Global health: paradigms, progress, priorities and partnerships

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INTRODUCTION

This symposium was not only about global health, but addressed a truly global audience. There were live web feeds to centres in Egypt, Sudan, Somaliland, Uganda, South Africa, Kuwait, Pakistan and India. The day started with a discussion of the current key issues in global health ('paradigms'); some of the success stories ('progress') were covered, and how to target research into the remaining challenges ('priorities'). Finally, 'partnerships' showed how stakeholders in different settings can collaborate to improve health outcomes.

SESSION 1 – PARADIGMS

We started with a discussion of the ongoing global threat from a familiar foe - infectious disease. Professor David Heymann (Head and Senior Fellow, Centre on Global Health Security, London) emphasised how easily infections such as influenza, severe acute respiratory syndrome (SARS) and more recently the Middle East respiratory syndrome (MERS) coronavirus outbreak[1] can spread across international borders. He stressed the importance of intergovernmental agencies working collectively to provide public health security. He argued that collaborating over global health is cost-effective both in the short (detecting and containing outbreaks early on) and long-term (improving health will eventually lead to lower birth rates and a stabilisation of population growth).

Dr Richard Smith (Director, United Health Chronic Disease Initiative, UK) also called for strong commitments from the United Nations (UN) and member states to tackle the growing challenge of non-communicable diseases. These are now the major cause of morbidity and premature mortality in low and middle income countries (LMICs) and include cardiovascular disease, diabetes, chronic obstructive pulmonary disease (COPD) and common cancers. The ways in which these are managed in high income countries are expensive and Dr Smith argued that we need to find new, cheaper ways to tackle them in LMICs. Methods might include increased utilisation of community health workers, legislation to make healthy lifestyle choices easier, and use of the polypill.[2]

Professor Joy Lawn (Professor of Maternal, Reproductive and Child Health and Director of MARCH Centre, London School of Hygiene and Tropical Medicine) demonstrated again that while high and low income countries often share the same problems, the burden of disease remains overwhelmingly in LMICs; 98% of the estimated 2.6 million stillbirths a year happen in these countries, and 1.19 million of these occur after women have gone in labour.[3] Effective interventions such as better obstetric care, higher use of folic acid, and treatment of malaria, syphilis and hypertension in pregnancy all exist. The challenge is to enable access to this care for the mothers who need it the most.

SESSION 2 – PROGRESS

Malaria is an example of how intensive research and investment can lead to improved health outcomes. Professor Sir Brian Greenwood (Professor of Clinical Tropical Medicine, London School of Hygiene and Tropical Medicine) showed that the number of deaths worldwide from malaria is falling, thanks to increased political and financial support for research, diagnosis and treatment. However, he stressed that major challenges remain, including predicted falls in funding due to the global financial crisis, and resistance to artemisinins in South-East Asia and to the pyrethroid agents used in insecticide-treated bednets in Africa. He warned that if pressure on the parasite and its vector falls, malaria will rebound.

Dr Mickey Chopra (Head of Health, UNICEF, New York) again highlighted progress made in recent years in reducing child mortality, in part due to reductions in deaths from malaria. However, he pointed out that the statistics hide lack of progress in some areas. In West

and Central Africa, for example, the absolute number of child deaths has remained static since 1990. He also showed that country level statistics mask profound inequalities between genders and different social groupings, with poor housing, rural location and poor maternal education all being risk factors for child mortality. Countries that have improved child mortality rates have often done so at the cost of increasing inequity, with widened disparities in mortality between the richest and poorest.[4] As with non-communicable diseases, expanding healthcare in a more equitable manner will require investment in primary care with increased use of community health workers.

SESSION 3 – PRIORITIES

In order to develop new treatments and understanding how to target these to local populations, research will be needed. Professor Igor Rudan (Professor of Global Health and Molecular Medicine, University of Edinburgh) described the recently developed Child Health and Nutrition Research Initiative (CHNRI) methodology.[5] This is a tool to generate, manage and prioritise research ideas. He argued that if used appropriately, it will help to reduce the inequities that exist in research into health problems in rich and poor countries.

SESSION 4 – PARTNERSHIP

The final part of the day covered ways in which health professionals in high and LMICs could work together to improve health outcomes in both settings. Ms Brenda Longstaff (Project Manager, Northumbria/Tanzania partnership, Northumbria Healthcare NHS Trust) talked about how the Northumbria-Tanzania partnership had delivered tangible benefits for both NHS and Tanzanian staff, and how in Tanzania, collaboration had led to improvements in all aspects of health care. Further talks from Dr Liz Grant (Deputy Director, Global Health Academy, University of Edinburgh), Ms Anne Mason (Senior Nurse Tutor, University of Edinburgh) and Ms Catriona Gorry (International Activities Manager, Royal College of Surgeons of Edinburgh) emphasised the benefits to both parties of international collaboration. They also highlighted the similarities in the challenges facing health systems in both settings: for example the difficulty of recruiting and retaining health professionals in rural areas, and the significance of social factors (for example easy access to alcohol in both Scotland and Ghana) in reinforcing pre-existing health inequalities.

TAKE-HOME MESSAGE

Despite recent advances, the global burden of communicable diseases remains high. In addition, that of the non-communicable diseases is rising. For all diseases distribution is inequitable, with the heaviest burden falling on the sectors of society who are least able to afford it. This symposium reminded us that it is in the interests of all involved to work collaboratively to implement changes where they are needed the most. Partnerships between organisations in high and low income countries, with local organisations setting the agenda, are becoming increasingly popular. However, as an audience member who worked for the World Health Organization (WHO) reminded us, there remains a need for coordination at an international level to minimise duplication of effort and promote a horizontal, rather than vertical, approach to solving global health problems.

REFERENCES

1 Coleman CM, Frieman MB. Emergence of the Middle East respiratory syndrome coronavirus. *PLoS Pathog* 2013; 9:e1003595. http://dx.doi.org/10.1371/journal.ppat.1003595

2 Thom S, Poulter N, Field J et al. Effects of a fixed-dose combination strategy on adherence and risk factors in patients with or at high risk of CVD: the UMPIRE randomized clinical trial. *JAMA* 2013; 310:918–29. http://dx.doi.org/10.1001/jama.2013.277064

3 Cousens S, Blencowe H, Stanton C et al. National, regional, and worldwide estimates of stillbirth rates in 2009 with trends since 1995: a systematic analysis. *Lancet* 2011; 377:1319–30. http://dx.doi.org/10.1016/S0140-6736(10)62310-0

4 Chopra M. Addressing health systems strengthening through an health equity lens. *BMC Health Serv Res* 2013; 13:s13.

5 Rudan I, Gibson JL, Ameratunga S et al. Setting priorities in global child health research investments: guidelines for implementation of CHNRI method. *Croatian Med J* 2008; 49:720–33. http://dx.doi.org/10.3325/cmj.2008.49.720