parents will walk for hours to ensure their children are immunized—they know how quickly these diseases can steal their children.

And when the parents take their children to be vaccinated, they can also receive health advice and information about issues like family planning and HIV/AIDS. Routine immunization serves as an access point for so many other health interventions.

GAVI’s work has accelerated production of the meningitis A, pneumococcal, rotavirus, and pentavalent vaccines to protect against a handful of deadly diseases. In the not-so-distant future, we hope to see new vaccines against Japanese encephalitis, typhoid, dengue, malaria, and even HIV. In any case, the gap is tightening between introductions in the North and introductions in the South. Nicaragua introduced the 13-valent pneumococcal vaccine in 2010, the same year that this latest generation pneumococcal vaccine was licensed for children in the United States.

Despite these successes, we still face significant obstacles when it comes to reaching more children. Many of these roadblocks are technical: do countries have the capacity to deliver vaccines from central storerothes to remote clinics and to keep them cold? Are there clinics nearby or if not, outreach facilities? Do parents actually know the vaccines are available?

Yes, these technical obstacles do exist, but arguably some of the biggest barriers are political.

While 109 million children now receive routine immunization against a handful of diseases, 19.4 million still go without. Some 8.8 million of these children live in India and Nigeria. Not by coincidence, these two countries also have some of the highest child mortality rates in the world. But both these countries have also shown a renewed appetite for vaccines.

Once infamous for its failure with polio immunization, a real worry for global health, Nigeria has recently reiterated its commitment to tackle polio and introduced new meningitis A and pentavalent vaccines to protect its children. Meanwhile, India marked the passage this February of 12 months without a single new case of polio, reducing the number of polio endemic countries from four to three. In a country where 26.5 million children are born every year and many of them are remote, nomadic, or even unregistered, this is an impressive achievement by any measure. Emboldened by this milestone, India is now rolling out pentavalent vaccines in a number of its states.

India’s extraordinary success brings hope that we are truly “this close” to polio eradication and that we can, in fact, reach every last child with immunization. To do this, we at GAVI are exploring both new strategies for performance-based funding and tailored approaches for fragile states and large countries where so many unimmunized children still live (and die).

The global health community has made staggering progress in the past 30 years. With new tools and news ways of working, we can do even more. GHG
A Call to Action

BY DR. RAJ SHAH
Father, Administrator, USAID

Child Survival: A Call to Action

As a father of three, I see unlimited potential when I look at my children. And I am reminded that my own parents came to the United States from India so that my sister and I could have a strong education and greater opportunity in life.

But around the world, many parents don’t have this luxury. And in many cases, the greatest fear of a parent is that their son or daughter won’t even reach the age of five—an important milestone for survival. By age five, most children can get past the early-life bottlenecks hampering survival—early childhood diseases, malnutrition and poor health conditions.

Seeing a child die from pneumonia, diarrhea or a mosquito bite is simply unimaginable to most parents, but that is the sad reality for many families each day. Last year over seven million children under five died of largely preventable causes.

For centuries, childhood deaths seemed inevitable, but considerable progress has been made in the past 50 years. In 1960 about 20 million children died annually. The number dropped to 12 million by 1990 and 7.6 million in 2010.

Today, the global community has the knowledge and the affordable tools to change the course of history. A $4 bed net protects a mom and child from malaria. Cost-effective vaccines offer life-long protection from diseases like pneumonia and diarrhoea. A trained community health worker can help a mother survive childbirth and ensure every infant takes its first breath. Treatment can prevent mother-to-child transmission of HIV. And adequate nutrition in the first 1,000 days can determine the rest of the child’s life.

At the current annual rate of decline of 2.6 percent, the gap in child death between rich and poor countries would persist until nearly the end of this century—but we are capable of much more. By working closely with countries and continuing our results-oriented investments in global health, we can bring the rate of child mortality in poor countries to the same level it is in rich countries.

Development is full of problems we have few ways to solve. Helping a child reach their fifth birthday is not one of them.

This is the vision for the Child Survival Call to Action in Washington, D.C. June 14-15 where the governments of the United States, India and Ethiopia, together with UNICEF and many others, are mobilizing the world to end preventable child deaths. It is not a pledging conference. Rather, our focus is on building political will, driving collective action around a global roadmap and developing mechanisms to hold all countries to account.

The goal of the Call to Action is to shift the focus of the dialogue on child survival from the “what” (the causes of child deaths) to the “how” (prioritizing the strategic investments and the most effective strategies to accelerate progress). Some of the strategies include scaling-up coverage, addressing the social determinants of health, removing barriers to access and increasing the demand for essential health services through cost-effective investments and technical innovation.

The vision is ambitious but achievable, if globally owned. Smarter, targeted investments on evidence-based interventions in countries will drive down child mortality. The lessons of the child survival revolution of the 1980s are valuable today. The killers of the past are the killers of the present (diarrhoea, pneumonia and malaria), just as they were in 1980. The interventions needed to prevent child deaths already exist and their efficacy is proven.

Every country and every stakeholder—from the government to civil society to the faith community to the private sector—is responsible for the survival of the world’s children. And their existing commitments, as well as future commitments, must be fulfilled.

Difficult, complex problems like child survival require global action, country ownership and accountability. Just five countries account for 50 percent of child deaths, two of which (India and Ethiopia) have committed to leading the world in this effort.

By providing a common rallying point, generating sufficient political will, encouraging mutual accountability, generating consensus around a global roadmap for action and targeting investments we will translate political commitments into tangible results for the world’s children.

Every Child Deserves a 5th Birthday—a campaign led by the U.S. Agency for International Development to raise awareness ahead of the Call to Action. Please join me in posting a photo of you or your kids at five and sharing it via our website and social media outlets. More than 100,000 shared the photo on social media. Everyone has a role to play when it comes to the survival of the world’s children. All we have to do is act.
Ghana’s Leaders Committed to Improving the Lives of Children

Ghana marked the first ever World Immunization Week, held in April, by becoming the first African country to include vaccines against pneumococcal and rotavirus in its national immunization program.

The launch of the new vaccines was led by First Lady H.E. Dr. Ernestina Naadu Mills, and served as an opportunity to celebrate the life-saving impact of the two vaccines, which will protect children against pneumonia and a major cause of diarrhea. Around the world, pneumonia and severe infant diarrhea are responsible for the deaths of more than 2.7 million children under age five every year, including one in five of the Ghanaian children who die every year.

The new vaccines represent just the most recent advance in Ghana’s strong national immunization program, which has vastly improved health over the past generation. Today, thanks to concerted, long-term investment and leadership at all levels, immunization program ensures that 90 percent of Ghanaian children are protected from a range of diseases. The program also routinely conducts supplemental immunization activities to reduce the incidence of diseases such as polio, measles and yellow fever.
Russian Contribution to Solving the Problem of High Infant Mortality Worldwide

BY DR. Gennady Sukhikh, Academician of RAMS, Professor, Director

BY DR. Elena Baibarina, Professor, Deputy Director

BY DR. Ekaterina Yarotskaya, Head, Department for International Cooperation

Federal Budgetary Institution, Research Center for Obstetrics, Gynecology and Perinatology
Ministry of Health and Social Development of the Russian Federation

Obama and reflects educational and cultural level, the gender and age composition of the population, the quality and availability of medical help, national traditions and the state of the living habitat, among other factors. Infant mortality determines, to a major extent, the average longevity as well as the scope of potential social and economic losses of a country.

According to the World Health Organization (WHO), newborns account for nearly 40 percent of mortality among children under five years of age. Up to two-thirds of newborn deaths can be averted by using modern approaches in perinatal medicine at birth and during the first week of life. Up to two-thirds of newborns account for nearly 40 percent of mortality among children under five years of age. Infant mortality is an important indicator of quality of life, which is characterized by the cumulative impact of social, economic, environmental and sanitary factors and reflects educational and cultural level, the gender and age composition of the population, the quality and availability of medical help, national traditions and the state of the living habitat, among other factors. Infant mortality determines, to a major extent, the average longevity as well as the scope of potential social and economic losses of a country.

The international forum “Ways to Decrease Infant Mortality” was held in Moscow at the Research Center for Obstetrics, Gynecology and Perinatology from October 11-13, 2011, was the first step in the implementation of this plan. It focused on decreasing infant mortality by ensuring safe delivery and basic, as well as specialized medical care to infants and pregnant women on a local basis, and on developing strategic and practical recommendations for the reduction of infant mortality. Infant mortality is an important indicator of quality of life, which is characterized by the cumulative impact of social, economic, environmental and sanitary factors and reflects educational and cultural level, the gender and age composition of the population, the quality and availability of medical help, national traditions and the state of the living habitat, among other factors. Infant mortality determines, to a major extent, the average longevity as well as the scope of potential social and economic losses of a country.

The forum program consisted of lectures, workshops and roundtables on strategic issues of decreasing infant mortality and workshops delivered and chaired by distinguished experts from the G8 countries and Russia. It also included an interactive, hands-on simulation training course at the recently opened Simulation Training Centre. The latter was especially highly appreciated by the Forum attendees, including healthcare authorities, and training courses combined with other educational programs were acknowledged as the key tools for capacity strengthening in the countries fighting high infant mortality. In the third part of the forum agenda, working groups of delegates and experts discussed and drafted prospective guidelines for programs to overcome high infant mortality for countries with similar causes of the problem. These draft programs promoted the use of the most efficient organizational models of medical care and the control of standardized medical aid quality, both of which proved to be effective in decreasing infant mortality.

The delegates agreed that further implementation of the five-year strategic plan should include: a series of educational training courses on basic practices and highly specialized medical aid, the creation of a network of clinics in the Russian Federation, experience exchange and joint audit of perinatal medical care, by Muskoka Initiative member-countries and countries fighting high infant mortality, as well as regular forums or conferences to follow the progress of and make adjustments in the implementation of national programs.
As world leaders gather at the G8 and G20 summits to discuss the most pressing global challenges, they are prioritizing health and development issues by asking questions such as: Where can we have the biggest impact? What is the return on investment (ROI)? How many disability-adjusted life years (DALYs) can we save?

These questions are critical. However, we tend to get caught up in using jargon like “ROI,” “DALYs,” “disease burden,” and “cost-effective interventions” – and we can sometimes forget that we’re talking about real people’s lives – their health and well-being, and their opportunities and desires for the future. The title of my article refers to “human capital development” – talk about jargon! What I mean by that is building a strong foundation and investing in the right building blocks to give people throughout the world the best chance to live a healthy and productive life.

Certainly there are many competing priorities on the agenda at the G8/G20 summits, but overcoming any of these global challenges hinges on a strong, healthy human foundation, and investments aimed at strengthening our human capital must begin early. It is widely recognized that healthy, well-nourished children are better able to grow and prosper.

Vitamins and micronutrients help create a strong human foundation. In fact, they are essential: vitamins play a vital role throughout every stage of the human lifecycle, from pregnancy through infancy and childhood and into adulthood and old age. Our bodies need vitamins to grow, to function, to stay healthy, and to prevent the onset of disease.

It was 100 years ago, in 1912, when scientist Casimir Funk...
coined the term ‘vitamin’ to describe the bioactive substances proven to be essential for human health. The past century has seen remarkable advancements in our understanding of vitamins—and in many parts of the world we take the essential role of vitamins in our health for granted. The story of vitamins in many developing countries is, however, vastly different. Many people—due to the complex inter-relationship of poverty, disease and lack of availability to a variety of nutritious foods—still suffer from vitamin deficiencies. Deficiencies that, although not often visible to the human eye, lead to stunted growth and impaired cognitive development, high mortality rates and increased susceptibility to disease throughout their lives. One hundred years after vitamins were named, more than two billion people suffer from hidden hunger, with devastating effects on individuals, communities and national economies.

A strong, healthy start for all children rests on ensuring optimal micronutrient intake during the critical 1,000 day window of opportunity from pregnancy until a child reaches age two. Poor nutrition during this period causes irreversible damage to a child’s cognitive and physical development. If we miss this critical window to establish a strong foundation, the next generation falls a step behind, and they can never catch up. Moreover, early malnutrition will have long-lasting effects on the development of obesity and non-communicable diseases (NCDs) later in life, a legacy that will even be passed to the next generation.

There is an enormous, yet untapped potential to use this knowledge to significantly improve public health and well-being and productivity. To compensate for the increased burden that both under- and over-nutrition pose, governments and donors will consistently need to ramp up investments in education, economic development, agriculture and health as the cycle continues to stagnate progress. However, simply by ensuring that women and children have access to essential micronutrients from the start of life, we can significantly increase ROI across all of the sectors, and provide a brighter future for children, families and nations.

We know what to do. There are simple, cost-effective interventions that reach across sectors to increase access to the vitamins essential for normal growth and optimal health. For example, providing access to nutritious foods by supporting small-scale farmers and increasing access to markets through agricul-tural development can increase vitamin intake through more diverse diets. Increased micronutrient intake can also be achieved through cost-effective fortification efforts, at the home level through the provision of targeted micronu-trient powders and lipid-based nutritional supplements; and more broadly reaching entire vulnerable populations through staple fortification (such as through flour, rice or oil) which can also work to support local industries in developing countries.

Yet despite all of our knowledge, vitamin deficiencies still abound in the developing world. Globally, around one billion people—one in seven—are starving and suffer from a lack of food and at least 2 billion people do not receive an adequate supply of the vital vitamins and micronutrients. Even in the developed world, where an array of nutritious foods is more plentiful, shifting patterns of diet and lifestyle are leading to nutritional gaps.

Addressing micronutrient deficiencies is one of the most cost-effective interventions—a “best buy” in global health. In fact, multiple studies have shown that micronutrients are the best low-cost solution to improving health in the developing world. As one example, in 2008, the Copenhagen Consensus ranked micronutrients as the world’s best investment for development, offering a return on investment as high as 39 to 1.

At Sight and Life, we are committed to championing the role of vitamins in advancing nutrition, health and development. In honor of the vitamin’s 100 year anniversary, we are leading a campaign to celebrate the century of contributions vitamins have made in protecting human health, while raising awareness of the urgent need to increase access to essential vitamins so that all people are given a chance to grow strong and live healthy lives as contributing members of society.

The 100 Years of Vitamins campaign is just part of the growing momentum supporting the role of nutrition in advancing progress of health and development initiatives across sectors. Efforts such as the Scaling Up Nutrition (SUN) Movement highlight the far reaching impact of nutrition across sectors. Leading the SUN Movement are countries who have declared nutrition a core component in advancing progress in their nation. Multi-sectoral partners including Sight and Life aligned behind SUN Movement principles are working collaboratively to support SUN country efforts to scale-up nutrition policy, programming and investment.

I applaud the G8 foreign ministers for including nutrition as a priority item for this year’s summit agenda and for specifically recognizing the great progress being driven by the SUN Movement’s efforts to align partners and donors across sectors to advance nutrition.

In order to catalyze the high-level global support for improved nutrition, leaders must now quickly transition from building momentum to focusing on tactical planning and implementation to achieve concrete progress. The approach to programming and policy should be holistic, aiming to improve nutrition through increased access to essential vitamins and micronutrients across a wide range of health and development interventions. This must start with building a strong foundation in the first 1,000 days of life. Most importantly, we must commit to funding these evidence-based nutrition interventions, not just for today, but for the long term. Putting all of the jargon aside, nutrition is not just a smart investment it’s the right thing to do. GHD
When Water Flows, Prosperity Follows

BY DANIEL W. YOHANNES
CEO, Millennium Challenge Corporation

The river near Ruby Reyes’ home was a lifeline for her family, providing a vital source of drinking water and a place to wash clothing.

But little did Ruby’s family know this very lifeline also robbed them of the chance at a more prosperous future.

Ruby, an 11-year-old from a small town called Cantón Pitahaya in northern El Salvador, spent a few hours each week at the river collecting water and doing the wash. Microbes lurking in the dirty water, however, often made her sick, forcing her to miss classes and requiring her to seek medical treatments that took a toll on her family’s income: the U.S. Government’s Millennium Challenge Corporation (MCC) facilitated the installation of a faucet near Ruby’s home. For the first time, clean water is now only a short walk away. The importance of water in economic and human development is well known. According to the United Nations, nearly 1 billion people worldwide do not have access to clean water. About 2.5 billion people lack basic sanitation, and a child dies every 20 seconds as a result of water-related diseases. In fact, it might surprise many to learn that more people die from contaminated and polluted water than from all forms of violence, including wars.

In addition, our latest compact—a $355 million partnership with Zambia—focuses exclusively on expanding water and sanitation services in the capital, Lusaka. With clean and plentiful water and sanitation, prosperity follows. Improved water and sanitation services in countries such as Ruby’s have been known to lead to health improvements, increased school attendance, higher productivity and thriving entrepreneurship. In many cases, this can mean a more educated workforce and fewer work hours lost to illness. Because businesses depend on reliable and adequate supplies of water, MCC’s investments help to create a more attractive climate for private investment while also driving economic growth.

The importance of water in economic and human development is well known. According to the United Nations, nearly 1 billion people worldwide do not have access to clean water. About 2.5 billion people lack basic sanitation, and a child dies every 20 seconds as a result of water-related diseases. In fact, it might surprise many to learn that more people die from contaminated and polluted water than from all forms of violence, including wars.

The search for water falls mainly on the shoulders of women and girls, who are often the ones to miss school as they walk long distances to find water for their families. In Uganda, for example, the World Bank found that women may spend up to 17 hours per week searching for water during the dry season.

The benefits of expanding access to clean water and sanitation can transform families, communities, and countries. The world has made great strides already: The World Health Organization and UNICEF announced earlier this year that the Millennium Development Goal (MDG) target of cutting in half the number of people without access to safe drinking water has been met. This means a gain of millions of school days, billions of workdays and billions of dollars saved each year treating waterborne infectious diseases.

Not every country will reach this target or the MDG on sanitation—but MCC is helping to improve this situation. We have water investments in every one of our partner countries that is not on track to meet the clean water MDG target because our partner countries have prioritized these investments.

In addition, we have sanitation investments in nearly half of our partner countries not on track to meet the target for sanitation. This is not just a matter of economics: Universal access to water and sanitation could prevent 2 million child deaths per year over the next decade, according to the United Nations.

Last year, I visited Tanzania to witness firsthand MCC’s investments in the WASH sector. I toured the Lower Ruvu water treatment plant, which provides water to Dar es Salaam, the booming coastal metropolis. When MCC-funded upgrades to the plant are completed, it will produce 270 million gallons of improved water each day—a 50 percent increase from its previous capacity. We expect this $41.9 million investment to spur $113 million in household income over the next 20 years, improving the lives of hundreds of thousands of Tanzanians.

Reducing poverty by generating long-term, sustainable economic growth is MCC’s goal, and it is the measure by which we will ultimately be judged. And while we focus on economic analyses and statistics, we are also motivated by the knowledge that our investments transform the lives of real people and real communities. Because of MCC’s investments in water across the globe, a young girl in El Salvador is no longer getting sick washing clothes in a polluted river. A boy in Tanzania will miss fewer days of school and devote more energy to homework. A family in Mozambique will not have to spend scarce earnings to purchase medicine to treat diseases caught from dirty drinking water. A new business will be able to start up in Lesotho.

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It all begins with clean water.
that a preventive focus is essential to improving health from before birth through the first years of a child’s life.

The Seguro Popular, the operative arm of the System of Social Protection in Health, is one of three pillars along with the Mexican Institute of Social Security (IMSS) and the Institute for Social Security and Services for Federal Employees (ISSSTE). Through universal and public financing of the Seguro Popular, we work to ensure the right to health of all Mexicans, regardless of age or employment status.

In child health, the Seguro Popular has implemented two programs that guarantee the right to health from birth. First, the Medical Insurance for a New Generation program has extended medical coverage to more than 5.9 million children from birth until five years old, including those with disabilities and those who are at high risk for common, deadly diseases. Second, the Healthy Pregnancy Strategy has provided timely care during pregnancy, childbirth, and in the early post-partum period, to more than 1.7 million women as well as newborns.

Along with these programs, we have promoted other actions with a preventive emphasis to improve the determinants of children’s health and, in turn, to produce a long-term, positive impact on children’s health.

IMMUNIZATION
With the National Program of Immunization, we have expanded preventive actions as well as implemented permanent immunization against 15 diseases. This strategy puts Mexico as the country with the 5th highest investment in vaccines. The anti-pneumococcal immunization has been universalized as well as vaccines against rotavirus, which has evidenced an accelerated fall in mortality due to diarrhea and respiratory infections, allowing us move towards achieving the Millennium Development Goals (MDGs).

CHILDHOOD CANCER
In Mexico, cancer is the main cause of death in children between five and 14 years of age. Therefore, we have consolidated preventive, diagnostic, and treatment to mitigate the impact of childhood cancer. Through the Seguro Popular, we provide medical coverage for all types of cancer in affected children and adolescents younger than 18 years of age. We finance around 2,500 cases each year and have estimated that, as result of this program, 7 out of 10 children survive cancer after a 30 month follow up, and rates of children abandoning cancer treatment have dropped from 30 percent to 5 percent.

NEONATAL SCREENING & TREATMENT
In Mexico, 1-to-3 newborns out of every 1,000 births have a hearing disability, and between 2,000 and 6,000 children are born with congenital deafness each year. To tackle this issue, the Neonatal Auditory Screening Program was developed to guarantee integrated care for children with hearing impairment and deafness by providing, without cost, hearing aids and cochlear implants as well as all medical procedures, surgeries, and language and visual therapy. In doing so, the program aims to reduce the prevalence of child hearing impairment and to promote the social inclusion of children with hearing impairment, including their integration into regular schools.

BREASTFEEDING AND INFANT CARE PRACTICES
The World Health Organization and UNICEF recommend exclusive breastfeeding up to six months of age. Children who have been breastfed show better cognitive development, are less at risk for malnutrition, and early in life are more resistant to infections and diseases such as diarrhea, septicaemia and bacterial meningitis.

For these reasons, Mexico has made great efforts to promote breastfeeding, along with other healthy newborn care practices. Among these are initiatives such as Friendly Hospital to Child and Mother, the International Code of Breast-Milk Substitutes Marketing, and an agreement between producers and distributors of breast-milk substitutes and the Secretariat of Health and the National Maternal Breastfeeding Committee. Additionally, the Seguro Popular has put forward the Life Skills Program (Social Development Model), which promotes behavioral change and positive attitudes toward the practice of exclusive breastfeeding during the first six months of life. To date, the program has been administered in 23 states, training more than 12,000 physicians, nurses and health personnel and impacting over 60,000 women.

Within this model, the “National Program to Reduce Infant Stunting” disseminates evidence-based information to the health personnel as well as the population in general about recommended positions to put babies to sleep. This program is based on the understanding that a bad position (tummy) is considered a major risk factor and for mortality between 30 days and one year in developed countries, and that campaigns to raise awareness can have a major impact on reducing that risk.

CONGENITAL HEART DISEASE
Recently, we moved to include cardiac surgery in the Seguro Popular insurance for children with congenital heart disease. It is estimated that half a million people in the country were born with a congenital heart condition and that most are waiting for treatment. The goal is to increase to 2,500 surgeries per year, reduce health care costs by 50 percent, ensure that each institution builds its own capacities to meet its needs and to standardize the quality of health care in order to provide better opportunities in life to a vulnerable group of the population.

NEWBORN SCREENING TEST
This year we implemented a pilot study for the extended newborn metabolic screening test program, which allows the early detection of galactosaemia, cystic fibrosis, endocrine diseases, urea cycle syndromes, and more than 39 inborn errors of amino acid, organic acid and fatty acid metabolism, among others. These diseases produce different degrees of disability, morbidity and mortality if they are not detected and treated at the earliest opportunity.

OVERWEIGHT AND OBESITY
In Mexico, more than four million children between the ages of five and 11 are at risk for being overweight and obese, and it is estimated that one in every four children, and one in every three adolescents, are either obese or overweight. In order to address this issue, we established the National Agreement for Nutrition and Health, which engages public and private organizations, as well as civil society as a whole, to bring about a change in attitude toward nutrition, healthier habits and food consumption patterns.

The framework of the National Agreement includes a school-based action program with three objectives: 1. Health education and health promotion, 2. Promotion of physical activity, and 3. Regulation of food and beverages supply in educational institutions.

The program promotes five key healthy habits: to be active, drink water, eat fruit and vegetables, keep track of weight and height and finally, to share. Each habit is promoted in five settings: family, school, work, recreational settings such as stadiums and parks and in municipalities. It currently operates throughout the country and in 50 Mexican consulates in the United States.

For the government of Mexico, all of these actions push us closer to a future in which men and women are able to benefit from educational opportunities and to contribute to the development of Mexico.
Over the last decade, I have made it a priority to ensure that the U.S. plays a greater role in providing access to clean water, sanitation, and hygiene (WASH) for the poorest populations across the globe. That’s because dirty water and a lack of sanitation directly affect all areas of development assistance. This is especially true when it comes to global health.

Investing in global health is the tip of the spear for American soft power. From stabilizing markets in developing countries, to strengthening fragile states which can become a threat to our national security, we benefit daily from the investments the U.S. is making abroad.

Using water as an example, emerging markets could be significantly strengthened through investments in water. For example, according to the World Bank, inadequate sanitation costs India $53.8 billion, or 6.4 percent of its Gross Domestic Product (GDP), every year. When nearly 800 million people spend hours collecting clean water. In fact, half of the world’s hospital beds are filled with people suffering from water-related illnesses.

Part of the solution to achieving our global health goals clearly depends on how well the U.S. can integrate water, sanitation, and hygiene assistance into the broader development conversation.

Effective integration will require the U.S. to do more with less. While I believe the U.S. should be increasing investments in development assistance, the reality is that, with the current policies and budget constraints, this will be difficult. Regardless, Congress needs to prioritize programs that deliver the highest return on investment. The case for water is compelling: Increasing access to clean water, sanitation, and hygiene is one of the most efficient uses of taxpayer dollars. The World Health Organization estimates returns of up to $34 in saved health care costs and increased economic productivity for each $1 invested.

Another piece of the integration puzzle is greater U.S. leadership. We took a giant step when Congress passed the bipartisan Paul Simon Water for the Poor Act of 2005. Working with then House Majority Leader Bill Frist, a Republican, and Senate Majority Leader Harry Reid, a Democrat, our legislation made access to clean water and sanitation an American foreign policy objective for the first time in history. It made clear that the U.S. understands the cross-cutting effects water has for other areas of development, elevated the profile of the issue, and has translated into millions of lives saved and improved.

On World Water Day two years ago, we heard an impassioned and eloquent speech by Secretary of State Hillary Clinton on the importance of water. Under her leadership, the U.S. has made significant progress on developing an integrated U.S. approach for water, sanitation, and hygiene assistance, especially for building the capacity needed in developing countries to solve these problems on their own.

While significant progress has been made, we still have a long way to go. That is why I have introduced the Paul Simon Water for the World Act of 2012 with my Texas colleague, Representative Ted Poe. This legislation would give the U.S. the tools needed to leverage our investments. It would elevate the current positions within the State Department and USAID to coordinate the diplomatic policy on global freshwater issues, integrate water into other development assistance, and increase the focus on monitoring, evaluation, and local capacity building.

Nothing is more fundamental to the human condition and global health than clean water and sanitation. In order to do more with limited resources the U.S. will need to take on a greater leadership role. Greater commitment and focus will make a lasting difference.
2012 – A Year of Opportunity in Saving Children’s Lives

BY JASMINE WHITBREAD
CEO, Save the Children

In July 2011, Arooj, a baby girl, was born in Haripur, Pakistan. Her mother, Sobia, had been careful to space her birth after her first child was born, by using contraception—a decision that her husband supported. Iron injections allowed Sobia to avoid the anaemia that affected her in her previous pregnancy, while neonatal care, at a clinic supported by Save the Children, helped to ensure a safe delivery. Following the advice of local health workers, Sobia breastfed Arooj exclusively during the early months and the baby is thriving and healthy. Sobia contrasts Arooj’s early months with that of her older child, Abdullah, whose early months were plagued by bouts of pneumonia and diarrhoea.

Arooj’s story is one of many around the world that exemplifies a remarkable and steady reduction in the global toll of child deaths. In 1990, 12 million children died before their fifth birthday. By 2010, that number had declined to 7.6 million. This number is still inexcusably high and progress is unacceptably slow, but improved access to basic healthcare, better diets and increased household income mean that fewer children than ever have their lives cut short by preventable causes. This is a case for optimism.

At the same time, we should be impatient, not complacent. With three years to go before the 2015 target date for the Millennium Development Goals, we have a narrowing window of opportunity to achieve the two-thirds reduction in child mortality that the world set for itself in 2000. Only 24 out of 75 countries with high child mortality rates are on track to reach this target. We need an intensified effort between now and 2015 to sustain the progress that has already been made and to accelerate it further in countries that are off-track. Encouragingly, this year contains real opportunities to make this kind of shift.

In June, the U.S. government, with the support of the United Nations and developing country governments, will host a ‘Call to Action’ on child survival. This campaign will highlight policies and technological changes that can spur progress and establish the steps necessary to end preventable child deaths within a generation. In July, the UK government will convene a high-level meeting in London that will galvanize efforts to expand access to family planning services in the poorest countries, helping women to space their births and improve their own chances of survival as well as those of their children. It is critical that these events not only create a sense of momentum and urgency but that they also leverage real changes on the ground at a time when aid budgets are being squeezed and political attention is at risk of being diverted from international development.

Both of these initiatives contribute to the wider UN framework on Women’s and Children’s Health, ‘Every Woman, Every Child’, which was launched by Ban Ki-moon in September 2010 and has generated an unprecedented number of commitments from governments, international institutions, the private sector, and non-governmental organizations, including Save the Children. The challenge now is to move from commitment to implementation, and to ensure that governments take the budgetary, policy and legislative steps to place a health worker within reach of every child, to provide vaccines for all and to tackle the underlying causes of child deaths, malnutrition foremost among them. Unless it is addressed, child malnutrition threatens to frustrate efforts to save children’s lives. 2.6 million child deaths each year have malnutrition as an underlying cause and progress in reducing stunting, caused by chronic malnutrition, has been painfully slow. The limited progress that has taken place now risks being rolled back by a combination of volatile food prices, economic uncertainty, and climate change. Action must be taken now to prevent the current malnutrition crisis worsening and more children suffering the life-long consequences. By mid-2015, it will already be too late to help the last generation of children who will reach their second birthday—a critical nutrition milestone—by 2015.

This is why our global campaign to save children’s lives, EVERY ONE, is focused in 2012 on tackling malnutrition as a leading cause of child mortality and ill-health. We know what the direct solutions are, from simple, cost-effective supplements to breastfeeding. The experiences of countries such as Peru and Vietnam, which have made rapid progress in reducing malnutrition and improving children’s health, point the way forward.

Greater political attention on chronic malnutrition will require more effective ways of monitoring progress, which is why the current discussions, led by the World Health Organization on a new global target to reduce stunting, are encouraging. We also need effective measures to overcome the demand- and supply-side obstacles that keep children from receiving the nutrition they need to survive and thrive. In June, the G20 could make a significant contribution to addressing this challenge in its discussions about the role of social protection in boosting families’ incomes so that they can afford an adequate diet. So, too, could the decisions reached at the G8 about what succeeds the L’Aquila food and agriculture initiative and whether nutrition goals are better integrated.

2012 has the potential to be a momentous turning point in efforts to save children’s lives. Over the past half century, the world has cut child deaths by 70 percent. The goal of completing the job, and ending child deaths from preventable causes, is within reach for the first time in history. The decisions taken this year will set the course for the period up to 2015 and beyond. GHID

GLOBAL HEALTH CHALLENGES

PHOtO: LUCIA ZORO / SAVE tHE CHILDREn

IN BRIEF

- Only 24 out of 75 countries with a high child mortality burden are on track to reach the target set by Millennium Development Goal 4. We need an intensified effort between now and 2015 to sustain the progress that has already been made and to accelerate it further in countries that are off-track. Encouragingly, this year contains real opportunities to make that kind of shift.
- In addressing stunting caused by chronic malnutrition, the limited progress that has taken place is now at risk of being erased by a combination of volatile food prices, economic uncertainty, and climate change. Action must be taken now to prevent the current malnutrition crisis worsening and more children suffering its life-long consequences.
About Select Photographers in this Issue

Olivier Asselin grew up in Eastern Quebec, Canada, where he studied and worked in the IT field before dedicating himself to photography. Currently based out of Dakar, Senegal, he has lived in West and Central Africa since 2005 and continues to shoot throughout the continent for development and humanitarian organizations, as well as commercial or editorial clients.

Riccardo Gangale is a freelance photojournalist in Africa for The Associated Press, Magazines, Newspapers, UN Agencies and Advertising Agencies.

Edward Harris is a manager of Media & Communications at the GAVI Alliance. A former multimedia journalist for Reuters in East Africa.

Doune Porter is manager, advocacy and communications on the GAVI Alliance Introduction initiative. She has worked in communications in human rights fields for many years.

Dan Thomas is Head of Media & Communication at the GAVI Alliance. A former TV producer for UNICEF, Reuters and BBC News, he has reported on global health issues from more than 40 developing countries.

Hassana Ousmane rests her head against the bed where her daughter Zeinab, 21 months old, who suffers from malaria and diarrhea, lies at the Princess Marie Louise Children's hospital in Accra.

Women comforting their sick infants in the diarrhoea ward at Matlab Field Hospital in Bangladesh.
Life
A nurse vaccinates a child against pneumococcal disease.

Death
Isiah Anane, just nine-months-old, breathes oxygen to help his laboured breathing. Pneumonia with diarrhea is the leading cause of child death both in Ghana and across the world. He died a few hours after this picture was taken.
A Decade of Vaccines

BY DR. PEDRO ALONSO AND DR. CIRO DE QUADROS
Co-chairs Decade of Vaccines Collaboration

FOLLOWING A LEGACY OF PROGRESS IN DISEASE TREATMENT during the 20th century, we believe the next 100 years will deliver major breakthroughs in disease prevention. It is on this foundation that the World Health Organization, UNICEF, the GAVI Alliance, the National Institute for Allergies and Infectious Diseases, and the Bill & Melinda Gates Foundation established the Decade of Vaccines (DoV) Collaboration to serve as a catalyst for providing all individuals and communities with the opportunity to enjoy lives free from vaccine-preventable diseases.

The DoV mission is to extend, by 2020 and beyond, the full benefits of immunization to all people, regardless of where they are born, who they are, or where they live. To achieve this, a Global Vaccine Action Plan (GVAP) will be presented to the 194 member states at the World Health Assembly in May 2012. This plan was developed by more than 100 immunization experts over the past year, and refined through a global consultation process that involved over 1,100 individuals from 140 countries (representing 290 distinct organizations).

The GVAP outlines five inspirational goals that include: achieving a world free of polio, meeting disease elimination targets and vaccine coverage rate targets (at global, regional, national and community levels), introducing new and improved vaccines and technologies, and meeting or exceeding the Millennium Development Goal for two-thirds reduction in global child mortality by 2015.

The GVAP also outlines six strategic objectives: 1) all countries commit to immunization as a priority, 2) individuals and communities understand the value of vaccines and demand immunization as both their right and responsibility, 3) benefits of immunization are equitably extended to all people, 4) strong immunization systems are an integral part of well-functioning health systems, 5) immunization programs have sustainable access to predictable funding, quality supply and innovative technologies, and 6) research and development innovation exists for maximizing benefits of immunization at country, regional and global levels.

With commitment from the key stakeholders across the immunization community (governments, development partners, civil society organizations, manufacturers, academia and others) towards the GVAP implementation, DoV projections show 24-26 million deaths could be averted due to immunization services around the world in the decade to come. GHD
UK Government will host the first ever global family planning summit in July. The summit aims to bring together leaders from developing and developed countries, foundations, civil society groups and the private sector behind a simple vision: to give women in the developing world the same access to lifesaving family planning as women in the developed world.

Our aim is to reduce by half the number of women who currently want contraception but cannot access it. Unprecedented political commitment and resources will be called for at the summit but the return on our collective investments will be huge. If we can enable 120 million more women and girls in the world’s poorest countries to access contraception by 2020, around 300,000 fewer girls and women will die in pregnancy and childbirth, and three million fewer pregnancy and childbirth continue to be a death sentence for a third of a million girls and women in the developing world every year. In Afghanistan, a girl is more likely to die in pregnancy and childbirth than she is to attend secondary school.

Giving women access to family planning so they can decide whether, when and how many children they have, is one of the most effective ways to tackle the scandal of maternal death that afflicts the world’s poorest women.

That is why, as part of our efforts to put girls and women at the heart of our work, one of the UK’s top development priorities this year is to rally a renewed global emphasis on family planning.

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infants will die from complications in their first year of life.

The benefits of family planning go far beyond the number of lives it saves. Thousands of teenage girls drop out of school in developing countries every year due to pregnancy. In fact, half of all the world’s first-born children are born to adolescent girls, the majority of whom are married. When girls are able to delay the age of their first pregnancy, including through using contraception, they are far more likely to complete their education and gain the skills they need to work their way out of poverty.

I will not shy away from recognizing that one of the benefits of improving access to family planning is smaller family size. Discussing fertility and population dynamics has been taboo for political leaders for too long. Studies find that when women and couples have the ability to decide for themselves, the number, spacing and timing of their children, fertility rates fall and families are better able to increase their household income and invest more in their existing children. We must not allow out-dated taboos to get in the way of helping women to make decisions about their own lives.

Where overall fertility is very high, it is inevitable that national governments will feel the strain of ensuring access to key basic services, such as healthcare, education, water and sanitation. Natural resources are also likely to come under increasing pressure, and it is the poorest families, those who are most reliant on the natural environment for their basic survival, who are likely to feel the greatest impact.

In short, family planning is one of the most cost-effective investments a country can make in its future. It saves women’s and children’s lives, drives broader economic growth and development and offers incredible value for money. Every US$1 spent on family planning services leads to savings in country budgets of up to $6 in sub-Saharan Africa and $13 in South Asia.

Yet, despite the wide range of benefits family planning provides, progress in enabling women and girls to access contraception has largely stalled over the past two decades. The British Government is proud to be playing its part to put family planning back on the global community’s agenda and help more women decide for themselves whether, when and how many children to have.

We know that millions of couples in developing countries who want to delay or avoid a pregnancy do not have access to effective methods of contraception. It is high time their needs were met.
I believe that health is a fundamental human right and that all people deserve access to the health care they need. In fact, I have spent my entire career fighting for this ideal, urging our leaders to deliver on their promises and touting the importance of holding ourselves accountable for the health of our neighbors. Disease spreads with a total disregard for national boundaries, so it is my firm belief that when tackling this issue we must first look at the world as a whole, then push for policies and programs that aim to improve the health of all people. In developing economies, women and children die each day from preventable illnesses—measles, malaria, tuberculosis, pneumonia, malnutrition, HIV/AIDS and pregnancy-related complications. The numbers are staggering: 216 million people were afflicted by malaria in 2010 alone and that same year, 215 million women were identified as having an unmet need for family planning. As mothers, caregivers and teachers, research shows women have a higher disease exposure rate and therefore, bear a disproportionate burden of death to their male counterparts. Yet, it is my firm belief that this tragic and excessive loss of life is quite preventable. You cannot speak with a mother about sustainable development or the global financial crisis if she is sick or her child is dying—that is why I am working in Global Health, with various initiatives, including ALMA and the Global Leaders Council for Reproductive Health. Meeting the unmet need for family planning and preventing the spread of malaria, stopping the spread of HIV and ensuring that new technologies and vaccines reach every child will build the foundation for a healthy and prosperous Africa.

In the past decade we have made great progress by reducing the number of deaths from malaria, tuberculosis, pneumonia and HIV/AIDS throughout our nation, but there is more to be done. Much of the progress we have made can be attributed to disease-specific funding streams and vertical interventions, but it is my belief that the problems of global health can only be solved if we are willing to go one step further. Together, we must focus on building a strong health care system—one that is based on a continuum of care and service delivery, emphasizing prevention, care, and treatment.

In my work as Minister of Health, I witnessed, firsthand, the importance of monitoring and responding to emerging global health developments. At that time, AIDS had reached Botswana, but the HIV/AIDS treatment had not yet reached the people; our community health workers had been phased out and our prevention programs were weak. AIDS was devastating Botswana and we had no tools to combat the spread of this deadly disease. I saw what AIDS was doing to my country and was not willing to accept that treatments were only available to the wealthy people in the developed world. Particularly when the majority of men, women and children who fell victim to the disease were dying. Giving up was not an option. Through lots of hard work with partners who were prepared to support us, Botswana became the first country in Africa to introduce a comprehensive HIV/AIDS treatment program in the public sector. Our actions reflected our belief that access to treatment should never be determined by an individual’s income.

Our experience with HIV/AIDS has taught us an important lesson: in order for any country to deliver prevention, care and treatment effectively, it must be able to rely on a strong health system—one formed by investing in people through community engagement, training health care professionals and streamlining and integrating prevention and treatment programs.

We are at a critical juncture, now that we have access to many of the technologies and treatments necessary to prevent the spread of disease and treat those who become ill. What we need is greater accountability, sustained political will and resources. Accountability will help us generate results. Those results can be measured in lives saved. Political leaders are prioritizing the health of their citizens and making sure that everyone has what he or she needs to enjoy a healthy life. ALMA brings 42 heads of state together with government to use innovative financing programs and accountability mechanisms. ALMA uses a scorecard for countries that allows us to assess how countries are doing on malaria as well as some basic health care indicators, including access to prevention and treatment, family planning services and funding for health. The scorecard demonstrates that health care is best delivered in an integrated fashion and that leaders are committing to actions not only words. ALMA showcases African leadership against malaria and within the global health community.

In my own life, I have seen the difference that access to health care and health care providers can make. I was born in rural Botswana during the malaria season. My grandmother acted as midwife. It was a particularly bad year where many children born in my area died but I was fortunate—I survived. Later, when I was about 4 years old, my sister died of German measles. Again, I was fortunate, but these deaths left a lasting impression on me. I knew that had my community been given access to vaccinations, health care workers and malaria control, most of those deaths could have been prevented. I like to think that many of us in developing countries have taken this first step, by simply surviving. We are on a journey to ensure that all people, especially the women and children of Africa, have access to health services including skilled health care workers, from the time they are born until they die. Thinking back to my childhood health experiences, I recognize the importance of protecting the health of mothers, newborns and children, as well as the importance of family planning—it is vital for a woman to have information about how to space her children. Women who can space their births have fewer, healthier children.

I am driven by a sense of urgency! The time for talking is over, the time to act is now.
Health Care and Security: Canada’s Role in Helping Save Lives in Insecure Environments

BY HONOURABLE JOHN BAIRD
Canadian Minister of Foreign Affairs

Ensuring that the millions of people affected by instability, armed conflict and natural disasters have safe access to critically needed health care services has never been easy, but in much of today’s world, the obstacles can seem even more challenging.

In countries experiencing conflict, like Syria, Somalia or Sudan, violence is often inflicted against patients and the health care personnel trying simply to save lives. Ongoing insecurity compounds the problem of poor access to health care. Health care professionals struggle to reach the most vulnerable people, particularly those in rural areas, which, in turn, impedes our ability to reach our Millennium Development Goals of improving child and maternal health and eliminating diseases like polio.

Then, there are catastrophic disasters, such as the 2010 earthquake that struck Haiti, a country whose ability to provide much needed health care services was already stretched. The International Committee of the Red Cross recognizes these issues as some of the most pressing humanitarian challenges of our time.

Under the leadership of Prime Minister Stephen Harper, Canada has emerged a world leader in development assistance in some of the world’s most unstable regions. Security-related health care challenges demand leadership and concerted action, both in terms of urgent short-term crisis assistance, and in addressing long-term health care and security issues globally. Canadians can be proud of the vital role we play in responding to these needs.

In June of last year I had the opportunity to travel to Libya and meet with the leadership of the National Transitional Council. What I saw was devastating. The Gaddafi regime had ruthlessly targeted its own people, using rape and torture as a sick and twisted method of intimidation.

Despite the best efforts of the international community and medical volunteers—some of whom were Canadian—the lack of access to emergency health care was shocking.

In addition to the timely resources provided by the Canadian International Development Agency (CIDA) to agencies working in Libya, I delivered on behalf of all Canadians hundreds of much needed trauma kits to Benghazi. Unfortunately, the Libya example is not unique. In Syria we have watched the Assad regime perpetrate a campaign of terror against the Syrian people, killing thousands, while denying access to basic medical and emergency humanitarian assistance for its people. Hospitals are routinely targeted with attacks, and the wounded often choose not to seek treatment for fear of detention, torture or worse, death. Health care workers continue to risk their own lives for the sake of saving others.

Again, Canada has responded. We have imposed the toughest sanctions in the world against the Assad regime, while still providing the Syrian people $7.5 million to address the urgent humanitarian crisis.

In Somalia we see the disruption of humanitarian assistance far too often. Al Shabaab, a terrorist network, has cut off assistance to large portions of the Somali people—a population suffering from acute famine and food insecurity. In 2009 a suicide bomber took the lives of 20 people (mostly doctors) at a medical school graduation ceremony in Mogadishu. This one act symbolizes the tact of this cowardly

We have imposed the toughest sanctions in the world against the Assad regime, while still providing the Syrian people $7.5 million to address the urgent humanitarian crisis.
organization. The combination of conflict, violence and crushing poverty only deepens the demand for serious action.

The Government of Sudan has restricted international efforts to deliver urgently needed food aid and health care in the conflict-ridden states of South Kordofan and Blue Nile. These examples underscore the challenges we face, as well as the importance of supporting humanitarian and medical workers whose goal is simple—to save lives and alleviate suffering.

Canada is practical in its approach and strategic in its vision. Operationally, we support efforts to strengthen the availability of immediate health care needs. Canada is providing much needed financial support to humanitarian organizations working around the world to help those affected by conflicts and natural disasters. We have developed, in partnership with the Canadian Red Cross, a deployable Canadian Red Cross field hospital. And in extraordinary circumstances, such as the January 2010 earthquake in Haiti, we have deployed the Canadian Forces Disaster Assistance Response Team to help meet immediate medical needs.

We also recognize that certain health care challenges are systemic and long-term, and that healthy mothers and children are critical for the well-being of families and communities. Concerted international leadership is required, and when applied, can deliver tangible results. Under the guidance of Canada’s Prime Minister Stephen Harper, Canada assumed a leadership role within the G8 of advancing a global agenda for improving maternal, newborn and child health. My colleague, Beverley Oda, Canada’s Minister for International Cooperation, is diligently overseeing Canada’s investment of $1.1 billion in support of this initiative over five years.

AIDS and tuberculosis and were early proponents of ensuring children get access to vitamin A. The correlation, however, is clear: despite all the good that Canada offers the world, when security is at risk, health care suffers.

In December 2011, Canada joined member states from around the world to endorse a resolution by the International Committee of the Red Cross to bring greater attention to the issue of health care in danger. We now need to ensure practical and common sense solutions overcome the challenges we face. Our responses must be decisive. Our commitment must be for the long term. Politically, we will condemn and isolate those responsible for reprehensibly denying access to health care while working to find sustainable solutions to the challenges the world faces.

Canadians are a naturally generous people. Our government only intends to extend that same sentiment around the world.

Amplifying voices on the ground. Working across sectors. Advancing innovative solutions.
Why Human Rights and Laws are Key to Preventing NCDs in Children

BY DR. IRENE KHAN
Director-General, International Development Law Organization

Having been born and raised in one of the poorest countries in the world, I have seen many children with bloated tummies—a key sign of malnutrition. Today, distended bellies are a sign across the globe, not of hunger, but of over-weight and obesity.

These conditions are major risk factors for non-communicable diseases (NCDs), and, according to the World Health Organization’s (WHO) “Global status report on non-communicable diseases,” are linked to more deaths globally than HIV/AIDS at any age. An overwhelming majority of adult smokers take up the habit before the age of 18, and that about one third of them will eventually die from smoking. Overall, in 2008, NCDs (primarily cardiovascular diseases, cancers, chronic respiratory diseases and diabetes) killed three times more people under the age of 60 than HIV/AIDS at any age. Given the global toll of NCDs, it is vital that major risk factors be substantially reduced.

While the global burden of disease shifts away from infectious diseases, NCD’s (primarily cardiovascular diseases, cancers, chronic respiratory diseases and diabetes) killed three times more people under the age of 60 than HIV/AIDS at any age.million children under the age of five are obese or overweight, most of them in developing countries. Obese children suffer from breathing difficulties, are at increased risk of fractures, and display early signs of cardiovascular disease. They also experience hypertension and insulin resistance, and suffer from adverse psychological effects. Childhood obesity is also associated with obesity later in life, disability in adulthood, and premature death.

Alcoholism and smoking are two other risk factors for NCDs, and they, too, affect children. The American Journal of Psychiatry study, “Age at First Alcohol Use: A Risk Factor for the Development of Alcohol Disorders,” found that in Canada, people who began drinking alcohol before they turned 15 were five times more likely to abuse it than those who started at age 19 or older. Similarly, the Campaign for Tobacco Free Kids’ “Smoking and Kids” study found that in the United States, an overwhelming majority of adult smokers take up the habit before the age of 18, and that about one third of them will eventually die from smoking. Overall, in 2008, NCDs (primarily cardiovascular diseases, cancers, chronic respiratory diseases and diabetes) killed three times more people under the age of 60 than HIV/AIDS at any age. Given the global toll of NCDs, it is vital that major risk factors be substantially reduced.

Yet even as the global burden of disease shifts away from infectious diseases, NCD’s have been entirely ignored in the Millennium Development Goals. In fact, it was not until September 2011 that the United Nations General Assembly put NCDs on the agenda, demanding that the WHO set up specific targets and indicators. Even with new high-level recognition of NCDs, the declaration adopted by the General Assembly last September failed to frame prevention and control of NCDs as a matter of human rights. Nor did it include deadlines or link commitments to legislative reform. This oversight is at odds with the United Nations’ acknowledgement, from as far back as 1948, that governments have a primary role in addressing the determinants of health. In fact, Article 25 of the Universal Declaration of Human Rights enshrines each individual’s “right to a standard of living adequate for the health and well-being of himself and of his family, including food...” And Article 24 of the Convention on the Rights of the Child, which has been adopted by 193 countries, states it as a core right to “the highest attainable standard of physical and mental health.”

Furthermore, the Convention on the Rights of the Child, which has been adopted by 193 countries, states that a child has the right to “the highest attainable standard of physical and mental health.”

Human rights are fast becoming the backbone of the international development agenda—a common goal, a working practice, and a lingua franca for sharing and coordinating visions and agendas. The language of human rights is increasingly spoken by governments, development agencies, foundations, and tens of thousands of civil society organizations.

Time and again, we have seen the value of human rights. Ignore human rights and the rule of law, and there can be no just, long-term development. That is why the International Development Law Organization’s human rights program seeks to embed human rights in all aspects of global policymaking. In our view, the lack of a human rights dimension in the NCD debate, as highlighted last September, constitutes a failure of vision, all the more so because a template for action already exists in HIV/AIDS programs.

The world’s long experience in tackling HIV/AIDS has highlighted the importance of a human rights-based approach to disease, both in substance and in process. From the moment it was created in 1996, the UN’s HIV/AIDS program, UNAIDS, adopted human rights and gender as cross-cutting themes. For a decade now the relevant monitoring framework has examined legislative and other measures to protect and promote HIV-related human rights in great detail. Civil society is consulted. Country reports are posted publicly on the UNAIDS website. In addition to encouraging good laws and policies, these measures promote accountability, participation and transparency.

It is imperative that the WHO’s monitoring framework for NCDs include indicators for government policies and legislation to prevent disease, such as marketing restrictions on foods and beverages high in salt, fats and sugar (especially in advertisements which target children), as well as food taxes and subsidies to promote healthy diets. It is far cheaper and more effective to use policies, laws and regulations to reduce risk factors for NCDs in children and adolescents than it is to treat diseases once they have taken hold.

None of this is to say that the task of taking on NCDs is an easy one. Tobacco, alcohol and processed food companies know that drinking, eating, and smoking habits which begin in childhood can last a lifetime. Global business empires are built on marketing unhealthy products to children and adolescents as both current and future consumers. Industry resistance to government regulation is substantial and far-reaching, so all governments will need superior legal capacity to fend off legal challenges in national courts and international forums.

Global solidarity should help. The evidence and arguments used in one setting can inform the response to similar challenges in other countries. A Crown Department of Health Report, “Changes in Food and Drink Advertising and Promotion to Children,” outlines the measures the United Kingdom has taken over the past five years to limit television advertising aimed at children which promote snacks and drinks high in sugar. Initiatives such as this one should be documented, evaluated and widely shared.

Developing countries must also nurture future leaders in the field of public health law and rights, and take action to identify and address the social determinants of NCDs. The broader and stronger the civil society demand for action against NCDs in children, the more likely the political will. For this demand to be heard, the right to protest, speak out and mobilize must be protected. In other words, respect for all rights underpins the right to a health. In tackling the challenge of NCDs, as in all other areas of public policy, human rights are universal and inalienable, indivisible, interdependent and interconnected.
A Public Voice for a Private Pain to Save Lives from Breast Cancer

BY DR. BEATRICE WIAFE-ADDAI
CEO, Breast Care International and Peace and Love Hospital Ghana

BY KATRINA D. McGHEE
CEO, Katrina McGhee Enterprises

A n often-referenced verse states, “My people perish for lack of knowledge.” In issues of public health, this saying applies to cases in which ignorance leads to unnecessary and sometimes preventable deaths. It is particularly true when addressing the growing global crisis of breast cancer, a leading killer of women worldwide.

The mortality rate from breast cancer in Ghana has risen to the tenth highest in Africa. Nearly 5 million of its 24 million people are reported to be at high risk for developing the disease. Women are routinely diagnosed at advanced stages when treatments are more costly and less effective and the death toll is higher.

The latency in seeking care is often due to superstitions and a lack of understanding about the disease’s early symptoms. However, we know that the early detection of any breast pathology provides better opportunities to manage the symptoms. However, we know that the early detection of any breast pathology provides better opportunities to manage the symptoms. However, we know that the early detection of any breast pathology provides better opportunities to manage the symptoms. However, we know that the early detection of any breast pathology provides better opportunities to manage the symptoms.

To increase awareness, one of the alliance’s first priorities was to bring the conversation about breast cancer into the light. No longer could we afford to suffer in silence, to believe that they were cursed and could not survive or that going to a hospital was a death sentence. It was imperative that we address the myths and misperceptions that were holding women in fear.

Several NGOs had already established successful outreach programs that worked in coordination with hospitals and community and faith-based organizations to conduct education, screening and awareness programs. Particularly impactful and committed were survivor organizations such as Reach for Recovery, Peace and Love Survivor Group and Sister’s Support Network. However, working independently they lacked the critical mass and coordination necessary to attract national attention and much needed resources to expand their efforts.

Our vision was a collaborative national campaign supported by media, government and opinion leaders, community and faith-based organizations and corporate supporters, one that unveiled the urgency of the breast cancer crisis in Ghana and highlighted the resources available for women in need. To accomplish our goal, we needed a rallying point for mobilizing the country. Thus, the Susan G. Komen Ghana Race for the Cure was selected as the signature event for the alliance, for which BCI served as the lead NGO.

Rather than expend resources to create a new model from the ground up, the Komen Race for the Cure provided an already proven framework on which we could build a unique campaign for community sensitization and engagement. It also allowed BCI to recruit new collaborators and additional resources. It was not the first breast cancer walk in Ghana, but the collective support of all of the partners in the event alliance ensured that it was the biggest and most impactful.

In May 2011, nearly 15,000 people, young and old, from across the country gathered for the inaugural event in conjunction with the Komen Race for the Cure. It was a spectacular day of celebration, kicked off by H.E. Vice President John Dramani Mahama and supported by the Minister of Health, members of Parliament, district and municipal chief executives, and queen mothers from all of the surrounding towns and villages. Of special significance was the survivor parade that included nearly 500 breast cancer survivors from around the country. Their participation was a message to the women of Ghana that it was okay to talk about breast cancer, there was no need to be ashamed. You can beat breast cancer. You can survive.

That one-day event was a public statement to the world that Ghana was serious about battling breast cancer. What once were independent efforts was now a collective network of NGO, hospitals, government and opinion leaders and corporate partners committed to saving the lives of women in their communities.

As we prepare for the second Ghana Race for the Cure, the work to expand year-round outreach efforts continues to evolve. Through a new partnership with the Ministry of Education, BCI is now training girls in senior high school. The organization is helping to create young ambassadors for the fight who can guide their own bodies and empowering them with the tools needed to help spread the word in their own communities. By helping a new generation of women release their fear of the unknown, we are empowering them to change the future where they no longer worry about breast cancer.

The mortality rate from breast cancer in Ghana has risen to the tenth highest in Africa. Nearly 5 million of its 24 million people are reported to be at high risk for developing the disease.

A Public Voice for a Private Pain to Save Lives from Breast Cancer

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Cervical Cancer Prevention in Zambia – Rewriting the Script

BY DR. GROESBECK P. PARHAM
Co-Director Cervical Cancer Prevention Program in Zambia and Professor, Gynecologic Oncology, Department of Obstetrics and Gynecology, Division of Global Women's Health, University of North Carolina at Chapel Hill

THE SETTING: Millions of women on the African continent contend daily with the hellhounds of food insecurity, early marriage, early and unplanned childbirth, poor health awareness, and the high probability of dying before age 40. All of these realities manifest, in some form or the other, as risk factors for the cancer that causes more deaths on the African continent and kills more African women, each year, than any other—cancer of the uterine cervix. African women continue to die needless deaths because of the absence of life-saving interventions that seem simple, yet can be so extremely complex to deliver.

THE TRAGEDY: In Africa, cancer of the cervix is not just a disease, but a tragedy. It is a tragedy played out in the theatre of silence in Africa's informal settlements, townships, squatter camps, peri-urban locations and rural villages. In communities, where the muted moans and groans of women tormented by the incessant, intractable, knife-like pelvic pain of advanced cervical cancer go unheard and unheeded. In societies, where prevailing attitudes about cervical cancer are rooted in the belief that it is the result of a fatal curse for having lived an immoral life, and thus is a disease of shame. Such ideas seem simple, yet can be so extremely complex to deliver.

The Antagonist: Cervical cancer is a cancer of the opening into the uterus, commonly referred to as the "mouth of the womb." It is now known that this form of cancer is caused by a virus, the human papillomavirus (HPV). There are four (4) major steps in the development of cervical cancer that usually occur over a 15-20 year period of time:

1. Transmission of the HPV virus from male to female. This usually occurs during heterosexual intercourse, but does not always require penetrative sex.
2. Persistent HPV infection. The majority of women who become infected with HPV are usually able to rid themselves of the virus if their immune systems are healthy. However, for reasons not yet completely known, in some women the virus is not readily cleared, leading to what is called "persistent" infection. It is the persistent infection with certain
Most African governments lack a unified national strategic plan, policy or roadmap for the prevention and treatment of cervical cancer. This lack of planning represents a serious lag in the response to a growing threat.

1. Cancer-causing types of HPV (e.g., HPV16, HPV18) that puts women at risk for developing precancer and cancer of the cervix.

2. Development of precancer. Precancer exists when abnormal cells are only located on the surface (lining) of the cervix and have not yet taken root in the underlying tissues. The lag time between an original HPV infection and the appearance of a precancer may be up to five years. The main purpose of cervical screening programs is to detect precancers because they are almost 100 percent curable. These screenings are especially important because precancers cause no symptoms so women will not know they are present unless they undergo cervical screening.

3. Development of precancer to cancer. The step from precancer to cancer takes place over a period of 10-15 years. When cancers first develop they begin to cause symptoms such as bleeding after sex, irregular menses or vaginal infections that are not cleared with antibiotics.

4. Development of precancer to cancer. It is estimated that 50% of cervical cancers first develop they begin to cause symptoms such as bleeding after sex, irregular menses or vaginal infections that are not cleared with antibiotics.

The Zambian Ministry of Health (MOH) was recently provided free doses of HPV vaccine through Merck’s Gardasil Access Program. These vaccines will be used in an upcoming MOH-led HPV Demonstration Project during which time 5,800 school girls (ages 9-13 years), in urban and rural locations, will be vaccinated in preparation for a national GAVI-supported HPV vaccination program.

In September 2011, the “Pink Ribbon Red Ribbon” (PRRR) initiative was launched in Washington, D.C. An innovative partnership between the George W. Bush Institute, PEPFAR, Susan G. Komen for the Cure, and the Joint United Nations Programme on HIV/AIDS (UNAIDS), its purpose is to expand the availability of cervical cancer screening and treatment, especially for high-risk HIV positive women, and promote breast cancer awareness and screening in Sub-Saharan Africa and Latin America.

Large beneﬁt of the cervical cancer prevention efforts, Zambia was chosen as the ﬁrst country in which the PRRR initiative will be implemented. Resources provided by PRRR were adapted to the critical need for expanded cervical cancer prevention services in the country.

Each year more than 160,000 children are diagnosed with cancer and it is estimated that 90,000 of them will die from the disease. Although childhood cancers represent only a small percentage of all cancers and a fraction of the global cancer burden, for children with the disease and their families, it is an issue that deserves high priority in the global health agenda. This is especially true in low-developed countries where childhood cancer is frequently detected too late for effective treatment, and where appropriate treatment is, too, often not available.

The causes of childhood cancer are still largely unknown and therefore cannot be entirely prevented. There also exist many types of childhood cancer, which differ in their development, symptoms, level of invasiveness and cure. These cancers develop in different parts of the body, can be aggressive and can grow more rapidly than cancer in adults.

The most common types of pediatric cancer are those related to blood cells, some of which are known as leukemias (particularly the acute lymphoblastic leukemia), which is the most common among children, brain and central nervous system cancers (e.g. gliomas and medulloblastomas) and retinna cancer (retinoblastoma). The good news is that most childhood cancers can be cured if prompt and essential treatment is administered.

It is therefore natural to believe that if treatment and cures exist, a child who is affected by cancer should have access to the best existing medical care, regardless of his or her circumstances. This is not the case (however, and the situation is vastly different for families in developing countries as it is for families in developed countries. As detailed in The Harvard Global Equity Initiative’s article, “Global Task Force on Expanded Access to Cancer Care and Control in Developing Countries” (“Developing Countries”), the disparity in survival rates between wealthy and poor countries is greater for childhood cancers than for any other typology of cancer and it is estimated that 90% of the children affected by cancer will die in a developing country, as opposed to the 12% of those who die in a developed country. Pediatric cancer affects children in developed and developing countries in the same way, but the possible cures and outcomes vary greatly between the two.

As underlined by experts in “Developing Countries,” 85% of child deaths from pediatric cancer occur in low-developed countries where access to information, treatment and health care is not readily available. This factor has contributed significantly to the estimated 90,000 child cancer deaths annually, and thus collectively, childhood cancers represent an important global public health problem.

Although AIDS and immunodeficiency viruses are the most critical in sub-Saharan Africa, cancer is emerging as a growing cause of child mortality in countries in Asia, Central and South America, northwest Africa, and the Middle East. Childhood cancer in these areas, however, is simply an issue that has not been properly addressed at the government level, according to the St. Jude’s Research Hospital article, “Pediatric cancer lacks priority in developing countries.” Given its rarity in terms of numbers, governments consider childhood cancer to have ‘inferior urgency’ and are reluctant to allocate resources toward establishing an effective response to the issue. With this gap in the healthcare system, it is crucial that civil society and international organizations take a stronger lead in fighting childhood cancer in developing countries to address these inequalities in survival rates.

It is a sad reality to think that when we talk about childhood cancer, over 80 percent of children could be cured, but in developing countries, over 80 percent die, simply because they do not have access to the proper health care. (Alessandra Contigiani)
Zuebeyde Horus is a young woman with an intellectual disability from Turkey, and a Special Olympics athlete. Like most young adults, she leads an active and healthy life. Her family and friends join in cheering her achievements in sport, just as they would any typically developing peer. But, neither she nor her family could possibly have been prepared for the shock of her most recent visit to a Special Olympics event. There, Zuebeyde was invited to the Special Olympics Healthy Athletes venue for a checkup with highly trained physicians and health educators. Away from the sun of the athletic competitions, Zuebeyde Horus was diagnosed with atrioventricular septal defect, a condition that causes holes between the various chambers and valves of the heart. She had no idea that she had lived her entire life with a condition that easily could have killed her.

But, that’s not what had happened to Zuebeyde. Instead, despite being a relatively common condition that is also simple and inexpensive to detect, Zuebeyde’s heart defect was not identified by screening after birth, nor was it identified during childhood or adolescent visits to the pediatrician. For her, the primary problem was not her heart condition, it was the way in which the medical profession failed to diagnose or treat the defect. Over and over again, Zuebeyde came into contact with medical professionals, and over and over again, their failure to detect a relatively common condition left her at risk for developing a life-threatening condition.

How does such a serious condition go unnoticed so long?

Through decades of field work and scientific research, Special Olympics International has documented millions of stories like Zuebeyde’s, linked to one overriding factor: subtle but persistent discrimination against people with intellectual disabilities. This discrimination compromises the quality of health systems worldwide, limits the effectiveness of care and, as a result, diminishes the quality of life for people with intellectual and developmental disabilities. The problem is as simple as it is shocking: patients with different intellectual abilities are considered to be less valuable human beings than their typically developing peers. This attitude is prevalent across geography and culture, and is sadly common in the profession most charged with compassion and healing: medicine. Health care systems, training programs, insurance schemes, research endeavors—all of these are designed to accord fair treatment to people with intellectual disabilities. And what’s more, people with developmental disabilities who do see a doctor have a low chance of receiving quality care.

As one health professional confided to me years ago, people with intellectual disabilities often receive “a quick and dirty examination—get them in and get them out. They don’t complain and they don’t have complex tasks in life. Quality isn’t important.”

“Quick and Dirty.” Those words should be treated as evidence of a crisis. Discrimination in health care should be a source of outrage. Instead, it is often overlooked or ignored. Even when health care systems and aid programs attempt to meet the needs of marginalized populations—those living in extreme poverty, ethnic minorities, women and children—they almost never count people with intellectual disabilities among those in need of outreach. Medical training programs and graduate schools generally offer little or no training in the care needed by people with intellectual disabilities. In many countries, health ministries and insurance schemes discriminate boldly and with impunity: “We know they’re not getting care but there’s nothing we can do about it. We have limited resources.” The implications of this frequently repeated plea are unmistakable: others are more deserving.

More than one billion people in the world live with some form of disability, according to the World Bank and World Health Organization’s “World Report on Disability”, published in 2011. Unfortunately, this report does not offer numbers specifically for intellectual disability, but estimates suggest that more than 200 million people worldwide have an intellectual disability. The first-ever “World Report on Disability” documents the myriad of barriers people with disabilities must overcome on their own to access health care.

Issues such as cost, transportation, providers’ lack of training, and arguably most disturbing, providers’ unwillingness to see patients with intellectual disabilities are well-documented. A shockingly high percentage of people with disabilities, especially in high-income countries, reported that they “tried but were denied care.” Special Olympics has developed and maintains the largest collection of health data on people with intellectual disabilities, and has documented dramatic health disparities that support the findings of the “Report on Disability”.

- Nearly 40 percent of Special Olympics athletes have obvious, untreated tooth decay.
- 16 percent have a disease of the eye.
- 26 percent fail a basic hearing test.
- 20 percent have low bone density, putting them at risk for injury and chronic osteoporosis.
- 36 percent of adults are obese.

Perhaps the most alarming finding is the lack of concern or awareness of this neglect on the part of the general public. Despite so much evidence to the contrary, 68 percent of people worldwide believe that those with intellectual disability receive the same or better health care than those without disability. It is clear that public attitudes are badly misinformed, and that inaction persists as a result.
Finding Solutions
Fortunately, the outlook for people with intellectual disabilities is more hopeful today than it has been in the past. Although long overdue, the United Nations Convention on the Rights of Persons with Disabilities (CRPD) came into force in May 2008 and had 153 signatories and 111 parties as of March 2012. Parties are required to promote, protect and ensure the full enjoyment of human rights by persons with disabilities and ensure that they enjoy full equality under the law. Article 25 of the CRPD reinforces the right of persons with disabilities to attain the highest standard of health care, without discrimination.

Perhaps even more importantly, advances in the law are being matched by advances among citizen groups. In recent years, Special Olympics has been joined by over 100,000 health care practitioners around the world, all dedicated to improving the quality of professional training, bringing the data on injustice to light, and providing front line education and care to people with intellectual disabilities in their own communities.

As a grassroots organization, Special Olympics, and the promising results of our work, provide one small example of the motivated citizen-level communities of enforcement that can ensure high standards of health justice. With support from the U.S. Centers for Disease Control and Prevention and numerous corporate and non-profit partners, Special Olympics Healthy Athletes has been an active force for bringing people with intellectual disabilities out of the shadows and into doctors’ offices. When doctors’ offices are too difficult to reach, bands of dedicated volunteers venture out to institutions and community centers and village fields with the basic tools of care and a willingness to break down the barriers that have stood for too long. Day after day, Healthy Athletes teams train health providers in care and treatment, provide screenings and health information in seven different disciplines, deliver needed referrals and, in some cases, follow-up care.

Since its official launch in 1997, the Healthy Athletes volunteer corps has provided nearly 1.4 million health screenings to Special Olympics athletes, distributed more than 90,000 pairs of eyeglasses free of charge, partnered with dental schools and dental treatment organizations to provide oral care, helped launch new organizations dedicated to training in developmental medicine, organized water cleanliness and nutrition education for tens of thousands, and more. Recent work with partners has also triggered new efforts to provide follow-up dental work, hearing aids, and other forms of free care to athletes.

Those of us who are part of the worldwide Special Olympics are determined to continue to expand our model. We hope to close the gap in development funding for the health needs of people with intellectual disabilities in the world’s poorest nations, strengthen the engagement by existing public health organizations and foundations of people with intellectual disabilities, and continue to highlight shocking episodes where the human dignity of our friends with intellectual disabilities are violated—whether those violations take place in the dark institutions of the developing world or in the shiny and bright hallways of elite hospitals or governments. Despite all of our efforts, we are just scratching the surface. We cannot be anything but relentless in our pursuit of justice, acceptance and health. Our very dignity depends on our capacity to bring to reality the dignity of all.

Today, Zuebayde is receiving treatment that is expected to add 20 or 30 years to her life, all because one volunteer doctor took the time to see her and treat her like he would any other patient. She is our role model of change—a wonderful human being who is able to live her life to the fullest because of the goodness of another. For over 40 years, Special Olympics has been powered by this goodness, which has, in turn, confirmed our belief that the world can change, one person at a time. Our conviction remains that each one of us can have the honor to take part in building a more just and healthy future, and that each one of us—no matter where we live, no matter our level of influence, no matter our previous relationships with people with intellectual disabilities—can be the next person to change the world.

That is our dignity revolution, and we intend to follow our athletes in pursuit of it every day until the scourge of intolerance is forever removed from communities the world over. 

PHOtO: SPECIAL OLYMPICS
Global Health Partnerships and Solutions

Economy, Technology and Partnerships
There are many who believe economic growth to be the sole antidote for the rampant spread of deadly and destructive diseases throughout Africa. I, however, believe this to be a grave misconception. While the symbiotic relationship between a strong economy and a healthy population cannot be denied, the diseases currently plaguing Africa know nothing of our nation’s border. Why then, should our treatments and preventative measures stop there?

While we pursue economic growth, as governments, I believe we must also invest in the health of our people. Diseases must not only be prevented, but also eradicated, if members of a society are to make measureable contributions to their nation’s economic growth. At the same time, I believe it is essential that our efforts not stop at national boundaries. Disease spreads quickly across borders, national economies are inextricably linked and perhaps most importantly, our greatest hopes for meeting the persistent challenges in both of these areas lie in our ability to work together.

I am happy that the global community has come to appreciate the notion that longevity and wellness are key indicators of development. It is my belief that the MDGs represent a remarkable turning point in diplomacy, not to mention efforts to reduce poverty and spur development.

While there are formidable challenges to be met on many African fronts, including Tanzania, I believe the full MDG agenda represents concrete evidence of what focused diplomatic efforts can achieve, regardless of whether all the goals are met on time. As President, I am proud to support Every Woman Every Child, the UN Global Strategy designed to improve women and children’s health. It offers all of us an opportunity to improve the health of women and children.

Diplomacy, Health and the Economy

By His Excellency Jakaya Mrisho Kikwete
President of the United Republic of Tanzania
directly related to the health of society. Access to family planning information, services and supplies is a critical part of improving the health of women and children.

As Co-Chair of the UN Commission on Accountability and Information for Women's and Children's Health, I recently had the opportunity to work with Prime Minister Stephen Harper of Canada, along with 30 commissioners from around the world, representing a range of stakeholder groups. As a commission, we developed a set of recommendations aimed at bolstering accountability and transparency around countries' work toward MDG's 4 and 5. The framework we developed places accountability right where it belongs, at the country level. It doesn't stop there, however. This framework also relies heavily on the active engagement of governments, communities and civil society, with strong links between country-level and global mechanisms. While I believe country-level accountability is critical, in everything we do we must also have an eye to what is happening beyond our borders, the lessons that we can draw from the experiences of other countries as well as the opportunities we may have to work together to achieve change that benefits us all.

In Tanzania, the pervasiveness of malaria and HIV/AIDS reflects the close ties among economic growth, health and diplomacy. The economic consequences of HIV/AIDS are well known, and, in Tanzania, we have substantial data reflecting the ways in which AIDS so often leads to social and economic disruption among affected individuals, families and communities. The poorest households are quite often the least able to cope with the impact of adult deaths due to AIDS, and are frequently unable to obtain even the most basic needs in the short term. This is to say nothing of the severe impact AIDS has been known to have on the nutrition, education, health and living standards of child survivors. In Tanzania, infection rates have declined from 18 percent in the 1990s to less than 6 percent today, and there is evidence this downward trend will continue. Over 13 million Tanzanians have counseled and tested for HIV since July 2007 when my wife and I launched a nationwide campaign for voluntary counseling and testing. These milestones could never have been reached, however, without our ongoing commitment to improving the health of our citizens. Now, meeting persistent challenges (such as ensuring the more than 40 percent of HIV-positive pregnant women receive the drugs they need to keep their babies HIV-free) depends on both our efforts in Tanzania as well as our continued commitments from around the world.

Like HIV/AIDS, malaria has been a major cause of death, as well as a major area for success in recent years. USAID recently reported, in its sixth update of the President's Malaria Initiative, that its efforts to expand the use of insecticide-treated mosquito bed nets, indoor residual spraying, improved diagnostic tests and malaria medications has resulted in fewer child deaths from the disease. These findings are significant because they are not limited to children in Tanzania. Instead, this success has been experienced among children in Angola, Ethiopia, Ghana, Kenya, Madagascar, Malawi, Uganda and Zambia, as well.

While we are eager to celebrate our successes in improving health while working closely with partners around the world, I know Tanzania still has a long way to go to ensure our children are able to not only survive, but grow into prosperous members of society. I am incredibly proud of the success that we have achieved since 1990, when 155 of every 1,000 children died before the age of five. In 2010, that number was drastically reduced to 76. Yet, I also know that continued progress will require even more hard work. We have achieved so much, yet our challenges have not diminished. Instead, reaching the remaining children with interventions like bed nets and PMTCT will require even better tools than we have used to date. Further, taking on challenges like childhood cancers, which we in Tanzania still know too little about, will require additional efforts to build awareness, make treatment more accessible and explore new possibilities for prevention.

**Conclusion**

I believe very strongly that improving health is critical to achieving economic growth and ensuring the benefits of society as a whole. At the same time, my position as President of Tanzania has provided me unique opportunities to take part in diplomatic efforts that will have an impact on health not only in Tanzania, or even in Africa, but around the world.
Malaria: A Sound Economic Investment

BY HRH PRINCESS ASTRID OF BELGIUM
Special Representative to the Roll Back Malaria (RBM) Partnership

Despite best efforts and tremendous progress, malaria continues to infect an estimated 216 million people around the world each year, killing more than 650,000. Approximately 560,000 of those killed by malaria are children under the age of five. In the time it takes you to read this article, roughly three more children will lose their lives to this preventable and treatable disease. These are precious lives lost for lack of a $1 course of antimalarial treatment or a $7 long-lasting insecticide-treated net. Malaria disrupts communities and wrecks lives. It keeps children out of school and parents out of work. It costs governments and societies billions of dollars in healthcare costs and lost productivity. In Africa alone, malaria costs an estimated minimum of US $12 billion in lost productivity each year. But there is a glimmer of hope.

In 2008, the United Nations Secretary-General, Ban Ki-moon, appointed his Special Envoy for Malaria, Mr. Ray Chambers, and called on us to end deaths from malaria by 2015. The world responded tremendously, resulting in an estimated US $3.2 billion funding gap in Africa through 2015 that places our progress in great jeopardy.

Additionally, we face the very real threat of resistance to ACTs that stands to unravel the hard-won gains achieved in recent years. Our programs and policies are working, but if we don’t continue to invest in them, we will lose the fragile advances we’ve made and millions will continue to suffer. Now more than ever, we must find creative ways to work together to maximize the effectiveness of our efforts and identify alternative sources of funding so we can sustain our progress and continue saving lives. Never before has diplomacy and partnership been so important.

Just recently I was in Indonesia, where I participated in the launch of the country’s national RBM Partnership Forum, an initiative that harnesses the unique skills of various sectors to support the malaria-control strategy of the Ministry of Health. I also had wonderful meetings with political leaders and government officials, during which I was encouraged by Indonesia’s commitment to national investment and regional leadership, to ensure appropriate scale-up and coordinated efforts against malaria. I am convinced that this spirit of partnership and diplomatic leadership will be crucial as we work to advance the malaria agenda globally.

Investments in malaria prevention and control have been among the best investments in global health, resulting in a dramatic decrease in malaria deaths and illness. We know that when we invest in malaria, the return is high and the cost is low. In the case of Africa, for example, a US $3.2 billion investment now stands to not only save an estimated 3 million lives through 2015, but it could also avert US $36 billion in lost productivity over the next three years.

Beyond being morally compelling, investing in malaria is sound economics. Health is the building block of all development, and when we invest in malaria, we invest in communities. Recognized as one of the UN Millennium Development Goals, we know that investments in malaria also accelerates progress in other health and development areas by reducing school absenteeism, fighting poverty, and improving maternal and child health.

Recently, the UN Secretary-General announced that malaria was among his top priorities for his second mandate. This announcement shows his clear commitment and determination to defeating this leading killer. I only hope we will respond as enthusiastically as we did in 2008 and make malaria one of our priorities as well. To be honest, we can’t afford not to.

As Special Representative to the Roll Back Malaria Partnership, I urge donor countries to make smart investments and fill the US $3.2 billion funding gap in Africa.

The road ahead will be difficult, but if we are able to maintain our commitment, the reward will be substantial. As we work to defeat malaria, let us do so with bold conviction and collaboration, working together to identify creative solutions to overcome the challenges threatening the progress we have made so we can help communities around the world to thrive.

The Roll Back Malaria Partnership (RBM) is the global framework for coordinated action against malaria. Founded in 1998 by UNICEF, WHO, UNDP and the World Bank and strengthened by the expertise, resources and commitment of more than 500 partner organizations, RBM is a public-private partnership that facilitates the incubation of new ideas, lends support to innovative approaches, promotes high-level political commitment and keeps malaria high on the global agenda by enabling harmonizing and amplifying partner-driven advocacy initiatives. RBM secures policy guidance and financial and technical support for control efforts in countries and monitors progress towards universal goals.

Economic Investment
The Data Revolution for Global Health

BY DR. OLIVER HARRISON
Director of Strategy at the Health Authority - Abu Dhabi (HAAD)
Head of Public Health for HAAD

The rise of non-communicable diseases (NCDs), such as heart disease, cancer and diabetes, has sharpened the focus on longstanding issues with health systems across both developing and developed economies. According to the United Nations Department of Economic and Social Affairs, the roots of the changing disease burden cut across demographics (such as aging populations), and widespread changes in lifestyle (particularly poor diet, lack of exercise, tobacco smoking, and alcohol consumption). To make matters worse, health systems are typically geared towards acute and curative care rather than preventive and long-term care, with the bulk of health services provided by scarce clinicians, using expensive health care assets. As these dimensions collide, health benefits (for example, life expectancy) are beginning to plateau, while costs are rising sharply.

And yet, it is clear that the global sense of urgency on NCDs has not yet been matched by concerted action, or even a clear action plan, targets and timelines. This is due, in part, to the complexity of the task; the causal web that underlies the bulk of health services provided by scarce clinicians, using expensive health care assets. As these dimensions collide, health benefits (for example, life expectancy) are beginning to plateau, while costs are rising sharply.

Put simply, data holds the key to helping health systems act as true ‘systems,’ that is nodes acting in a coordinated manner to achieve integrated goals. In turn, this transformation can help better manage the growing challenges of NCDs (as well as other diseases), and unlock unprecedented opportunities for health research and development (R&D).

Disruptive innovation is taking place on a larger scale outside the traditional R&D markets (Europe, the Far East and the United States). Health data is no exception. For example, the Health Authority in Abu Dhabi (HAAD) has pioneered a unique data system that underpins the entire health market in the emirate. In Abu Dhabi, health data for every resident is processed in real-time through a secure, online clearing house called Shafafiya (Arabic for “transparency”). Copies of the data are stored on a secure, universal database, which serves as a central ‘source of truth’ for facilities, professionals, insurers and the regulator (this hub is called KEH, “Knowledge Engine for Health”). The Abu Dhabi system is far more than simply a record; it is now processing ePrescribing, Authorisations, and Eligibility Checks. From late 2012 the system will be fully integrated into user-accessible disease management programs through a secure cloud computing interface.

According to Progress in Cardiovascular Disease’s “The Abu Dhabi Cardiovascular Program: The Continuation of Framingham,” in Abu Dhabi, KEH already provides invaluable data for the entire health system. In addition, HAAD is now building a unique, population-wide, secure health cloud based on KEH through a scalable NCD programme called “Weqaya” (Arabic for “prevention”). The Abu Dhabi solution is adaptable and scalable, and eHealth transaction costs are near zero. HAAD has recently made its basic architecture and source code public (through the Shafafiya website), and has been approached by a number of countries for support in implementing the Abu Dhabi model.

With health data size does matter. Greater scale means greater statistical power, and an ability to derive more value at the granular, even individual, level. Scale can transform the statistical power of data analysis for a range of clients, such as:

• Pharmaceutical companies
• Health insurers
• Employers
• National and local governments
• Companies with products that affect health, such as food, exercise
• Academia

In addition, growth in participation will help attract new entrants. Building momentum creates positive feedback loops with Internet start-ups such as Google and Facebook. Such effects have already been seen in analogous data systems (for example, Visa and MasterCard which dominate the data portability market in personal finance). To make sound and rapid progress, the approach must be grounded in solid scientific evidence, and ensure rigorous data security, whilst embracing open innovation.

Towards a Global Health Data Strategy

There are five keys to meeting the NCD challenges through eHealth:

1. Deal with ethics upfront

The ethics of data collection, storage, use and destruction are currently focused on a single issue: confidentiality. Security and consent continue to be central to health data ethics, however there is now a growing theme: failing to fully use data that could save lives and improve health.

Conversations are now underway (for example, the World Economic Forum “Rethinking Personal Data”) on a new formulation for health data that simultaneously addresses both these issues. A new compact must be codified in legislation and hard-wired into systems. A scalable IT solution will help drive the conversation and unlock the global opportunity. Other data systems, for example the Bankers’ Automated Clearing Services (BACS) and personal finance systems, such as Visa and MasterCard, provide lessons that can be applied as we seek to balance confidentiality and portability with health data. Building on ubiquitous web technologies such as secure authentication, data encryption, and key management a scalable solution can be made very secure. Data identifiers can be anonymised with description keys owned and managed by individuals or on their behalf by data guardians. A range of health systems around the world have already begun to implement eHealth solutions and provide exemplary legislation and regulations that can be adapted.

And yet, in many geographies data protection laws were drafted decades ago, and there is concern that technology is advancing more rapidly than legislation and regulation. Now is the time to address the concerns head-on to create a more sophisticated, though no less robust, formulation. Central to this will be to ensure that important (and valuable) information can be unlocked, while the essential rights of all parties, particularly consumers, remain protected.
As with the journey from gold coins to paper money to checks, credit cards, PIN numbers, and eMoney it will be important that the fundamentals of health data are preserved along the way. The countries that get this right first will develop significant first-mover advantage.

2. Ensure open innovation

The data standards should be open-source, and an application’s programming interface (API) created for a range of health related “Apps” as push-pull clients of the database. Akin to the power of iTunes to innovate on Apple hardware and iOS platforms, managed diversity can help drive innovation and deliver global health impact.

3. Build community fast

Again, size does matter. Greater engagement creates scale-up for impact and bigger datasets that generate the statistical power required to drive radical new analyses and create a revolutionary approach to protecting and improving health. The growth of internet companies, such as Google and Facebook, demonstrates the momentum that rapidly scaling-up community brings.

4. Don’t compete – integrate

There have been considerable efforts to standardize health data (for example, diagnoses/symptoms and signs–WHO International Classification of Disease (ICD), activity–Current Procedural Terminology Codes (CPT), and clinical observations–Logical Observation Identifiers Names and Codes (LOINC). In addition, the Healthcare Leadership Alliance (HLA) has spearheaded efforts to create a common language for health data transmission.

Some countries have already made great strides in building large health datasets; examples include Denmark and Singapore (plus Iceland in population genomics). Other countries are exploring the creation of health datasets (for example, India and China), seeking to link health data (for example, the United States), or currently creating national health data systems (for example, Australia). A smart strategy aims to integrate such international efforts rather than competing with them. Rapidly scaling-up the community covered by a shared dataset exponentially grows the value proposition for new joiners. In addition, there is much that can be learned from other governments, for example Abu Dhabi, where the health regulator (HAAD) has created a Data Access Panel to share anonymized health data, and recently made its data standards and technical code open-source. A successful health data clearing house solution will be compatible with a range of health languages, generating a standardized database.

5. Partner for diversity and growth

Exposing a rich source of data to analysis by leading experts in the fields of epidemiology, pharmaceuticals, eHealth and public health will yield novel insights leading to the development of precisely targeted and calibrated public health programs. Critical to success will be achieving a balance of public, private, and civil sector groups, each doing what they do best to achieve common goals. A specific priority is training a skilled team of health data analysts - the generation who will work behind the scenes to make the real advances happen. With data flowing, previously untapped sectors can, and should, become involved in health, such as the marketing and creative industries, proving health can be attractive, accessible and fun! As The Journal of Health Communication’s “Communicating Health through Health Footprints” suggests, open data may even be used to drive innovation in key areas such as food, urban design and schools by influencing consumer choice—shifting the demand function.

Summary

There have been many revolutions in healthcare: From germ theory came the development of antibiotics and vaccines, and from the discovery of DNA came innovative treatments for cancer and the genomics revolution. We now stand on the verge of another revolution. The complexity and scale of NCD challenges comes at a time when technology has matured to the point of secure scalability. Global leaders must play their role in shaping legislation, supporting investment and ensuring advocacy. GHD

REFERENCES

Uganda’s Role in Improving Women’s and Children’s Health

BY HER EXCELLENCY MRS. JANET MUSEVENI
First Lady of Uganda and Minister for Karamoja Affairs

As the United Nations family prepares for the final push toward the 2015 deadline for the review of the Millennium Development Goals (MDGs), I am glad to report that my country, Uganda, has made real progress, not only in changing health indicators, but also in laying the groundwork for change in the future. As we look toward 2015, I hope that Uganda will benefit from the experiences of other countries and that our experience will, in turn, provide critical lessons for other parts of Africa and around the world. When I consider Uganda’s experience, there are two critical lessons from which I believe other countries can learn. First, our experience shows that progress in the health arena is possible. Uganda’s rapid decrease in the prevalence of HIV is well known: we have reduced the infection rate from 30% to less than 7% over the last 25 years. Perhaps most impressively, Uganda managed to achieve this goal, not because our country is rich, but because our Government chose to adopt a comprehensive “Multi-sectoral Approach” strategy and continues to provide unwavering public support for all nationally coordinated efforts aimed at tackling the epidemic. As a direct result of this focused and coordinated effort, all of Uganda’s stakeholders, to include policymakers, parliament, government ministries, local governments, civil society organizations, professional bodies, academic, private sector, religious and cultural institutions as well as donors and international organizations, are now able to effectively fulfill their respective roles.

Another area in which I feel Uganda’s success may serve as a positive example for other countries is our reduction of infant and child mortality rates. In 1990, 175 out of every 1,000 babies born did not make it to their fifth birthday. That number is now below 100. I learned recently that our infant mortality rates are falling even more dramatically, with new reports showing a decline from 76 to 54 deaths between 2006 and 2011. When I look back at the steps our country has taken to make this change possible, or look ahead at the important steps we still have yet to take, one thing is clear: we must work together.

Researchers: With increasing research, information and knowledge, we have come to gain a clear sense of where we are making progress and where moving forward remains a challenge. At the same time, careful research provides us with important insight regarding the causes and underlying conditions that continue to undermine the health status of our women and children. The evidence is clear: not only does poor maternal health impact the well-being of so many of our nation’s unborn children and families at large, but research shows the simplest of interventions for these very women have measurable, far-reaching and positive effects. We have seen time and again the benefits of interventions like family planning and immunization. Indeed, evidence now shows us that family planning is to maternal health what immunization is to child health: a low-cost, effective way to avoid preventable health risks.

International, regional bodies and forums: International meetings like the Millennium Summit as well as the International Family Planning Meeting that took place in 2009 in Munyonyo, Uganda, have provided critical opportunities to turn evidence into action. The priorities these meetings set for action have reinforced our understanding of that making simple, low-cost interventions available can save lives—a notion which reflects the commitments of our stakeholders and is supported by governments, continental bodies (such as the African Union) and development partners (such as donor agencies).

In particular, we rely on our development partners to act from a shared understanding of the close, mutually exclusive relationships that exists among social development, economic development and health issues, and to put out a call to action. We know well the far-reaching impact of individual women and children’s good health on their families, communities and countries. At the same time, we rely on our partners to work with us on the priorities we set for ourselves.

Government: As First Lady and Patron of Save Motherhood, I am firmly committed to ensuring that women and children are healthy. In Uganda, we have spoken on many occasions about the need for a zero-tolerance policy regarding maternal deaths, and have spent much time reflecting on the lessons that our experience addressing the HIV/AIDS epidemic have taught us. I know the Government of Uganda is doing everything it can to put a stop to the needless deaths of women in pregnancy and childbirth. Just as when we were faced with frighteningly high levels of HIV infection in the 1980s, we now know that it is the highest levels of government leadership that are truly responsible for ensuring all stakeholders, from community members to health providers to religious leaders, are engaged and committed to making a change.

In Uganda, I was associated with the official launching of the Roadmap to reduce maternal mortality and newborn deaths in 2008. The Roadmap is Uganda’s comprehensive strategy for bringing all key stakeholders together to play their respective roles, each according to their comparative advantage. In this Roadmap, Uganda is very clear that its main focus of interventions will be antenatal care, safe deliveries under trained and skilled health personnel and improved human resources for health, along with family planning. Communities: Communities provide a level most critical to the improvement of women and children’s health because on a human level, members of a community understand the toll these issues can take on its families, as well as the communities and countries. In order to make a positive change in this arena, community participation is vital, namely because members must be committed to ensuring that key health interventions reach the women and children who need them. I have seen the benefits of community participation first-hand while travelling the country to mobilize and energize Village Health Teams (VHTs) and in my touring of hospitals which provided life-changing care for women suffering from obstetric fistula.

As we approach the review year 2015 for the MDGs, we do not have much time left. We in Uganda, as in so many countries around the world, continue to make some progress, but it is not enough. In Uganda, we still face many challenges, especially in the area of women and children’s health. I am counting on everyone to work together, in partnership, to ensure good health for Africa’s women and children.

I know the Government of Uganda is doing everything it can to put a stop to the needless deaths of women in pregnancy and childbirth. Just as when we were faced with frighteningly high levels of HIV infection in the 1980s, we now know that it is the highest levels of government leadership that are truly responsible for ensuring all stakeholders, from community members to health providers to religious leaders, are engaged and committed to making a change.
The visibility of maternal, newborn and child health (MNCH) on the global agenda has skyrocketed in recent years. The exponential rise in prominence of MNCH and the concept of the continuum of care can be traced to major health diplomacy and coalition-building efforts beginning around 2005. The Partnership for Maternal, Newborn & Child Health (PMNCH) was created in 2005 as the result of a marriage between the Safe Motherhood Initiative, Healthy Newborn Partnership and Child Survival Partnership. Since its inception as the global platform for aligning and harmonizing efforts to achieve Millennium Development Goals (MDGs) 4 and 5, aimed at reducing child mortality and improving maternal health, respectively, the PMNCH has played a crucial role in fostering collaboration across all major constituencies and raising the profile of MNCH on a national, regional and global scale.

Collaborative efforts in the 2000s among technical experts from developed and developing countries led to numerous high-level publications in the scientific literature highlighting the evidence of effective, low-cost interventions that, if brought to scale, could accelerate global progress towards MDGs 4 and 5. This evidence based advocacy, most notably the three separate Lancet series on maternal, newborn and child survival, compelled global leaders (such as the heads of state of Canada, Chile, Ethiopia, Norway and Tanzania) to become champions of MNCH. In addition, it contributed to efforts to position MNCH on the agenda of major political entities such as the G8, African Union, APEC.
A Global Network of Leaders was formed in 2007 to coordinate the activities of the heads of states committed to the improvement of MNCH. The Network was instrumental in increasing the visibility of MNCH on the global landscape and in generating additional financial resources for MNCH.

The Partnership for Maternal, Newborn & Child Health (PMNCH) was created in 2005 as the result of a marriage between the Safe Motherhood Initiative, Healthy Newborn Partnership and Child Survival Partnership.

Major political leaders responded to the call of the PMNCH and the global health community to make maternal, newborn and child health a global priority.

The Global Strategy for Women’s and Children’s Health launched in 2010 is an ambitious plan to save the lives of 16 million women and children by 2015 and has mobilized an unprecedented additional financial resources for MNCH.

The UN is actively encouraging stronger partnerships with the private sector to continue the movement forward for MNCH. In 2012, the United Nations launched a high-level commission to improve access to essential, but not yet widely accessible life-saving health commodities for women and children. The President of Nigeria and the Prime Minister of Norway will serve as founding co-chairs of the commission, which will also include global partners from the public, private and civil society sectors.

The events of the past seven years are a clear demonstration of the power partnerships plays in increasing awareness of and political will for MNCH. Realizing the opportunities for improving women’s and children’s health, put into motion by the Global Strategy and other global and regional activities, will require well-coordinated efforts that use the best available science. At the core of these efforts must be synergized partner collaborations, aimed at advancing the science, advocacy and financing necessary to improve the lives of women and children around the world.

GLOBAL HEALTH PARTNERSHIPS AND SOLUTIONS

and the Inter-Parliamentary Union (IPU).

One critical contribution to the elevation of MNCH on the political map was the launch, in 2009, of the Global Consensus for Maternal, Newborn and Child Health, in conjunction with the report of the High-Level Task Force on Innovative International Financing for Health Systems. The Global Consensus presents key pillars for action for women’s and children’s health and an estimate of the financing gap needed to meet MDGs 4 and 5. The consensus statement, coupled with greater recognition of roadblocks to progress (such as the human resource crisis and insufficient financing for MNCH) made it evident that a global platform for action was needed. In response, the United Nations Secretary-General issued a call for a joint plan for fulfillment of MDGs 4 and 5 in April, 2010. This call was followed by a series of high-level events featuring MNCH, including the joint Women Deliver/Countdown to 2015 conference, the G8 meeting with its flagship Muskoka Initiative spearheaded by the Canadian leadership, the African Union Summit, the initiation of the Campaign for the Acceleration of Maternal Mortality Reduction in Africa, and the G20 Summit. These events culminated in the launch of the Global Strategy for Women’s and Children’s Health by United Nations Secretary-General Ban ki-Moon in September 2010 at a United Nations General Assembly Summit.

The Global Strategy for Women’s and Children’s Health is an ambitious plan to save the lives of 16 million women and children by 2015. It has mobilized an unprecedented commitment of over $40 billion from heads of governments and states, the private sector, academics, NGOs, health care programs and UN Agencies. The PMNCH has taken a leadership role in the analysis of these commitments with its 2011 report entitled, “Analyzing Commitments to Advance the Global Strategy for Women’s and Children’s Health.” The report, which was released at the time of the 2011 UN General Assembly, coincided with the ‘one year on’ Every Woman, Every Child event and was designed to assess progress in realizing commitments in the first year.

The World Health Organization played a key role in the establishment of the Commission on Information and Accountability for Women’s and Children’s Health. The Commission’s report published in 2011, “Keeping Promises, Measuring Results,” echoes the recent resolution of the United Nations Human Rights Council in stressing the fundamental human right of all women and children to health, and includes 10 recommendations for action. These recommendations have been translated into an action-oriented work plan that has the potential to radically transform women’s and children’s health worldwide. An independent Expert Review Group was appointed by the Secretary-General in September 2011 to review annual progress in implementing the Commission’s recommendations regarding reporting, oversight and accountability in 75 priority countries.

The Global Strategy and the recommendations of the Commission on Information and Accountability for Women’s and Children’s Health have created considerable momentum for MNCH and a much overdue window of opportunity to achieve dramatic reductions in maternal, newborn and child deaths.

Concurrent with the stream of events resulting in the Global Strategy were other critical activities building political commitment for MNCH at global and regional levels. A Global Network of Leaders was formed in 2007 to coordinate the activities of the heads of states committed to the improvement of MNCH. The Network was instrumental in increasing the visibility of MNCH on the global landscape and in generating additional financial resources for MNCH. Political support also came from the IPU, which positioned MNCH as a key area of action for parliamentarians and approved an MNCH resolution at the IPU Assembly in Kampala in 2012. At a regional level, PMNCH’s work with the Pan-African Parliament resulted in resolutions in 2010 and 2011, calling for prioritized policy and budget action for MNCH. This high-level advocacy work elevated awareness of the importance of strengthening health systems, as well as contributed to the building of a consensus that MNCH indicators can serve as a proxy for assessing health system responsiveness. Although MNCH does not feature prominently in the Rio + 20 agenda,
Dr. Fred Sai’s Reflections on Advancing the Fight for Girls and Women

The distinguished Ghanaian physician Fred Sai has devoted his entire career to issues of health and reproductive rights. He is best known for drawing attention to the food and nutrition problems of Africa – particularly in connection to children – and is an internationally recognized authority on health, nutrition, population and family planning. He is the author of the memoirs, *With Heart and Voice: Fred Sai Remembers.*

In recent years there has been unprecedented momentum advancing the inextricably linked issues of maternal and child health. Initiatives such as the United Nations Secretary General’s *Every Woman Every Child* campaign, and new research, including the World Bank’s recent World Development Report on gender equality, highlight the need to improve the lives of girls and women for better child health outcomes.

Dr. Fred Sai’s Reflections on Advancing the Fight for Girls and Women

My friend and colleague Jill Sheffield has made a strong argument in these pages for family planning’s impact on the health of children. I would like to add to her comments three issues on which we should also focus to significantly advance progress: prioritizing maternal and reproductive health in the post-2015 development framework, including youth in all of our work, and developing a global ‘call to action’ for girls and women.

In 1994 I was honored to chair the Main Committee of the International Conference on Population and Development (ICPD) in Cairo. In 2000, the UN Millennium Development Goals, including MDG 5 to improve maternal health, were established. Today, as we near the ICPD and MDG ‘expiration’ dates in 2014 and 2015, respectively, we see that MDG 5 is the furthest behind in progress of all the MDGs. We must understand why this is the case and work together to ensure these lessons are learned. If not, we risk that future global development frameworks will neglect the salient.

As we look to the future, we must focus on young people who will lead the way and drive change. Their perspective, their experiences, and their willingness to ask tough questions offer the greatest hope for challenging the social norms and decades old policies that harm girls and women. When young people are engaged, informed and empowered, they can advocate for themselves and the need to invest in solutions that save the lives of girls and women.

To take on these tasks, we must continue to call in unison for programs, resources and strategies to improve the lives of girls and women everywhere. The Women Deliver global conferences are excellent examples of building political will and collective action. I co-chaired Women Deliver’s 2010 global conference, a gathering of more than 3,500 advocates, researchers, and experts from every sector and more than 146 countries. I look forward to meeting with even more of my compatriots at Women Deliver’s next conference in Kuala Lumpur in May 2013. The future is looking bright and I am eager to see what we will do together to continue our fight for girls and women. GHD
Climate Change

BY HONORABLE MARY ROBINSON
Former President of Ireland, President of Mary Robinson Foundation – Climate Justice and Chair of the Global Leaders Council for Reproductive Health

If someone were to ask me what the defining issue of our time was, I would answer the threat of climate change.

Climate change undermines the full enjoyment of basic human rights. It is an issue that should have particular resonance for the global health community, given the potential scale of adverse impacts that the human population is facing, and the diffuse and unequal distribution of those impacts.

In assessing the impact of climate change I would like to introduce you to the concept of climate justice. That is the issue which is the focus of my foundation, the Mary Robinson Foundation - Climate Justice (MRFCJ). Climate justice puts people at the center: it looks at the causes, the impacts and the solutions to the problem from a human perspective. Climate justice is fully informed by science but it communicates and relates solutions from the perspective of human needs and rights. Climate justice takes a human rights-based approach to combating climate change, while seeking equitable outcomes to protect the vulnerable and provide them with access to benefits arising from our transition to low carbon development. As such, it seeks equity in the way in which we deal with the negative impacts of climate equity in accessing benefits.

It is widely accepted that climate change will raise temperatures, change precipitation patterns and distribution of water, threaten biodiversity, raise the sea level, increase flooding and storm surges, threaten unique systems such as coral reefs, and cause large-scale ‘singularities’ such as the melting of ice shelves. These changes in the natural environment are increasingly causing human impacts: an increase in water insecurity and the time required to collect water; changes in agricultural productivity and food insecurity, with a loss of livelihoods, and effects on the wider economy. There are health risks, such as malnutrition, water-borne and vector-borne diseases and deaths from natural disasters.

Vulnerability to climate change impacts is not just a matter of geography. The Intergovernmental Panel on Climate Change defines vulnerability as “the degree to which a system is susceptible to, and unable to cope with, adverse effects of climate change, including climate variability and extremes. Vulnerability is a function of the character, magnitude, and rate of climate change and variation to which a system is exposed, its sensitivity, and its adaptive capacity”.

That phrase, ‘adaptive capacity’ is critical to understanding how people cope with the impacts of climate change. Adaptive capacity is dependent on wealth, planning, access to resources and technology, skills and know-how, and it varies between communities and countries. In general those with least adaptive capacity are the poor, those reliant on climate affected livelihoods, those who are already socially vulnerable and at risk, and those whose coping strategies are exhausted.

Climate change disproportionately impacts poor women and children as socially vulnerable members of society. When communities living in poverty are impacted by weather shocks–drought or flooding–it is women who try to hold them together and cope. When subsistence farmers are affected, we must remember that the vast majority of them are women. They live in a food insecure environment and yet, the right to food is one of the most basic rights of humankind. However, hunger remains unacceptably widespread while many systems of food production in use are simply unsustainable. I witnessed the terrible impact this has on women when I travelled with several Irish aid agencies to Somalia to see the situation there. Conflict, high food prices and drought combined to cause the UN to declare a famine. As with the floods last year in Pakistan, this indicated what a world impacted by climate change will be like. I felt a sense of anger and outrage that famine was being declared anywhere in the world in the 21st century.

There are 925 million men, women and children who are already food insecure in our world and with the world’s population set to reach 9 billion by 2050, we must address the issue of agriculture, food and nutrition security as a matter of urgency.

Climate change affects food and nutrition security and undermines efforts to reduce hunger and protect and promote nutrition. Furthermore, malnutrition affects the coping mechanisms of vulnerable populations and reduces their capacity to resist and adapt to the consequences of climate change. While agriculture is responsible for 14 percent of greenhouse gas emissions, it also has the potential to be an important part of the solution—but only if it is examined in a holistic way.

Integrating the gender dimension into nutrition and agriculture policies is a critical step to ensuring improved food and nutrition security. It is also important to remember other interrelated issues such as water, energy, land use, biodiversity, health and education. Poor and vulnerable women smallholder farmers don’t think in silos. They struggle to achieve their basic human rights and we should bear this in mind when discussing these issues. Ignoring or undervaluing the contribution of women restricts our potential for innovation and our capacity to act.

The empowerment of women is a cornerstone to mitigating the impacts of climate change. To enable this empowerment, we need to provide women with access to education and credit, active participation at all levels of decision-making, and the chance to have their contribution valued.

MRFCJ has been working to harness the power of women’s leadership on gender and climate change. We are building on work done over many years by the Global Gender Climate Alliance, (GGCA), Gender CC and other international and local networks, and encouraging the women ministers in the forefront of climate negotiations to join forces to ensure that the gender dimensions of all aspects under discussion (mitigation, adaptation, financing and transfer of technologies) are fully recognized and addressed in fora such as COP at Rio+20 and beyond. Through the Troika+ of Women Leaders on Gender and Climate Change and the Women Leaders on Climate Justice Network we are helping to raise awareness of the need for gender sensitive responses to climate change.

PHOTOS: MARY ROBINSON FOUNDATION
GLOBAL HEALTH PARTNERSHIPS AND SOLUTIONS

There is something remarkable happening right now in the field of global health: more so than ever, there’s a growing movement of young leaders who want to contribute to improving health outcomes around the world. According to a recent report by the Consortium of Universities for Global Health, the number of students enrolled in global health programs has doubled over the past three years and 70 universities have created global health programs to meet this growing demand. Despite tremendous desire, the challenge of turning interest into action has only recently found a means of resolution.

In 2008, five other young entrepreneurs and I created Global Health Corps to harness the passion and energy of our generation to confront the massive health challenges around the world. We knew that young leaders could make an impact in the field of global health today, while gaining skills to become future leaders tomorrow. In particular, we hoped that by engaging a new work force, we could do something about the critical shortage of healthcare professionals and on-the-ground workers, particularly in resource-limited regions.

As recent college graduates, we each had seen firsthand how the inspiring Teach for America model, now being spread across the globe through the Teach for All network, mobilized our generation to step up and address education disparity in the U.S. We aimed to create a similar opportunity—one that would engage young people at the beginning of their careers and show them that whatever skill set they possessed could be utilized just as much in the global health arena, as it could in any other field.

Global Health Corps (GHC) mobilizes a global community of emerging leaders to build the movement for health equity. In just three short years we have placed 126 fellows (from nine countries) in leading U.S. and East African public health organizations, such as Partners In Health, Clinton Health Access Initiative, and USAID. Our fellow class has expanded steadily each year—growing from just 22 fellows to 90 for our incoming 2012-2013 class. During this past application season, almost 5,000 young leaders applied—a record for GHC—proving, once again, that there is a surplus of young people who are eager to take action for health equity. This generation of twenty-somethings has a voice that they are now able to share in a powerful way—through a new framework of social and business networking.

From counseling homeless youth in Newark, New Jersey, to offering HIV-testing and education in Washington, D.C., to strengthening the drug supply chain in Neno, Malawi, to designing and building a district hospital in Burera, Rwanda, GHC fellows are making a consistent and much-needed impact in the field of global health.

GHC’s fellowship model is unique in that it is built on partnership. By joining forces with successful, existing organizations, our fellows can help increase the impact they are having on global health while learning from models that have already been tested. Whether in East Africa or the U.S., all fellows are placed on a team comprised of an international fellow and a national fellow—allowing for a true cross-pollination of ideas and creating an atmosphere that encourages global problem-solving. The new fellows who come through our doors are just setting out on their journeys as leaders in global health equity. Throughout the year, we provide them with professional development, mentorship, and leadership training so that they may also become great practitioners. We are committed to supporting our alumni as they pursue careers that contribute to this movement, whether directly or indirectly. The GHC community of alumni, staff, founders, partners and peer organizations works hard to foster an environment where individuals can learn to use their spheres of influence to affect greater change, whether it be through advocacy, policy or entrepreneurship.

Take, for example, Heena Patel and Evode Uwanyirigira, a fellow pair currently working for The Access Project in Rwanda. Heena grew up in Southern California and has...
a degree in Information and Computer Science from the University of California at Irvine; Evode, a native Kigalian, studied Finance at the School of Finance and Banking in Rwanda. As District Health Fellows, Heena and Evode spend everyday in the field, conducting visits to one of the 12 health centers they support within the District of Ngoma, located in the Eastern Province of Rwanda. Every day, this pair focuses on improving the management of the health centers in their district, across domains such as Finance, Human Resources and Infrastructure.

Through the diverse and complementary nature of their backgrounds and skill sets, Heena and Evode have been able to attain real results in their close work together. Remedying the impact of their work, Heena noted that in just the past 9 months of their fellowship they have seen “great improvements in the skills and leadership that have been transferred to health center staff. They are beginning to adopt electronic tools for managing finances, health information, pharmacy inventory and community health insurance enrollment. By making these facilities more efficient, the health center staff can improve quality of care and access to drugs to under-served communities.” For those living in the Ngoma District, The Access Project is transforming the way health centers are run—a transformation that began first in the hearts and minds of the next generation of leaders.

Both fellows knew that GHC was the vehicle for them to make this crucial impact. For Evode, the reasons for joining were personal, “I had always had the passion to serve my community as a way of giving back. I had also seen the misery that my country (Rwanda) had suffered from and felt that it was my time to give my contributions by using my skills to build a better world. I also wanted to gain and share more skills from other members of the movement who all share the same vision.” After meeting a GHC alum, Heena decided to join. Like Evode, she was craving a means to apply her drive and skill set to yield real results, “I wanted to be a part of a community of global health changemakers. I wanted to learn more about the challenges in global health delivery. I also wanted to understand how I could apply my technical skills in an organization that aims to improve healthcare access to resource-poor communities.”

Evode and Heena’s passion is matched by that of each of our GHC fellows and alums, whose drive both to lead and to learn in the field of public health is only amplified by the support of the community at GHC. “It takes a diverse group of changemakers with a shared vision to work together, to share stories and to advocate for health equity,” observed Heena. “As young leaders, I believe that we are all working within our own spheres to build upon knowledge and experiences which can, over time, transform into a greater movement.”

GHC fellows are a powerful and irreplaceable force in the movement for change because they are proud to identify themselves as leaders-in-training. It is the shared vision to work together, to simultaneously teach and to learn, that allows for real leadership to emerge and real solutions to materialize.

GHC’s fellowship model is unique in that it is built on partnership. By joining forces with successful, existing organizations, our fellows can help increase the impact they are having on global health while learning from models that have already been tested.
While significant progress has been made in reducing child mortality over the past 50 years, it is recognized that the progress is not equitable. In rich and poor countries alike, the poorest and most disadvantaged children and mothers continue to miss out on life-saving interventions. The next 1,000 days are critical. The achievement of Millennium Development Goals 3 through 6 will require intensified efforts at all levels. This includes increased political will at the international and national levels as well as an acknowledgment of the important role played by individuals themselves at the district, community and household levels.

As the world’s largest humanitarian organization, the Red Cross and Red Crescent movement is playing an active role in reducing vulnerabilities through its presence both in the last mile and in the most remote communities around the globe. Furthermore, the movement participates at global and national decision-making tables. The Red Cross and Red Crescent National Societies, as independent auxiliaries to their governments, enjoy a unique relationship entailing mutual responsibilities based on international and national laws. Thus, the Red Cross and Red Crescent National Societies are well positioned to advocate for the increased political will that will be necessary to ensure the world’s sustained commitment to child survival and women’s health. National Societies support the achievement of national health priorities, with a focus on ensuring that the poorest and most disadvantaged children and mothers are able to access life-saving interventions.

The Red Cross and Red Crescent’s 13 million volunteers, as members of their own communities, are familiar with their environments and know how best to bridge the social, cultural and other barriers that impede progress towards reducing preventable maternal and child deaths. Red Cross and Red Crescent volunteers extend health services beyond the health facility doors through innovative operational models that are culturally appropriate, cost-effective and sustainable. These volunteers have learned two important lessons from first-hand experience: (1) strengthening community action with innovative approaches ensures that health care reaches the most vulnerable, targets appropriate gatekeepers and crosses local barriers to uptake of health services; and (2) increased biological and community resilience is not something outsiders can accomplish or bring to individuals or communities. The starting point for any humanitarian or development support must be the recognition and appreciation of the efforts of individuals, households and communities to strengthen their own resilience. The Red Cross and Red Crescent fully supports the commitment governments made at the Busan High Level Forum on Aid Effectiveness in 2011, that “development strategies and programmes prioritise the building of resilience among people and societies at risk from shocks, especially in highly vulnerable settings.” It also supports their claim that “Investing in resilience and risk reduction increases the value and sustainability of our development efforts.” For example, most interventions related to maternal, newborn and child health focus primarily on improving women’s knowledge and practices to maternal health issues. However, in many societies women are dependent on the male members of the family to either accompany or permit them or their children to seek medical care. Hence it is pertinent that men and boys are aware of risk factors for both women and girls. Women as well as girls who are married early can face many complications during and after pregnancy.

These interventions which aim to build communities’ resilience and achieve improvements in maternal and child health need to involve the elders (both men and women), religious leaders and more specifically men and boys given their familial and social roles within communities in order to improve maternal and child health outcomes.

The world will stand accountable in one thousand days.
On May 25, 2012, Rwanda launched Africa’s first national rotavirus vaccination program with RotaTeq® (rotavirus vaccine, live, oral, pentavalent), Merck’s vaccine for the prevention of rotavirus gastroenteritis.

The first vaccinations included infants at a health center in Musanze district, Northern Province, Rwanda. Over the next year, the Government of Rwanda’s Ministry of Health expects that more than 100,000 children will receive the vaccine.

Rotavirus is responsible for more than 450,000 deaths worldwide each year, and most of these deaths occur in low-resource countries eligible for support by the GAVI Alliance. Recent cost effectiveness models have shown that vaccination against rotavirus in GAVI-eligible countries would prevent 2.46 million childhood deaths from 2011 to 2030. Two separate case control studies were conducted to assess the impact of the vaccine. The first showed 58 percent protection against severe disease over a one year period and the second showed 76 percent protection against severe disease over a two year period. Given the high burden of disease, launch of effective vaccines, and demonstrated cost-effectiveness, the World Health Organization recommended in 2009 that all countries include rotavirus vaccines in their national immunization programs.

In Rwanda, diarrheal infections rank third among causes of death in children less than five years of age. Nearly 22 percent of all Rwandan children aged six to 11 months and 25 percent of children aged 12 to 23 months suffer from diarrheal infections. Thus, working to reduce rotavirus disease in Rwanda represents a critically important public health goal.

The rotavirus vaccination program builds on a tradition of “firsts” in Rwanda’s innovative approach to public health including the Rwandan government’s comprehensive efforts to bring life saving vaccines to its people and to promote disease awareness. In 2009, Rwanda launched a national immunization program against pneumococcal disease, the first such program in a developing country. As stated by Dr Agnes Binagwaho, the Minister of Health of the Republic of Rwanda, Rwanda has also “declared war on cervical cancer.” In April of 2011, the Government of Rwanda, together with QIAGEN N.V. and Merck, announced the launch of a comprehensive national cervical cancer prevention program. The program is the first of its kind in Africa, and focuses on vaccinating girls 12 to 15 years of age as well as Human Papillomavirus (HPV) testing for women between the ages of 35 and 45. As described in the inaugural issue of Global Health and Diplomacy, Rwanda has launched a three-pronged initiative to tackle cervical cancer by: 1) vaccinating all girls between the age of 12 and 15 years against HPV; 2) offering cervical cancer screening to women at risk; and 3) providing timely diagnosis and treatment of women who have already developed cervical cancer.

In addition to facilitating the implementation of the rotavirus and HPV vaccination programs in Rwanda, Merck is proud to be a founding member of two other groundbreaking partnerships that have the potential to help protect the health of women and children in sub-Saharan Africa. Merck is contributing three million over three years to the Pink Ribbon-Red Ribbon initiative to help address both cervical and breast cancer in sub-Saharan African nations by supporting disease education, screening and treatment efforts, as well as increased access to cervical cancer vaccination in HIV prevention and treatment centers (http://www.state.gov/r/pa/prs/ps/2011/09/172244.htm). The goal of Pink Ribbon-Red Ribbon is to help reduce the number of women in Africa impacted by cervical and breast cancer and help increase access to breast healthcare and clinical exams in a number of African nations. The program will leverage the significant investments already made in the HIV/AIDS and infectious diseases infrastructure to deliver additional targeted resources for breast and cervical cancer disease education, screening, and treatment efforts. This historic initiative brings together the President’s Emergency Plan for
GLOBAL HEALTH PARTNERSHIPS AND SOLUTIONS

AIDS Relief (PEPFAR), UNAIDS, the U.S. government, Susan G. Komen for the Cure, the George W. Bush Institute, as well as a number of corporate partners. Merck also launched Merck for Mothers, a long-term effort to create a world where no woman has to die from complications of pregnancy and childbirth. The initiative will start with a ten year, $500 million commitment to helping the United Nations accelerate progress toward achieving Millennium Development Goal 5. Through investments in new products which may help stop hemorrhage, detect eclampsia, and/or improve access to family planning, Merck is lending its core strengths to the efforts of other global and local partners to improve maternal health.

About two years ago, the Wellcome trust and Merck announced the creation of the MSD Wellcome Trust Hilleman Laboratories (www.hillemanlaboratories.in). This joint venture marked the first time a research charity and a pharmaceutical company have partnered to form a separate entity with equally shared funding and decision-making rights. Pairing two of the world’s preeminent healthcare institutions provides an opportunity to integrate the best of both to drive the investment and expertise needed to develop and deliver vaccines to low-income countries. The venture’s vision is to create a sustainable, not-for-profit operating model to turn innovative science into practical solutions for those in greatest need. The first focus of the laboratory is to optimize current and/or pipeline vaccines for practical use in developing countries through measures to decrease production costs, decrease the need for temperature controlled supply chain that enhance pharmaceutical stability (cold chain requirements), and facilitate less expensive distribution.

Merck congratulates the Government of Rwanda for the launch of this important public health initiative and commends the GAVI Alliance and donor organizations, governments and partners for their commitment to protecting the lives of children from vaccine preventable diseases. Merck is proud to be a part of this and other innovative initiatives, and will continue to take on the challenge of providing affordable access to vaccines for the people who need them most.

REFERENCES


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A PROTECTED CHILD, EVERY MOTHER’S HOPE

Every mother’s greatest hope is for her child to grow up healthy and happy. Vaccines protect against killer diseases such as severe diarrhoea and pneumonia. The GAVI Alliance, a public-private partnership, works to protect children and give their mothers hope. Since 2000, the Alliance has immunised more than 320 million children. Find out more: www.gavi alliance.org

GAVI brings together developing country and donor governments, WHO, UNICEF, the World Bank, the vaccine industry in both industrialised and developing countries, research and technical agencies, civil society organisations, the Bill & Melinda Gates Foundation and other private and corporate partners.