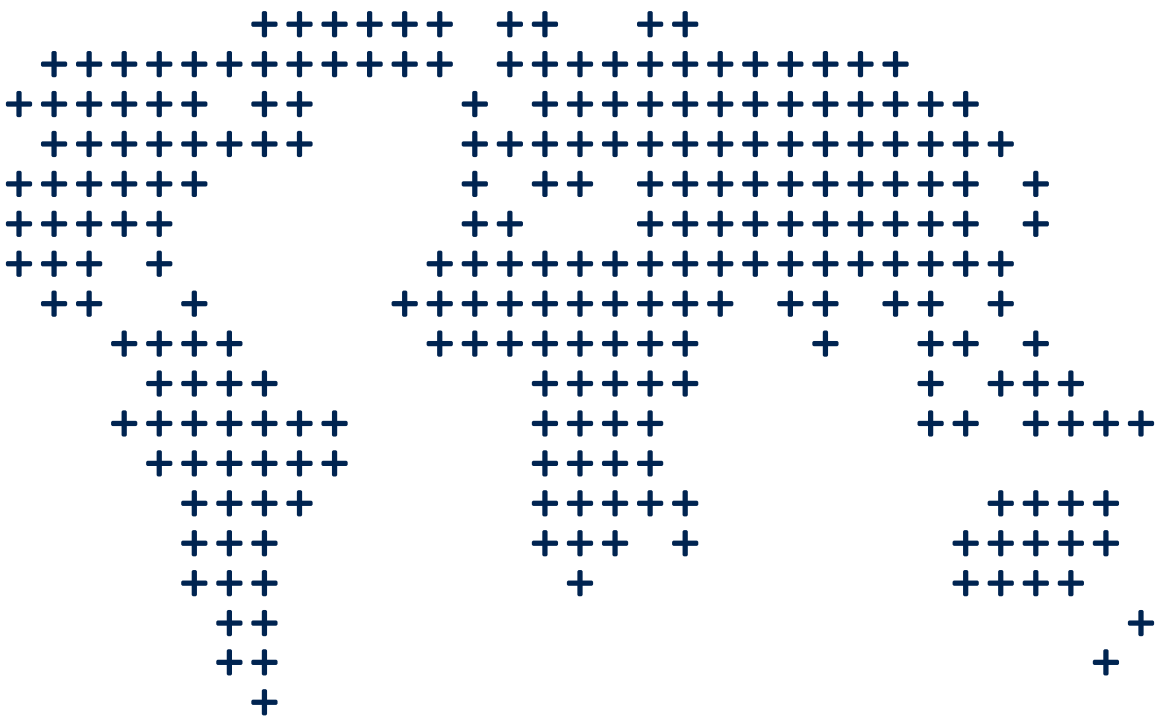
COMMONWEALTH HEALTH REPORT 2020



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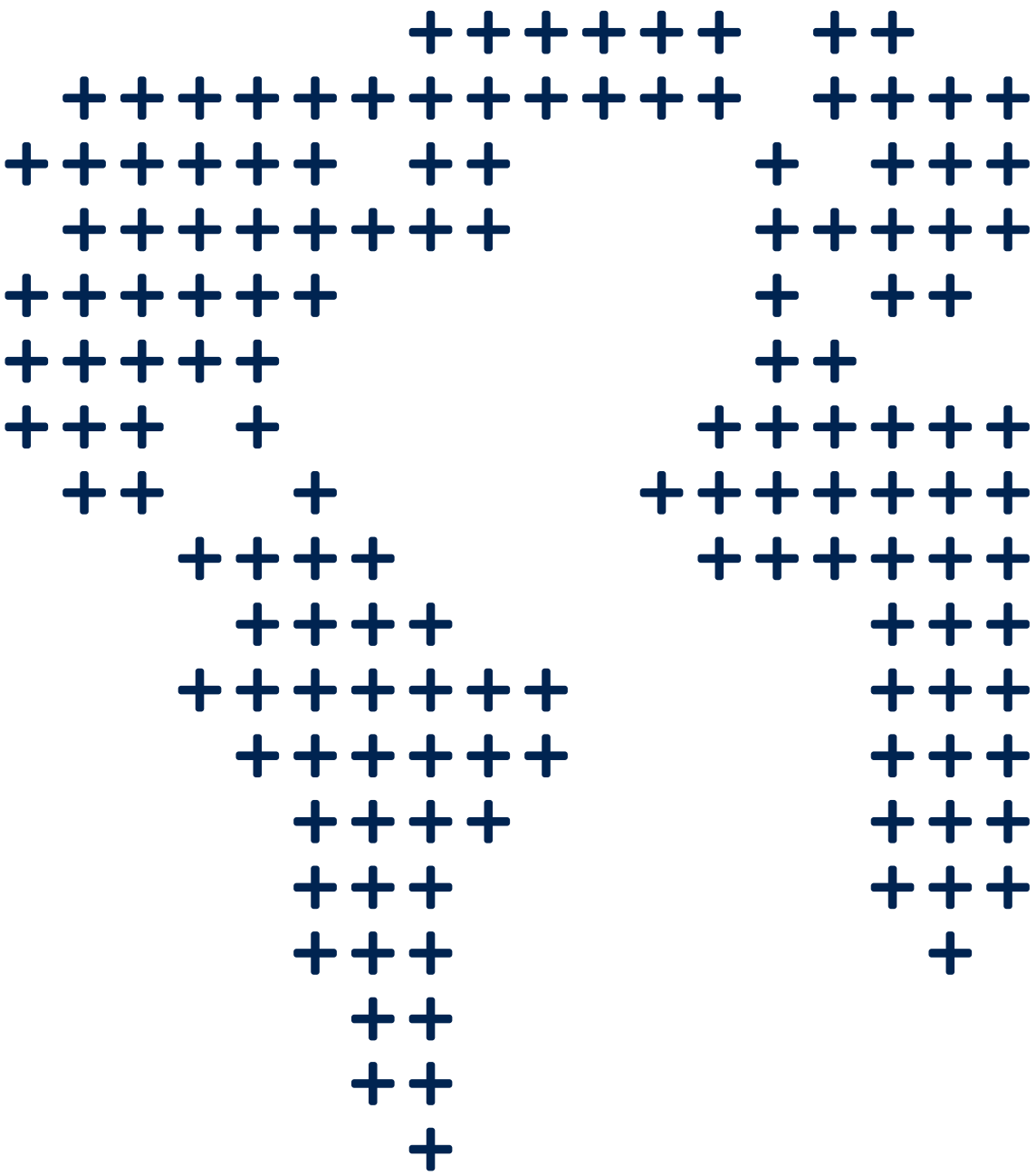

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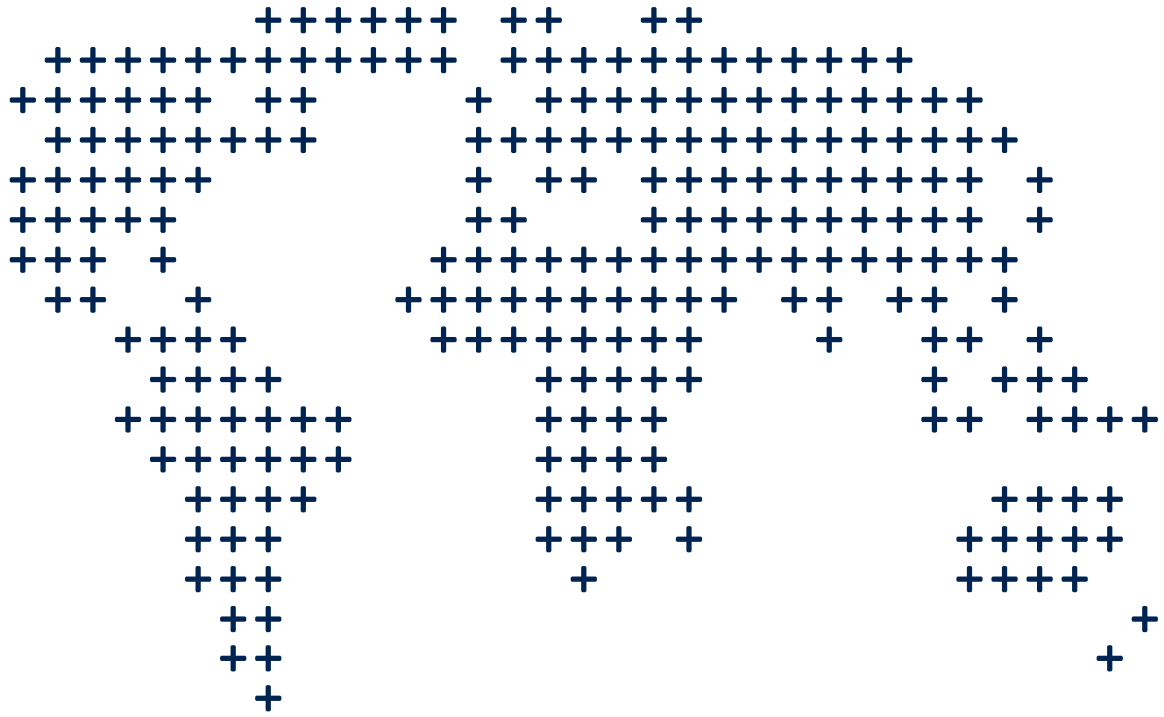

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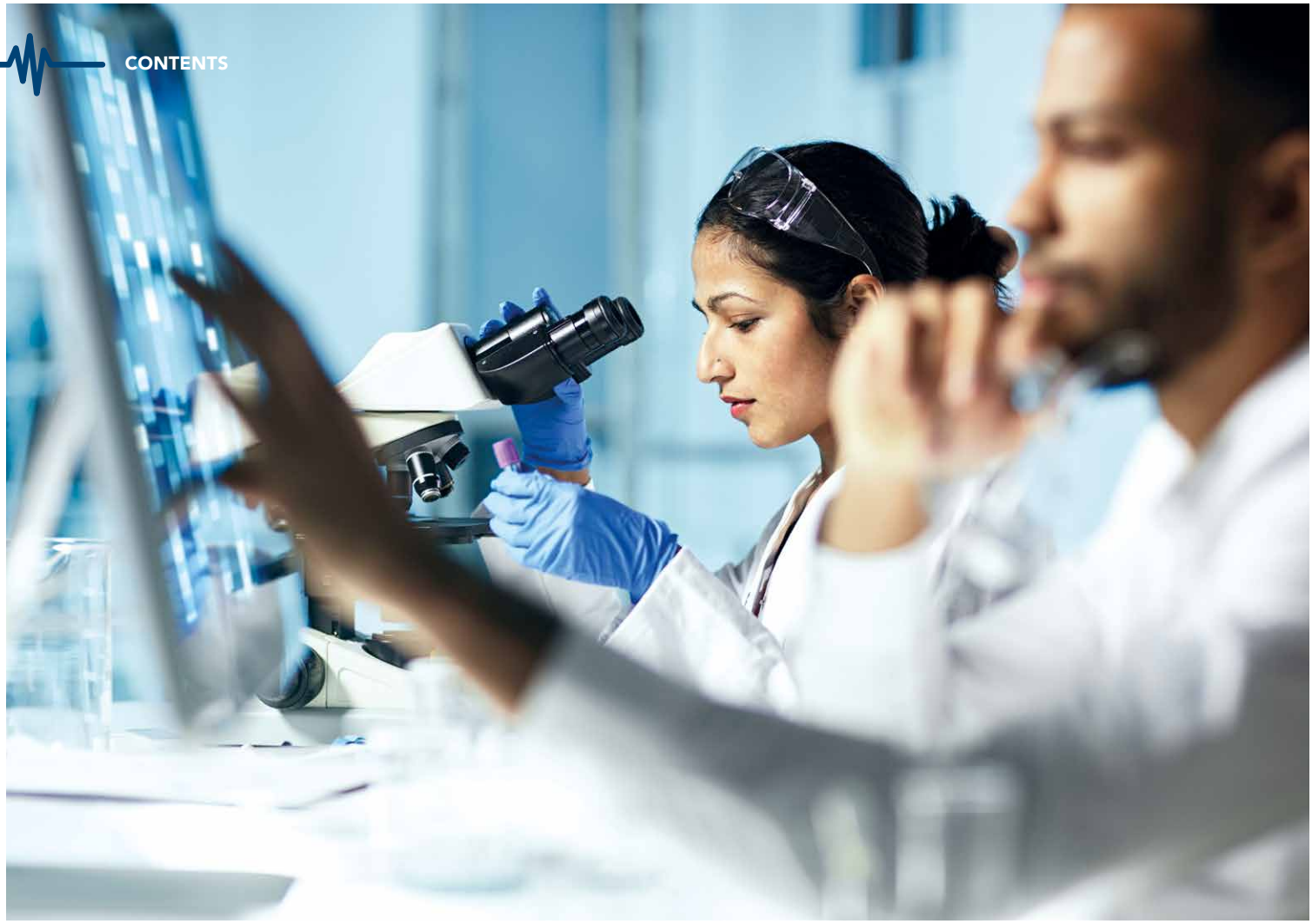
The Hon Dr Ifereimi Waqainabete, Minister for Health and Medical Services, Fiji



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"NCDs remain the largest cause of preventable morbidity and premature death in the Commonwealth."

Dr Ashley Bloomfield, Director-General of Health, New Zealand

"The international mobility of health workers, if appropriately governed and any adverse effects addressed, can deliver numerous benefits."

Professor Kathleen McCourt, President, Commonwealth Nurses and Midwives Federation

NMA
Nigeria Medical Association

INTERVENTIONAL STRATEGIC FLAGSHIP PROGRAMMES

Dr. Francis Adedayo Faduyile
President, Nigerian Medical Association

Since 1964, the Nigerian Medical Association (NMA) has been the umbrella professional body of all medical practitioners registered to practice in Nigeria, but accommodates also the Nigerian-trained doctors throughout the diaspora. It currently boasts of over 36,000 members across Nigeria and has abundant specialists in all fields of medicine and surgery, including Project Management Specialists. The Association's integrity, transparency, accountability and people-oriented approach to issues are catalysts to enduring strategic partnerships. Accordingly, the Association has a dedicated **National Strategic Project Management Unit (NSPMU)** that is well positioned to implement effective and evidence-based interventions to improve the health of Nigerians, including a drive towards Universal Health Coverage. The NSPMU is house at Plot 443, Zambezi Crescent, Maitama Abuja, Nigeria.
Our current flagship programmes include:

The ICON Project
(Improving the Cardiovascular-Health Of Nigerians)

The **NMA ICON Project** is the programming platform to support the implementation of the components of the World Health Organization's Global Action Plan on Non-Communicable Diseases on a broad scale across the country. The ICON platform commenced in 2018 with the ongoing implementation of the WHO-formulated REPLACE package, aimed at eliminating the consumption of industrially produced trans fatty acids in our national diet through a mix of prescriber actions, but with an emphasis on the National Policy Option. Other complementary actions include consumer awareness and enforcement of policies and regulations. It is our firm belief that working alongside industry regulators, and leveraging the appropriate partnerships, the ICON Project will see cardiovascular mortality traceable to NCDs reduce across the general population.

Project 5x3

This Project is targeting sustainable and affordable healthcare service delivery to Nigerians through managed care. It is a Project designed to support the public sector-driven efforts at achieving UHC in Nigeria by mobilizing and adding 5 million Nigerians to the pool covered by any form of insurance every 3 years. It shall play a **Third Party Administrator's** role in the Nigerian health insurance sector to ameliorate the **failure factors** of past experimentations to achieve UHC in Nigeria. It will be part of the public sector pool but providing a reliable GUARANTEE for the practitioners and their clients over the payment for services rendered. To this end, NMA is seeking partners with technical and material resources to help implement the Project.

RESCUE Project Network

This is a digital network of ambulances operated by the NMA nationally and it has various value chains in which other investors can operate, including the provision of optimally manned and equipped ambulances, digital connectivity and payment platforms. The market space for the services are enormous and we welcome partnerships on this Project.

ADAPT Project
('Advancing Greater Public Good through Policies')

The vision is to support the people of Nigeria to lead healthy, purposeful and economically-viable lives in a safe and sustainable environment. To do so, we hold the conviction that cost-effective citizen-level interventions are best undertaken through policies. We work in collaboration with the relevant Government regulators at all levels, and other civil societies, to drive various legislative and policy issues aimed at catalyzing the engendering of a political environment that is responsive to the rights of the people to good health. The Association mobilizes all relevant stakeholders across various sectors to champion public good through robust and people-centred policies as the leader of the sector. We welcome robust partnerships for this Project.

President Buhari receives the National Officers Committee of the NMA

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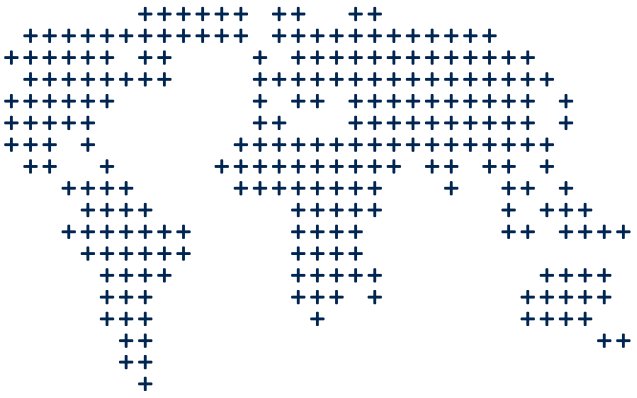

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Safeguarding for all in 2020

Dr Tedros Adhanom Ghebreyesus, Director-General of the World Health Organization (WHO), stresses that health is an essential component of global security and yet most Commonwealth countries remain unprepared for health emergencies. He calls for investment not only in emergency preparedness, but importantly, also in primary healthcare, for a healthier, safer and fairer world.

Dr Tedros Adhanom Ghebreyesus,
Director-General, World Health Organization

People often ask what keeps me awake at night. I answer without hesitating: pandemic flu.

While the current outbreak of coronavirus disease 2019 (COVID-19) has not, at the time of writing, reached pandemic status, it is a stark reminder of how large-scale public health emergencies can result in major loss of life and significant disruption to health systems, economies and societies. No one knows what the final bill will be for COVID-19, but it has already had a severe impact on China's economy, and on markets and industries globally. Other recent outbreaks teach a similar lesson: the 2014-16 West Africa Ebola epidemic reversed nearly five years of regional investment, gravely setting back the region's development prospects. The 2003 SARS outbreak led to estimated losses of more than $52 billion USD.

And yet, as a recent report of the Global Preparedness Monitoring Board highlighted, most countries remain unprepared for a pandemic, including Commonwealth countries.

Recently, several Commonwealth countries have seen cases of COVID-19, others have faced the risk of Ebola virus transmission, while elsewhere in the Caribbean and Americas, countries have been affected by tropical storms such as Hurricane Dorian. In Asia and the Pacific, many small-island states have experienced health emergencies caused by climate change, including extreme weather events.

There is an urgent need for all countries to increase their capacity for managing health emergencies, including disease surveillance, national laboratory systems and risk communications.

"My call to all Commonwealth countries is to invest in emergency preparedness, and above all in primary healthcare, for a healthier, safer and fairer world."

public health and beyond

Building preparedness to mitigate risk

'Keeping the world safe' has been a central part of WHO's mandate since its founding in 1948. More recently, strengthening the capacity of all countries for early warning, risk reduction and management of health risks was included in the Sustainable Development Goals, and is reflected in one of three main targets in WHO's 13th General Programme of Work – to see one billion more people better protected from health emergencies by 2023.

The primary instrument for assessing emergency preparedness is the International Health Regulations (IHR). Established in 2005, it is a legally-binding framework to which 196 countries and territories are signatories, and aims to prevent the international spread of diseases, while minimising disruption to international trade and travel. It requires countries to build and maintain their capacity to prevent, detect and respond rapidly to public health threats. It also requires multisectoral coordination for health security that transcends national borders. In addition to the IHR, countries have also adopted the Sendai Framework on Disaster Risk Reduction, a non-binding agreement to reduce the impact of disasters.

Regular monitoring of emergency preparedness is essential to ensure progress towards a safer world. Countries that participate in regular evaluations of their preparedness can identify points of vulnerability and take steps to address them. Such evaluations are also an opportunity to bring in additional partners and work together.

Health emergencies and disasters are driven by many factors. Population growth, increased international travel and migration and dense urbanization, all compound the risk for health emergencies. That's why global health security challenges cannot be solved without addressing their often complex underlying determinants, many of which lie beyond the health sector.

Multisectoral engagement is therefore key to ensuring that countries can build effective preparedness and meet the requirements of the IHR. For instance, the health of humans and animals is closely connected. As COVID-19 and Ebola both demonstrate, most emerging and endemic human diseases have their origins in animals. A shared responsibility and cross-sectoral collaboration must be strengthened between the human and animal health sectors to address zoonotic diseases and other threats at the animal-human interface. Governments need to work together across sectors to ensure health security, including financial contributions that can be provided both by the public and private sector.

To date, 64 countries have developed and costed National Action Plans for Health Security, but financing preparedness remains a challenge, despite the known economic risks of health emergencies. In many countries, cross-sector engagement between ministries of health and ministries of finance should facilitate joint goals of protecting communities and safeguarding national investments.

RIGHT:
Cross border disease outbreak simulation exercise reinforces preparedness in East Africa.

Credit: WHO/Light in Captivity

"Coronavirus is a stark reminder of how large-scale public health emergencies can result in major loss of life and significant disruption to health systems, economies and societies."

In early October 2019, WHO Director-General Dr Tedros visited devastated sites in the Bahamas to assess health impacts of Hurricane Dorian.

Universal health coverage – the goal we must all achieve

Ultimately, the greatest threat to global health security is the fact that at least half the world's population lacks access to essential health services, and that almost 100 million people are pushed into extreme poverty every year as a result of out-of-pocket health spending.

Many communities in both high-income and developing countries lack access to essential public health services and, too often, the health infrastructure is inadequate to support preparedness for emergencies.

These gaps leave entire populations vulnerable to fast-spreading viruses like COVID-19 that could quickly become a global health threat. At the time of writing, no cases of COVID-19 have been detected in low-income countries, but our greatest concern is the damage the virus could do if it started spreading quickly in a country with a weak health system. The best investment in health security therefore, is in resilient health systems, based on strong primary healthcare. Health security and health systems are two sides of the same coin. Evidence and experience show that universal health coverage is within reach for all countries, at all income levels. Ultimately, universal health coverage is a political choice.

Targeting investment for a healthier future

Disease outbreaks and other health emergencies are a fact of life and the world remains vulnerable. Commonwealth countries have been leading the way in demonstrating how effective health emergency and disaster risk management can reduce the threats and consequences of all types and scales of emergencies.

WHO is committed to working closely with the Commonwealth Secretariat to address health security challenges, enhancing progress across the Sustainable Development Goals, the Sendai Framework for Disaster Risk Reduction and the Paris Agreement on Climate Change, and in strengthening multisectoral collaboration to improve implementation of the IHR. Investing in preparedness is relatively inexpensive and affordable.

Investment in emergency preparedness doesn't just save lives; it saves money. The current Ebola outbreak in the Democratic Republic of the Congo (DRC) is a case in point. So far, at least $1 billion has been spent responding to the outbreak. By contrast, relatively modest amounts have been spent on preparedness in Uganda and other neighbouring countries.

Those investments have paid off. Although several people with Ebola crossed the border from DRC into Uganda, the government's preparations, with support from WHO and other partners, have prevented the further spread of the virus. This is a vital lesson that the world must heed.

Many countries have well-developed counterterrorism plans and conduct regular exercises to stress-test their readiness. But many are totally unprepared for an attack of a virus, which has the potential to be far more deadly, and far more damaging to their economy, as well as political and social stability.

If we fail to prepare, we are preparing to fail. Now more than ever, my call to all Commonwealth countries is to invest in emergency preparedness, and above all in primary healthcare, for a healthier, safer and fairer world. ■

Commonwealth health priorities:

Reaching the unreached, ensuring no one is left behind

Dr Ifereimi Waqainabete is Fiji's Minister for Health and Medical Services and was Chair of the 2019 Commonwealth Health Ministers Meeting. He outlines the commitments made by ministers at the meeting and reinforces the call for Commonwealth member states to accelerate progress in delivering universal health coverage and safeguard vulnerable populations.

The Hon Dr Ifereimi Waqainabete,
Minister for Health and Medical Services, Fiji

Bula Vinaka!

I was honoured and humbled to Chair the Commonwealth Health Ministers Meeting (CHMM) in Geneva on 19 May 2019, in which the health ministers of the 54 member countries, representing some 2.4 billion people, acknowledged the many challenges we now face, and re-emphasised the commitment of the Commonwealth towards the global goal of universal health coverage (UHC).

The theme of the meeting – Universal Health Coverage: Reaching the unreached, ensuring no one is left behind – was fitting at a time such as this, when many internal and external influences are threatening the health of our communities and, in some instances, the very existence of our people.

As I write, climate change – the greatest threat of our time to global health – is causing rising sea levels that eat away our shorelines, damaging coastal flora and fauna, while sea water penetrates into farming land and natural underground water reservoirs, threatening food and water security and pushing affected populations towards processed food and drinks. It is causing an increase in severe storms, flooding and adverse weather patterns around the world that threaten our ecosystems and economies. It is displacing communities, causing mental anguish, and contributing to unexpected weather changes that promote the presence and proliferation of pests and disease-carrying vectors, and the emergence and even re-emergence of climate sensitive diseases.

At the meeting, ministers acknowledged the diversity of the Commonwealth – which houses advanced economies as well as developing countries, some of which are island nations – and the progress each country has made. They noted with concern that half of the world's population is yet to have full coverage of essential health services, and that vulnerable groups including elderly, women, children, people living with disability, and members of displaced communities, are at the highest risk.

In terms of women's health, including mothers and babies, 40 per cent of pregnant women are not receiving early antenatal care, two thirds of women experiencing gender-based violence are not accessing any services, and many do not have access to sexual and reproductive health services. Neonatal and under five mortality averages are 18 deaths per 1,000 live births and 39 deaths per 1,000 live births respectively, which is still unacceptably high. Only 26 per cent of children living with HIV receive effective treatment.

The ministers were concerned that 1.1 billion people were reported to be living with mental health challenges and substance abuse disorders, and major depressive disorders ranked in the top ten causes of ill health in all but four countries worldwide. One billion people suffer from disability across the world, and one in six adults in developing countries are estimated to have a discernible disability that is too often associated with poverty and inequality.

On a personal level, as a surgeon, it is worrying to note that five billion people in the world still lack access to safe, affordable surgery and anaesthesia care, when needed, while an estimated 100 million people are pushed into extreme poverty because of healthcare expenses.

At the 2019 meeting, the Commonwealth Health Ministers recalled the policy options they had considered at the previous year's meeting, recognising progress made on the agreed actions, particularly the countries' achievements, experiences and lessons learned. We applaud those countries that have placed UHC implementation under the office of the Head of Government to give it the highest possible support, as well as the innovative ways that other communities have been engaged with to plan and deliver interventions that will accelerate UHC.

The health ministers noted the importance of each member nation in setting their own context-specific UHC goals, including an adequate sized, competent, knowledgeable and appropriately distributed workforce that is passionate and committed, to promote and protect the rights and dignity of all people

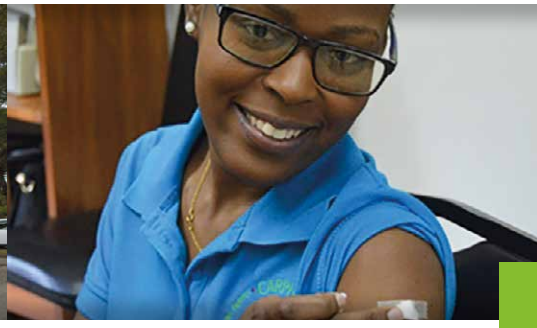
We must continue to advocate for greater collaboration and innovation, and leverage the convening power of the Commonwealth to accelerate progress towards UHC. This will ensure that we can bridge the gaps that restrict access to healthcare for our peoples, increase the range that health services cover, and include previously unreached population groups, without financial hardship to the individual or the family.

In health, we must leave no one behind! ■

"We must continue to advocate for greater collaboration and innovation, and leverage the convening power of the Commonwealth to accelerate progress towards UHC."

The Caribbean Public Health Agency (CARPHA)





According to the World Health Organization, Universal Health Coverage (UHC) means that all people have access to the health services they need, when and where they need them, without financial hardship.[1][2]Caribbean countries have uniquely defined UHC through their actions, as they were among the early implementers of the principles, outlined in the 1978 Declaration of Alma-Ata, investing in Primary Health Care (PHC) that improved access to basic health services.

Some notable achievements of the PHC system in CARICOM countries include:[3]

- Improved maternal and child health, the availability of contraceptive services, reductions in maternal and infant mortality, high levels of vaccine coverage and the elimination of polio, indigenous measles and rubella;
- Establishing a network of PHC facilities that provide access to essential services, medicines and technologies, as well as data on service delivery and quality; and
- Extensive opportunities for health education across the nations.

All of this occurs in an environment of economic loss from frequently occurring natural disasters, the high incidence and prevalence of Non-Communicable Diseases (NCDs) and the challenges of an ageing population.

The main funding arrangements for health in Caribbean countries are public, private and community measures, as well as funding from regional and sub-regional agencies. Direct out of pocket spending and private insurance payments remain mainstays of financing.

The equity gap is in danger of widening as health systems grapple with new and emerging health challenges, while the productivity of Caribbean populations has been undermined by the pervasive effects of NCDs.

A focus on PHC has and will continue to be essential, since this approach has greater economic value in the short and long term and results in more equitable access.[4] More specialised treatment programmes may benefit from being developed as regional public goods, as espoused in the Caribbean Cooperation in Health.

Several studies and assessments have demonstrated progress to UHC in the Caribbean. The 2018 KPMG publication reports on a survey carried out in nine Caribbean countries. The study identified three categories of countries: Those committed to UHC, 3 countries, designing, 7 countries and 9 classified as implementing and those expanding and improving progress for individual countries.[5][6]

These achievements have demonstrated better health outcomes, for instance the increase in life expectancy or the decline in mortality rates of children under five years of age.

CARPHA, as the uniquely Caribbean product, has a mandate which, by definition, supports affordable and sustainable Universal Health Coverage.

Environmental management and environmental health, improving access to quality essential medicines, provision of accredited essential laboratory services, an integrated surveillance strategy, tourism and health programmes, a healthy food environment, field epidemiology training, vector control, all work to ensure health systems are strengthened through CARPHA member states effectively applying competencies, adopting policies, standards and guidelines towards attaining Universal Health Coverage.

www.carpha.org

Dr. Joy St. John,
Executive Director

1. https://www.who.int/campaigns/world-health-day/world-health-day-2019
2. https://www.who.int/news-room/fact-sheets/detail/universal-health-coverage-(uhc)
3. https://www.who.int/health-topics/universal-health-coverage#tab=tab_1
4. https://www.who.int/publications/almaata_declaration_en.pdf
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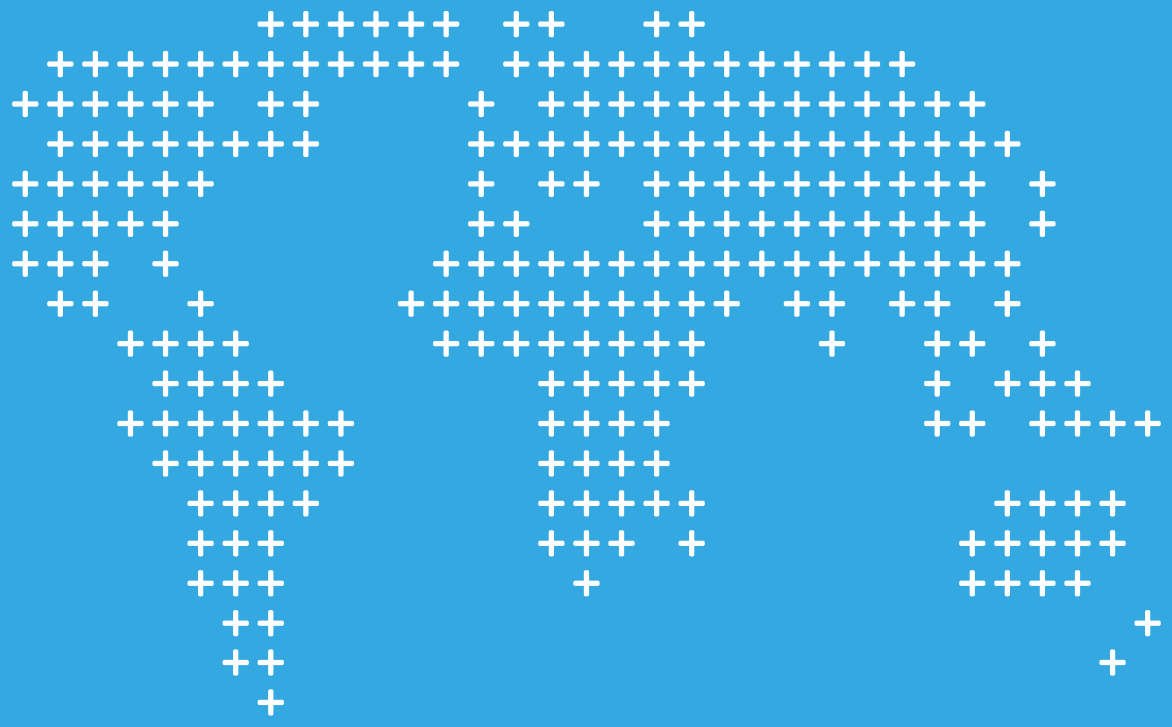
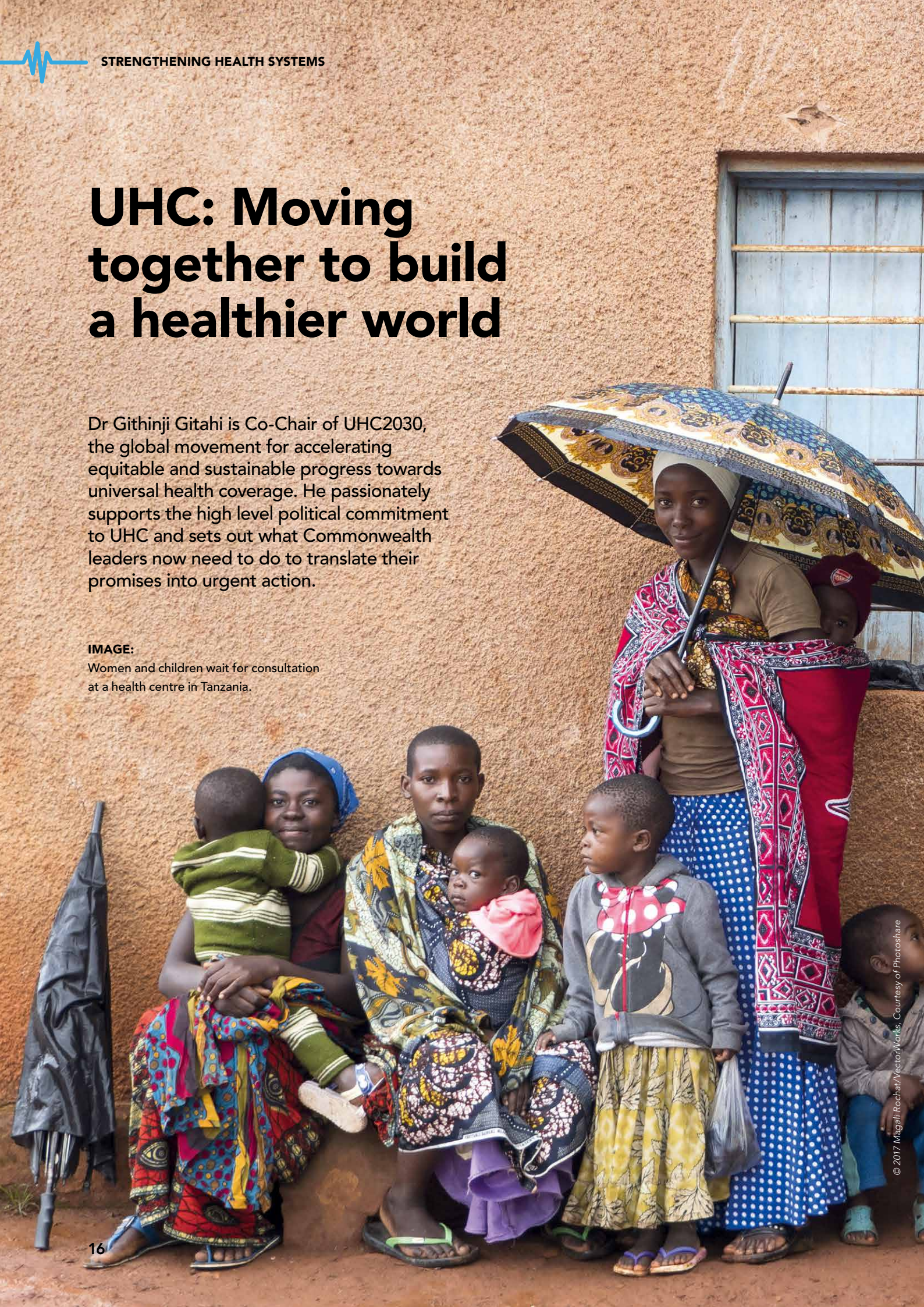
Strengthening health systems



UHC: Moving together to build a healthier world

Dr Githinji Gitahi is Co-Chair of UHC2030, the global movement for accelerating equitable and sustainable progress towards universal health coverage. He passionately supports the high level political commitment to UHC and sets out what Commonwealth leaders now need to do to translate their promises into urgent action.

IMAGE:
Women and children wait for consultation at a health centre in Tanzania.



Dr Githinji Gitahi,
Co-Chair, UHC2030 and
CEO, Amref Health Africa

Universal health coverage (UHC) is a political choice. From us in the global UHC movement to national leaders the world over, this message cannot be any clearer. All nations – including the 54 Commonwealth member states – have made the commitment to Sustainable Development Goal (SDG) 3 to ensure healthy lives and promote wellbeing for all at all ages. How then to translate this commitment into action at country level in meaningful and impactful ways is a political choice.

What does that mean? It means choosing to increase public financing for health and to remove retrogressive means of financing, like out-of-pocket payments. It means choosing to invest in primary health care and increasing that investment or reallocating existing resources by at least one per cent of GDP, as recommended by WHO. It means choosing to ensure equity so that everybody gets the health services they need and no one is left behind. It means choosing to create a strong regulatory and legal environment, with parliament ratifying UHC and approving a framework for allocating and tracking resources. It means choosing to strengthen transparency and accountability in health policy processes. It means choosing participatory governance mechanisms and ensuring social participation so that all voices, including those from the most vulnerable and marginalised groups, are heard. Finally, it means choosing to engage all stakeholders, including those beyond the health sector, to 'move together' to build a healthier society. This might seem like a lot of choices to have to make, but they are all crucial for countries to achieve UHC.

In all these actions, we must remember this is not just a one-way street for populations to benefit from healthcare. Health for all is an investment in humanity and wellbeing and prosperity for everyone. UHC has proven to be a catalyst for economic growth that benefits individuals, families, communities, businesses and economies. When it comes to choice, the decision should already be made.

Embarking on the UHC journey requires political will to ensure people's health as a social contract at all levels of development and making political choices in often controversial political contexts. It means bringing society together as an expression of solidarity between people who have the resources to pay and those who do not, people who are healthy and those who are not, people who are young and people who are old. Globally too, it is a social contract because present levels of funding for UHC are insufficient. There is a need for continued support from donors for health service provision in low- and lower-middle income countries and, on the other hand, creating favourable international trade environments so that these countries eventually raise adequate resources that can be channelled to health financing. The journey towards UHC implies redistribution, social justice and rights, ensuring that the most vulnerable and marginalised groups are included. And, it implies that the rights and the contributions of women are fully recognised.

Time to celebrate

Monday 23rd September 2019 in New York was a truly historic moment for UHC. The UN High Level Meeting (HLM) 'Universal Health Coverage: Moving Together to Build a Healthier World' was a hugely significant achievement for member states that reached agreement on a political declaration and reaffirmed their high level political commitment to UHC. It was also a time for celebration for everyone in the global UHC movement that has campaigned long and hard to get here. Most important of all, this highest level political commitment for achieving UHC holds life-changing potential for the 3.65 billion people who currently lack affordable and accessible quality health services, many of whom are living in the Commonwealth.

The UN Secretary-General António Guterres called it: "The most comprehensive agreement ever reached on global health – a vision for universal health coverage by 2030". Dr Tedros Adhanom Ghebreyesus, Director-General of the WHO, said: "Today we made history. Together we have committed to a world where no one misses out on quality health services because they cannot access or afford them". He added: "UHC is a political choice: today world leaders have signalled their readiness to make that choice".

With around 50 heads of state present during the UN HLM and 84 member states making statements during the plenary, world leaders have now agreed to take ambitious actions to institute UHC in their countries and are committed to strengthening primary health care. "Country leadership is critical. If leaders commit to building smarter, data-

"Move Together means moving the UHC agenda forward with all partners across and beyond the health sector, recognising that a 'whole of government' approach is needed."

driven, cost-effective health systems, they can deliver affordable, quality healthcare. They can build a healthier, prosperous, promising future for their people," said David Malpass, World Bank Group President.

The political declaration on UHC is important in two ways. Firstly, it makes a strong case for investment in health, and secondly, it sets the vision for achieving UHC by 2030. It suggests that robust and resilient primary health care systems will drive progress over the next decade on tackling communicable diseases, including HIV/AIDS, tuberculosis and malaria, while addressing noncommunicable diseases and the growing threat of antimicrobial resistance.

Time to act

Having made such high level commitment to UHC, it is now time for countries to keep their promises. Action is sorely and alarmingly needed. The 2019 UHC Global Monitoring Report warns that the world will need to double health coverage between now and 2030 to achieve UHC and that if current trends continue, up to five billion people will still be unable to access healthcare in 2030. Most of these people are poor and already disadvantaged. Data in the report indicated good news in that coverage of health services is increasing; but the bad news is that financial protection is not improving, and therefore coverage is expanding at the cost of catastrophic expenditure and impoverishment for millions. Over 930 million people spend above ten per cent of their household budget on healthcare and 210 million spend more than 25 per cent. Millions more end up in poverty as a result of seeking healthcare. It is clear that business as usual will not achieve SDG 3.

What actions and choices can country leaders take that will really make a difference to their progress towards UHC?

Include those who are 'left behind'

The UHC2030 Civil Society Engagement Mechanism (CSEM) responded to the 2019 UHC Global Monitoring Report with the observation that the report fails to specifically identify those that are most left behind yet it is these people that we need to focus on the most if we are to achieve UHC. "There is almost no data disaggregation by the key dimensions of equity, such as gender, age, wealth, ethnicity, disability, geographic location, fragile states and conflict situations, nor analyses of inequity due to factors that cause marginalisation such as migratory status, sexual orientation, gender identity or identification registration," says their commentary 'Leaving No One Behind: Delivering on the Promise of Health for All'.

Therefore, when UHC is designed and implemented, countries must have heightened awareness of their poorest and most vulnerable populations that are consistently missing out on the healthcare they need. Extending healthcare to all geographical areas, and touching the most marginalised and hard-to-reach populations, are essential to achieving positive health outcomes. Ensuring the right to health, including sexual and reproductive health for women and girls, is fundamental to equity.

Introduce legal and regulatory measures for UHC

UHC requires a sound legal and regulatory framework and institutional capacity to ensure the rights of people and to meet their needs. The role of parliamentarians at this moment, following on from the political declaration, is crucial in passing laws for UHC, approving a framework for implementation and allocating resources.

In October 2019, the 141st Assembly of the Inter Parliamentary Union adopted the landmark resolution 'Achieving Universal Health Coverage by 2030: The Role of Parliaments in Ensuring the Right to Health'. The resolution calls on parliaments and parliamentarians to "take all possible measures to achieve UHC", stressing the need for robust legal frameworks and to allocate adequate resources. Like the UN declaration, it highlights the importance of assuring strong primary health care, the provision of essential health services at the community level and strengthening health systems. This is another significant milestone in achieving UHC and another area where choices must be made.

Ensure accountability and social participation

All governments will be held accountable for their commitments under the political declaration on UHC. Member states will have to report back to the UN in 2023 on the progress they have made and citizens in countries around the world will be able to use the political declaration as a basis from which to hold their government accountable.

Social participation is vital to securing the human right to health and equitable progress for UHC. The added value of social participation is to ensure that marginalised voices are heard, which strengthens transparency and accountability in health policy processes. Participatory governance mechanisms are therefore vital for responsive, needs-based reforms that leave no one behind in pathways towards UHC.

Participation and citizens' voice are core principles of the SDGs, as reflected in target 16.7, to "ensure responsive, inclusive, participatory and representative decision-making at all levels". Several member states have established mechanisms for large scale population engagement, such as the National Health Assembly in Thailand, the Etats Généraux de la Santé in France and the Societal Dialogue for Health in Tunisia. Yet these remain the exception, as few countries systematically and meaningfully engage populations, communities and civil society in

health sector decision-making and review processes. Much more needs to be done around the world to ensure meaningful participation and harness better health outcomes to achieve UHC. There is a need for more work to advocate higher levels of public health spending, encouraging governments and development partners to implement progressive financing and observe aid effectiveness principles, as well as adopting more efficient procurement mechanisms.

'Move Together'

Since the beginning of 2019, UHC2030 helped prepare for the HLM through working with partners and a broader range of health stakeholders that collaborated to produce six Key Asks from the UHC Movement. This allowed the global UHC movement to speak with a common voice and send powerful and coherent messages to political leaders. Indeed, these messages are contained within this article and continue to be the foundation for what is needed to achieve UHC.

The sixth key ask from the UHC movement was 'Move Together' and never does that seem more appropriate than now, in the moments following the UN HLM, where sustained political and practical action is required to ensure that UHC is implemented in all countries. Move Together means moving the UHC agenda forward with all partners across and beyond the health sector, recognising that a 'whole of government' approach is needed to achieve and sustain UHC. Move Together means that disease-specific programmes are now sharing the same platform as those from the broader UHC movement, all for the common goal of achieving UHC. The implications of this are powerful, as every disease and every health issue is part of the political declaration on UHC – as we all work towards health for all, we all move together. Move Together also means involving

ABOVE:
A health worker measures a child in India.

"We know that UHC is an affordable dream because we have heard from countries that decided it was the only direction to take because they were poor."

LEFT:
A child receives a vaccination in a clinic in Mozambique.

"Achieving UHC is essential for inclusive development, prosperity and fairness."

all stakeholders in approaches to strengthen health systems. One exciting example is the UHC2030 Private Sector Constituency Statement on UHC, which highlights how the private sector can work together with other stakeholders to achieve better health and wellbeing for all people at all ages. This is detailed by the World Economic Forum in its article later in this report.

As the dust settles from the excitement of the HLM on UHC, we must now turn to the serious matter of implementing UHC. Health is the foundation for people, communities and economies to reach their full potential. Achieving UHC is essential for inclusive development, prosperity and fairness, and requires political decisions that go beyond the health sector.

UHC is primarily the responsibility of governments, which must ensure people's health as a social contract. What governments do next is crucial. Political leaders have a significant list of actions to take including: make laws for UHC and establish implementation frameworks; add one per cent of GDP or more on public spending for primary health care; ensure that the most vulnerable populations have access to affordable health services; and create participatory governance structures for better accountability. The world is watching.

Communities also have a critical role to play and must be at the centre of efforts to achieve UHC. Mobilising the necessary domestic resources to increase the public spending needed to achieve UHC is about taxpayers' money. We know that UHC is an affordable dream because we have heard from countries that decided it was the only direction to take because they were poor. There is ample evidence that UHC is technically and financially feasible. What is left is political will.

What remains to be done? Civil society organisations and communities play an important role in amplifying individual voices and connecting political leaders, policymakers and providers to the communities they serve, making health services more responsive to the specific needs of different population groups. It is also important to ensure that people can express their voice in policy making and how they want their money to be used, and hold governments accountable to deliver results. This HLM was a unique opportunity to secure social participation as a core principle of health system reforms. Now let's make our power count for UHC. ■

Universal health coverage in the Commonwealth

Dr Mbololwa Mbikusita-Lewanika, Health Adviser at the Commonwealth Secretariat, discusses the commitment of Commonwealth countries to achieve the health-related Sustainable Development Goals and outlines examples of best practice from member states that are making healthcare accessible to all.

Dr Mbololwa Mbikusita-Lewanika,
Health Adviser,
Commonwealth Secretariat

"Although good health is a human right, there are many challenges in ensuring that the most marginalised have access to quality health services and are not left behind."

The Commonwealth is committed to actively pursuing the attainment of the UN Sustainable Development Goals (SDGs), particularly as they relate to the health and wellbeing of Commonwealth citizens. The latter reflect and affirm the Commonwealth Charter's values and principles of promoting access to affordable healthcare, and removing wide disparities and unequal living standards. In particular this entails accelerating universal health coverage (UHC), strengthening health systems and addressing communicable and noncommunicable diseases (NCDs), as a means of securing a more sustainable future for Commonwealth citizens.

In 2012, the UN unanimously endorsed the goal of UHC. In 2019, the high-level meeting on UHC held at the UN General Assembly focussed on accelerating progress towards UHC, by seeking to 'garner financial and political commitments from countries and sustain health investments'. The resulting political declaration on UHC was endorsed by heads of state.

Similarly, the acceleration of UHC in the Commonwealth enjoys high level support and commitment. At the 2015 Commonwealth Heads of Government Meeting (CHOGM), heads reaffirmed their commitment to UHC, to addressing communicable and noncommunicable diseases, and to building resilient health systems in their countries. In 2018, they reiterated their commitment to achieving the health-related goals of the 2030 Agenda, particularly SDG 3, as well as to the associated principles and values of the Commonwealth Charter.

The importance of ensuring that UHC and addressing NCDs were central to the 2030 Sustainable Development Agenda was emphasised by Commonwealth health ministers in 2014, in their collective contribution to shaping the global consensus on the post-2015 development framework. Since then, health ministers, in their successive annual meetings (Commonwealth Health Ministers Meetings (CHMM)), have focussed on various aspects of UHC, including ageing and good health in 2015, health security in 2016, and sustainable financing and global security in 2017. In the 2017 meeting, ministers reaffirmed their commitment to UHC as a 'critical component of sustainable development and a key element of reducing social inequities'. In 2018, ministers focused on resource mobilisation for the global fight against NCDs, in the context of UHC. In 2019, they focused on one of the core values of UHC: 'reaching the unreached and ensuring no one is left behind'.

Indeed, through its Charter, the Commonwealth commits to reducing disparities and unequal

standards, which resonates with the UHC principle of universal access. Although good health is a human right, there are many challenges in ensuring that the most marginalised have access to quality health services and are not left behind. Those who are most often left behind include the poor, people with unpredictable incomes, those who have no power over household resources, as well as people that are geographically remote from main urban centres. Thus, groups such as women, older people, children and the disabled tend to be most disadvantaged when it comes to accessing quality health services.

The main challenges to access include poverty, user fees (official and unofficial) and social isolation, as well as barriers based on age, gender, religion, culture, geography and legal status. Additionally, inadequate quality and supply of care and services, as well as lack of effective community and individual participation in decisions, all undermine universal access. It is an uphill battle to overcome these challenges. Nevertheless, many Commonwealth countries have been making commendable efforts in accelerating UHC, through investment and planning.

The UK has been providing health services that are free at the point of delivery since 1948, when the idea of free, quality healthcare for all was a radical one! Several countries in the Commonwealth followed the UK's lead in developing their own systems offering free access to care. Sri Lanka has been providing universal, publicly financed healthcare to its entire population since 1951. Tuvalu has done so since independence in 1978, and has since achieved 99.9 per cent health coverage for its population. Despite economic challenges, Malawi has also provided free public healthcare to its people since independence and has been resisting pressure to charge user fees. Thus, while the global community only passed a UN resolution on UHC in 2012, the essential concept is not new

ABOVE:
The UK has been providing health services that are free at the point of delivery since 1948. The National Health System (NHS) is still ranked among the best healthcare systems in the world.

"These different examples from across the Commonwealth demonstrate the importance of sharing best practice around different approaches to making healthcare accessible."

RIGHT:
The 2019 Commonwealth Health Ministers Meeting focused on one of the core values of UHC: reaching the unreached and ensuring no one is left behind.

to many Commonwealth countries.

Although the UK's National Health Service (NHS) is currently facing challenges, particularly in meeting the needs of an increasingly ageing population and their related NCDs such as cancer, heart disease, respiratory disease and diabetes, the NHS is still ranked among the best healthcare systems in the world. Other shining examples of UHC implementation in the Commonwealth include Sri Lanka, which has been outperforming other countries at the same level of development, in increasing coverage of essential health services and protecting its people from the costs of these services. Its maternal mortality rate, for example, is lower than some states in the USA, which is 15 times richer than Sri Lanka. Additionally, Sri Lanka has eliminated malaria and was certified malaria-free by the WHO in 2016.

Kenya recently established an insurance scheme that entitles all pregnant women to a defined package of care, including four antenatal visits, delivery and postnatal check-ups. Under this 'free maternity insurance cover for poor women', the government will pay 6,000 Kenyan shillings directly to a healthcare facility for each woman, thus expanding services for the poorest women.

The acceleration of UHC in Kenya greatly benefits from the highest political commitment and action – ensuring affordable healthcare for all is one of President Uhuru Kenyatta's 'Big Four' legacy agenda items. Indeed, progress towards UHC delivery mainly depends on political will. Rwanda has prioritised UHC by allocating 20 per cent of its state budget to health and by subsidising its national health insurance system, resulting in an 80 per cent reduction in the child mortality rate since 2000, while Malawi was one of the few low-income countries to achieve the child mortality Millennium Development Goal. Caribbean countries have made much progress towards UHC and the dividends are evident in their citizens living longer and healthier lives.

Other Commonwealth countries benefitting from the highest political commitment and action towards UHC implementation include South Africa, where a 'war room' has been set up in the office of the president, to 'oversee and push forward an ambitious strategy to unify and integrate the health system, and to push through the National Health Insurance Bill that will ensure that healthcare is delivered free at the point of need, in all public health facilities, as well as accredited private ones'.

Zambia's implementation of UHC has benefitted greatly from the highest level of political commitment for the National Health Strategic Plan goal of 'improving the health status of people in order to contribute to increased productivity and socioeconomic development'. The high level political commitment is also accompanied by a desire to transition from external support. Inspired by Prime Minister Narendra Modi, and in an effort to scale up healthcare to the poorest and most vulnerable, in 2018, the Indian Government launched the world's largest national health protection scheme 'Ayushman Bharat (ModiCare)', covering 500 million people.

Australia and Rwanda – Commonwealth countries at different stages of development – are close to eliminating cervical cancer, both demonstrating the value of turning political commitment at the highest level into action.

In the Pacific, Tuvalu operates centrally funded government health facilities providing free healthcare to all. Legislation bars the establishment of private health services across the island, as health is deemed to be the full prerogative of the government. In response to the NCD crisis in the Pacific region, Vanuatu has a village health worker programme, which embeds them into the health system with support and monitoring, so that they are linked to formal services.

These different examples from across the Commonwealth demonstrate the importance of sharing best practice around different approaches to making healthcare accessible and organising its funding. The Commonwealth Secretariat health programme enables such experience-sharing and supports the efforts of member countries through facilitating collective Commonwealth action and consensus, as well as the development of an information and price-sharing database for essential medicines, vaccines and health technologies and the development of a UHC Financing Toolkit. ■

CAAM-HP
Caribbean Accreditation Authority For Education In Medicine and Other Health Professions

CAAM-HP

THE ESTABLISHED AND RECOGNISED ACCREDITATION AUTHORITY

After fifteen years of existence, The Caribbean Accreditation Authority for Education in Medicine and Other Health Professions (CAAM-HP) has firmly established its relevance and importance as the body, legally empowered under the aegis of the Caribbean Community (CARICOM), to determine and prescribe standards and to accredit programmes in education of medical and other health professions in the Caribbean.

As more and more medical schools have set up business in the Caribbean, the demand for the services of CAAM-HP as the principal means of providing quality assurance has grown, including from non-English speaking Caribbean countries. Medical Schools on the Dutch islands of Aruba and Curaçao are already on board and, prior to the signing of an MOU with the Government of the Dominican Republic, one such School had already gained accreditation. At present, six others are preparing their self-studies as the first step in the process.

INCREASE IN DEMAND FOR CAAM-HP SERVICES

Since the 1970s, medical education in the Caribbean has experienced a significant change with the establishment of medical schools outside of the flagship University of the West Indies Medical Faculty, for example at the University of Suriname in 1969 and the University of Guyana in 1985. And, since the start of the millennium, it is estimated that there has been a 40% growth in medical education throughout the Caribbean region – a virtual explosion, in fact, since data from the **International Medical Education Directory** indicates that there are now over 30 offshore medical schools operating within the English speaking Caribbean, for the most part catering for US students.

Additionally, researchers from the **Foundation for Advancement of International Medical Education and Research** (FAIMER), in an overview of medical schools globally, reported in 2007 that the Caribbean region has a higher density of medical schools per capita – with 1.42 medical schools per 1 million inhabitants – than any other region of the world! Some of the factors influencing the increasing number of US citizens attending medical schools outside their country with the intention of returning home to obtain licensure include:

- Lower tuition fees
- Proximity to the US
- English being the language of instruction
- Flexibility of the academic calendar, with more than one intake per year
- Fulfilling the dream of qualifying as a medical doctor from a quality programme

Following the 2010 announcement by the **Educational Commission for Foreign Medical Graduates** that, effective from 2023, medical graduates applying for their certification will be required to graduate from a medical school which has been appropriately accredited, the **World Federation for Medical Education** (WFME), in collaboration with FAIMER, developed a ***Programme for Recognition of Accrediting Agencies*** and invited CAAM-HP to participate in the inaugural pilot process for evaluating and recognising agencies that accredit undergraduate medical education programmes, using globally accepted criteria.

Utilising the criteria for WFME Recognition, CAAM-HP submitted the completed 'Application for Recognition' in January 2011. The application process was exceptionally rigorous and called for an evaluation of the institution's documentation, procedures, strengths and weaknesses. With the application submitted, members of the WFME and FAIMER decided to visit to review our documentation and

"The mission of CAAM-HP is undergirded by the principles of professionalism, integrity, accountability, transparency and collaboration"

CAAM-HP and the Minister of Higher Education, Science and Technology, Dominican Republic, sign MOU, May 2019

Signing on behalf of CAAM-HP were Professor Emerita Marlene Hamilton, Chair (right) and Mrs Lorna Parkins, Exective Director (left). Signing on behalf of the government was Doctora Alejandrina Germán Mejía, Minister of Higher Education, Science and Technology (centre).

our procedures. By chance, the joint WFME and FAIMER team's visit coincided with an upcoming CAAM-HP survey team site visit and they were therefore able to observe the standards and procedures of CAAM-HP in action.

The WFME and FAIMER team accompanied our team of surveyors, sat in on their discussions and observed all the processes utilised by CAAM-HP. The result was that CAAM-HP became the first accrediting agency to achieve WFME recognition, effective for a period of ten years, which indicated that CAAM-HP's documentation and procedures were deemed to adhere to the highest accreditation standards.

The achievement of our '**Recognition Status**' did not mean that the Authority sat on its laurels. In fact, CAAM-HP has become more aware of its strengths and weaknesses as a result of the process and has worked to further improve in the areas identified by the WFME and FAIMER team in its initial report. The achievement of Recognition Status augurs well for our student stakeholders as well, since they would qualify for ECFMG certification upon graduation, allowing them to practice in the USA. Additionally, the Recognition Status placed CAAM-HP in a premier role as an internationally recognised accrediting body.

There are challenges, which CAAM-HP must and will overcome, such as finding an efficient way of dealing with the scheduling of site visits, given the multiplicity of affiliated clinical sites that must be assessed in each cycle. Consideration is being given to strengthening the capacity of our Secretariat to undertake the numerous visits. However, we remain exceedingly grateful for the commitment and dedication of our current pool of excellent site visit team members, without whom the Authority could not function.

ABOUT CAAM-HP

The Caribbean Accreditation Authority for Education in Medicine and other Health Professions (CAAM-HP) was established in 2003 under the aegis of the Caribbean Community (CARICOM), empowered to determine and prescribe standards and to accredit degree level programmes in medicine, dentistry, veterinary medicine nursing and other health professions offered by schools in the participating countries of CARICOM, thereby ensuring that these programmes are recognised nationally, regionally and internationally as being of the highest standard. Upon request, CAAM-HP also assesses education programmes for the purpose of accreditation, of schools in Caribbean countries outside the CARICOM framework, including the Dutch Caribbean and the Dominican Republic.

Membership of the Authority is multi-disciplinary, with representatives from the universities throughout the region – including senior faculty and students, the contracting parties, civil society, professional associations and external professionals with the relevant expertise in and knowledge of the accreditation and administration of the education programmes.

www.caam-hp.org

Who should pay for universal health coverage?

Graça Machel, Deputy Chair of The Elders, argues that delivering publicly financed healthcare is a political choice and challenges leaders to invest in their people's futures and ensure an equitable route to universal health coverage across the Commonwealth.

Graça Machel,
Deputy Chair, The Elders and former Education Minister, Mozambique

The Commonwealth embodies a huge range of experiences and lessons in moving towards universal health coverage (UHC). Some countries are nearer that goal than most, but at all income levels, there are some shining examples of Commonwealth countries outperforming their peers.

In South Asia, Sri Lanka has provided universal, free, publicly financed healthcare to its entire population since 1951 and, as a result, has achieved great success in improving health outcomes. Its maternal mortality rate is lower than in some states in the USA – which we all know, has yet to achieve UHC despite being 15 times richer than Sri Lanka.

In my own continent of Africa, the Commonwealth's newest member, Rwanda, has given a very high priority to extending health coverage by allocating 20 per cent of its state budget to health, and has massively subsidised its national health insurance system. As a result, the child mortality rate here has reduced by 80 per cent since 2000.

Another example of success is Malawi. I have seen first-hand, how despite economic challenges, the country has managed to provide free public healthcare to its people since independence, resisting pressure to charge healthcare user fees.

But other countries in the Commonwealth are still far away from achieving UHC. Six of the ten biggest countries in the world by population fail to provide effective health coverage to large proportions of their people. Four of these are Commonwealth countries: Bangladesh, India, Nigeria and Pakistan. In every case, these countries allocate less than 1.5 per cent of their gross national incomes to public health spending, and three of the four lowest spenders in the world are Commonwealth member states.

We may have reached a global consensus about the goal of achieving UHC, but there is no such agreement on how to get there. According to the accepted definition of UHC, we should ensure that everyone is covered, with healthcare benefits allocated to needs, and the health system financed according to people's ability to pay. Governments should also prioritise services for high-need groups, including: women, girls, adolescents, the elderly, disabled people, the terminally ill and those with chronic health conditions, including noncommunicable diseases.

It is now well known that healthcare user fees are the least efficient and most inequitable way to finance a health system. The provision of essential health services is an obligation of the state, and governments have a responsibility to provide the fundamentals for their populations. Citizens should not have to pay from their own pockets to enjoy the basics for their wellbeing and dignity.

"We may have reached a global consensus about the goal of achieving UHC, but there is no such agreement on how to get there."

High levels of out-of-pocket health spending, which are as high as 72 per cent of total health expenditure in some Commonwealth countries, make it impossible to achieve SDG 3 and represent a threat to global health security. The fact that some countries are underfunding their health systems is not only inhibiting their own progress to UHC, but they are shirking their responsibilities, and this also threatens to undermine health improvements across the Commonwealth and the world.

Another dire consequence of out-of-pocket health financing is that it plunges tens of millions of Commonwealth citizens into poverty – including 64 million in India alone. It also results in tens of thousands of poor people being detained in health facilities because they cannot pay their hospital bills. Most of the victims of these illegal imprisonments are women and babies who needed emergency caesarean sections to save their lives. These detentions represent a gross violation of the human rights of the victims. In the 21st century, there is no justification whatsoever for hospitals to operate as debtor prisons!

Unaffordable user fees also force people into the unregulated private sector and, in particular, into buying medicines over the counter in drug shops. This often results in people receiving inadequate doses of medicines or inappropriate or fake medicines, and can have disastrous consequences for the health of individuals and for the long term health of populations through increased antimicrobial resistance.

Governments must have the courage to approach healthcare differently, bringing the public and private sector together to align around the provision of UHC.

Furthermore, in maximising efficiency and equity in public health spending, we should focus on scaling up the provision of primary care services over costly specialist services in tertiary hospitals.

It is perfectly feasible for a developing country to provide a package of publicly financed health services to the entire population, especially if the benefit package focuses on primary care. Sri Lanka has been doing this for decades and has been joined by countries like Fiji, Malaysia, the Maldives and Rwanda in recent years. It is not an economic constraint that determines which route a country takes; it is a political choice.

Some members of The Elders have been heads of state and led UHC reforms themselves, so appreciate its vital importance for the welfare of their people. This was also the experience of the group's founder, Nelson Mandela, whose first major social policy when coming to power in 1994, was to provide universal free healthcare for all pregnant women and young children in South Africa.

I believe that the National Health Insurance reforms proposed by South Africa's President Cyril Ramaphosa can complete Madiba's work and bring UHC to the entire South African population.

The overarching mantra of the SDGs is to 'leave no one behind', and in terms of UHC, this applies above all, to vulnerable groups like women, girls and adolescents.

Global leaders, policymakers and influencers recently met in Nairobi to mark the 25th anniversary of the ground-breaking International Conference on Population and Development in 1994.

The Nairobi Summit took place at a time of critical importance for sexual and reproductive health and rights. Ideologically driven forces are seeking to roll back hard-won gains, to slash funding for essential services, and to remove references to these services and rights from international agreements.

At a time when there is a growing political momentum in countries to provide universal quality healthcare for all, we must ensure that the full panoply of sexual and reproductive health interventions are included in national health plans, with the financial resources to back them up.

Millions of women across the world are still denied autonomy over their own bodies, including access to sexual and reproductive health services, to enable them to control whether or when to have children.

UHC is a matter of universal human rights. Across the Commonwealth and across the world, we should work together to hold our leaders to account, and take responsibility for our own actions as global citizens.

Together, we can deliver health and human rights for all and make sure no one is left behind. ■

The Elders are a group of independent global leaders, founded by Nelson Mandela in 2007, who work for peace, justice and human rights. Further information can be found at: www.theelders.org

Seven ways the private sector can contribute to UHC

This dynamic article is based on the Statement by the UHC2030 Private Sector Constituency (hosted by the World Economic Forum) and outlines specific and effective steps that the private sector can take to help bring equitable access to quality healthcare for all by 2030.

Dessislava Dimitrova,
Head of Healthcare Transformation, World Economic Forum
Sofiat Akinola,
Global Health and Healthcare Project Specialist, World Economic Forum

Global health expenditures are rising but government funding has stalled and personal spending is filling the gap. A 2019 World Bank report, for example, found that people in developing countries, including the Caribbean, spend half a trillion US dollars (over $800 USD per person) annually on out-of-pocket payments.

Universal health coverage (UHC) is about ensuring that all individuals and communities have access to the healthcare they need. UHC does not mean healthcare is free, but that personal payments do not deter people from using health services, and that people are protected from 'catastrophic health expenditure', or spending more than 30 per cent of their household income on health.

The private sector has enabled better health for communities and individuals in many ways. It provides services ranging from hospitals, clinics and laboratories, to drugs, vaccines and diagnostics, and ancillary services like ambulances and insurance. It contributes to advances in technology, governance, research and development, workforce development and capacity building. In many developing countries, the private sector plays an enormous role in the provision of health services, such as in India, where 70 per cent of services are provided by the private sector.

The private sector, alongside all UHC stakeholders, has a key role to play but all too often, the sector's involvement is fragmented. This needs to change.

UHC2030 is the movement to accelerate progress towards UHC by providing a multi-stakeholder platform that promotes collaboration on health system strengthening at the global and country levels. The new UHC2030 Private Sector Constituency Statement outlines seven ways that the private sector can contribute to achieving UHC by 2030.

Credit: World Economic Forum

"UHC is the overarching umbrella for the SDGs. We need to create the conditions for all actors to work together, with a particular mention of governments and private sector entities."

Arnaud Bernaert, Head, Healthcare Industry, Member of the Executive Committee, World Economic Forum

Credit: World Economic Forum

"It is essential to reframe public and private sector engagement as a partnership for shared outcomes. This statement provides a helpful basis for dialogue to promote shared universal health coverage goals."

Peter Salama, Executive Director UHC/Life Course, World Health Organization

1. Offer quality products and services that consider the needs of all people, including poor and marginalised populations, and make these affordable, accessible and sustainable.

The private sector is a major provider of products and services in most countries. For example, reach52, a social enterprise empowering rural and remote communities in South-East Asia, provides custom digital platforms to local peer workers so they can collect comprehensive individual health data and create a health profile for the community. This led to the provision of free vitamin A supplements to thousands of infants and young children.

Pharmaceutical company GSK makes its vaccines available in a sustainable and affordable manner using a tiered pricing policy in which prices are linked to the country's ability to pay. GSK has committed to providing Gavi, the Vaccine Alliance, with more than 850 million vaccine doses at reduced prices, to help protect 300 million children in developing countries by 2024.

The self-care industry is focusing on creating high quality products to ensure primary health care is available to all. Members of the Global Self-Care Federation develop digital healthcare innovations to drive insights and accelerate healthcare without costly and time-intensive consultations. The goal is to make healthcare more affordable, more accessible and therefore, more sustainable.

2. Incorporate UHC principles, including leaving no individual behind, in core business models and objectives.

To develop resilient and sustainable health systems, it is critical to think long-term. Healthcare company Novo Nordisk established the Changing Diabetes programme in 2009 to provide care and lifesaving medicine for children with type 1 diabetes in low-and-middle income countries. Currently, 14 countries are enrolled in the programme and it has reached more than 25,000 children and young people with the disease. This success also demonstrates the importance of public-private partnership between various actors in UHC, with the involvement of the International Society for Pediatric and Adolescent Diabetes (ISPAD), the World Diabetes Foundation, and pharmaceutical company Roche, alongside Novo Nordisk.

In another example, Fullerton Health delivers affordable and accessible care across the Asia-Pacific region with Project Big Heart, which provides free consultations and medication to elderly and underprivileged Singaporeans, targeting identification and treatment for chronic diseases such as hypertension, diabetes and high cholesterol.

3. Develop, test and scale innovative business models aligned with UHC goals.

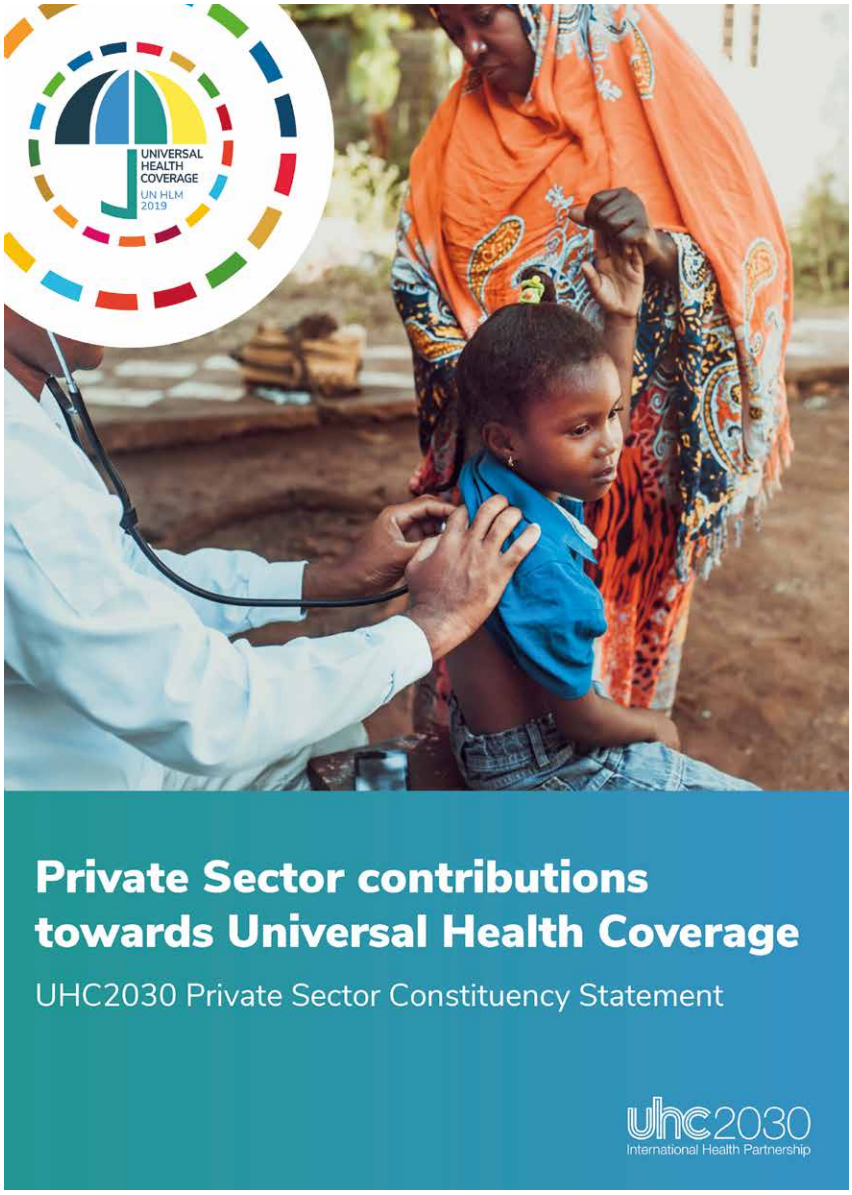
Innovation can happen on many levels, especially in approaches that drive greater and more equitable access, quality and sustainability of health products and service offerings. Philips and Amref Enterprises, in partnership with Makueni County Government in Kenya, are testing an innovative model for primary health care delivery in three clinics. Serving over 20,000 people, this intervention has vastly improved the quality of services, use of and enrolment in national health insurance, and will scale up in Makueni to 200 facilities, serving a million residents across Kenya.

Accessibility and availability of essential medicines are often absent in many countries with dilapidated transport and logistics systems, especially in sub-Saharan Africa. Absence of and inconsistent access to essential products and services, which are vital to provide quality care, led to the development of Informed Push Model (IPM-3PL).

Credit: World Economic Forum

"The private sector is vital in efforts towards universal health coverage. It is exciting to see the diverse membership of UHC2030's Private Sector Constituency agree these common principles and actions."

Dr Githinji Gitahi, Co-Chair, UHC2030 and CEO, Amref Health Africa



ABOVE:
The new UHC2030 Private Sector Constituency Statement outlines seven ways that the private sector can contribute to achieving UHC by 2030.

MSD for Mothers, in partnership with the Senegal Government, National Supply Pharmacy (PNA), IntraHealth International and the Bill & Melinda Gates Foundation, piloted and scaled IPM-3PL in Senegal with the aim of leveraging the capacity of local private organisations to reduce stock. In less than three years, IPM-3PL reached all public health facilities in Senegal and significantly reduced contraceptive stock-outs. Given this success, the model extended to include essential commodities for maternal health, HIV/AIDS, tuberculosis, malaria and other conditions.

4. Create, adapt, apply and scale innovations.
Private sector innovation is an engine for new products, techniques and insights, with the ability to improve healthcare, strengthen health systems and increase efficiencies. Sumitomo Chemical invented the first long-lasting insecticidal mosquito nets (LLINs), which are highly effective at preventing malaria. Vector control, primarily through LLINs, was responsible for an 81 per cent decline in malaria cases by 2015.

In Aragonda Village, located in the Chittoor District of the Andra Pradesh in India, Apollo Hospitals Enterprise provides accessible, affordable, sustainable and quality healthcare to over 70,000 people through Apollo's Total Health Program (THP). It integrates all components of the healthcare ecosystem including delivery, skilled workforce, health communication and technology, quality assurance mechanisms and a strong monitoring structure. THP fosters innovative partnerships for activities including provision of safe drinking water, nutrition and sanitation facilities.

5. Help strengthen the health workforce, responding to local context, priorities and needs.
GE Healthcare's Primary and Referral Care initiative is an innovative and sustainable health delivery approach to strengthening primary care, an essential step towards attaining UHC in Africa. This involves training and capacity-building of local healthcare workers to improve access to quality and


Credit: World Economic Forum

"To achieve universal health coverage, it is critical to ensure strong cooperation and partnership between public and private sectors."

Dr Zweli Mkhize, Minister of Health, South Africa

affordable essential health services and better health outcomes. It has already trained over 1,500 workers.

With communication difficulties in many countries in sub-Saharan Africa, Takeda, in collaboration with Elewa Cancer Foundation, educates primary care professionals in Kenya to provide knowledge for comprehensive cancer control and care. This approach translates into more timely diagnosis, referral and effective management of cancer patients.

Becton Dickinson and Company (BD) global health partnerships enable health system strengthening by reinforcing education and training. A collaboration between BD and USAID called STRIDES aims to strengthen systems and provide training to close the large gap for drug susceptibility testing in countries with high burden multi-drug-resistant tuberculosis. BD has also worked with the London School of Hygiene and Tropical Medicine (LSHTM) on a new Massive Open Online Course (MOOC) on antimicrobial resistance and diagnostics in response to a substantial lack of education and training in this space.

6. Contribute to efforts to raise financing available for UHC.

Contributing to innovative finance models and tools can articulate the business case for investing in health, specifically UHC. The Pfizer Foundation, in partnership with M-TIBA, launched a Health Financing App in Kenya to help people without health insurance to save money on health expenses. Using M-TIBA's platform, users save money that can only be spent on services at qualified, licensed and approved healthcare providers. The app also provides monetary incentives for saving a certain amount of money each month. Users have already paid approximately $6.7 million USD in medical expenses.

Also, in partnership with M-TIBA, PharmAccess and CarePay, Sanofi runs a mobile healthcare platform connecting patients, payers and providers through a mobile health wallet, called Ngao ya Afya Shield for Health. This platform generates an unprecedented amount of data, enabling transparency on cost and outcome of care. It also provides real-time feedback to patients, providers and payers to improve the value of care.

Credit: World Economic Forum

"This UHC2030 private sector constituency commitment to overarching UHC principles of affordability, quality and equity in accessing essential health services is imperative."

Muhammad Ali Pate, Global Director, Health, Nutrition and Population, Global Practice of the World Bank and Director, Global Financing Facility for Women, Children and Adolescents

7. Engage in, build and champion policy dialogue and partnerships with government and other stakeholders.

To achieve UHC, it is important to identify shared objectives and collaborate on shared outcomes. The public-private partnership between the World Economic Forum, Novartis and Harvard Medical School Center for Primary Care has strengthened and transformed primary care in Vietnam. It ensures a coordinated approach to fragmented health investments and initiatives, and could help the country meet its goal of UHC by 2030.

To ensure no one is left behind, Mission & Co – a platform for technology-driven solutions and partnership to achieve the Sustainable Development Goals (SDGs) – developed Health in Your Hands, an initiative focusing on last-mile solutions. True to its name, the initiative places the health in the hands of patients and healthcare providers to deliver affordable services to low-resource communities.

What's ahead?

UHC remains an aspiration for many countries but it cannot be achieved unless we recognise how the private sector has contributed to and continues to accelerate and amplify efforts towards improving health for all. When world leaders gathered at the UN in New York in 2019 to reaffirm their commitment to UHC by 2030, they acknowledged the crucial role of partnerships for shared outcomes, and engaging the private sector. ■

Growing the UHC2030 Private-Sector Constituency

The World Economic Forum – the international organisation for public private cooperation – hosts the UHC2030 Private-Sector Constituency, which is the convening platform for private sector entities wishing to exchange and collaborate on universal health coverage. The Constituency accepts new private sector members every three months. For-profit private entities that are directly working on strengthening health systems can apply to join.

Accelerating universal health coverage in Africa

WHO Regional Director for Africa, Dr Matshidiso Moeti, tells how many African countries are now rallying towards universal health coverage and proactively turning commitment into action to make health for all a reality.

Dr Matshidiso Moeti,
Regional Director for Africa,
World Health Organization

"In the African Region only one in three people has access to essential health services and even among those that do have access, less than half are using the available services."

No person should suffer ill health because the cost of care is too high or because a health centre is too far away. However, in the African Region only one in three people has access to essential health services and even among those that do have access, less than half are using the available services.

Social and economic barriers – long waiting times, fear of not being understood, not being excused from work and misinformation about healthcare systems – contribute, along with costs and distance, to an unmet need for healthcare in many countries.

Health is both a human right and a national economic concern. The estimated productivity losses due to ill health and premature death in Africa exceeded $2.4 trillion INT in 2015.

Health systems perform better in higher-income countries, but overall in the African Region, health systems are delivering at 51 per cent of their potential functionality, with large gaps in access to services and resilience to external shocks. This poses challenges to safeguarding health in a region that experiences more outbreaks of infectious diseases each year than any other.

Recognising these challenges, a growing number of advocates are calling for universal health coverage (UHC) to protect the most vulnerable populations and improve our collective health and wellbeing – and we are pleased that the day for UHC has finally come. The first high level global meeting on UHC was held during the UN General Assembly in September 2019.

In the African Region, political will for health has never been higher. In early 2019, heads of state at the African Union committed to increasing investment in health. In Cameroon, Ghana, Kenya and South Africa, among other countries, presidents have publicly declared their determination to make progress towards UHC. More countries in the region have rallied towards UHC and are exploring what they need to do, to translate this commitment into practical action.

At WHO, we are working with countries to advise on the design of reforms and interventions and to support legal efforts to get reforms underway, and we are now seeing progress across the continent. Reforms are being focused on three major areas: more services being made available; services reaching previously unreached people; and reducing financial hardship and catastrophic expenditure in using health services.

Several countries are showing the way. Seychelles is providing a range of free services for all. Cameroon and Kenya are increasing the range of services available for their people through private and public means. Mauritius is accelerating action to ensure services are closer to hard-to-reach communities. South Africa and Zambia are introducing national

ABOVE:
WHO is supporting countries across Africa to develop their health systems to move towards and sustain UHC.

health insurance legislation. Ghana, Kenya and Tanzania are reforming their health insurance schemes to increase coverage and sustainability.

In addition, we are seeing system reforms in different countries, from service delivery improvements in Nigeria, where primary health care facilities are being constructed in every health zone, to Sierra Leone, where the health workforce budget has increased by 500 per cent. Ghana and Mozambique are moving from a one-size-fits-all basic service delivery model to a redesigned system based on the evidence of the disease burden and the needs of different age cohorts. Malawi is enhancing delivery of community-based services. Botswana and Namibia are reforming their health information systems, and Mauritius is improving cancer registration and has established a virtual health library.

Momentum is building, and we need to accelerate this action.

However, we are not blind to the challenges ahead. As a region, we are coming from a very low base, and so need significant investment to get us to where stakeholders expect us to be. In the past, we have focused on addressing major causes of ill health and death rather than on overall health and wellbeing. We need to rethink how services are designed and integrated, to respond to the essential needs of all people, at all ages.

Physical, social and economic barriers hindering people from using available services need to be overcome and resources mobilised, without relying on household incomes. We need to increase domestic investment for health and innovations to reach the most vulnerable people in our communities.

Enhancing efficiency to ensure allocated funds are fully dispersed will further contribute to improving the delivery of services. Stronger negotiation on medicines and healthcare products can free up resources for other uses. As an example of how significant the savings can be, the price of insulin (a single 10ml vial) in the public sector at the point of care has decreased from a regional average of $20 USD in 2014 to $1.14 USD in 2018.

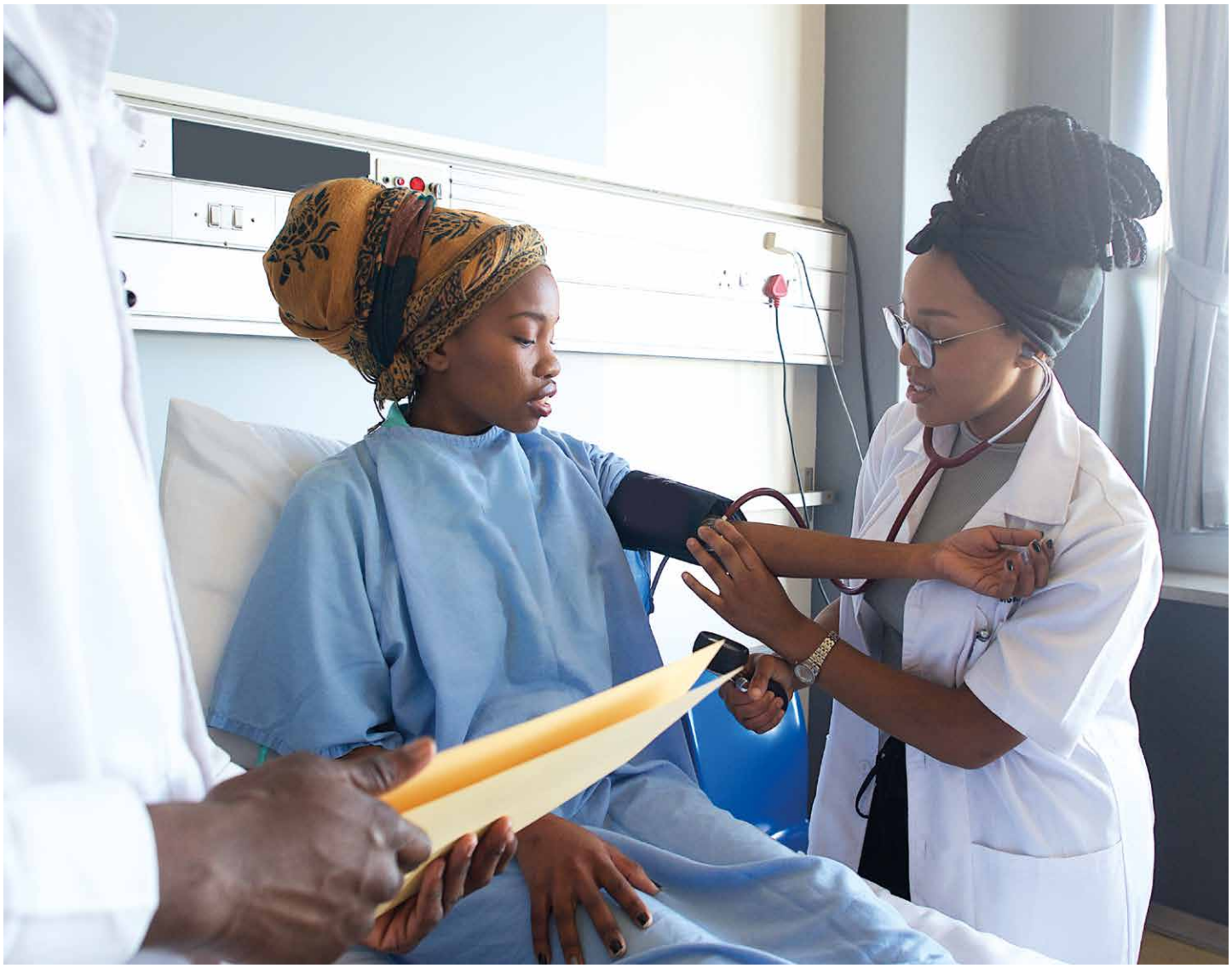
What is clear, is that UHC will transform the lives of millions of people in Africa. We cannot afford to miss this opportunity and will require the support of all stakeholders – governments, communities, the private sector, civil society, academia and development partners – to make health for all a reality in Africa. ■

"We will require the support of all stakeholders to make health for all a reality in Africa."

ACHIEVING UNIVERSAL HEALTH COVERAGE IN SOUTH AFRICA

Dr Fareed Abdullah is an HIV clinician and a specialist in public health medicine. He is the Director of the Office of AIDS and TB Research at the South African Medical Research Council based in Pretoria. He leads the SAMRC's work on universal health coverage and the NHI.

www.samrc.ac.za



For a small middle-income country at the tip of the most ancient of continents, news from South Africa has been catapulted onto the stage more often than one would expect, not least of all the country's rugby team's lifting of the Rugby World Cup trophy in Yokohama. This was a triumph by two spectacular tries as much as it was the triumph of non-racial sport on the world stage.

Little is known about the health system challenges facing the country, its history since the first civilian hospital was built in Cape Town in 1818 and its latest attempts at finally addressing this 200-year old vestige of its troubled past.

On 3 December 1967, Cape Town heart surgeon Christiaan Barnard performed the world's first heart transplant at the Groote Schuur Hospital. The world received such an important advance in medical science with the appropriate wonderment that it deserved, but the backdrop of squalor in the health service that the population had to endure at the time hardly made the headlines.

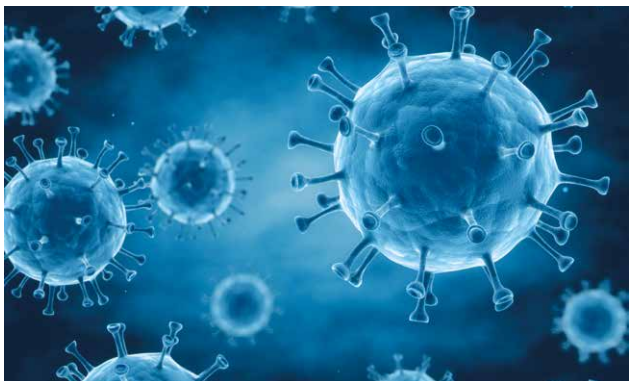
It did ten years later, when black consciousness leader Steve Biko was killed in detention and the Medical Association of South Africa exonerated two of its members, who had broken every oath of medical ethics, in the cover up of a death that was a breach of the Tokyo and the Geneva Conventions.

A spotlight was cast on the extreme racial bifurcations in the provision of healthcare in South Africa and the differential health outcomes of children and adults in the country. The struggles on the health front locally, and on the international stage, led to a torrential condemnation of a moribund health system, lasting through to the early nineties when democracy finally landed on the shores of the country, with Nelson Mandela marching for peace and setting about the rebuilding and weaving of the diverse and divided population into a rainbow nation.

The Mandela government achieved its most urgent task when it came to healthcare and set about dismantling a racially based health system by rapidly integrating 14 separate administrations into a single health service, which served everyone on equal terms. Equity across provinces was a key feature of the Mandela administration and substantial progress was made, though, as we have learned, the goal of meaningful equity is never really achieved and remains elusive over generations as is clearly still the case in South Africa.

Mandela's government made a good start when it comes to healthcare, but subsequent administrations dropped the ball. At the worst possible time in the rebuilding of the domestic health sector, the country was besieged by the AIDS epidemic. By the time Mandela retired in 1999, 2.36 million South Africans had contracted HIV. Mandela's successor, Thabo Mbeki, and his Health Minister chose a disastrous 'AIDS denialist policy' delaying antiretroviral treatment and second-guessing the science of HIV. The policy crushed the public health service even further through this large and largely unmanaged epidemic, resulting to over 5 million South Africans living with HIV a decade later.

Fast-forward another decade and the country experienced more difficulties from systemic corruption and stripping of management and leadership in the public service. The health sector was hard hit. In 2016, South Africans awoke to the news of the worst medical atrocity of the post-Apartheid era, the LIFE Esidimeni tragedy, in which 143 patients died of neglect in a failed downward referral exercise from a mental health facility in Johannesburg. In the meantime, the number of people living with HIV had grown to almost eight million and the health system encountered systemic collapse in many parts of the country.



South Africa's new President, Cyril Ramaphosa, and his Health Minister, Zweli Mkhize, have proposed bold steps to tackle this legacy, and to live up to the Commonwealth Health Ministers and G20 goals of achieving universal health care (UHC) in the period of their administration. Whilst the public health service has slipped beyond what can be expected in a middle-income country, the private sector has ballooned in an unregulated fashion. Almost half of all expenditure in the country is now spent on healthcare in the private sector, serving about 15% of the country's population. A six-year investigation into the private sector, initiated by the Competition Commission of South Africa, has just been concluded and published. A fourth report, commissioned under the aegis of the Lancet, has identified serious challenges with the quality of healthcare and recommends that quality should be as important a marker of progress as coverage.

This has triggered a proposal from the Ramaphosa administration to introduce a system of National Health Insurance (NHI) aimed at improving equity and reforming the health sector. The NHI proposal, now a Bill before Parliament, aims to create a single-payer system, with the intention of reducing supply side inefficiencies and controlling runaway costs in both the private and public sectors.

The Bill borrows from the UK's purchaser/provider split, which implies a reform of the governance of public clinics and hospitals away from provincial and local government, and the creation of semi-autonomous primary care units and hospital entities. These are major reforms and the source of intense public debate about the feasibility of these sweeping changes.

Simultaneously, the Ramaphosa government has put together a multi-stakeholder plan to reform the public health sector, titled the Presidential Health Compact, signed in July 2019 with widespread support from different stakeholders. This is a wide-ranging plan to address all aspects of the health service including human resources, infrastructure, financing and the modernization of the IT platform on which the health system should be built.

The South African Medical Research Council (SAMRC) has been actively engaged in all aspects of health research. Its past three Presidents have each made gargantuan contributions to the AIDS epidemic. South Africa boasts the best health systems and policy researchers in Africa, and the SAMRC has launched a UHC Collaboration that brings together the experts, with their knowledge generation capacity, together with decision makers in government, from the Ministry of Health officials, down to provincial and institutional leadership. The first sitting occurred in November 2019 with the aim to bring evidence and the latest data to bear on health reform policy decisions, that will ensure that success, and not failure, is the outcome over the next period.

Delivering UHC to the people of Sri Lanka

Sri Lanka's publicly financed, high-performing healthcare system is widely acclaimed. In this article, Pavithra Wanniarachchi, Sri Lanka's Minister of Health and Indigenous Medical Services, describes the main challenges and opportunities in delivering healthcare for all in a middle income country, and imparts lessons for other Commonwealth nations striving to achieve universal health coverage.

Pavithra Wanniarachchi,
Minister of Health and Indigenous Medical Services,
Woman and Child Affairs and Social Security, Sri Lanka

"Each year, the national health sector serves seven million inpatients and over 35 million outpatients."

Sri Lanka embarked on a universal health coverage (UHC) delivery process almost seven decades ago, through a comprehensive, free-at-the-point-of-delivery healthcare system. It covered promotive, preventive, curative rehabilitation care, almost fully supported by the government. As a result, Sri Lanka stands out in the region as a middle income country with relatively high social and health indicators – life expectancy of 74.9 years, an average literacy rate of 93.3 per cent, maternal mortality of 33.7 per 1,000 live births (2015), a neonatal mortality rate of six per 1,000 live births and an infant mortality rate of 8.6 per 1,000 live births (2015) – all of which are showing a downward trend.

A British crown colony for over a century, in 1931, Sri Lanka inherited a legacy of strong government institutions and self-rule, based on universal adult franchise, as well as a system of governance committed to delivering free healthcare services to all its citizens.

Our country's expenditure on health, which stood at 1.8 per cent of GDP in 2017, is gradually moving towards a target of 4 per cent. In spite of the present, relatively modest level of health expenditure, as a country with a low cost, high impact model of healthcare, Sri Lanka has achieved its many health goals through well synchronised, regularly upgraded primary, secondary and tertiary health care facilities, with a special focus on strengthening primary care in the plantation sector. In order to reverse the trend of seeking initial treatment at secondary/tertiary facilities and bypassing primary services, the government is now in the process of adopting a family medical model with an empanelled population.

Each year, the national health sector – which operates alongside a vibrant private sector – serves seven million inpatients, accounting for nearly 95 per cent of the national total, and over 35 million outpatients, or 45 per cent of the national total. The health sector has over 19,500 medical officers, over 32,000 nursing staff and nearly 30,000 paramedical and support staff. Overall, staffing per bed is 1:4, indicating efficient use of available staff.

Immunisation – a cost-effective intervention

Sri Lanka's robust National Immunisation Programme works well within the primary health care delivery system and is a key, cost-effective component of the successful delivery of UHC. The programme uses effective, safe and quality vaccines and has almost 100 per cent coverage. Immunisation began during the British era, with vaccination against smallpox in 1886, and has since helped the country to successfully control

several communicable diseases. The Expanded Programme on Immunisation, established in 1978 with a special focus on childhood TB, tetanus, whooping cough, diphtheria, polio and neonatal tetanus, has continued to make excellent progress over the years. The most recent addition to the programme is a vaccine for the Human Papilloma Virus that causes cervical cancer.

Meanwhile, we have also initiated a programme of inbound health assessments to detect conditions of public health importance, with a special focus on TB, HIV, Malaria and Filariasis, adopting an inclusive approach to assessing and treating those who are planning to reside in the country for a long period of time.

We do not want to leave anyone behind!

To face the challenges of international public health emergencies such as coronavirus, Sri Lanka has put in place a special programme in collaboration with the World Health Organization. In parallel, training programmes are being conducted to build the capacity of the health staff to face possible chemical, biological, radiological and nuclear threats.

Meanwhile, the conduct of National Health Research Symposia in 2017 and 2019 and the publication of 'Research Governance Strategy' and the 'Code of Conduct for Research' has contributed towards the expansion of health research, fortifying the research culture among health professionals while enhancing the evidence based decision making process.

The challenge of demographic change and noncommunicable diseases

Like many countries in the region, Sri Lanka is facing demographic transition, with an ageing population alongside a shift of disease pattern from primarily communicable diseases to noncommunicable diseases (NCDs). NCDs now account for 65 per cent of all hospital deaths, from conditions such as heart disease, stroke, diabetes and chronic respiratory diseases.

To mitigate this situation, Sri Lanka has implemented both individual and population-based strategies to address awareness-raising, NCD prevention, treatment and rehabilitation, as well as palliative care. These include introducing screening at 930 healthy lifestyle centres and 840 well-women centres at all levels of healthcare institutions island-wide, providing everyone with access to screening within a radius of 3km. Those identified as having a higher risk for particular diseases through primary care screening are referred, without charge, to secondary or tertiary care hospitals with expanded test facilities, or to a curative care centre for further management or healthy lifestyle counselling, as appropriate. All citizens aged over 35 are encouraged to enrol at a primary care centre. Steps are also being taken to establish a new nursing cadre to provide domiciliary care to NCD, cancer and mental health patients.

Nutrition labelling for sugar-based drinks using a traffic light system has been introduced to address excessive sugar and calorie intake among school children. A similar system will follow for sugar content in snacks and salt in prepared foods, in line with the National Salt Reduction Strategy (2018–2022).

To tackle malnutrition and undernutrition among vulnerable groups, the manufacturers of Thriposha nutritional food supplement supplies nearly three million soya/maize/milk powder packs per month, through a mixed marketing scheme using indigenous ingredients. The product is issued free of charge to around 1.3 million pregnant mothers and malnourished children through primary health care providers. The range of available products is expanding, with the private sector also supplying the market with parallel products.

Addressing the socioeconomic and health burden of tobacco and alcohol

In a bid to mitigate the serious social and health implications of smoking and excessive alcohol consumption, the National Authority on Tobacco and Alcohol (NATA) has taken decisive steps, including signing the Framework Convention of Tobacco Control (FCTC). Sri Lanka is the first country to do so in the South-East Asian Region, and this is in spite of the attractive tax income potential to the government from increased sales of tobacco.

Regardless of strong opposition from the tobacco industry, the government has also banned smoking in public places, required that 80 per cent of cigarette packs are pictorial health warnings, hiked the tobacco taxation from 70 to 90 per cent, introduced new steps towards plain packaging and an eventual move away from tobacco cultivation, as well as mobilising

"The healthcare delivery model has many provisions to reduce out-of-pocket expenses for target populations and make curative services more affordable to the public."

a strong social movement against tobacco and tobacco products through awareness creation, while banning the sale of cigarettes within a 100m radius of schools.

Financial risk protection

The healthcare delivery model in Sri Lanka has many provisions to reduce out-of-pocket expenses for target populations and make curative services more affordable to the public. As a developing nation, the capacity of households to bear costly medical expenses and interventions is limited, and so several financial risk protection measures were taken to sustain and further expand a universal healthcare process in the country.

One of the major interventions has been the introduction of Maximum Retail Prices (MRP) for 48 of the most commonly used medicines, in consultation with pharmaceutical manufacturers and distributors, 16 of which are important for addressing NCDs. A further 28 were subsequently added to the list, resulting in price reductions in the range of 30 to 300 per cent. The government also promoted the issuance of generic prescriptions, to enable patients to make informed decisions about purchasing medication. The steps taken to expand local manufacturing of pharmaceuticals is also designed to introduce competitively priced medication to the market.

Under the free healthcare system, the government provides intraocular lenses used in cataract surgery, hearing aids, cardiac stents and certain other medical devices free of charge to patients seeking treatment at government hospitals. Laboratory facilities in these hospitals have been upgraded to enable patients to have the majority of their investigations performed in one place, to ensure reliability of reporting and reduce the financial burden on these individuals. If any investigation is not available inhouse, they can be conducted elsewhere using government funds.

E-health – improving service efficiency

The launch of the e-Health information system, which assigned a Personal Health Number to all, was another initiative designed to improve health service availability, accessibility and capacity, and deliver quality people-centred integrated care. The scheme enables health information to be transferred electronically to care providers, enabling more efficient long-term management of chronic NCDs, while also encouraging information-sharing through telehealth applications, when a second opinion is needed.

The service helps to reduce associated travel and ancillary costs and avoid unnecessary travel, as well as contributing towards streamlining the procurement and supply of medicines and medical supplies and efficient resource allocation through drug management systems, while minimising wastage and drug shortages.

The challenges ahead

However, all is not rosy in our drive towards UHC, as we still have some critical challenges to overcome. To address the lack of human resources in the medical and paramedical categories, we need not only the mechanisms to increase supply and recruitment, but also to revisit staff quality and tasks in the context of aggressive primary care reforms. In a system that has been performing well for maternal and child health in the past, it will be quite a challenge.

To change the mindset of those choosing to seek initial treatment at secondary/tertiary units and bypass the closest primary care hospital, we hope to adopt a family medical model with an empanelled population. With a current doctor-patient ratio of 1:1000, this requires a significant growth in the number of trained and skilled healthcare professionals.

The interventions that bring us closer to free medical supplies and enhanced services, though costly, will have positive socioeconomic and health returns in the long term, while ensuring sustainability of the move towards UHC. ■

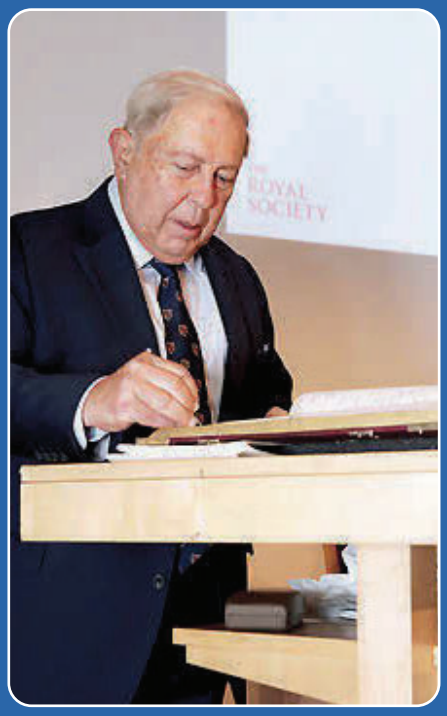
Cipla – Caring For Life

Making a Difference to Patients

Established in 1935, Cipla is a global pharmaceutical company where Caring for Life is a tradition and a promise. It encompasses everything from being ever-vigilant in manufacturing the highest quality medicines for its patients to thinking ahead about ways to shape the healthcare ecosystem of the future.
In Cipla, the phrases 'patient-centricity' and 'innovation' contain a rich and permanent synergy. Our patient-centricity is innovative, and our innovation is always patient-centric.
We invest in today for a brighter tomorrow. But even as we grow from strength to strength, 'Caring for Life' will always remain our true north. Because in the end, putting smiles on faces of the patients and their loved ones is what we aspire for.

Cipla and the Commonwealth

With its headquarters in India, Cipla also has manufacturing facilities in South Africa and Uganda among others. Cipla has been supplying quality medicines to Asian and African members of the Commonwealth as well as United Kingdom, Australia and Canada.
Cipla identifies with values enshrined in the Charter: tolerance, respect, understanding, gender equality, involvement of young people, respect of environment and hatred of corruption.



> **"The right to live should not be contingent on the ability to pay... Lives cannot be sacrificed at the altar of corporate profit and greed."**

Dr. Yusuf Hamied
Chairman, Cipla Limited
Elected Honorary Fellow of the Royal Society in 2019

Leadership in Respiratory

Cipla has a long heritage of being a world leader in Respiratory Therapy - India, South Africa and other key countries.
The products are available in over 80 countries worldwide. In1996 Cipla launched world's first transparent dry powder inhaler - the simplicity and ease of use thereafter changed the face of inhalation therapy in India. In 2003 the Company launched world's first pressurized Metered Dose Inhaler (pMDI), in India for the long-term management of Chronic Obstructive Pulmonary Disease (COPD). Today Cipla has the world's largest respiratory range of drugs, dosage forms and devices for COPD and Asthma.

The Highest Quality Standards

Cipla believes that the key to strengthening the foundation of a responsible brand lies in consistently achieving high standards of quality in everything we do.
Our manufacturing unit in Africa (Uganda) has been pre-qualified by the World Health Organization and supplies international agencies with medicines of the highest quality. Cipla has earned a name for maintaining world-class quality across all manufacturing units, products and services.

Providing Access to Life-Saving Drugs

For over eight decades, making a difference to patients has inspired every aspect of Cipla's work. Cipla's paradigm-changing offer of a triple anti-retroviral therapy in HIV/AIDS at less than $1 a day in Africa in 2001 has been widely acknowledged and have contributed to bringing inclusiveness, accessibility and affordability to the centre of the HIV movement.

On World AIDS Day 2019, Cipla announced a new, quadruple combination of ARV which is the most advance innovation for the treatment of HIV in Children. The new more palatable pediatric formulation will be available at a price of $1 a day.

A Company with a Soul

Cipla Foundation, has made impactful interventions with communities in India and South Africa, changing thousands of lives through initiatives in Health, Skilling, Education and Disaster Response.
Over the last 20 years, the Cipla Foundation has been running a one-of-its kind Palliative Care & Training Centre in Pune that has provided free of cost care to over 16,000 cancer patients and their loved ones, till date.
Cipla, believes in living by its ethos of contributing towards a greener environment and sustainable value creation. As a responsible corporate citizen, it is committed to managing its operations in a manner that reduces our environmental footprint. Cipla has made special architectural efforts to make its manufacturing plants beautifully integrated in its landscape and cultural environment.
Each official visitor to the Cipla manufacturing facility is requested to plant a tree, contributing to the environment.

Access to quality medical products will define the journey to UHC

Dr Poonam Khetrapal Singh, Regional Director of the WHO South-East Asia Region, looks at how the region is tackling the challenges involved in providing access to safe, effective, quality and affordable medical products, which is fundamental to achieving universal health coverage.

Dr Poonam Khetrapal Singh,
Regional Director,
WHO South-East Asia Region

"Since 2014, the WHO South-East Asia Region has pursued UHC as a flagship priority, with a specific focus on increasing access to medical products."

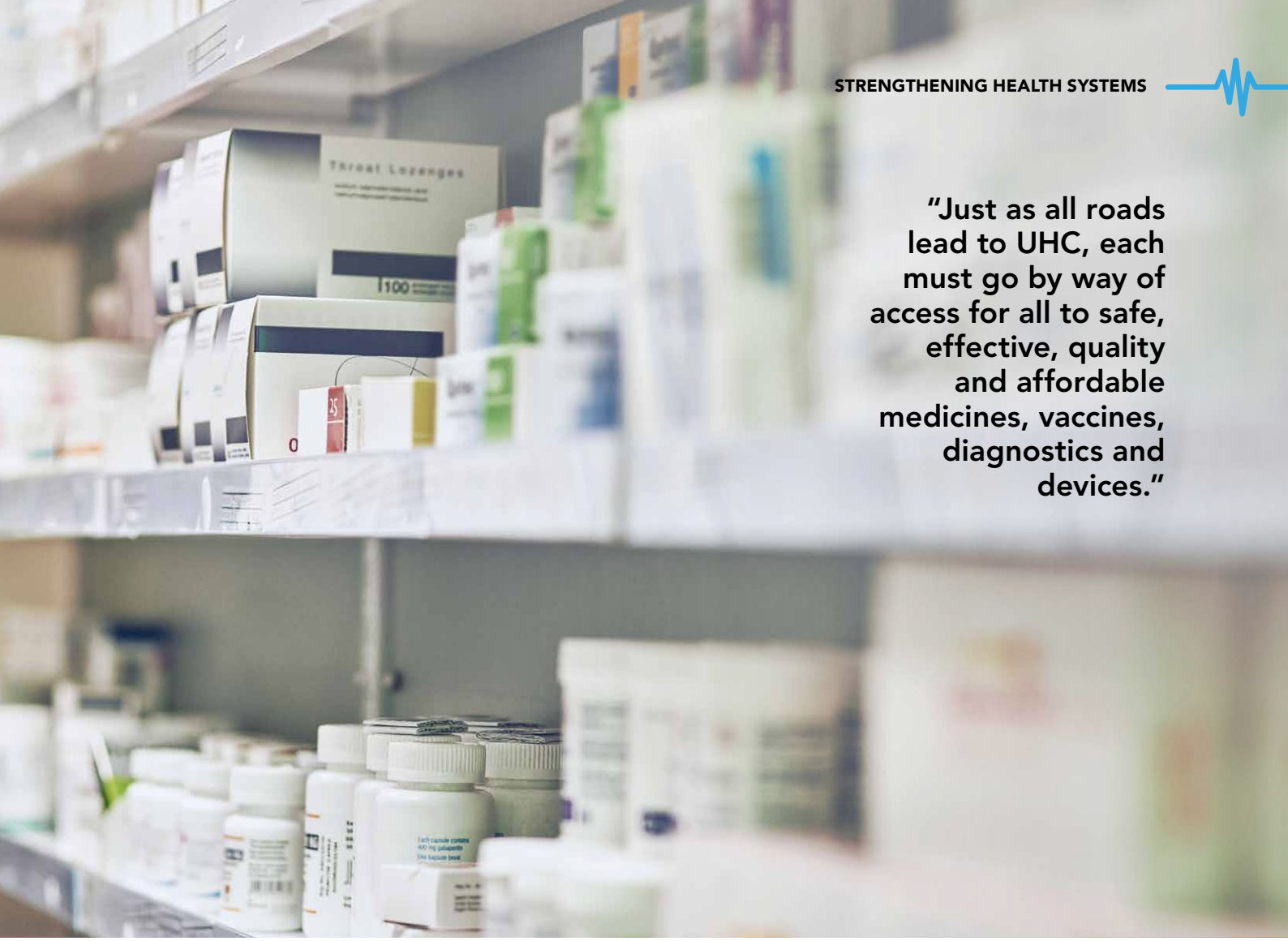
Access for all to safe, effective, quality and affordable medicines, vaccines, diagnostics and devices (medical products) is a core part of universal health coverage (UHC) – when all people can access the healthcare they need, without financial hardship. Since 2014, the WHO South-East Asia Region has pursued UHC as a flagship priority, with a specific focus on increasing access to medical products. In addition to reducing end user costs and the impoverishment they can cause, regional member states are striving to ensure that all medical products are of adequate quality and are reliably available. Both outcomes will enhance trust in primary health care services and reduce the current tendency to bypass them in favour of tertiary facilities.

To ensure that all people in the region have access to quality medical products, the WHO is pursuing a two-pronged approach: first, to consolidate and build the capacity of national regulatory authorities and other agencies responsible for quality assurance, such as procurement agencies; and second, to enhance regional collaboration aimed at providing national level technical support.

The WHO-supported South-East Asia Regulatory Network (SEARN), which first convened in 2016, is an example of this approach in action. SEARN's mission is to foster regulatory cooperation and collaboration to improve the availability, quality and safety of essential medical products. By bringing national regulatory authorities together to share information on associated policies, guidelines, standards, procedures, outputs and regulated products and entities, SEARN will enhance regulatory efficiencies regionwide.

Member states have already agreed on and are pursuing a range of initiatives, from creating an online information sharing platform, to developing training modules on medicines and vaccine safety monitoring. Notably, India is facilitating a jointly assessed pilot programme of new treatments for several priority diseases, which will allow countries to potentially adopt lifesaving drugs simultaneously, without the need to replicate regulatory procedures. This will be especially useful for the region's smaller countries, whose regulatory authorities, in many instances, are already working above capacity.

SEARN's work complements member state efforts to harness the WHO's Global Benchmarking



"Just as all roads lead to UHC, each must go by way of access for all to safe, effective, quality and affordable medicines, vaccines, diagnostics and devices."

ABOVE:
The risk of sub-standard medicines continues to be a challenge.

Tool (GBT) to assess the capacity of national regulatory authorities. To date, benchmarking exercises have guided regulatory authorities to implement corrective actions and preventive measures, in addition to institutional development plans, in several countries that produce medical products. Coalitions of interested parties are increasingly active on the issue and are informing multi-year capacity development plans. Owing to the GBT's success, the WHO is working with member states to explore its application at the sub-national level.

The WHO's prequalification programme is likewise strengthening the capacity of manufacturers to produce quality-assured products. This is particularly important given that the majority of prequalified generic medicines are manufactured in the South-East Asia region. Several member states are now procuring these medicines in bulk, providing excellent value for money. The risk of sub-standard products – both branded and generic – nevertheless, continues to be a challenge in several countries. The WHO is supporting national agencies to improve public procurement systems, as well as government supply and distribution chains. It is essential that all medical products do exactly what they are supposed to.

While overcoming issues of safety and quality, the region is focused on affordability. To that end, fully implementing the Delhi Declaration on improving access to essential medical products, which was adopted by member states in 2018, is crucial. As per the declaration, member states are encouraging information sharing on the availability, price and quality of medical products, as well as best practices in strategic price negotiations. Member states are also looking to leverage flexibilities in the World Trade Organization's global TRIPS (Trade-Related Aspects of Intellectual Property Rights) Agreement, which will help them to access new therapies for priority diseases in the region, such as tuberculosis, hepatitis and cancer.

It is imperative that these and other initiatives are accompanied by an increase in the public funds allocated to health. An increase in financial resources, if strategically applied, can allow each country to reduce out-of-pocket expenses, most of which go on medical products. It is no coincidence that Sri Lanka, which spends a commendable 8.6 per cent of its government budget on health, and provides essential medicines for free in public health facilities, has one of the region's

lowest rates of impoverishment due to health spending, at 0.7 per cent of the population. Though increased public spending on health will by no means overcome all barriers to UHC, it can certainly help in reducing one of the most significant barriers: out-of-pocket spending on medical products.

Expanding access to vaccines is an important part of the region's quest to achieve UHC. Since 2016, the Regional Vaccine Action Plan has guided progress, with the WHO supporting national priorities, including the introduction of new vaccines. This is in addition to helping member states achieve several regional goals, such as the elimination of maternal and neonatal tetanus, which was accomplished in 2016. The region is now focused on eliminating measles and rubella by 2023. Bangladesh has shown itself to be a leader in this respect, with the country being one of six in the region to have controlled rubella. It is also one of four to have controlled hepatitis B. Coverage of the routine diphtheria, pertussis and tetanus vaccine in Bangladesh is a remarkable 98 per cent – a figure that many other countries are striving for.

In pursuing the region's 'Sustain. Accelerate. Innovate' vision, as it relates to immunisation, member states are now implementing several innovations aimed at increasing coverage and equity and ensuring last mile delivery. These range from GIS (geographic information system) mapping of high risk areas, to empowering volunteers and implementing mobile health solutions. Importantly, member states are also focused on securing adequate financing for immunisation, particularly as countries develop and transition away from external assistance. India is a case in point. Following the injection of catalytic Gavi funding, increases in domestic funding have allowed the country to expand its Universal Immunisation Programme's vaccine basket from seven to 12 in the last five years alone.

Our winning trajectory must continue. Regionwide, all countries are firm in their conviction that just as all roads lead to UHC, each must go by way of access for all to safe, effective, quality and affordable medicines, vaccines, diagnostics and devices. Present member state and regional initiatives are demonstrating that together, we can surmount any and all challenges as we strive to ensure that all people can access the healthcare they need, without financial hardship.

A healthier, happier and more productive future is possible. The future is ours to make. ■

ABOVE:
Expanding access to vaccines is an important part of the WHO South-East Asia Region's quest to achieve UHC.

"Together, we can surmount any and all challenges as we strive to ensure that all people can access the healthcare they need, without financial hardship."

Accelerating action against AMR

Dr Manica Balasegaram, Executive Director of the Global Antibiotic Research and Development Partnership, calls for a global, holistic and multi-sectorial approach that brings together public and private stakeholders to solve the urgent challenge of antimicrobial resistance.

Dr Manica Balasegaram,
Executive Director, Global Antibiotic Research and Development Partnership

"The challenge of developing antibiotics to address the greatest global public health needs cannot be solved by one country or actor alone."

Antibiotics have transformed the world by making previously incurable illnesses treatable and allowing medical procedures to be performed safely. But today, the rise of antimicrobial resistance (AMR) is outpacing drug discovery at an alarming rate.

While drug resistance occurs naturally over time due to genetic changes in bacteria, other factors also contribute to the increase in drug-resistant bacteria. These include the over use and inappropriate use of antibiotics in human and animal medicine and in food production, poor infection prevention and control, as well as a lack of affordable, globally available quality medicines.

With few antibiotics in development, AMR is a major and rapidly growing global challenge that is making previously easy to treat infections harder to manage. Approximately 700,000 people worldwide die of drug-resistant infections every year, but this could grow to ten million each year if effective measures to tackle the issue are not implemented, according to the UK Government-commissioned 2016 review on AMR.

AMR and the SDGs

AMR is a global development issue that affects all Commonwealth countries. Drug-resistant infections are having a critical impact on human health. Making progress on addressing AMR has been recognised by the UN General Assembly as critical to achieving the Sustainable Development Goals (SDGs), particularly the target for good health and wellbeing for all (SDG 3).

While the burden is highest among vulnerable populations – women, children, the elderly, immuno-compromised people – and those in countries with weak health systems, AMR can affect anyone, of any age, in any country.

Governments have an essential role to play in addressing AMR, and one way they can do this is by documenting their approach and commitments through developing national action plans on AMR. 2019 WHO data showed that 29 Commonwealth countries had developed such an action plan.

A public-private partnership approach to address AMR

The challenge of developing antibiotics to address the greatest global public health needs cannot be solved by one country or actor alone. It can only be addressed through a global, holistic and multi-sectorial approach based on partnerships that bring complementary stakeholders together.

The Global Antibiotic Research and Development Partnership (GARDP), a not-for-profit public health research and development (R&D) organisation, was created to

address this global challenge. Co-founded by the WHO and the Drugs for Neglected Diseases Initiative in 2016, GARDP is a core element of the Global Action Plan on AMR.

By bringing together public and private sectors to develop new treatments for bacterial infections, GARDP can build sustainable access measures into partnerships, and promote responsible use and affordability, particularly for low- and middle-income countries. Global collaborations with industry, academia, governments and civil society can help ensure resources are optimised and that the right actors are on board to accelerate antibiotic development. GARDP has already developed 50 partnerships in 20 different countries, several of which are in the Commonwealth.

GARDP also actively drives R&D to develop treatments in late-stage clinical development that target bacteria on the WHO's priority pathogen list and diseases in underserved populations, while ensuring sustainable access – an area where few others are active. After three years in operation, GARDP has already built a pipeline to address infections in children including newborns with sepsis, hospitalised adults and sexually-transmitted infections.

Working in partnership to accelerate the development of new treatments

GARDP's focus on sepsis in children reflects the fact that the number of preventable deaths in newborns remains unacceptably high. While significant progress has been made in recent years to improve child health globally, including a 50 per cent reduction in child mortality since 1990, deaths in newborns represents

ABOVE:
The rise of antimicrobial resistance is outpacing drug discovery at an alarming rate. GARDP was created to bring public and private sector stakeholders together to address this mounting challenge.

"Global collaborations with industry, academia, governments and civil society can help ensure resources are optimised."

44 per cent of all deaths in children under the age of five.

Data published in The Lancet in 2018 (Cassini A et al) show that drug-resistant infections are responsible for an estimated 2,300 disability-adjusted-life-years per 100,000 people every year in Europe – the richest part of the world. And the burden, which is highest in infants under one, has increased significantly since 2007. Of further concern is the estimated 214,000 deaths in newborns that are attributable to drug-resistant infections (Laxminarayan R et al). Addressing this is critical to achieving SDG 3.

Developing treatments for children is particularly challenging as they require medicines that are adapted in terms of regimen, dose and formulation. While regulatory agencies obligate pharmaceutical companies to develop paediatric plans to evaluate new antibiotics for use in children, few new drug development projects are implemented.

GARDP, in partnership with St George's University in London and Penta – the paediatric infectious disease network – is building the evidence base needed to evaluate future interventions that could be used to treat newborns with sepsis. Through one of the largest ever global observational studies, data from 3,000 hospitalised newborns with sepsis is being collected. Outcomes from 11 countries, including Bangladesh, India, Kenya, South Africa and Uganda, will plug knowledge gaps and transform prevention and treatment of newborns with sepsis.

In addition, GARDP has completed a study to confirm the correct dose and evaluate the safety of the antibiotic treatment fosfomycin for use in newborns. Data collected from this study, conducted in Kenya in partnership with the KEMRI-Wellcome Trust Research Programme, and involving collaboration between St George's and University College London at the University of London, and the Centre for Tropical Medicine and Global Health at the University of Oxford in the UK, is now in the analysis phase.

Based on data from both these studies, as well as ongoing evaluations and other published data, GARDP will inform which antibiotics to take forward into a large scale clinical trial. This will help increase the evidence base needed to develop and deliver a new first line treatment for newborns with sepsis. Providing policymakers with evidence on which antibiotics are being prescribed in their country is an important step in helping government agencies deliver their national action plans on AMR and ensure antibiotics remain available and effective for generations to come.

Whilst a number of initiatives have been launched in the past several years to reinvigorate the antibiotic R&D pipeline, more can and must be done to ensure these efforts sit within a public health-focused R&D framework. Commonwealth countries, such as South Africa and the UK, as well as Germany, are already showing strong leadership and financial commitment towards addressing this global health and development crisis by supporting GARDP. The Commonwealth is uniquely placed, given its geographical span, common challenges and resources, to lead and drive solutions that ensure a balance between making new treatments affordable, accessible and used appropriately, at national and regional levels, in the efforts to curb the rise of AMR. ■

"Commonwealth countries, such as South Africa and the UK are already showing strong leadership and financial commitment towards addressing this global health and development crisis."

Building antimicrobial stewardship to tackle AMR

Dame Sally Davies, UK Special Envoy on Antimicrobial Resistance, and Victoria Rutter, Executive Director of the Commonwealth Pharmacists Association, emphasise the urgent need for effective antimicrobial stewardship to tackle the complex global problem of antimicrobial resistance, and highlight examples of effective stewardship in the Commonwealth.

Dame Sally Davies,
UK Special Envoy on Antimicrobial Resistance
Victoria Rutter,
Executive Director, Commonwealth Pharmacists Association

"Investment from the UK is intended to help countries develop their capacity to tackle AMR, improve global surveillance, and foster international research and development collaborations."

Antimicrobial resistance (AMR) is recognised to be one of the greatest global health security threats this century. A review commissioned by the UK government attributed 700,000 deaths per year to AMR, and predicted that this could escalate to ten million by 2050 without prompt and appropriate action. While AMR is a natural phenomenon (bacteria evolve to survive), inappropriate use of (particularly broad spectrum) antibiotics has accelerated this process and threatens to leave our current antibiotic armoury ineffective, returning us to the pre-antibiotic era. This issue is magnified significantly in lower resource settings.

AMR is a serious and complex global problem. International partners need to share their work and innovative approaches to tackling this global health threat with relevant stakeholders, to speed the development of effective interventions.

The UK raised the profile of AMR on the global agenda by working with partners to secure commitment to a global action plan in 2014, and the subsequent historical political declaration on AMR at the UN in 2016. This declaration was signed by all 54 countries of the Commonwealth. As of 2017-18, 51 per cent of Commonwealth countries had a national action plan in place; 25 per cent had a national action plan in development; and six per cent had no action plan for AMR.

Investment from the UK is intended to support the transformation of these declarations into action, help countries develop their capacity to tackle AMR, improve global surveillance, and foster international research and development collaborations. One aspect of this is to address inappropriate use of antimicrobials to treat and prevent infections in healthcare settings. In other words, effective antimicrobial stewardship (AMS) must be established.

As part of its commitment to helping address AMR at a global level, the UK government's Department of Health and Social Care created the £265 million Fleming Fund to support efforts to tackle AMR in low- and middle-income countries through laboratory capacity-building and country grants. This will enable more effective monitoring of resistance patterns and use of antimicrobial agents, allowing countries to make informed, evidence-based antimicrobial prescribing decisions guided by appropriate protocols and supported by prudent and effective AMS – thus developing organisational governance structures to help ensure antimicrobial 'access without excess'. This can involve many different interventions, as was summarised in a recent consensus paper (Pulcini et al, 2019). Effective AMS teams involve a multidisciplinary approach, and, as medicines experts,

pharmacists play a key role in ensuring access to and promotion of the rational use of antimicrobials. This has become increasingly evident in the UK, with pharmacists taking leading roles in AMS teams.

That is why the Commonwealth Pharmacists Association (CPA) – a UK-based charity affiliated to the Commonwealth, with the aim of improving the health and wellbeing of Commonwealth citizens through developing more effective systems of medicines use – is well-placed to act on the better use of antimicrobials.

The CPA has been supporting its member organisations and Commonwealth countries with implementation of the WHO Global AMR Action Plan in a number of ways, including through the Commonwealth Partnerships in Antimicrobial Stewardship (CwPAMS) scheme. CwPAMS was developed in October 2018 with the Tropical Health Education Trust (THET), financed by the Fleming Fund and based on THET's longstanding Health Partnership Scheme (HPS) model. Led by pharmacists, CwPAMS is facilitating the partnering of multidisciplinary teams of volunteers from UK health institutions with healthcare teams in Ghana, Tanzania, Uganda and Zambia, to share skills and knowledge and co-develop interventions to enhance AMS in healthcare settings.

A systematic approach was applied to identify gaps in AMS, which led to the creation of a set of recommendations that framed the selection of 12 partnerships between the UK health institutions and those across four African nations. While developing the scheme, the CPA engaged with and sought views from stakeholders including government officials and frontline healthcare workers. Projects are currently in their early stages but have already demonstrated improved implementation of AMS, as well as increased clinical capacity of pharmacists. The UK pharmacists involved are also seeing vast benefits to their own professional development, as well as to the National Health Service. Pharmacists are not typically involved in global health programmes, so CwPAMS has provided valuable opportunities to build their project management and leadership skills, refine their AMS knowledge and innovate news ways to implement AMS in low resource settings. In recognition of this, Health Education England (HEE) has developed a global fellowship for pharmacists associated with the scheme.

The current CwPAMS scheme is envisaged to continue until April 2020. Within this time, the teams will deliver and report on projects to provide training, clinical support tools and collection of antimicrobial use data. It is anticipated that the outcomes of CwPAMS will lead to implementation of AMS structures (such as committees, dedicated teams and protocols), improved adherence to treatment guidelines and ultimately, reduced use of broad spectrum antimicrobials, which are the most likely to contribute to AMR.

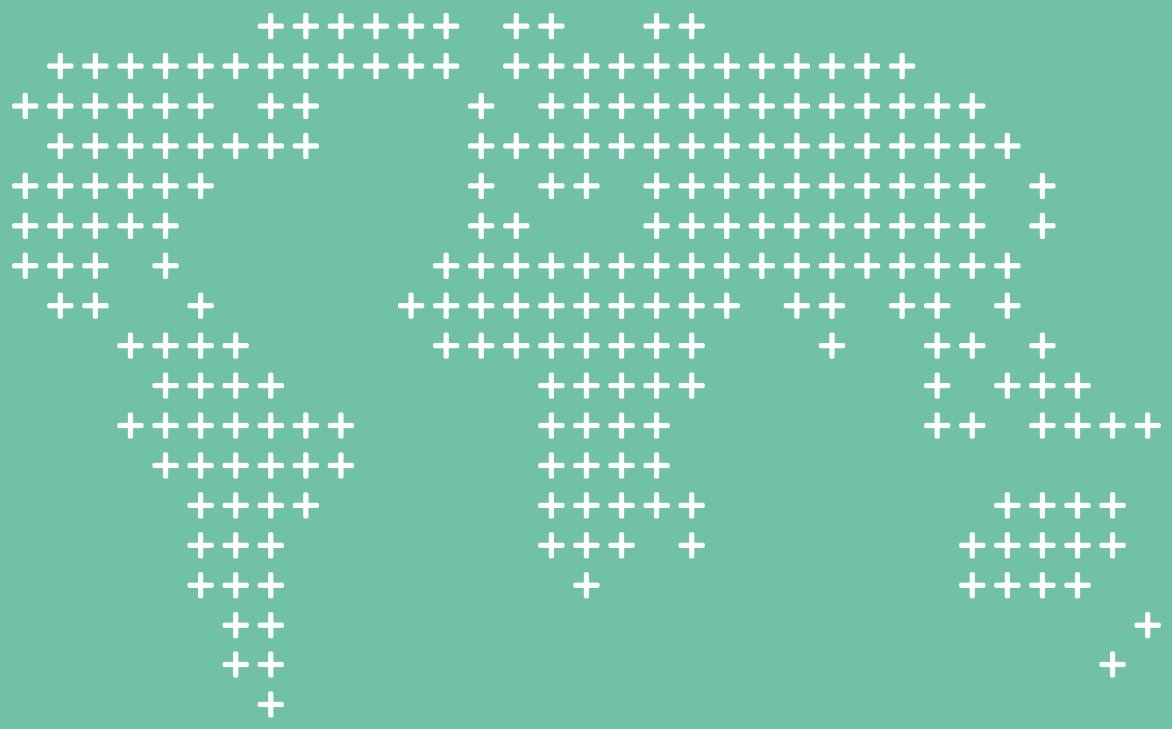
It is hoped that relationships between partners will continue to develop and provide ongoing mentorship beyond the official end date. Consideration may be given to further extending CwPAMS to other Commonwealth nations, should there be a need.

These outputs should also be used to inform policy around antimicrobial use. In the longer term, the scheme is anticipated to positively impact on the health of Commonwealth citizens through reducing multidrug resistant infections and its associated morbidity, mortality and financial burden. ■

Further information about the CwPAMS project can be found at: https://commonwealthpharmacy.org/commonwealth-partnerships-for-antimicrobial-stewardship/

The authors would like to acknowledge and thank the CwPAMS team at the CPA, including: Dr Diane Ashiru-Oredope, Global AMR Lead, Mrs Sarah Cavanagh, International Partnerships Lead, Ms Chloe Tuck, International Projects Lead and Ms Ayodeji Matuluko, Global AMR Intern.

Tackling communicable diseases



Global solidarity to end epidemics

Marijke Wijnroks, Chief of Staff at the Global Fund, celebrates the unprecedented global solidarity to end HIV, TB and malaria by 2030 at the organisation's Sixth Replenishment Conference and believes it demonstrates that the world is truly stepping up the fight to work stronger, faster and together to end these devastating epidemics.

Marijke Wijnroks,
Chief of Staff, The Global Fund

Despite the division and uncertainty affecting our world, something extraordinary happened in October 2019. Donors meeting at the Global Fund's Sixth Replenishment Conference pledged more than $14 billion USD to fight HIV, TB and malaria – the largest contribution ever raised for a multilateral health organisation. The gathering in Lyon, France, was an unprecedented display of global solidarity and an inspiring lesson in what can be achieved when the world comes together to address the needs of the poorest and most vulnerable. The money raised will help to save 16 million lives, cut the mortality rate for the three diseases in half and build stronger health systems.

Global health is a shared responsibility and, in 2019, a record number of new donors made pledges

"The better we collaborate and coordinate with partners, the more impact we can have. No single organisation, no matter how big, can do this alone."

RIGHT:
Marijke Wijnroks, Global Fund Chief of Staff, visits a clinic supported by AMREF in Embakasi, Kenya.

to the Global Fund and increased their own domestic financing for health. We received commitments from 58 countries, which was a significant increase on the 35 countries that pledged in the 2016 Replenishment Conference. Expanding our donor base, the Global Fund welcomed 20 new and returning public donors. A total of 24 African countries, including many from the Commonwealth, made pledges, and most of them as new donors. Commitments from the private sector totalled $1.04 billion USD, the highest ever.

We recognise that $14 billion USD represents only a portion of the funding required to fight the epidemics over the following three years, and that most of the money will come from the affected countries themselves. The Global Fund plays a catalytic role in mobilising domestic resources for the fight against HIV, TB and malaria through its co-financing policies. We are also engaging more with international financial institutions on co-financing and technical work, and with civil society on advocacy. It is working: domestic funding for programmes to fight the three diseases over the period 2021-2023 is projected to grow to $46 billion USD, an increase of 48 per cent over the current three year period. Domestic financing for health leads to sustainability of national health programmes. South Africa, for example, has the largest antiretroviral treatment programme in the world, and these efforts have been largely financed from its own domestic resources.

It is this global approach that has led to enormous progress against the world's three deadliest infectious diseases. We have cut annual AIDS-related deaths and new HIV infections by half. Malaria death rates reduced by 60 per cent, while TB deaths have fallen by 38 per cent.

Investment in health is essential for sustainable development and for ending poverty and promoting peaceful and inclusive societies. It also paves the way for universal health coverage. The Global Fund invests $1 billion USD a year to

"Donors meeting at the Global Fund's Sixth Replenishment Conference pledged more than $14 billion USD to fight HIV, TB and malaria – the largest contribution ever raised for a multilateral health organisation."

BELOW:
Supporters of the Global Fund celebrate at the successful conclusion of its Sixth Replenishment Conference in October 2019.

build resilient and sustainable systems for health. By forging stronger supply chains, improving data and training health workforces, the positive impact of the Global Fund goes beyond the three diseases, building the delivery platforms that support treatment of noncommunicable diseases and reproductive, maternal, newborn, child and adolescent health.

Despite all our progress, we cannot be complacent. There is still a lot of work to be done and new threats have pushed us off the trajectory needed to reach the Sustainable Development Goal target of ending the three epidemics by 2030. Adolescent girls and young women continue to be disproportionately affected by HIV, especially in sub-Saharan Africa. Worldwide, nearly 1,000 young women and girls are infected with HIV every day. We will not end the spread of the diseases without tackling structural factors and deep-rooted gender inequalities – social, political and cultural – that make adolescent girls and young women more vulnerable.

Similarly, we won't end the epidemics without removing human rights barriers to health. Discrimination, stigma, punitive laws and policies are fuelling the epidemics and driving people away from health services. And it is the most vulnerable that are paying the price. We must be more responsive to the needs of key populations, including sex workers, men who have sex with men, transgender people, those who inject drugs, prisoners, refugees and displaced people.

To do this, we need to work closer with communities so that we can deliver more effective and integrated people-centred care. The better we collaborate and coordinate with partners, the more impact we can have. No single organisation, no matter how big, can do this alone. More effective collaboration with partners is needed to better coordinate efforts, align resources and create synergies. The Global Fund is a key supporter of the Global Action Plan for Healthy Lives and Wellbeing for All, a joint commitment to reinforcing cooperation among the 12 multilaterals involved in global health.

We will only achieve our goals through global solidarity, which jointly allows us to innovate and mobilise dramatic domestic and international resources for health. Donor governments and philanthropists recently pledged $2.6 billion USD to the Global Polio Eradication Initiative. We hope that this continued momentum and energy will be a platform for the successful replenishment of Gavi, the Vaccine Alliance, in 2020.

This is a time of exciting opportunity but also of daunting responsibility. We need to translate this extraordinary display of global solidarity into impact and change. We owe it to our donors and our partners. Even more, we owe it to the people we serve, in particular the most vulnerable and marginalised. ■

Credit: © The Global Fund / David O'Dwyer

Cepheid®
A better way.

An interview with Philippe Jacon, Senior Vice President, Global Access, at Cepheid

Philippe, could you please provide us with a brief outline of the origins and history of Cepheid, and your own role within the organisation?
Cepheid is a global leader in molecular diagnostics. Established in 1996 in California, Cepheid provides systems for the detection of bacteria, viruses and cancer in humans and has been setting the standard for innovation in automated molecular diagnostics.

As Senior Vice President, Global Access, my role is to lead a team whose mission is to remove the barriers preventing Global Health Priority programs from optimally implementing Cepheid's technologies around the globe.

For non-experts, what are molecular diagnostics, and what is the process through which your GeneXpert technology works within this field?
Molecular diagnostics is based upon the detection of genetic material (DNA or RNA) from infectious organisms or human cells. It allows the identification and quantification of bacteria and viruses and can also be used to determine whether a particular treatment is likely to be successful.

It is also a powerful tool to characterize mutations in cancer cells, to select a treatment strategy and in some cases, predict the likely outcome.

What are the principal benefits of a rapid and early diagnosis of infectious organisms, and what does this mean for patients and healthcare institutions?
In general, a condition that is diagnosed early, can be treated more rapidly and successfully. In the case of a transmissible infection, this reduces the opportunity for it to be passed to another person or family member. More rapid treatment and the avoidance of transmission also reduce the time patients have to spend in hospital thus making the hospital more efficient and reducing healthcare costs.

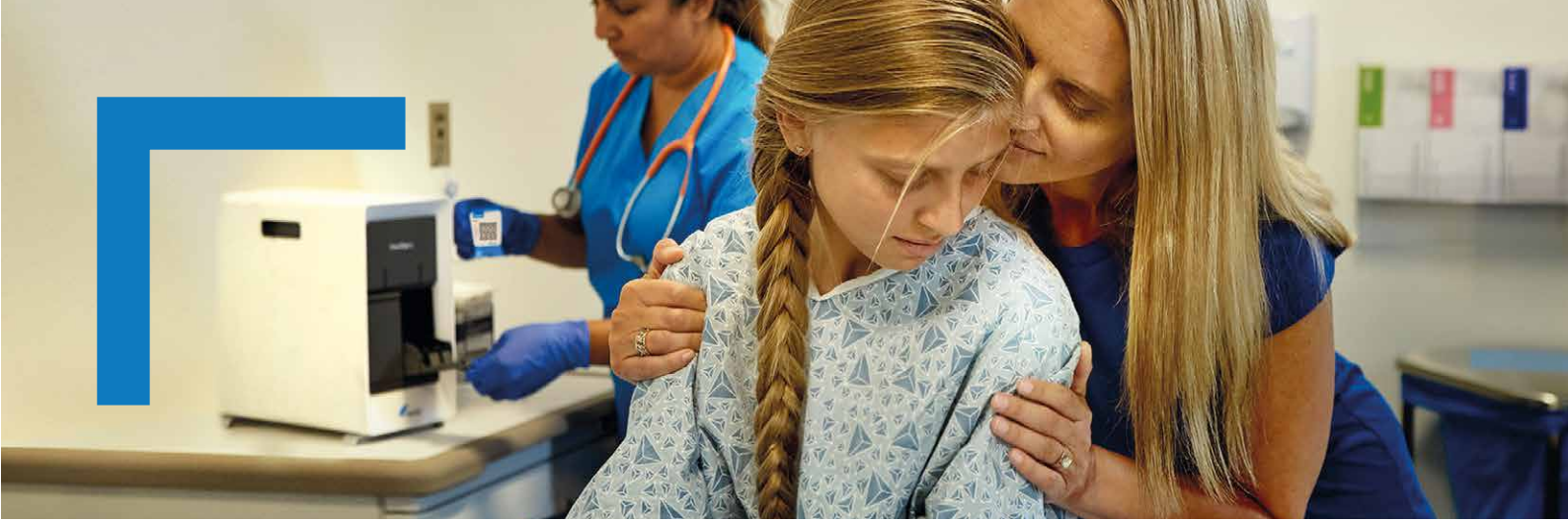
Rapid diagnostic results also help eliminate Empiric therapy, or therapy begun on the basis of a clinical "educated guess" in the absence of diagnostic information which can lead to potential overuse or misuse of antibiotics.

In the context of low- and middle-income countries (LMIC), a rapid result means that the individual who has to spend up to several hours to reach a healthcare center, can get the result of his test during the same trip, thus reducing the economic impact of days out of work. For a baby who is tested positive for HIV infection while he/she is still in the maternity it is also increasing dramatically his/her chance to survive beyond 5 years.

Finally, in LMIC, a rapid result improves dramatically the linkage to care, by reducing dramatically the number of people tested who are lost to follow up when it takes days to get the result from centralized and/or remote lab centers.

Sustainable Development Goal 3 aims to "ensure healthy lives and promote well-being for all at all ages". Broadly, how can GeneXpert rise to this challenge?
Cepheid's GeneXpert System is also widely deployed outside of the hospital, closer to the people needing testing, being robust and simple to use. The GeneXpert System provides diagnostics at the earliest opportunity and provides clinicians with essential information to optimally manage their patients from a new-born baby to an elderly struggling to combat an infection.

Caption



The broad and growing range of tests available for GeneXpert empowers even remote clinics to treat a range of conditions.

Many Commonwealth countries experience the highest rates of communicable diseases globally. How can GeneXpert technology best be deployed to counter this?
Being modular, the GeneXpert System can be configured to match the requirements at any level of the healthcare system. As workload increases, additional modules can be added.

Where patients may be hard to reach, the GeneXpert can be taken to the point of need. Numerous examples exist of GeneXpert systems being deployed in mobile units for tuberculosis screening of populations in remote villages or mining communities.

A significant number of GeneXpert systems are deployed in Commonwealth countries, used predominantly to test for tuberculosis, but also increasingly used to test for other diseases including HIV, STIs, HPV and Hepatitis.

In 2017, Cepheid launched Xpert MTB/RIF Ultra, which was then endorsed by WHO. Are you able to share what effect on diagnosis and mortality rates has been seen over the past two years? Also, regarding AMR detection?
Two years is a very short time in the history of tuberculosis, when statistics are published with almost a year delay. What we are seeing are signs that fewer tests are being processed in some of the early adopter countries which is a good indicator of a reducing burden.

Recently, solid evidence of the impact of Xpert MTB/RIF appeared in the New England Journal of Medicine. Marks et al reported significantly reduced tuberculosis incidence in villages in Vietnam where, over a period of 4 years, the adult population who could produce sputum were systematically screened with GeneXpert when compared to the national standard of care.

Being more sensitive than the test used in this study, Xpert MTB/RIF Ultra is expected to increase case detection while detecting resistance to rifampicin, the key first-line antibiotic in the treatment of tuberculosis. Early detection of resistant cases contributes to the prevention of the dissemination of resistant strains throughout the population.

Lastly, what innovations are planned by Cepheid between now and the SDG Agenda deadline in 2030, especially in terms of your partner organisations, and specifically in respect of the 53 Commonwealth countries?
We are entering field validations of our new GeneXpert Omni, which will make GeneXpert truly portable and being battery-powered ensures that no community is beyond reach.

Cepheid continues to expand the range of cartridges that can be processed on the GeneXpert. In 2020, the launch of Xpert MDR TB is anticipated. This will allow the rapid detection of resistance to a range of second-line antibiotics widely used in the treatment of tuberculosis allowing doctors to accurately tailor the treatment of patients infected with resistant strains.

We announced our R&D investment in a blood-based assay, which is an easier sample to collect than sputum, mainly in people living with HIV and young children.

Finally, we continue to support the implementation of the multiplexing capabilities of GeneXpert, ensuring all countries that have invested in our technology that it can be utilized at its full potential.

To learn more visit

www.cepheid.com

Pandemic preparedness must be prioritised

Elhadj As Sy, Co-chair of the Global Preparedness Monitoring Board and Former Secretary General of the International Federation of Red Cross and Red Crescent Societies, emphasises the devastating potential - and inevitability - of pandemics. He calls on international organisations and governments to engage more effectively at a local level to ensure preparedness is prioritised and communities are protected.

Elhadj As Sy,
Co-chair, Global Preparedness Monitoring Board, and Former Secretary General, International Federation of Red Cross and Red Crescent Societies

"We must hold ourselves accountable, learn from and not repeat past lessons and take real action to ensure that preparedness is prioritised and so communities are protected."

In September 2019, the Global Preparedness Monitoring Board, which I co-chair with Dr Gro Harlem Brundtland, published its First Annual Report on the state of the world's preparedness for health emergencies. In the report we said:

"If it is true to say 'what's past is prologue', then there is a very real threat of a rapidly moving, highly lethal pandemic of a respiratory pathogen killing 50 to 80 million people and wiping out nearly five per cent of the world's economy. A global pandemic on that scale would be catastrophic, creating widespread havoc, instability and insecurity. The world is not prepared."

The latest novel coronavirus outbreak is a stark reminder of emerging, pandemic-potential risks – as we noted in our report it is 'not if, but when.' At the time of writing, this outbreak has spread to at least 25 countries and killed more than 1,000 people in the space of several weeks. More needs to be learned about this virus, but it should be taken seriously.

Unfortunately, the findings of the Board remain as relevant today. Despite progress, many countries are currently unprepared to respond to the coronavirus outbreak and urgent action is needed, especially in lower resourced countries, to ensure that the virus can be detected early and stopped.

On top of this, we are still fighting major outbreaks of other infectious diseases worldwide. More than 2,250 people have died of Ebola in the Democratic Republic of Congo and individual cases have escalated to over 3,400. Measles is making a vicious comeback across many parts of the world, in spite of a safe, affordable and effective vaccine that has succeeded in entirely eliminating this terrible childhood disease from many countries. Commonwealth countries are not immune. In 2019, India and Nigeria were among the top ten countries with the largest measles outbreaks in the world. Cholera, a disease of the middle ages, continues to bring suffering to millions of people in poverty. Recent outbreaks in Yemen and Mozambique have killed hundreds, even though we know how to prevent it with good sanitation and access to clean water.

We already have many of the tools needed to protect ourselves, but what we need is strong leadership and the will to act. Growing economic inequality and serious under-investment in public health systems and capacities leave many countries ill-equipped to respond to health crises quickly and effectively. In countries where health systems are chronically weak and unable to cope, more investment and training of local volunteers and

RIGHT:
Uganda Red Cross has trained local volunteers to both educate communities about Ebola, as well as to recognise and report individuals showing signs and symptoms of the virus.

"We already have many of the tools needed to protect ourselves, but what we need is strong leadership and the will to act."

community health workers, more clinics, more medical equipment, drugs and staff are all needed. These are the shortfalls that are, in part, responsible for the spread of Ebola in the Democratic Republic of Congo. But decades of violent insecurity, and communities' lack of trust in authorities and healthcare workers, has made this outbreak more complex and harder to contain regardless of a well-funded, well-equipped response, and newly available vaccines and medicines.

By contrast, in neighbouring Uganda, when a five-year old boy and his grandmother entered the country with Ebola, the country was ready. Preparedness and collaboration between government authorities and local responders, including Red Cross volunteers who used their unique community presence to undertake screening and sanitisation at border points, ensured that the virus did not spread beyond the boy and his grandmother, both of whom sadly lost their lives to the disease. As the coronavirus continues to spread, ensuring that communities are properly informed, know how to protect themselves and trust the medical response, will be crucial to controlling the outbreak. Building public trust must be a central element of our response to the novel coronavirus outbreak.

We need to invest in public health, research and development, medical infrastructure and treatment but this will only take us so far. The key to building trust lies in establishing long-term partnerships with communities. Consistent engagement before, during and after an outbreak is critical and is the cornerstone for enduring trust. Outbreaks begin and end in communities. And yet international organisations and local authorities have not made the necessary investments to support and enable action at a local level. This fundamentally weakens the effectiveness of any response.

Solutions to major health emergencies can no longer be solely focused on health, but must involve all parts and sectors of society, from the local to the international, in preparedness, detection, response and recovery. Are we collectively – international organisations and governments alike – doing enough to engage with communities, promote local ownership, invest in local action and build trust?

Across Commonwealth countries, Red Cross and Red Crescent volunteers are often on the frontline of support because they themselves come from the communities being affected. They see the first signs of unfamiliar illnesses and can sound the alarm. They can also quickly relay public health messages that are crucial to halting the spread of highly infectious diseases. And, of course, they can help treatment efforts, including offering care and support for the families of the sick and deceased. Right now, Red Cross and Red Crescent volunteers in China and across Asia Pacific are engaging people and communities – online and offline – in carrying out health education and promotion to prevent misinformation about the coronavirus, helping to reduce fear and stigma.

For too long, world leaders have reacted to health emergencies with panic and then failed to prepare for the next outbreak. So many promises made, but too many promises broken. We must hold ourselves accountable, learn from and not repeat past lessons and take real action to ensure that preparedness is prioritised and so communities are protected. We can no longer justify being caught unprepared. This has never been more true than today. ■

Ending AIDS by 2030: A matter of social justice

Global gains against the AIDS epidemic are slowing. In order for world leaders to deliver on their commitment to ending the disease as a public health threat by 2030, Winnie Byanyima, Executive Director of UNAIDS, stresses that we need to turbocharge the AIDS response with bolder political leadership and put an end to HIV-related stigma and discrimination.

Winnie Byanyima,
Executive Director, UNAIDS

Over the past four decades, the world has come far in understanding the HIV epidemic and has greatly increased its ability to reduce the impact of the virus. By harnessing the collective strength of international donors, governments, policymakers, civil society and community activists, medical experts, scientists and researchers, we now have a wide range of effective tools to prevent and treat HIV.

Today, more people have access to lifesaving treatment than ever before and millions of lives have been saved. This is to be celebrated.

And yet, there are an estimated 22.4 million people living with HIV in the Commonwealth – almost 60 per cent of the worldwide total of 37.9 million.

In 2018, 770,000 people died of AIDS-related illnesses worldwide. More than 14 million people living with HIV globally were still waiting for medicines that could keep them alive and well and, once a person is virally suppressed, stop the virus being transmitted. An estimated 1.7 million people became newly infected with HIV, and around 160,000 children aged 0–14 years acquired HIV – far wide of the target of 40,000 that world leaders had set for 2018.

Global gains against the epidemic are slowing, countries are showing mixed results and the goal of ending AIDS as a public health threat by 2030 is in danger of not being met. Clearly, there is a drag in response, and a bolder political leadership and vision are urgently required.

We need to turbocharge the AIDS response by adopting health policies and programmes that are grounded in human rights and respond to how people live their lives. We must end HIV-related stigma and discrimination and create legal environments that result in unimpeded pathways to health and other essential services.

Some Commonwealth countries are showing what can be done.

For example, Botswana, which has the third largest HIV epidemic in the world, has significantly expanded treatment access for people living with HIV over the past decade. In 2016, it adopted a treat-all strategy for citizens living with HIV and extended free treatment to foreign residents in 2019. These policy shifts will help build on the country's progress – since 2010, AIDS-related deaths in the country have decreased by a third, with new HIV infections down by 36 per cent over the same period.

South Africa has also made significant progress against HIV by rapidly expanding its treatment programme. In 2000, very few South Africans had access to treatment but today, almost 5 million people in the country are taking lifesaving medication and the government has committed to

"There are an estimated 22.4 million people living with HIV in the Commonwealth – almost 60 per cent of the worldwide total."

Credit: UNAIDS

ABOVE:
Jema Adamu, a woman living with HIV and a peer educator, helps her son and granddaughter with their school work in Nkuhungu, Dodoma, Tanzania.

"Global gains against the epidemic are slowing and the goal of ending AIDS as a public health threat by 2030 is in danger of not being met."

increasing this figure to more than six million by the end of 2020.

There has also been considerable progress made in many Commonwealth countries to end mother-to-child transmission of the virus. More than 95 per cent of pregnant women are accessing antiretroviral medicines in Botswana and Namibia, with over 90 per cent on treatment in Kenya, Uganda and the United Republic of Tanzania. The progress made by these countries shows what can be achieved through strong political leadership, rapid policy adoption and concerted effort by all stakeholders.

High-income Commonwealth countries like Australia, Canada, New Zealand and the United Kingdom continue to demonstrate global solidarity by investing in the AIDS response, even as some low- and middle-income countries take on more financial responsibility.

Belize, Botswana, India and Trinidad and Tobago are among those countries creating more enabling legal environments for groups at higher risk, such as men who have sex with men and transgender people, making it easier to reach them with HIV treatment, prevention and counselling services.

This is great, but we need more to be done, and faster.

Sustained progress towards the goal of ending AIDS depends on a much more consistent global approach that recognises the need to respect the

human rights of young women and girls and other groups at higher risk of HIV infection.

The extent to which gender-based violence and gender inequities continue to fuel the HIV epidemic is truly shocking. Every week, around 6,000 young women aged 15-24 become infected with HIV. In sub-Saharan Africa, four in five new HIV infections among those aged 15-19 years are in girls. Young women aged 15-24 are twice as likely to be living with HIV than men.

Enough is enough. Young women and girls must be educated, employed and empowered to make independent, informed decisions about their lives and their health. They deserve a future. Perpetrators of gender-based violence must face justice.

Too many countries in the world, including most Commonwealth members, maintain laws that criminalise and discriminate against lesbian, gay, bisexual, transgender and intersex people. Sex workers, people who use drugs, prisoners and migrants are marginalised and denied essential health services.

We will not end this epidemic without righting the social injustices and transforming the economic determinants that make people vulnerable.

And we need to invest. The AIDS response must be fully funded. In 2016, the UN General Assembly agreed in its Political Declaration on Ending AIDS, to a steady scale-up of investment in the AIDS response in low- and middle-income countries, increasing to at least $26 billion USD by 2020. At the end of 2018, however, only $19 billion USD was available for this purpose.

The AIDS response cannot succeed with one hand tied behind its back.

The world stands on the threshold of a new decade. World leaders must deliver on their commitment to ending AIDS as a public health threat by 2030. But they must recognise that it is not just about a clinical response but about creating societies where people feel safe and secure, educated, informed and confident to take care of themselves and their loved ones.

The next ten years must be a decade devoted to an expansion of human rights and social justice and to the creation of fairer societies and better health for all.

Millions of lives are counting on it. ■

"World leaders must recognise that it is not just about a clinical response but about creating societies where people feel safe and secure, educated, informed and confident."

BELOW:
We will not end the AIDS epidemic without righting social injustices and ending discrimination against lesbian, gay, bisexual, transgender and intersex people.

NATIONAL VETERINARY RESEARCH INSTITUTE

Vom, Nigeria

Animal Health leads to Human Health

What began in 1924 as a small laboratory for the production of an antiserum to control the deadly rinderpest scourge in cattle, has today grown into a renowned institution, with a wide mandate for animal disease surveillance and control across Nigeria, for research, and for animal vaccine development and production.

With a mission to be the foremost veterinary institute in Africa, research programmes are designed to deliver on the mandate of the National Veterinary Research Institute and to achieve that mission. The key to our success is a continued self-regulation and peer review process, to ensure that research is demand driven and generates technologies that will address animal and human health challenges.

As a strong advocate of 'One Health', NVRI champions collaborative research in zoonotic diseases, such as brucellosis, rabies, tuberculosis, which affect both humans and animals. With the commissioning of a 'Biosafety Level 3' laboratory in 2016, the National Veterinary Research Institute is well positioned as a leading centre for diagnosis and research into 'Risk Group 3' biological agents, which can cause such serious disease transmissions between humans and animals.

Dr David Shamaki DVM, MSc, PhD, FCVSN
Director/Chief Executive

www.nvri.gov.ng

A defining moment in the fight against malaria

CEO of Malaria No More UK, James Whiting, reinforces the Commonwealth's key role in efforts to eliminate malaria and firmly believes that now is the defining time to keep our promises and step up the fight against humanity's oldest and deadliest disease.

James Whiting,
CEO, Malaria No More UK

"This preventable and treatable disease still kills a child every two minutes and is the biggest killer of children under five in most of Africa."

Since 2000, the international malaria community has achieved significant success in cutting deaths from malaria by more than 60 per cent, saving almost seven million lives, many of which are young children and vulnerable people in Africa and around the world.

However, despite such impressive gains, this preventable and treatable disease still kills a child every two minutes and is the biggest killer of children under five in most of Africa. The 2018 WHO World Malaria Report revealed that in recent years, global efforts in combatting the disease have slowed down, progress has sadly stalled and many countries were experiencing a deadly malaria resurgence. With a similar warning message in 2019, it is a sobering reminder that humanity's oldest enemy will not go down without a fight. We simply can't sit back now.

Indeed, we are at the beginning of a critical decade of delivery and action on the UN Sustainable Development Goals (SDGs). The possibility of reducing malaria cases and deaths by 90 per cent in the next ten years represents a critical step towards achieving SDG 3 – 'to end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases by 2030' – as well as accelerating progress against multiple other SDGs and attaining universal health coverage (UHC).

History has shown us that malaria comes back rapidly and with devastating consequences if efforts are let up too soon. This is why Malaria No More UK is working with Commonwealth members and global partners to redouble our collective efforts.

In 2018, we were pleased to be able to support the London Malaria Summit, on the eve of the 2018 Commonwealth Heads of Government Meeting (CHOGM18), which brought together an historic partnership of governments, civil society, the private sector and multilateral organisations, to deliver an astounding $4.1 billion USD investment earmarked for the global malaria fight.

Two days later at CHOGM, all 53 world leaders in attendance collectively committed to halving cases of and deaths from the world's oldest and deadliest disease across the Commonwealth by 2023, and accelerating global efforts to cut malaria by 90 per cent by 2030. They agreed that progress on these commitments should be considered every two years at the Commonwealth Health Ministers' Meeting and should also be reported at CHOGM.

If we stick to our word, implement the right tools and strategies and strive to deliver the necessary funding and cutting-edge political leadership

"History has shown us that malaria comes back rapidly and with devastating consequences if efforts are let up too soon."

pledged at the summit, the next four years will prove to be a defining moment in humanity's long-running battle against this devastating disease.

Making good on these unprecedented promises will prevent an estimated 350 million cases of malaria and save 650,000 lives across 25 Commonwealth countries still working hard to eliminate the disease. It would also have a significant impact on the global trajectory of malaria, as the Commonwealth accounts for more than half of all cases and attributed deaths, and the commitment will drive vital progress towards the 2030 global goal for health and beyond.

So how are we going to propel progress, accurately monitor and ultimately achieve this ambitious, but attainable, target in the Commonwealth? Since the commitment was made in April 2018, there has been significant and notable action by many Commonwealth members and their partners to drive attention, resources and action to accelerate progress against malaria. These include, for example: the launch of High Burden to High Impact initiatives by seven of the Commonwealth member states most affected by malaria; the introduction of new tools like next-generation bed nets to help tackle insecticide resistance; the piloting of the world's first malaria vaccine in three Commonwealth member states; the E-2020 initiative for countries nearing elimination; the establishment of national multisector End Malaria Councils and Funds and the rollout of the Zero Malaria Starts with Me campaign to drive renewed attention and help mobilise public and private sector resources. Context-specific innovative interventions and programmes like these, designed and implemented by Commonwealth members, will be critical to driving progress towards the 2023 and 2030 targets.

In October 2019, France hosted the largest ever pledging moment for global health, with donor governments, implementing countries and the private sector pledging a record-breaking total of over $14 billion USD through The Global Fund to Fight AIDS, Tuberculosis and Malaria.

The newly replenished fund aims to help save 16 million lives over the next three years, cut the mortality rate for the three diseases in half and build stronger, more shock-resistant health systems for some of the poorest and most marginalised populations in the world. The UK's game-changing £1.4 billion investment alone will help save two million lives over the next three years and demonstrates global Britain at its best. The next big step is to stimulate

Credit: MMN UK

significant co-financing pledges in coming years.

This financial boost is a huge achievement for malaria endemic countries in the Commonwealth and beyond, since the Global Fund represents approximately 60 per cent of malaria funding worldwide and is a proven and reliable humanitarian mechanism for maximising health intervention impacts, with 131 million mosquito nets distributed and more than 32 million lives saved across the three diseases, since 2002.

However, despite the importance of this renewed action and commitment, there remain significant challenges ahead, including meeting resource gaps, the need to scale up proven and new interventions, reach all populations at risk, strengthen health and community systems, sustain and increase political will and multisector action to accelerate progress.

The next year will be critical for securing the country-by-country plans, and resource and implementation strategies needed to drive progress towards the 2023 target. There are some important opportunities on the horizon, including: harnessing the new Global Fund resources and leveraging domestic financing; using WHO data to implement a new digital tracker that allows countries and partners to check annual progress towards the 2023 targets, along with country-specific case studies to showcase some of the work that is helping to drive this progress; and profiling new commitments that come out of a critical high-profile moment during the 2020 CHOGM being hosted by Rwanda, where there is an opportunity to profile new and renewed multisector action and commitments, working to accelerate progress in individual countries and across the Commonwealth.

We and our malaria community partners are looking forward to an exciting year working with Commonwealth members and their partners to maximise these opportunities to increase momentum.

We firmly believe that if we keep our promises and step up the fight without delay, the historians of the future will look back on this time as a defining moment, when the trajectory of malaria was bent towards a world free from the disease. ■

ABOVE:
Many Commonwealth countries have accelerated progress against malaria in recent years, including introducing next-generation bed nets to help tackle insecticide resistance.

"If we stick to our word, the next four years will prove to be a defining moment in humanity's long-running battle against this devastating disease."

Neglected tropical diseases are neglected no more

Lesser-known tropical diseases affect a fifth of people and can ravage a person's health and wellbeing, and devastate communities. Dr Caroline Harper, CEO of Sightsavers, explains how relatively simple and inexpensive interventions can be used to eliminate these diseases when stakeholders come together to take action.

Dr Caroline Harper,
Chief Executive Officer,
Sightsavers

"Neglected tropical diseases can cause lifelong disabilities, chronic pain and, in some cases, total sight loss."

One of the most effective and achievable ways that countries can ensure their citizens are as healthy as they can be, and promote wellbeing for all, is by eliminating a group of previously little-known diseases which needlessly devastate lives. The impacts are life-changing; the difference between a life of pain and isolation and one of greater opportunity.

What are NTDs?

Neglected tropical diseases (NTDs) are a group of parasitic and bacterial infections affecting around one billion – or one in five – people across the world.

They became known as 'neglected' because historically, they did not spark the same public attention or investment as other epidemics such as malaria or Ebola. Also, they affect some of the poorest or neglected communities in the world, where sanitation is poor and families must travel long distances to reach healthcare services, if they can afford them at all.

The diseases can cause lifelong disabilities, chronic pain and, in some cases, total sight loss. They can stop children going to school, adults from working and all from having social lives. Among many others, NTDs include:

- Trachoma, which turns eyelids inwards and cause lashes to scrape painfully against the eyeball. It can eventually lead to blindness.
- River blindness, which causes an irritation so extreme that people scratch themselves until they bleed, and gradually results in irreversible blindness.
- Lymphatic filariasis (LF), which causes abnormal swelling to parts of the body, leading to painful disability and stigma.

Simple to avoid and inexpensive to treat

Almost all NTDs are easy to both treat and avoid. With advances in treatments and methods of distribution, it is well within our reach to manage and even eliminate them.

Rahinatu Adam, from the Yendi province of Ghana, had suffered years of crippling pain from her advanced trachoma when health teams found her. She had been stuck indoors, unable to work, isolated from her normal life. But all it took was a quick 20 minute operation to reverse her eyelids and this all changed. Particularly touching was the fact that this operation coincided with her granddaughter Mariam's naming ceremony. It took place soon after her bandages were removed, and as she was handed Mariam to hold as part of the celebrations, she told our teams it was the first time that she had actually seen her face properly.

The straightforward surgery cost just £44 GBP and yet it transformed life for Rahinatu, as it does for many

ABOVE:
Baraka Ango delivers Sightsavers' billionth NTD treatment for river blindness in Kaduna, Nigeria.

others like her. Antibiotics, which prevent those with the early stages of trachoma from progressing to advanced disease like Rahinatu's, cost just 15p per treatment.

Rahinatu's surgery was actually one of the last operations performed in Ghana before the country became the first in sub-Saharan Africa to eliminate trachoma as a public health problem. This trailblazing milestone showed us what can be achieved across the rest of the world to beat trachoma and other life-crushing NTDs.

Small actions, big goals

If we concentrate efforts, we really can make huge gains from comparably small actions and free millions of people from devastation.

In recent years, there has been an increasing awareness of these previously little-known conditions. Momentum has gathered and international organisations such as Sightsavers, as well as governments, donors and communities, are coming together to take action.

The Commonwealth has taken a lead in this. Among other things, the 54 member states committed to eliminating trachoma at the 2018 Commonwealth Heads of Government Meeting (CHOGM) in London. The leaders meet again in Rwanda in June 2020, where they will review progress and are expected to renew their commitment to combatting all NTDs with the aid of a new WHO NTD roadmap, to be presented at the 2020 World Health Assembly. NTDs are neglected no more.

How will we eliminate NTDs?

Eliminating these diseases is a big undertaking but a global taskforce has already made huge strides.

Development programmes support large-scale drug administration to get antibiotics to the people that need them, as well as surgical outreach to treat those with advanced symptoms. They also prevent the spread of disease by improving hygiene and sanitation. Health education programmes target communities and schools with information and behaviour change advice, encouraging children to wash their hands and faces thoroughly each day. Communal taps have also been installed to improve access to uncontaminated water sources.

One of the most important large-scale programmes to tackle the disease is the Trachoma Initiative. Funded by the Queen Elizabeth Diamond Jubilee Trust, it launched in 2014 and supported governments in 12 Commonwealth countries in their national and local initiatives.

There are many other influential programmes including the Commonwealth Fund, which targets blinding trachoma in ten Commonwealth countries, and

is managed by Sightsavers with funding from the UK Government. It was launched in April 2018 at CHOGM and is boosted by the Accelerate Trachoma Elimination Programme, which receives funding from philanthropists including the Children's Investment Fund Foundation, The ELMA Foundation, Virgin Unite and the Bill & Melinda Gates Foundation.

In September 2019, the UK Government made another exciting announcement when it launched its largest ever flagship NTD programme, 'Ascend'. The Ascend West and Central Africa part of the programme, led by Sightsavers, will treat five diseases in 13 African countries. The groundbreaking initiative will treat multiple diseases together on a large scale for the first time.

Working together for a lasting legacy

Key to treating and eliminating NTDs is partnership and collaboration. Success can only be achieved by working with ministries of health and communities, as well as other NGOs and academic partners, to ensure change comes from within and has a long term and sustainable impact.

It is vital that surgeons based in each country are trained to conduct operations and then continue to use these skills for future generations, and that health-strengthening infrastructure is put in place to ensure a lasting legacy.

Community volunteers, such as Baraka Ango who delivered Sightsavers' billionth NTD treatment in Nigeria at the end of 2017, are also integral.

Baraka is from the village in which she volunteers and is respected there – people trust her and allow her into their homes, accepting the antibiotics and health advice that she offers. She is driven to help from personal experience and told us she remembered when, in the late 90s, every home in her village in the Kaduna region had someone blinded by river blindness.

ABOVE:
Trachoma patient Rahinatu Adam from Yendi, Ghana, and her granddaughter Mariam.

Then, in August 2019, the Nigerian Government announced that this same disease had been removed from the region. Transmission of river blindness had been interrupted and so future generations freed from the threat of the disease that had plagued their ancestors.

This is just one example of the successes that we have already achieved in our fight against these destructive diseases. There is so much more to be done, but with continued support, collaboration and determination, I am confident that we will get there. ■

"Key to treating and eliminating neglected tropical diseases is partnership and collaboration."

Harnessing innovation to fight communicable diseases

Trevor Mundel, President of Global Health at the Bill & Melinda Gates Foundation, highlights the role of innovation in driving down the burden of communicable diseases around the world, and calls on Commonwealth governments to accelerate the next phase of progress through investment in global health research and development.

Trevor Mundel,
President of Global Health,
Bill & Melinda Gates Foundation

"Combined with greater resources, increased political leadership and improvements in health delivery systems, investment in innovation has fuelled a 21st century renaissance for human health."

In today's world, we experience the benefits of innovation every day. For many people, journeys that once took weeks now take only hours; information previously accessible to a few can be retrieved by millions; people thousands of miles apart can connect instantly using devices that fit in the palm of their hands.

Yet, none of these advancements has done more to shape modern society than the innovations in how we fight disease. In my lifetime, the advent of new tools to prevent, diagnose and treat infectious diseases such as malaria, polio, typhoid, river blindness and dozens of other maladies, has dramatically reduced the burden of sickness and poverty around the world.

Take measles, a highly contagious and often deadly disease. When I was born in 1960, measles circulated indiscriminately around the world, killing an estimated 2.6 million people every year, most of them children under the age of five. Just three years later, the first measles vaccine was introduced and the tide began to turn. Today, measles deaths have fallen by more than 95 per cent.

This is far from an isolated example. We can thank widespread uptake of insecticide-treated mosquito nets, new medicines and improved point-of-care diagnostics, for helping to avert 663 million malaria cases between 2000 and 2015. Along a similar timeline, advances in antiretroviral therapy and methods to prevent mother-to-child transmission, have turned HIV infection from a death sentence into a manageable chronic condition and helped save millions of children from contracting the virus.

Look back across history and a pattern emerges: when innovations become available to those who need them, sickness and death from disease plummet. In turn, families and communities become healthier, and economies more productive. Combined with greater resources, increased political leadership and improvements in health delivery systems, investment in innovation has fuelled a 21st century renaissance for human health.

But despite all our progress, too many people today continue to fall sick or die from problems that science has the potential to solve. In 2017, 219 million people were infected with malaria, and 128 million of these were in Commonwealth countries alone. Despite historic gains in the fight against HIV, 770,000 people died last year from AIDS-related illnesses. Data for other communicable diseases, including tuberculosis (TB), measles, hepatitis and various neglected tropical diseases, tell a similar story.

New medical challenges are emerging that even our most effective tools cannot overcome. For example, growing resistance to frontline drugs and insecticides is impacting our

ability to prevent and treat diseases like TB and malaria. Meanwhile, just as people and information can travel more widely, so too can communicable diseases. An outbreak of coronavirus, Ebola or Lassa fever in one country can quickly become an epidemic in another, halfway around the world.

Perhaps most troubling is that progress in human health has not been shared equally. Where you are born still determines how long you will live and the quality of your life. In the wealthiest countries, most communicable diseases pose little threat. In the poorest, millions of families live in fear of mosquito bites and the safety of their drinking water.

To achieve the Sustainable Development Goals and build a healthier and more equitable world, we must work collectively to overcome these obstacles. While innovation alone is not a panacea, history shows that it must be part of the solution. Sustained investment in research and development (R&D) is critical to tackling today's most urgent health challenges and laying the groundwork for future discoveries that could change the world.

Several recently announced breakthroughs hint at what's possible and demonstrate the tremendous potential of innovation to improve and save lives.

A great example can be found in the fight against HIV, where a new treatment will likely become available within the next few years. Unlike current treatments that require daily doses, this new medicine could prevent infection with just one dose per month. Additionally, a novel treatment for lymphatic filariasis has been developed that could shave years off the timeline for eliminating the disease in Commonwealth countries like Kenya or India, where it is being rolled out.

In other cases, the solutions we need are not so close at hand. We still lack the cures and vaccines needed to tackle diseases like HIV, TB and malaria, nor do we have a universal vaccine to protect against influenza, which kills hundreds of thousands of people each year. Developing these and other health technologies won't happen overnight – on average, developing a drug takes a decade and vaccines, even longer. That is why a sustained commitment to R&D over time is vital, so that investments made today can improve the health and wellbeing of future generations.

At the same time, health innovations can only have impact if they reach the people who need them most. In addition to developing new technologies, we also need to improve the speed and efficiency with which innovations advance from the lab to the field. In those countries most affected by communicable diseases, this means continuing the long-term work of strengthening healthcare systems.

Accelerating access to new tools will also require finding solutions farther upstream. That means streamlining regulatory pathways for approving drugs, establishing out-of-the-box finance mechanisms that draw new partners and funding to the table, and strengthening clinical trial capacity in the places most in need of game-changing innovations.

Harnessing innovation to fight communicable diseases requires shared commitment – from governments, industry, academia and philanthropy. Each brings unique resources and capacity that are essential to accelerate the development and delivery of the next generation of health technologies. Through closer and smarter collaboration, it is possible to build a more robust R&D ecosystem that saves and improves more lives than ever before.

The Commonwealth is uniquely positioned to transform this vision into reality. Member states are home to 12 per cent of the world's researchers and account for around ten per cent of global R&D spending – and could play an even larger role in translating innovation into safer, healthier and more productive communities.

From ending polio to reducing malaria deaths, the Commonwealth has already demonstrated the power to galvanise its partner countries behind ambitious goals that drive progress against communicable diseases. As the world faces new and evolving challenges, the Commonwealth's ongoing scientific investment and steadfast political commitment will be critical to developing the tools we need to face disease threats and unlock human potential.

In the 30 years since 1990, the world's efforts to develop and scale new health innovations helped reduce the number of children that die each year from communicable diseases by half. Together, I'm confident we can build on this progress and work to ensure that history repeats itself, creating a healthier, fairer and more prosperous world for everyone. ■

COMMONWEALTH

HEADS OF GOVERNMENT MEETING 2020 REPORT

9th in the series of Commonwealth Business Communications' biennial CHOGM publications

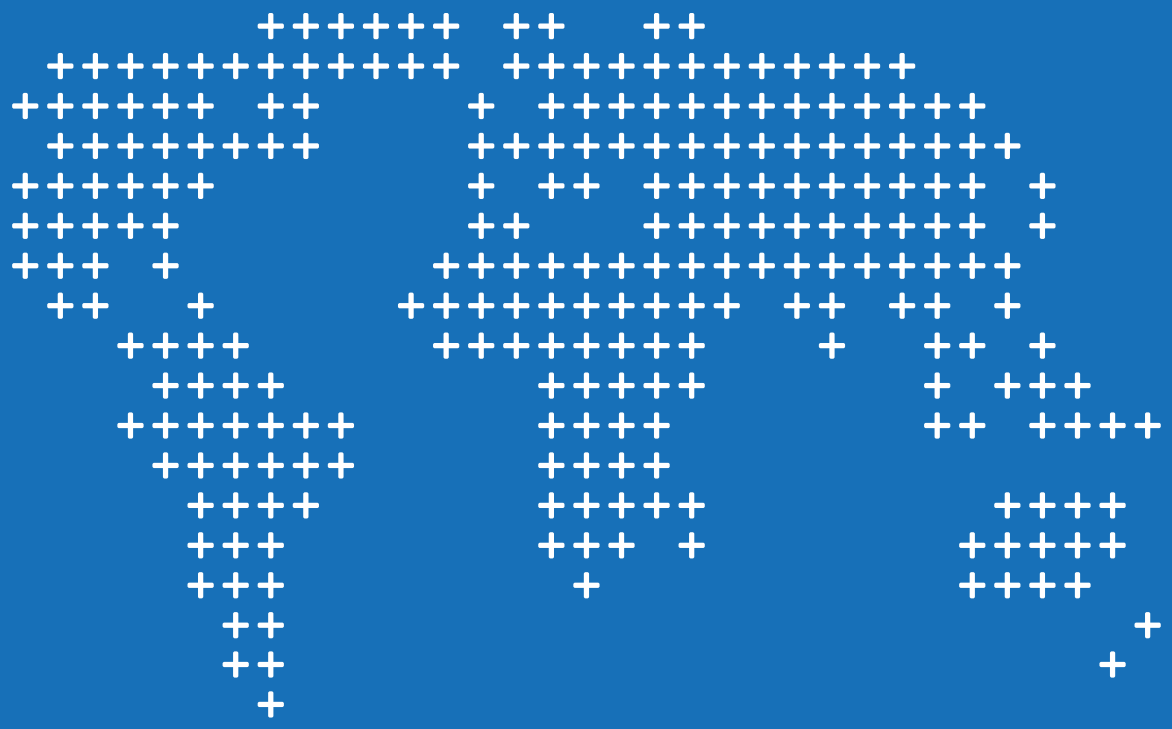
'Delivering a Common Future: Connecting, Innovating, Transforming'

The 2020 Commonwealth Heads of Government Meeting (CHOGM) will bring together leaders from Commonwealth countries to reaffirm common values and address shared global challenges. The theme for the Meeting is 'Delivering a Common Future: Connecting, Innovating, Transforming' and is focused on building on the strengths of the Commonwealth to ensure the unique organisation helps member states transform their societies and deliver a more prosperous, secure, sustainable and fair future for all citizens, in particular empowering women and young people.

If you would like to contribute an article or advertisement to the publication please contact Michael Malcolm:

mmalcolm@commonwealthministers.com

Addressing noncommunicable diseases



Our Commonwealth's silent epidemic

Dr Sania Nishtar, co-Chair of the WHO High Level Commission on NCDs and Special Assistant to the Prime Minister of Pakistan, calls on Commonwealth leaders to firefight the slow-burning crisis of NCDs with the same urgency as a global pandemic.

Dr Sania Nishtar,
Co-Chair, WHO High-Level Commission on NCDs, and Special Assistant to the Prime Minister of Pakistan on Poverty Alleviation and Social Protection

When asked to think about the biggest threats to global health, most people conjure images of diseases like influenza, Ebola and measles. Viruses that spread like wildfire with visceral symptoms capture the human imagination and media attention, yet a global epidemic responsible for more than ten million premature deaths across the Commonwealth every year is largely ignored.

Noncommunicable diseases (NCDs) are now the Commonwealth's top killers. Cancer, diabetes, heart and lung disease make up the bulk of NCD deaths. The slow but fateful onslaught of many NCDs means that fatalities often come after long hospitalisations and costly treatment, which puts huge pressure on already fragile health systems. Mental illness increases the risk of these chronic diseases, and vice versa, so developing a comprehensive strategy means effectively tackling both.

There are clear actions that Commonwealth governments can take to reverse current trends and prevent the early deaths of millions of our citizens. However, a new report by the WHO's Independent High-Level Commission on NCDs finds that despite global commitments, these chronic diseases have not been effectively prioritised by governments. Not enough has been done on financing, planning, integration with universal health coverage (UHC), measurement and overall implementation. As signified by the tobacco industry lobbying to prevent lifesaving interventions, economic, market and commercial factors have also impeded governments' abilities to implement the WHO's 'best buys'.

In all Commonwealth countries, obesity has been one of the primary drivers behind dramatic increases in cancer, type 2 diabetes and heart disease over the past decade. Despite well-established data showing how obesity causes these deadly diseases, not enough is being done to stop rates from spiralling in virtually every member state.

Many low- and middle-income countries in our network are increasingly facing a dual burden of malnutrition, with health systems simultaneously struggling to care for both the under- and over-nourished. Take Pakistan, for example, where 40 per cent of children suffer from stunting, but at the same time, rates of childhood obesity have doubled since 2011. This is why, through the umbrella Ehsaas programme – Pakistan's whole of government welfare initiative – there is a special emphasis on malnutrition in all its forms. The fact that the Prime Minister-led National Council oversees nutrition initiatives demonstrates that these challenges are viewed as top-level priorities.

Similarly, NCDs attributable to air pollution are increasingly complex problems, which now cause four million deaths worldwide every year. Cities across the Commonwealth

"The slow but fateful onslaught of many NCDs puts huge pressure on already fragile health systems."

"All Commonwealth countries have experienced dramatic increases in type 2 diabetes, cancer and heart disease over the past decade."

have begun to take action to promote cleaner transportation – ranging from a new traffic pollution charge scheme in London to car-free days in Kigali. However, these measures must become mainstream to stop the air people breathe putting them at risk of NCDs. Air inhaled inside homes – not just outside them – also needs to be accounted for, given that three billion people worldwide cook on dangerous open stoves. In Uganda, over 10,000 deaths annually are attributable to household air pollution, disproportionately affecting women and girls.

What all these drivers of the NCD epidemic have in common is that they require responses that go beyond the remit of ministries of health. Obesity connects to our food systems, education and commerce, while air pollution is linked with transport, industry and gender. Other risk factors like tobacco and alcohol are similarly multidimensional. That is why every country in our network must develop a whole-of-government response to NCDs, with approaches that span everything from agriculture to urban planning and finance to education. By sharing knowledge and experiences across the Commonwealth, we will maximise impact.

In all of our countries, we must rally allies beyond healthcare, including constructive engagement with the private sector – where appropriate – with vested interests managed and undue influence guarded against. Where they have proven effective, increased regulations should be deployed across the Commonwealth.

However, plans, strategies and alliances mean little without people to implement them. That is why governments must also commit to empowering health workforces, particularly nurses and community health workers. WHO declared 2020 as the Year of the Nurse and Midwife, expanding opportunities to engage this critical group of stakeholders.

As the health workers closest to their communities, nurses and midwives should be empowered to lead on the prevention, diagnosis and treatment of chronic diseases and mental disorders. This also relates to the need for strengthened primary health services, with interventions happening at the community level wherever possible. Supporting workforces and improving health systems will, in turn, make the world better prepared for future disease outbreaks – both communicable and noncommunicable.

Since the turn of the millennium, there has been nowhere near enough progress on stopping the global epidemic of NCDs and mental illness. The Commonwealth is uniquely positioned to provide a forum for collective action and shared learning. It was encouraging to see NCDs specifically mentioned in the high-level statement of the 2019 Commonwealth Health Ministers Meeting, rightly highlighting prevention and screening as two areas needing urgent attention.

All member states – no matter their economic profile – must demonstrate their willingness to engage with the thorny, entrenched problems that are coming to define the 21st century. To drive progress across the Commonwealth, national action plans for the prevention, promotion and control of NCDs must be developed, financed, measured and rolled out across government departments and other key sectors. Action must cover industry, agriculture, finance, sports, labour, the environment and education. Countries that face up to the hard challenges of NCDs will be well-positioned for tackling environmental change and inequality. Treating human capital as equally, if not more, important than economic growth will enable them to thrive by 2030 and secure long-lasting economic prosperity.

Now is the time to focus on delivering health for all, through political and economic commitment to tackling the world's biggest killers. Political and health leaders alike must firefight the slow-burning crisis of NCDs with the same urgency as a global pandemic. The core mission of the Commonwealth is to support member governments in improving the wellbeing of all their citizens. We have an opportunity to save millions of lives, so let's come together and start delivering. ■

Progressing the prevention and control of NCDs

Dr Ashley Bloomfield, New Zealand's Director-General of Health, looks at mobilising actors from across society to make further and faster progress in the prevention and control of noncommunicable diseases.

Dr Ashley Bloomfield,
Director-General of Health,
New Zealand

"Effective legislative and regulatory interventions, including the use of taxes, are needed to address the key risk factors for NCDs."

Great progress has been made in many Commonwealth countries over recent decades to reduce morbidity and early mortality from noncommunicable diseases (NCDs). This is the result of sustained effort across the continuum of prevention, early detection, managing conditions, rehabilitation and (where relevant) palliative care.

Key successes vary by country and include: significant reductions in tobacco consumption, improved nutrition, cancer screening programmes, more effective treatments, particularly for cardiovascular disease, mental health conditions and cancers, and better access to high quality palliative care.

However, NCDs remain the largest cause of preventable morbidity and premature death in the Commonwealth, with most of the early deaths occurring in low- and middle-income countries. Given that many of the drivers of this burden of disease are international – for example tobacco and alcohol production, marketing and sales – a global response is warranted, yet to date, the global policy response has not been proportionate to the associated health, economic and social burden.

This is also the case within many countries, particularly to address obesity and harmful use of alcohol. Policy and funding decisions happen in political contexts and a key challenge is to effectively influence the political context so it supports strong action on NCDs.

Mobilising society is fundamental for making further progress on NCD prevention and control, and there are three key dimensions of the societal response needed to make further and faster progress from here.

First, countries need to mobilise the resources required for effective interventions across the NCD continuum. Public funding for NCD prevention and control needs to be viewed by decision-makers as worthwhile and a high priority, given the multiple competing priorities even within health. For some Commonwealth countries, limited resources make this challenging, and more pressing health issues – such as communicable diseases and maternal and child health – may be considered a higher priority.

Societal concern about, and advocacy for NCDs will create an impetus for resource allocation. However, political leadership is also essential to ensure that commercial interests do not drown out the voices of concerned citizens and communities.

Second, individual communities and stakeholders can mobilise locally to address key NCD risk factors. There are many well-documented examples of this, including Healthy Families NZ. Based on the Healthy Together Victoria programme in Australia, Healthy Families NZ is a large-scale prevention initiative that

LEFT:
Healthy Families NZ is a large-scale NCD prevention initiative that includes exercise classes for families.

"NCDs remain the largest cause of preventable morbidity and premature death in the Commonwealth."

brings community leadership together in a united effort for better health. The focus is on improved nutrition, increased physical activity, more people smokefree and reduced alcohol-related harm. The programme supports communities to think differently about the underlying causes of poor health and to make positive changes to the social and physical environments in which people live, learn, work and play. These environments include, but are not limited to, education settings, workplaces, food outlets, sports clubs, businesses, places of worship, local governments and more. Similar community-based initiatives exist across the Commonwealth.

The origins of poor mental health and addiction include adverse childhood experiences, exposure to family and sexual violence and exposure to stressful and difficult events. Thus, efforts to improve mental health and wellbeing require wide societal action in a range of settings – including schools, workplaces, homes – as well as across the health system. An essential component of societal effort to improve mental wellbeing is destigmatisation. This requires community-wide action and there are many examples of countries that have effectively changed attitudes to greatly reduce the stigma experienced by people with mental illness so that they are empowered to seek timely help. This is surely an area where alignment of purpose across interest groups should be possible, as there are potential benefits for all stakeholders.

Third, effective legislative and regulatory interventions, including the use of taxes, are needed to address the key risk factors for NCDs. The challenge here is obvious – the significant political and economic influence of major industry players, notably in tobacco, food and alcohol. This requires, among other things, sustained and multi-pronged advocacy by a wide range of civil society actors working with communities to convince and support policy makers to take action. Progress with tobacco control is an excellent example resulting from such sustained societal action in many countries, supported by concerted global action under the auspices of the Framework Convention on Tobacco Control.

Of the three dimensions required to mobilise society for NCD prevention and control, the latter is arguably the most important given the significant impact that regulatory interventions play in reducing key NCD risk factors. However, all three are mutually reinforcing – communities that design and own their local interventions will be primed to mobilise and advocate for both resources and regulatory changes that will support their own efforts to improve health and wellbeing.

Ultimately, a successful and sustainable societal response requires alignment of purpose and action between government, citizens, civil society and private sector actors. To date, such alignment has proven elusive in addressing the main preventable NCD risk factors, not least because of the powerful commercial interests of some private sector players, which often overrides the public health imperative, at least in the short term.

There is a particularly urgent need for greater action to address overweight and obesity, which in most Commonwealth countries remain on an upward trajectory. Advocacy from the public health sector alone will not be sufficient to 'shift the dial'. Significant progress will require the interests of all key stakeholders to align, particularly communities, government and the private sector. Only then will decision makers feel they have the social licence to implement the full range of initiatives necessary, including regulatory ones.

Strong societal support is essential for the changes necessary to address key NCD risk factors and ensure people with NCDs have timely access to high quality diagnosis and treatment. There are now many effective examples of how to support communities in mobilising to address the significant burden of NCDs in Commonwealth countries. Lessons can and should be learned from other successes. A sense of urgency is needed and part of our role as health leaders is to ensure that communities have the resources and support to play their part. Let's get moving! ■

The role of civil society in combating NCDs

Katie Dain, Chief Executive Officer of the NCD Alliance, believes it is essential to involve civil society and communities in the battle against noncommunicable diseases and looks at how vibrant civil society movements can deliver advocacy, awareness-raising, access and accountability.

Katie Dain,
Chief Executive Officer,
NCD Alliance

"NCD civil society works to elevate the voices of communities and people living with NCDs, mobilising resources, advocating for political action and health policy reform, and holding governments and other stakeholders to account."

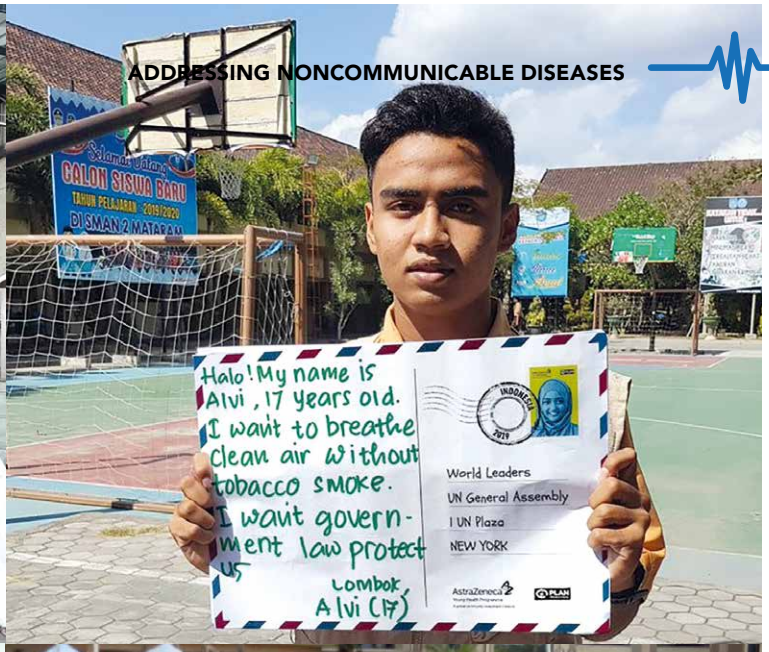
Since 2011, numerous commitments have been made by world leaders to reduce the burden of noncommunicable diseases (NCDs) at both global and national levels, as an integral component of meeting the Sustainable Development Goals (SDGs), and as a key element of achieving universal health coverage (UHC).

Many Commonwealth countries have acted as the engine behind the global political response to NCDs, particularly those in the Caribbean community (CARICOM), which anchored NCDs on the agenda of the UN via the instrumental Port of Spain Declaration of 2007.

However, global progress has been disappointingly slow and extremely unequal, leaving vulnerable populations behind in many countries. At the current rate, The Lancet NCD Countdown 2030 estimates that SDG target 3.4 – to reduce by one third, premature mortality from NCDs and promote mental health and wellbeing – will only be reached for women in 35 countries and for men in 30 countries by 2030. This is not good enough. We urgently need to see governments stepping up, for the sake of the millions of people dying every year from NCDs.

The 2019 WHO Global Action Plan for Healthy Lives and Wellbeing for All commits 12 global organisations, including the World Bank, UN Development Programme, UNICEF and UN Women, to engage civil society and communities as accelerators to reach the global health goals by 2030. This reiterates the recognition from governments in several UN declarations that they cannot achieve their NCD targets without a whole-of-society approach, nor without civil society as indispensable partners. These include the 2018 UN Political Declaration on the Prevention and Control of NCDs, as well as the WHO Independent High-Level Commission on NCDs' Time to Deliver report. More recently, in the 2019 Political Declaration on UHC, governments committed to engage all relevant stakeholders, including civil society, 'through the establishment of participatory and transparent multi-stakeholder platforms and partnerships'.

Civil society refers to voluntary, non-state, not-for-profit organisations formed by people in the social sphere, with commonly held values, beliefs or causes. NCD civil society organisations (CSOs) are a diverse group of actors, including non-governmental organisations, community groups, informal social movements, patient groups, consumer groups, women's groups, indigenous groups, youth organisations, faith-based organisations, professional societies, foundations and think tanks.



NCD civil society works to elevate the voices of communities and people living with NCDs (PLWNCDs), mobilising resources, advocating for political action and health policy reform, and holding governments and other stakeholders to account.

Meaningful involvement of the vibrant NCD civil society movement so that it is capable of delivering its four primary roles – advocacy, awareness-raising, access and accountability – is essential to accelerate progress at national and regional levels. Involvement and true engagement with civil society as partners has brought important victories in global health challenges, notably HIV/AIDS, and in achieving more equitable access to care. Involving PLWNCDs and civil society as experts in their own right in policy and programme design is both possible and greatly beneficial, increasing legitimacy and public acceptance as well as improving scale and sustainability of implementation.

Over the past decade, NCD civil society has grown to provide a bridge to communities and a platform for PLWNCDs. The integration of the diverse membership of NCD civil society can be seen in the formation of national and regional NCD alliances that bring together organisations working across multiple diseases and risk factors. Such coalitions are enablers for effective

ABOVE:
The Global Week for Action on NCDs takes place annually in the first full week of September and is coordinated by the NCD Alliance. In 2019, millions of people around the world called on governments to ensure healthy lives for all and make universal health coverage a reality.

civil society engagement, as our voices are stronger together in calling for change and holding governments to account.

NCD civil society's track record

Though NCD civil society is relatively young, it now encompasses 64 national and regional alliances, including those in a number of Commonwealth countries. There are many examples of their important role and impact in the NCD response. Here are just a few:

Advocacy: In 2017, the Healthy India Alliance took action to advocate for higher sugar-sweetened beverage (SSB) taxation by standing up to industry and coordinating closely between its 16 members, to formally present strong evidence-based arguments to policymakers. These debates resulted in an important victory: higher SSB taxation nationally.

Awareness: The Rwandan NCD Alliance participates in the popular monthly Car-Free Day in Kigali by raising awareness about NCDs and offering check-ups to community members. Through this channel, it provides thousands of people with physical activity opportunities and NCD screenings, and builds community health awareness.

Access: The Healthy Caribbean Coalition has worked to build civil society capacity to improve access to cervical cancer services for underserved populations since 2014. Alongside its national members, it trains outreach workers and conducts screenings among underserved populations in six countries.

Accountability: The East African NCD Alliance undertook a regional benchmarking exercise with its national member alliances in 2014 to track and advance regional NCD action. The findings were developed into a civil society NCD charter as an advocacy tool. The initiative also helped to build partnerships with governments, global partners and academia.

At the global level, the NCD Alliance has played a critical role in agenda setting, building the evidence base and momentum for global targets, political commitments and policies that are now shaping national responses. We have also put people at the centre of the response, by gathering the views of almost 2,000 individuals from 76 countries to articulate the clear priorities of PLWNCDs in the global Advocacy Agenda. These priorities echo what drives many CSOs working on NCDs: the need for a more holistic approach to health, that listens and responds to complex and individual needs by putting people at the heart of health services. The Advocacy Agenda has been adapted to national level by alliances in several countries, including Ghana and Kenya.

Next steps together

While governments have recognised the role that civil society plays in addressing NCDs, there is still a long way to go until we see a truly meaningful involvement of CSOs in the NCD response. Our potential remains untapped and approaches have been tokenistic at best in some countries. Therefore, we encourage Commonwealth countries to call on the valuable potential of civil society by:

1. Creating environments that protect civic space and the rights of CSOs. There is a worrying trend of shrinking civil space in some countries, with laws that curtail and restrict CSO activity.
2. Establishing governance mechanisms such as National NCD Commissions that include NCD civil society representatives, PLWNCDs and young people.
3. Investing in capacity building of CSOs as a global public good, to ensure communities and the people most affected are meaningfully engaged in the development, implementation and monitoring of NCD policies and programmes.
4. Implementing rights-based, inclusive and transparent accountability mechanisms that consult communities and NCD civil society.

Involving civil society and communities can only accelerate action on the biggest health challenge of our time and increase our chances to collectively reach the global health goals by 2030: 'If you want to go fast, go alone; if you want to go far, go together'. ■

"These priorities echo what drives many CSOs working on NCDs: the need for a more holistic approach to health, that listens and responds to complex and individual needs by putting people at the heart of health services."

The Commonwealth is losing the war against cancer

Director of the International Network for Cancer Treatment and Research (INCTR), Mark Lodge provides a stark update on the number of cases of cancer in the Commonwealth, which is above global averages and growing, and the urgent implications for policy makers.

Mark Lodge,
Director, International Network for Cancer Treatment and Research, UK

"In 2018, nearly 1.7 million people died from cancer in the Commonwealth – the equivalent to one death every 18 seconds."

Between 2008 and 2018 the number of new cases of cancer reported in the Commonwealth rose by 35 per cent. There is now a new case of cancer somewhere in the Commonwealth every ten seconds and more than seven million Commonwealth citizens are living with cancer. In 2018, nearly 1.7 million people died from cancer in the Commonwealth – the equivalent to one death every 18 seconds.

Based on expected population growth, Globocan predicts increases in Commonwealth cancer incidence by 35 per cent in the 12 years between 2018 and 2030, and in cancer mortality by 39 per cent. These figures are both higher than the projected world estimates of 33.4 per cent and 36.3 per cent, respectively.

The increased incidence will be unequally distributed across the Commonwealth (see Figure 1), and the acceleration in cancer mortality rate will be rapid: from 167 deaths per hour (dph) in 2008, to 193 dph in 2018, and rising to 268 dph by 2030.

In descending order of frequency, breast cancer, cervical cancer, prostate cancer, Kaposi sarcomas, colorectal cancer, cancers of the lip and oral cavity, liver cancer, lung cancer and oesophageal cancer are the first and second leading malignancies in Commonwealth countries.

While breast and prostate cancer rank highest in frequency in other regions of the world, the cancers associated with infection – cervical cancers (HPV infection), Kaposi sarcomas (HIV/AIDS and human herpes virus 8) and liver cancer (hepatitis B and C) – are the most common cancers in sub-Saharan African Commonwealth countries. The WHO estimates that 25 per cent of all cancers in low- and middle-income countries are associated with infection.

Across the Commonwealth, women are disproportionately affected by cancer. In 2018, over 425,000 women in the Commonwealth were living with cervical cancer and 13 women died every hour from the disease. Member countries carry a 34 per cent share of the global cervical cancer incidence burden and 38 per cent of global cervical cancer mortality.

Cervical cancer is a preventable disease. However, by 2030, the Commonwealth will have 265,627 new cases annually (representing 38 per cent of global incidence) and suffer 168,012 deaths from the disease (42 per cent of predicted global mortality). The prevention and down-staging of cervical cancers by vaccination, early detection (through screening), excision of premalignant lesions and the early diagnosis and treatment of malignancy, is an achievable goal for the Commonwealth. The elimination of cervical cancer should become part of the Commonwealth's collective mission.

"The poor quality of cancer registries in low- and middle-income countries results in a glaring knowledge deficit that adversely impacts healthcare delivery."

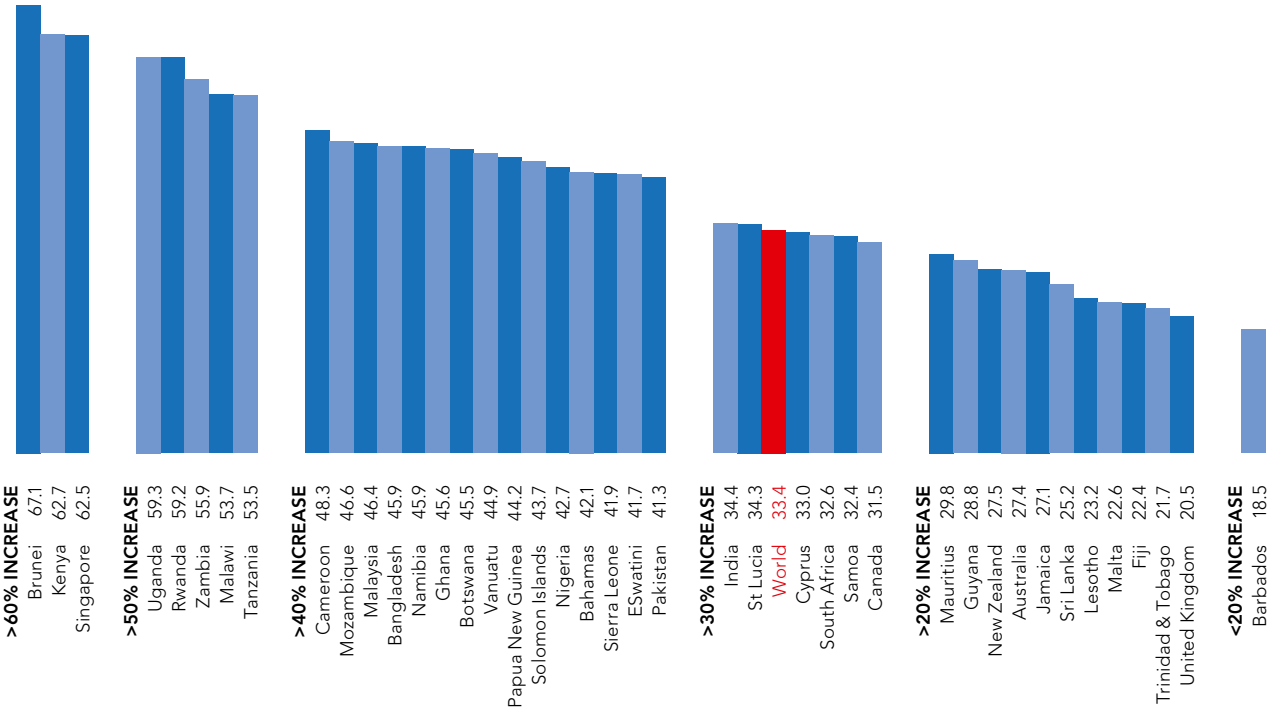
The implications of cancer morbidity and mortality are wide-ranging for policy makers. Productivity is impacted: cancers accounted for >200 million DALYs (disability-adjusted life years) in 2015. The fact that 65 per cent of new cases of cancer diagnosed in 2018 were in people under 70 years of age has economic implications and must inform ongoing discussions about universal health coverage.

A pressing need is the challenge to future health service provision. Because 12 years does not allow sufficient time for cancer prevention strategies to have an impact, Globocan's predictions serve notice to governments that they need to either realign priorities in healthcare to provide training, encourage technical innovation and improve access to early diagnosis and treatment in oncology before 2030, or else face a shortfall in service provision.

The poor quality of cancer registries in low- and middle-income countries results in a glaring knowledge deficit that adversely impacts healthcare delivery. Ten Commonwealth countries do not provide registry data to Globocan, even though counting the bodies remains the most reliable evidence of the effectiveness of policy outcomes. The Commonwealth should jointly encourage and support the collection of reliable evidence – including both epidemiological and economic data and published research outcomes – that can inform policy-making.

Globocan estimates cannot take into account the disruption to health services caused by the effects of climate change, nor the displacement of refugee populations due to conflict. Pacific Island countries and territories (PICTs) face four simultaneous challenges: rapid transition to lifestyle-related diseases, ageing populations, infection-related cancer and, increasingly, the need to respond to natural disasters associated with climate change.

Figure 1. Predicted increases in cancer incidence in select Commonwealth Member States, 2018-2030.



[Source: Globocan 2018]

In the Caribbean region, where extreme weather has impacted on the delivery of healthcare, rising cancer prevalence due to increases in the duration of ultraviolet radiation and changes in exposure pathways for chemicals and toxins, has been identified as an indirect effect of climate change.

Increasing inundations in South Asia and sustained conflicts in Central Asia, sub-Saharan Africa and the Middle East also indicate that all planners and donors should factor the likelihood of degradation of resources and unplanned population movement into their cancer control plans.

Health is a human right and governments are responsible for the health of their peoples. For the best chance of preventing or curing cancers, and because cancer can occur at any part of the body, every component of a country's health system needs to be working at maximum efficiency. Many of the obstacles that contribute to fatal delays in the detection and treatment of cancers – distance, levels of educational attainment, poverty, investment in infrastructure – lie outside the remit of ministries of health. In Commonwealth countries transitioning from majority communicable to majority noncommunicable disease, cancer prevention and treatment requires buy-in from and political oversight at the very top levels of government. ■

"Cancer prevention and treatment requires buy-in from and political oversight at the very top levels of government."

Let's end mental health discrimination

There's no quick fix for ending mental health stigma and discrimination, but now is the time to take action to build on momentum and share learning across the Commonwealth, says Sue Baker, Global Director at Time to Change.

Sue Baker,
Global Director, Time to Change

"There is really no health without mental health. It is in the interests of all families, communities, societies and economies to address the long-standing neglect and mistreatment of people with mental health problems in our cultures and societies."

Globally, too many people face exclusion and severe restrictions on their human rights because of their mental health problems.

One in four people around the world will experience a 'mental or neurological disorder' in their lifetime. Yet, nearly two-thirds of these people never seek help from a health professional. The availability of support is severely restricted – in many African sub-Saharan countries, 90 per cent of people affected have no access to treatment.

Stigma and discrimination are central to this and to the wide-scale violation of rights. As well as being excluded by families, friends, neighbours, employers and schools, people experience violence and abuse, inhumane treatment and even torture, just because they have a mental health problem.

But there is reason to be hopeful. Over the last few years, we have started to see more effort and a growing momentum to raise the profile of mental health. This is thanks to passionate advocates and organisations at local, national, regional and global levels. I want to urge ministers across the Commonwealth to keep up these efforts.

In 2018, London hosted the first Global Ministerial Mental Health Summit. The second annual event took place in Amsterdam, and the third will be held in Paris later this year. It is heartening to see ministers addressing mental health in this way and at many other global events, helping to raise it up the agenda.

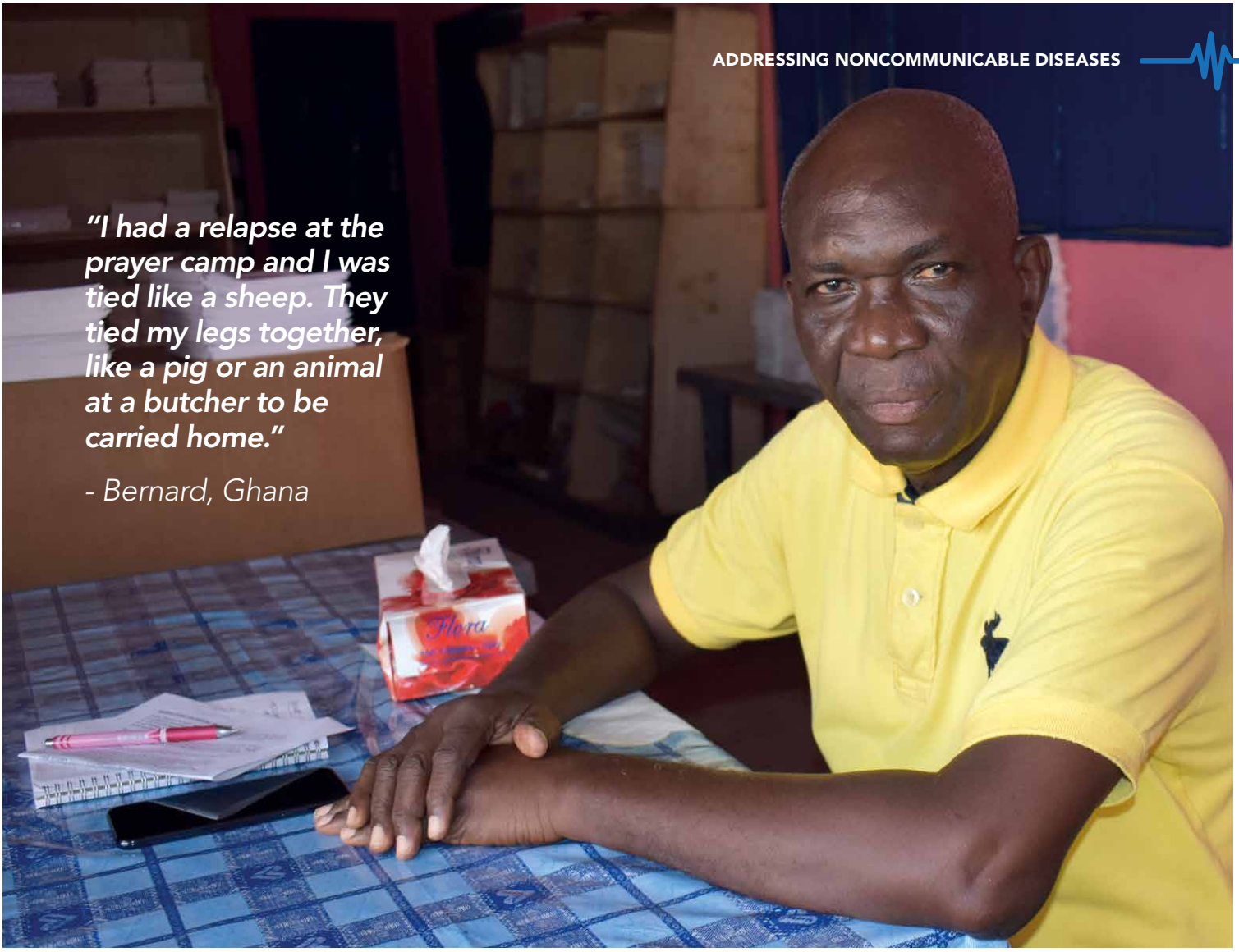
There really is no health without mental health. It is in the interests of all families, communities, societies and economies to address the long-standing neglect and mistreatment of people with mental health problems in our cultures and societies.

Ending mental health stigma and discrimination is the work of a generation. I think that's the most important thing that we've learnt since starting Time to Change more than ten years ago in England. It requires long-term approaches and long-term commitment.

Strategies for ending mental health discrimination

Mental health problems know no boundaries. They affect people of all ages, all income groups and all cultures. That's why, in 2018, we launched Time to Change Global. Partnership is central to the programme and essential if efforts to end mental health discrimination are to be effective. We are working with international disability and development organisation, CBM, and with local NGO partners and people with lived experience of mental health issues, to pilot anti-stigma campaigns in Ghana, Southern India, Kenya, Nigeria and Uganda.

The five pilot campaigns are being developed, tested and adapted with our local partners and a group



ABOVE:
Bernard received inhumane treatment for his mental health problems from other people at a prayer camp he was attending in Ghana.

"Mental health stigma and discrimination ruin lives. They can also end lives. Every 40 seconds we lose someone to suicide, somewhere in the world."

of Champions, all with their own experience of mental health problems.

While language, context and approach might look different, the pilots share three core elements based around learning and evidence from running Time to Change in England, and from wider global evidence: lived experience leadership, social contact and social marketing.

Lived experience leadership: To effectively tackle stigma, we know that people with lived experience of mental health problems must shape, lead and deliver social change campaigns. It is so important that their voices are heard. It means so much to me to see Champions planning and running events and sharing their stories, how they want to share them. Lived experience leadership runs through all aspects and levels of our work – including our management teams and governance groups.

Social contact: Conversations really do change lives. When we start talking more openly, we can reduce stigma and discrimination in our communities. By sharing our stories and telling others how it really feels to live with a mental health problem, we can change opinions and shift attitudes. In the five pilot countries, Champions are planning and running social contact events to engage the public and share their stories.

Social marketing: Alongside face-to-face activities, we must reach wider audiences through marketing campaigns. To be effective, we need to take time to understand public perceptions and then develop creative approaches that challenge and address public fears, misunderstandings and stereotypes.

RIGHT:
A Facebook campaign in Ghana to raise awareness of mental health featured mental health Champions telling their personal stories.

Time to Change worked with the Mental Health Society of Ghana (MEHSOG), and other local agencies to launch the first of our global campaigns in Accra in October 2019, aimed at 18-34 year olds. Focus groups helped us to identify a lack of public awareness of the mental health spectrum and about recovery. The campaign's key message that 'One in five Ghanaians experience mental health problems; It could be you' was communicated through a series of Facebook video ads featuring mental health Champions telling their personal stories, supported by a series of myth-busting posts, outdoor posters and radio features. After just five weeks, we achieved an incredible 15 per cent engagement rate on Facebook and received hundreds of messages of support.

Sharing learning across the Commonwealth

Mental health stigma and discrimination ruin lives. They can also end lives. Every 40 seconds we lose someone to suicide, somewhere in the world.

Together we must keep fighting to remove the barriers that stop people living their lives to the full. To address an issue that has been neglected for so long, we need joined-up efforts and shared learning. Our voices are stronger and louder together.

We know that there are so many powerful projects and campaigns happening around the world to tackle mental health discrimination. We want to learn from these campaigns and, in turn, share our learning, our tools and our approaches, in the Commonwealth and around the world.

In February 2020, Time to Change Global co-hosted an anti-stigma learning event in Nairobi, Kenya to share ideas, build capacity and develop the tools and plans we need to keep raising the profile of mental health. We are also producing an anti-stigma toolkit to give NGOs and individuals practical tools, guidance and case studies that help shape their own anti-stigma work.

Whether through events like this, or through partnerships with bodies like the Global Anti-Stigma Alliance (that represents major national anti-stigma programmes in countries including Australia, Canada and New Zealand), we must continue to share ideas and inspiration to drive real change. ■

Time to Change is very proud to be working with the following NGO partners:
Basic Needs Basic Rights Kenya
Gede Foundation (Nigeria)
Grameena Abyudaya Seva Samsthe (India)
Mental Health Society of Ghana
Mental Health Uganda

LEFT:
Time to Change Champions in India share their personal experiences of living with mental health problems.

Australia's ambitious health reforms: Prioritising mental health and preventive health

Australia's Minister for Health, Greg Hunt, explains how his government is aiming for a world-best patient-centred and integrated health system, with an unprecedented focus on mental health as well as other noncommunicable diseases.

The Hon Greg Hunt MP,
Minister for Health, Australia

"We are implementing the first ever Long Term National Health Plan to promote sustainability of the health system, support healthcare professionals and the broader health sector."

Australia's health system is recognised as one of the most successful in the world. It is comparatively safe, affordable and accessible. Australians are among the longest living people and the country tops international rankings for clinical outcomes.

When it comes to building on our successes the Government remains aspirational, to make our health system a world-best. We see an opportunity to build a genuinely patient-centred and integrated system that is connected and effective.

However, Australia also faces challenges in our health system as we aim to better support people as they age, better treat and manage chronic diseases and keep our system sustainable, by getting the best value for money from our investments.

That's why we are implementing the first ever Long Term National Health Plan to promote sustainability of the health system, support healthcare professionals and the broader health sector, which are essential to the success of health reform, and focus squarely on patients and people.

It is in this context that the Australian Government is bringing an unprecedented focus to our great national challenges of mental health and suicide prevention. For the first time, we are prioritising mental health equally with physical health, because mental health issues should be dealt with in the broader health system, just like diabetes or a broken bone.

Almost four million Australians suffer from some form of mental illness each year. Half of us will face a mental health challenge in our lives. This has an incredible impact on individuals, families and communities. Australia's Productivity Commission recently estimated that the total cost of mental ill health to the Australian economy is $180 billion AUD per year.

The Australian Government has made record investments in mental health across the lifespan. From the development of a new National Children's Mental Health and Wellbeing Strategy, focusing on the 0-12 age group, to investing in Australia's Headspace Network – a flagship programme providing mental health and wellbeing support for young people – and a new trial of adult mental health centres that will help people access the support they need.

Suicide has also been raised in the national consciousness, as each day, eight Australians – six men and two women – lose their lives to suicide. The Government is bringing an unprecedented focus and commitment to addressing this

challenge. We have committed to a 'towards zero' target for suicide and the Prime Minister has appointed Australia's first ever National Suicide Prevention Adviser, empowered to take a whole of system perspective to preventing suicide.

Our objectives for mental health and suicide prevention are ambitious. We are aiming to build a single, simple, unified mental health system, from prevention to recovery – a system that people can trust when they need help.

In Australia's federated system, responsibility for health is shared between the Federal Government, and States and Territories, which is why I have been advocating for partnership with the states and territories.

Recently, a meeting of health ministers from across Australian governments agreed to work in partnership to address mental ill health. This historic breakthrough sets a new direction that will help deliver a seamless, integrated mental health system – a once in a generation reform that puts the patient at the centre of care.

With mental health receiving – for the first time – the attention that it deserves, the Long Term National Health Plan also commits to ten-year plans for primary care, preventive health and medical research.

As we build on our successful fee-for-service Medicare and Pharmaceutical benefit schemes, our reforms to primary health care include support for GPs to provide more flexible care for patients aged over 70 with chronic and complex conditions, through to a new patient enrolment approach to Medicare items.

The Primary Health Care Plan will also embrace new technologies like genomics testing, progressively roll out universal telehealth, encourage more nurses to enter the primary care workforce and enhance the role of pharmacy in primary care.

We are also building on our successes in preventive health. Australia has successfully implemented some of the world's leading cancer screening programmes, and we are set to be the first country in the world to eliminate cervical cancer through vaccination and screening.

We are developing and implementing a ten year National Preventive Health Strategy to provide a better balance between treatment and prevention, that keeps people healthier and out of hospital.

The Preventive Health Strategy will continue investment in the National Immunisation Programme, partner with states and territories to address obesity, and deliver a $20 million AUD National Tobacco Campaign over four years, with the aim of reducing smoking rates to below ten per cent by 2025.

The Government is committed to ensuring that Australia is a health and medical research powerhouse – one of the key pillars essential for building a stronger and sustainable health system.

There are two distinct, but complementary funds available to support health and medical research in Australia: the Medical Research Future Fund (MRFF), funding priority driven research with a focus on research translation, and the National Health and Medical Research Council (NHMRC), focusing on investigator-led research. In addition, the Biomedical Translation Fund is giving funding certainty to our best and brightest researchers and start-ups.

A total of 54 clinical trials and eight large scale research missions

RIGHT:
The government is committed to ensuring Australia is a health and medical research powerhouse.

"Australia has successfully implemented some of the world's leading cancer screening programmes and we are set to be the first country in the world to eliminate cervical cancer."

are now being funded through the MRFF, covering: brain cancer, mental illness, genomics, ageing, aged care and dementia, indigenous health, stem cells, cardiovascular health and traumatic brain injury. Within ten years, we expect Australia to be a global centre for clinical trials, and over time, the research funded through these missions is expected to transform healthcare.

Of course, successful health reform needs the right health workforce in place to deliver it. The health workforce has grown organically in response to local demand for services, but practitioners are not always located where they are needed, despite the efforts of medical workforce planners. We are bridging the city-country divide so that rural Australians can access the services they need. Our Stronger Rural Health Strategy is delivering more GPs, nurses and allied health professionals to areas of need across Australia.

Australia's health reforms are unapologetically ambitious and collaboration has been a constant factor in our approach. Stakeholders, especially those who use and depend on health services, are essential partners in the reform process, and this approach will continue as we, together, build a world-best health system in Australia. ■

ABOVE:
For the first time, the Australian Federal Government is equally prioritising mental and physical health.

"We are aiming to build a single, simple, unified mental health system, from prevention to recovery."

Addressing the Pacific's biggest killers

Dr Colin Tukuitonga, who recently completed his final term as Director-General of the Pacific Community (SPC), discusses why the Pacific is taking an integrated approach to tackling noncommunicable diseases – the leading cause of death in the region, and the devastating health impacts of climate change.

Dr Colin Tukuitonga,
Former Director-General,
Pacific Community

"While debate over the existence of climate change continues in some parts of the world, here in the Pacific it has become a fact of life."

The Pacific region is home to a diverse community encompassing many unique traditions, cultures and experiences. The generally small island nations are spread across one of the largest and most important regions on earth. With small populations dependent on living in harmony with the natural environment, the people of the Pacific Islands are finding themselves at the forefront of some of today's more serious global challenges. Among the greatest of these are climate change and noncommunicable diseases (NCDs).

Climate change will have significant and damaging effects on communities and economies over the coming decades. The WHO estimates that globally, there will be an additional 250,000 deaths every year between 2030 and 2050 due to malnutrition, malaria, diarrhoea and heat stress, and over $2 trillion USD in lost productivity.

While debate over the existence of climate change continues in some parts of the world, here in the Pacific it has become a fact of life, and mitigating its effects is no longer a matter of politics, but rather, one of survival. Over the last ten years, our region has lost countless lives and more than $2 billion USD through natural disasters such as cyclones, tsunamis, flooding and droughts. In Fiji alone, annual losses due to extreme weather events could reach 6.5 per cent of GDP by 2050, with more than 32,000 people pushed into hardship every year. Today, our region is in the unenviable situation of having five of the top 20 nations considered most vulnerable to climate change impact.

In contrast to climate change, the global challenge of NCDs does not always receive the same level of attention, despite cancer, cardiovascular disease, diabetes and respiratory and mental health disorders being responsible for three-quarters of global mortality. Like climate change, the impact of NCDs is only expected to grow, with some estimates predicting an increase in global mortality of almost 20 per cent by 2030.

As with climate change, NCDs are having a disproportionate impact in the Pacific region. These conditions are now the leading cause of death, disease and disability in the region. Eight of the ten most obese nations in the world are Pacific Islands, and diabetes prevalence here is three to four times higher than elsewhere. Left unchecked, NCDs will cause increasingly serious health and social problems for individuals and their families, overwhelm national health systems and severely limit the development potential of the entire Pacific region.

At first glance, climate change and NCDs may appear to be serious but separate challenges. However, many of the causes and solutions to these challenges are interconnected. Climate change fundamentally alters the social,

LEFT:
A girl walks across flooded land in Fiji following Tropical Cyclone Winston in 2016. Climate change and NCDs have a disproportionate impact in the Pacific region and lead to thousands of deaths each year.

economic, cultural and commercial determinants of health. These changes, in turn, negatively impact the environment in which people live and work, which increases the risk of NCDs among the most vulnerable populations. Conversely, interventions to combat climate change present key opportunities to effectively address NCDs, and actions to reduce the burden of NCDs may have a positive impact on climate change mitigation.

For example, shifting to an increased use of renewable energy and investment in active transport systems would not only reduce greenhouse gas (GHG) emissions and air pollution, but also promote physical activity, contributing to a reduction in NCD incidence.

Or, consider how food production is managed. Investing in a sustainable food system – based on locally sourced, unprocessed foods – reduces reliance on imported, highly processed food items and has clear co-benefits in reducing NCDs and mitigating climate change.

But why make these connections? While many evidence-based, globally agreed interventions have been adopted to reduce the burden of NCDs, up until now these agreements have been weakly implemented. Similarly, international agreements to counteract the effects of climate change such as the landmark Paris Agreement are now under pressure, which threatens to reverse both the health gains from economic development and health benefits that accrue from sustainable development. A public health perspective has the potential to unite all actors behind a common cause. Simply put, by combining the research, expertise and political will behind each of these areas, we can create a stronger voice for positive and sustainable change, and help to achieve the common goals of both challenges.

As a region currently suffering some of the greatest impacts of both climate change and NCDs, the Pacific is well positioned to take the global lead in ensuring a more coordinated approach to finding solutions to these issues. Today, the members of the SPC are at the forefront of many such interventions across several sectors.

For example, SPC has adopted 'Climate-Smart Agriculture' as a key policy to guide our support for and work with SPC member states. This includes a range of activities, including: the formation of the Pacific Alliance for Climate Smart Agriculture (PACSA); promoting climate-smart food crops in support of the International Treaty on Plant Genetic Resources for Food and Agriculture; exploring nuclear technology to expedite breeding of climate-smart food crops; linking seed systems to climate change adaptation through 'Pacific Seeds for Life' (PS4L); promoting climate-smart approaches to soil fertility management as well as crop and livestock production systems in small island atolls; establishing a sanitation/phyto-sanitation platform to respond to pest and disease risks as a result of climate change; and promoting climate-smart, ecologically sound value chains.

On energy management, SPC and the Government of Tonga's Ministry for Meteorology, Energy, Information, Disaster Management, Environment, Climate Change and Communications (MEIDECC) established the Pacific Centre for Renewable Energy and Energy Efficiency (PCREEE) in the Kingdom of Tonga. PCREEE is part of the global network of regional sustainable energy centres for Small Island Developing States (SIDS), supporting access to modern, affordable and reliable energy services, energy security and mitigation of negative externalities for the energy system (e.g. local pollution and GHG emissions), and promoting renewable energy and energy efficiency investments, markets and industries in Pacific nations.

Climate change and NCDs are key challenges for the global community, and our ability to mitigate these challenges will go a long way towards determining whether we are able to meet national development objectives and international targets, such as the Sustainable Development Goals. In the Pacific, we are already integrating our work in these areas and showing how a combined approach can help build understanding, create consensus across nations and dramatically increase the impact of mitigation work. If the same approach can be adopted globally we have a real chance of creating a cleaner, safer, more sustainable and healthier world. ■

5th Commonwealth Nurses and Midwives Conference

Friday 6 and Saturday 7 March 2020, London UK

Celebrating …

nurses and midwives, breaking down barriers, leaving no-one behind

2020: a year of celebration of nursing and midwifery

The 5th Commonwealth Nurses and Midwives Conference is celebrating the past achievements, present endeavours, and future contributions of nurses and midwives.

Presentations will showcase how individual nurses and midwives, or nursing and midwifery groups, associations or institutions are contributing to global health and wellbeing across the lifespan in all settings within the following themes:

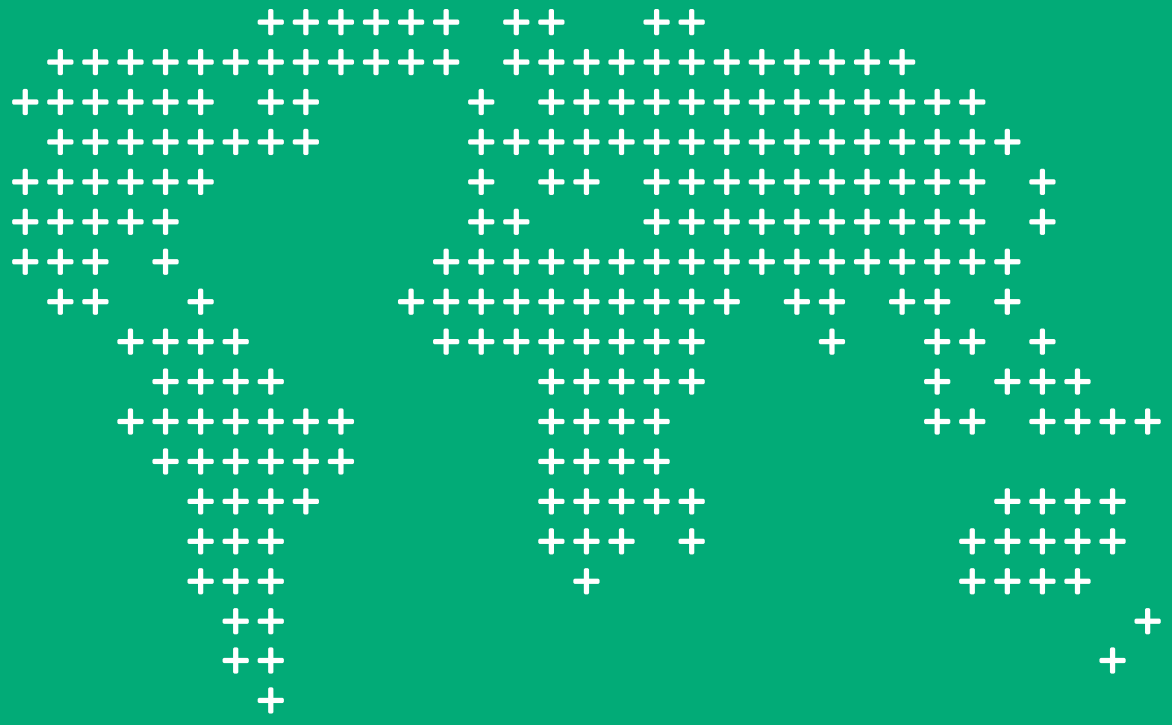
- Clinical practice
- Leadership and management
- Education and training
- Policy and projects
- Research and innovation.

Full details are available at:
www.commonwealthnurses.org/conference2020

The International Year of the Nurse and the Midwife

Commonwealth Nurses and Midwives Federation
http://www.commonwealthnurses.org

Human resources for health



Investing in health workers to achieve the SDGs

Her Excellency Ellen Johnson-Sirleaf is the WHO Goodwill Ambassador for Health Workforce. In this compelling piece, acknowledging the International Year of the Nurse and the Midwife in 2020, the former President of Liberia emphasises the need for Commonwealth countries to invest in the education and employment of health workers in order to deliver universal health coverage and achieve the Sustainable Development Goals.

Her Excellency Ellen Johnson-Sirleaf,
WHO Goodwill Ambassador for Health Workforce

"When Ebola struck my country, Liberia, we were painfully reminded of the perils of underinvestment in the health workforce."

The health workforce is foundational to achieving universal health coverage (UHC). Health workers care for us, educate us, support us and protect us. However, in 2014, when Ebola struck my country, Liberia, we were painfully reminded of the perils of underinvestment in the health workforce. One year later, as we began to recover from the epidemic, we committed to rebuilding that workforce as our first line of defence against disease and to serve as the backbone for securing UHC.

Even as the world made a historic commitment to UHC during the UN General Assembly in September 2019, shortages in the global health workforce continue to leave health systems dangerously vulnerable. The WHO estimates a global shortfall of 18 million health workers needed to achieve and sustain UHC by 2030, with over one-third in Commonwealth countries.

However, we can turn a looming crisis into an opportunity to improve progress on health, human capital, economies and gender equity. Meeting the world's growing and changing health needs will stimulate the creation of an estimated 40 million additional jobs in the health sector, particularly in upper middle and high-income countries, spurring economic growth.

Investment in the health workforce creates education opportunities, decent jobs and career pathways, particularly for youth and women. Women make up 67 per cent of the health workforce, and nurses and midwives represent a large portion of this. Investments in skills for the health sector workforce are also an investment in gender equality and women's economic empowerment. Scaling up investments in the health workforce creates a virtuous circle across all these sectors. Moreover, we are seeing a convergence of global political will and action plans.

With the clock ticking towards 2030, the global community is building unprecedented political momentum behind UHC as part of achieving the Sustainable Development Goals. In a May 2019 statement, Commonwealth Health Ministers emphasised their commitment to UHC and recognised primary health care as the gateway to leaving no one behind. In September of the same year, world leaders adopted the Political Declaration of the High-Level Meeting on UHC, entitled Universal Health Coverage: Moving Together to Build a Healthier World, which presented bold commitments to achieving UHC by 2030. Further, the World Health Assembly adopted resolutions to advance the agenda, such as

Credit: Rachel Larson/Last Mile Health

ABOVE:
A nurse coaches a community health worker on how to perform a rapid diagnostic test for malaria in Liberia.

WHA72.2 on Primary Health Care and WHA72.3 on Community Health Workers Delivering Primary Health Care: Opportunities and Challenges.

Global and country level politics are coalescing behind UHC. The question for us now is whether we will act on this political will, and whether the crucial health workforces will receive the investments they need.

Political will and global declarations are important, but they must be accompanied by country action and ownership; new approaches for educating, deploying and remunerating health workers; and, crucially, the investments to match the needs to ensure that declarations translate into reality.

Declarations must also be rooted in country ownership. For instance, through the Working for Health Programme, established in May 2017, the ILO, OECD, and WHO are currently working with 30 member states to catalyse the investment and action needed to scale up education and employment in the health sector. This effort builds on the WHO Global Strategy on Human Resources for Health: Workforce 2030, and findings of the High-Level Commission on Health Employment and Economic Growth, all setting the broad international agenda and policy recommendations to help address health workforce challenges at country level.

In addition, we must rethink our traditional models of educating, deploying and remunerating health workers. This requires strengthening our approaches to long-term system planning and building, leveraging comprehensive labour market data and systems, and prioritising the participation of women, to create a strong health workforce for Commonwealth nations. By focusing in on these areas, among others, we can change the narrative in Commonwealth nations from one of reacting to crises, to one of leveraging opportunity – where health and social sector job creation and employment stimulates inclusive growth and drives the achievement of the Sustainable Development Goals.

Finally, we need to reorient our thinking about cost and investment. Estimates of the financial investments needed to reach the 2030 health targets in the Sustainable Development Goals show that health system investments account for around 75 per cent of the total cost, with health workforce and infrastructure (including medical equipment) as the main cost drivers. The health workforce is the largest component and when the cost of education is added, the health workforce will account for more than half.

As a WHO Goodwill Ambassador for Health Workforce, and as we celebrate the International Year of the Nurse and the Midwife, I urge governments and all relevant stakeholders in every country to join the urgent call for action to strengthen health workers' contribution to their national development. It is imperative that all countries invest in jobs, particularly in primary health care, to close the gap and deliver health for all. ■

Health worker mobility: Challenges and opportunities for the Commonwealth

Francesca Colombo, Head of the Organisation for Economic Co-operation and Development's (OECD) Health Division, reviews the latest data on the continuous international movement of health workers and explores the challenges and opportunities posed by these flows for both destination and origin countries in the Commonwealth.

Francesca Colombo,
Head of Health Division,
Organisation for Economic
Co-operation and Development

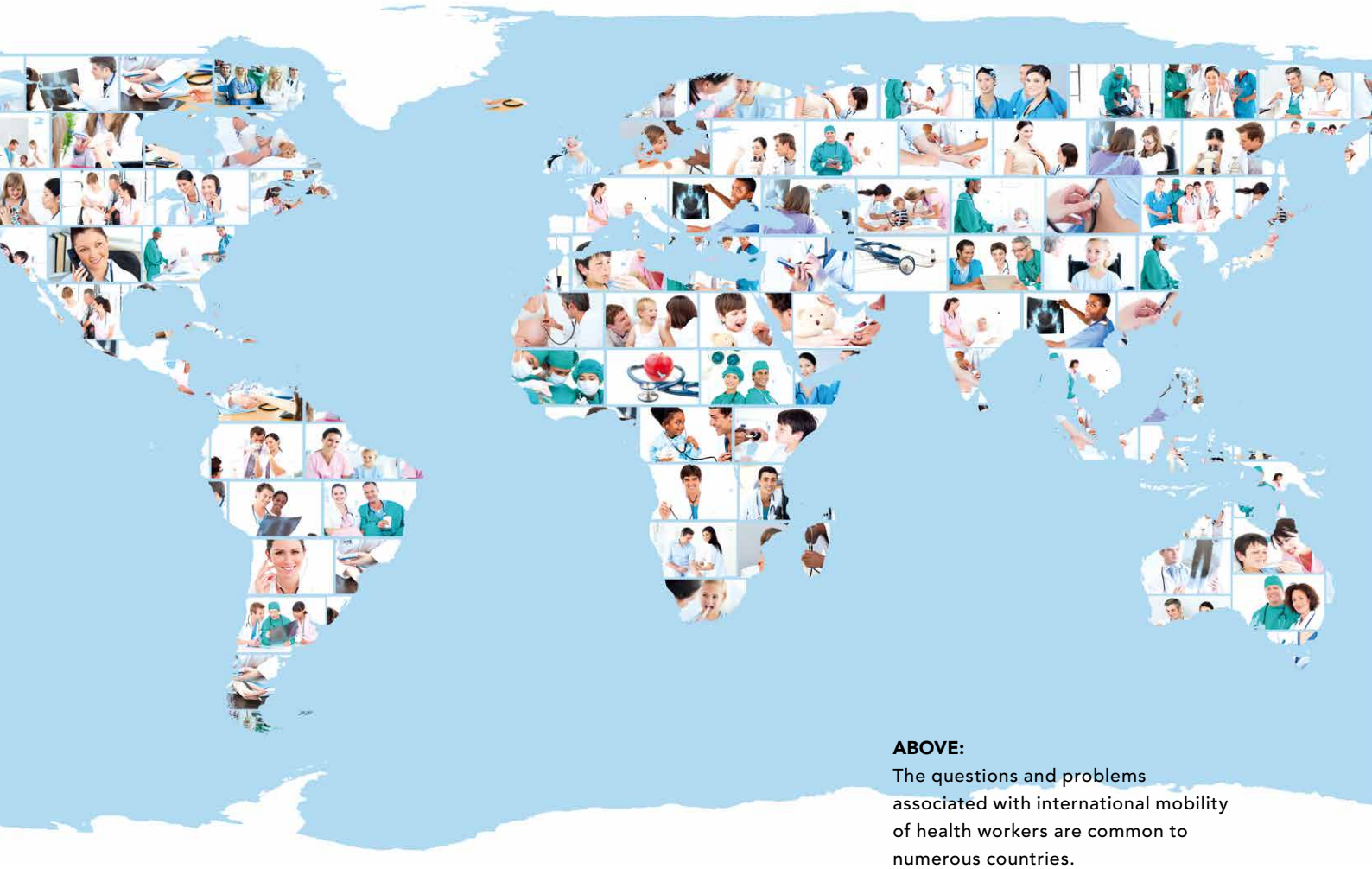
"Commonwealth members figure among the top countries of destination, as well as the top countries of origin, with respect to both the number and the share of migrant doctors and nurses."

Health systems around the world are increasingly confronted with an internationally mobile health workforce. A 2019 analysis for the OECD area (comprising 36 countries including a number in Europe, the US, Canada, Japan, Australia and New Zealand) reveals that the number and share of foreign-trained doctors – and in some countries foreign-trained nurses – continued rising over the previous decade, reaching, on average, nearly 20 per cent of doctors and six per cent of nurses by 2017. Commonwealth members figure among the top countries of destination, as well as the top countries of origin, with respect to both the number and the share of migrant doctors and nurses.

Australia, New Zealand and the UK are the most important destination countries for foreign-trained health professionals. The UK has traditionally attracted the largest absolute numbers – somewhat surpassed only by the US – with nearly 30 per cent (over 50,000) of its doctors and 15 per cent (over 100,000) of its nurses, educated abroad as of the end of 2018. These shares have remained stable over the past decade.

In Australia and New Zealand, foreign-trained doctors and nurses are less numerous, but account for an even larger and growing share of medical and nursing personnel. In 2017, one in three doctors (up from around one in four in 2007) and nearly one in five nurses (up from one in seven in 2007) working in Australia, obtained their degree in another country. As for New Zealand, the share of foreign-trained doctors has remained stable at around 40-44 per cent since the early 2000s, while the share of nurses exceeded one quarter in 2018, up from around one fifth in 2008. Canada is also one of the top destinations among OECD countries, with 25 and eight per cent of foreign-trained doctors and nurses, respectively, in 2017 – shares somewhat higher than in 2007.

The top countries of origin for foreign-trained doctors practising in Commonwealth countries are other Commonwealth countries, including not only low-income or emerging countries, such as India, Nigeria, Pakistan and South Africa, but also high-income countries like the UK and Australia. While in the UK, the majority of foreign-trained doctors come from India (31 per cent) and Pakistan (12 per cent), Australian doctors are trained primarily in the UK (19 per cent) and India (18 per cent). Similarly, among Canadian doctors, nine per cent received their



ABOVE:
The questions and problems associated with international mobility of health workers are common to numerous countries.

education in India and nine per cent in the UK, surpassed only by the share of doctors trained in South Africa (11 per cent). As for New Zealand, 60 per cent of all foreign-trained doctors studied either in the UK (43 per cent) or, in smaller proportions, in Australia, the US or Ireland.

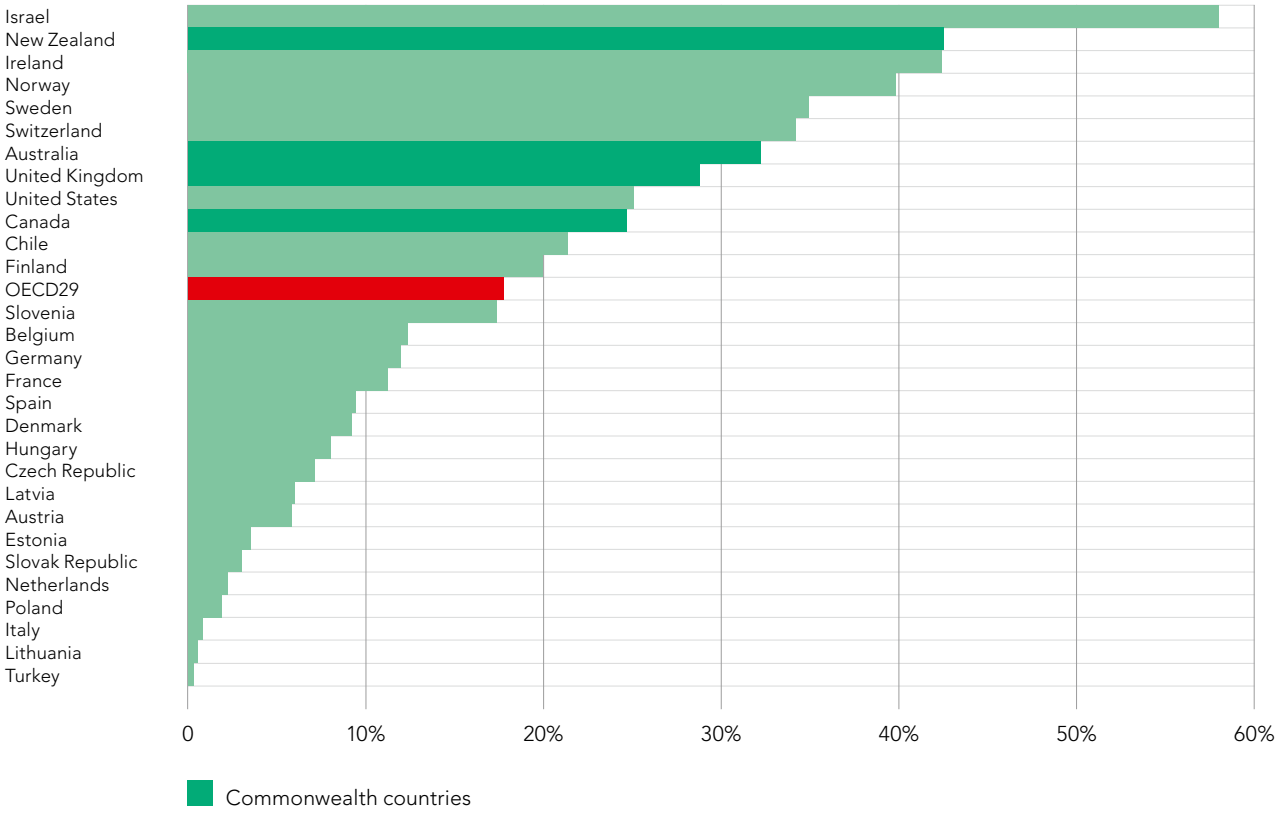
Overall, India remains the main country of origin for doctors, but its share has been decreasing since 2007, with many foreign-trained doctors increasingly coming from other OECD countries. Moreover, a rapidly growing and relatively large group of migrant doctors receive their education in Caribbean countries – especially Dominica and Grenada, as well as St Kitts and Nevis. These countries have become international medical education hubs, attracting almost exclusively fee-paying foreign students from the US and Canada, who generally return to their home countries upon graduation. Caribbean-trained American graduates have largely replaced Indian graduates coming into the US. In 2017, for example, American citizens were by far the most numerous group (more than 30 per cent) of all foreign-trained graduates who obtained a certification for practise in the US.

The trends look similar for nurses, with the main country of origin, The Philippines, accounting for around one-fifth of all foreign-trained nurses working in Australia, Canada, New Zealand and the UK in 2017. Other important countries of origin are India and the UK.

The growing magnitude and complexity of international mobility patterns create a number of challenges and opportunities. One of the key issues is the impact on the availability of health workers in the countries of origin. OECD and WHO 2019 data show that India, Nigeria, Pakistan and South Africa, for example, with less than one doctor and less than two nurses per 1,000 population, remain far behind the OECD average of 3.5 doctors and nearly nine nurses per 1,000 population in 2017. That said, for countries of origin that are very large, migration does not seem to affect domestic density at an aggregated level.

Small countries with a very small starting density of health professionals and weak health systems, on the other hand, might experience the greatest impact on their health system. As for the countries of origin belonging to the OECD area, they remain net receivers of migrant doctors and nurses from other countries, despite the outflows of some of their domestically trained health professionals. The outward migration from these countries often signals issues with the attractiveness of working or specialist training conditions. In general, patterns of

Share of foreign-trained doctors in OECD countries, 2017 (or nearest year)



migration of health professionals follow patterns of migration of similarly highly skilled professional groups, and reflect complex determinants including working and living conditions in home countries and the opportunities abroad.

The international mobility of health workers can be a short term measure to address labour market imbalances, reducing shortages in the countries of destination and unemployment, or as a response to barriers to training in the countries of origin. There are, however, difficulties with controlling the levels and periods of international flows, in part due to the lack of complete and timely data, as well as challenges with the verification and recognition of the qualifications of foreign-trained health workers, even where bilateral agreements between countries of destination and origin exist. Furthermore, international migration cannot be seen as an efficient solution to addressing more structural imbalances between the supply of and the demand for health professionals.

As for the impact on the countries of origin, difficulties remain in balancing the individual freedom to migrate with international equity concerns and related issues such as 'active recruitment' or 'critical shortages' of workers. A key question in this debate is whether the country of origin or the workers themselves pay for the training of health workers. Nursing education in The Philippines or medical education in India, for example, is often provided on a fee-paying basis by private institutions. Many Caribbean countries host medical schools oriented towards supplying medical graduates for the North American market. These countries, however, have a limited capacity to offer specialist medical training, which means that as the mobility of medical students/graduates grows, the countries of destination tend to be the ones providing the specialist training.

There is no unique response to the challenges and opportunities posed by the international mobility of health workers. The related questions and problems are common to numerous countries. International collaboration – including better data collection and analysis to fill critical knowledge gaps, refinement of international recruitment strategies in line with the WHO Code of Practice, and the development of instruments for effective and timely verification and recognition of workers' qualifications and skills – will help to construct and scale up initiatives that share the benefits of international mobility between the countries of destination and origin, while ensuring an individual's right to move. ■

The author wishes to acknowledge the valued contribution of Karolina Socha-Dietrich, Policy Analyst, Health Division, Organisation for Economic Co-operation and Development.

SOUTH AFRICAN MEDICAL ASSOCIATION

Doctors are Central to Achieving the Universal Health Coverage Goals

A health system cannot serve its population without a sufficient, skilled, committed and responsive human resource capacity. Everyone in South Africa has a right of access to healthcare, which should be appropriate, good quality, efficient, equitable, integrated, patient-centred and safe. Quality of healthcare should not only be enjoyed by the wealthy in society, and the implementation of Universal Coverage, in an effort to distribute resources efficiently, should not reduce the quality of care already enjoyed by people from the higher socio-economic class.

Primary healthcare remains the backbone of any health system for effective Universal Health Coverage and the achievement of the Sustainable Development Goals. Primary Healthcare (PHC) is the most inclusive, effective and cost-efficient vehicle through which we can prevent diseases, promote wellbeing, provide curative services and coordinate higher levels of care for patients with complex needs. SAMA, therefore, advocates that an ideal PHC would be doctor-led, nurse-driven and involve a wide range of health professionals and community workers.

Unfortunately, South Africa has suffered from an historical hospi-centric delivery of care. Attempts by the national Government to pilot the contracting of doctors to provide PHC, as part of the multidisciplinary teams in Government clinics, have not produced the expected outcome. We are concerned that the capacity of existing general practitioners and specialists in the private sector is not being adequately utilised to expand effective and quality primary and specialised healthcare. Incorporation of existing general practitioners into the existing District Health System will ensure that a doctor-led multidisciplinary team can effectively look after a community of 2,500 to 5,000 people. The successful implementation of public-private partnerships requires the National Department of Health to develop a policy direction, and a clarity of roles for provinces and districts, and the practitioners working with them, as well as centralised data management.

Similarly, SAMA also recognises the role of played by community health workers as an essential link between health professionals and the community. Under the leadership of operational managers, they play an important role in accessing difficult-to-reach communities, assessing the community health status, conducting home visits, basic screening, heath education and adherence support. They also play an important role in a linkage to care and the care coordination of all household members who need further care at a facility.

SAMA acknowledges that the uneven rural/urban/peri-urban distribution of doctors remains a barrier to an equitable access to healthcare and advocates for the implementation of Government-wide pull-strategies to undesirable areas, such as a rural allowance within reimbursements and salaries.

Healthcare workers can only do so much. Addressing broader social determinants of health, such as poor rural and peri-urban infrastructure, access to water, roads, schools and employment opportunities will be necessary to address inequitable distribution but will improve health outcomes of the affected communities. This will necessitate inter-sectoral action on an unprecedented scale.

Successful implementation of Universal Health Coverage should aim to reduce the burden of disease by the prevention of communicable and non-communicable diseases through upstream policy measures aimed at individualised prevention strategies, early detection of diseases and early access to diagnosis and treatment of diseases.

This is the role that doctors can play as coordinators of care.

Empowering nurses to help deliver UHC

Professor Ilona Kickbusch, Co-Chair of UHC2030, emphasises the vital work of nurses in delivering health for all, but highlights the alarming deficiency in the number of trained nurses around the world, as well as their lack of presence at policy-making levels.

Professor Ilona Kickbusch,
Co-Chair, UHC2030 and Chair, International Advisory Board, Global Health Centre

"We will not reach UHC if countries around the world do not find a way to train, hire and retain nine million nurses."

We know well this statistic: the world has a shortfall of 18 million health workers. Perhaps less well known is that nine million of these are nurses. Nurses actually make up half of the health workforce and play a crucial role in delivering primary health care in communities – recognised as the bedrock for achieving universal health coverage (UHC). Quite simply, we will not reach UHC if countries around the world do not find a way to train, hire and retain nine million nurses in the coming years.

It is, of course, easy to write these words and advocate the need for more nurses globally, but what does this mean in practice for different countries? It is important to emphasise that nurses offer more than just strength in numbers. A report published by the World Innovation Summit for Health (WISH) and the UHC Forum 2018 makes the case for investing in nurses and midwives to improve services, as well as to bolster health promotion and disease prevention. Achieving UHC also requires both investing in women – who make up 70 per cent of the global health workforce – and addressing gender inequality in the health and social workforce, which weakens health systems and health delivery.

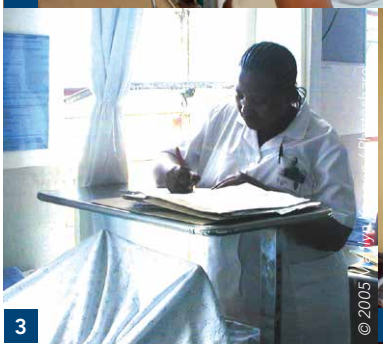
The global movement for UHC, facilitated by UHC2030, produced a set of six Key Asks to influence the UN High-Level Meeting on UHC in New York in September 2019 and beyond. These political asks detailed how member states can change their policies and practice in order to achieve UHC by 2030. Number five in the Key Asks is to 'Uphold Quality of Care' and a core request is for countries to:

"Train a health workforce based on quality and competence, with a special focus on nurses, midwives and community health workers. Education must improve overall management capacity and skills and foster the appropriate use of technology. UHC requires supportive education policies, labour market regulations, effective environmental stewardship and monetary and non-monetary incentives for health workers and health organisations."

For us to achieve UHC by 2030, all of us in national and global health communities need to take this point literally and act upon it.

Moreover, in order to realise the huge nursing dividend, nurses need to be at decision-making tables and have a say in influencing policies that matter. Health is a political choice and nurses need to be present where and when these choices are made. There are some good examples from the Commonwealth where work is taking steps in the right direction.

In South Africa, a number of health professionals organised themselves to lobby for the rural



healthcare environment, but these conversations were taking place with the startling absence of the nursing profession. In order to take the lead and create a voice for rural nurses among many other conversations, a doctor and eight fellow nurses, established Rural Nursing South Africa with the aim of cultivating nurse leadership.

In The Bahamas, nurse leaders recognised the need to meet regularly to discuss key national issues that cut across the public and private nursing sectors and to then take recommendations for changes in current nursing policies and/or legislation to the Ministry of Health. As a result, the Chief Nursing Officer in The Bahamas established a National Nursing Advisory Committee, comprising representatives from the public and private health services, professional nursing organisations, schools of nursing and regulatory bodies.

Importantly, our focus becomes ever tighter on nurses if we take seriously the premise of the SDGs, which is to leave no one behind. In reality, it is nurses who can reach those people who are most likely to be left behind. Annette Kennedy, President of the International Council of Nurses, said in a recent UHC2030 interview: "Nurses are really important for UHC because of their ability to reach vulnerable people. You find nurses in remote areas where the only health professional that a community will ever see is a nurse. Nurses go out to remote areas – whether areas of conflict, or natural or human-made disasters, whether they are hospitals or communities – and they are saving lives."

The WHO realises the importance of bringing nurses on board and empowering them for UHC. It has designated 2020 as the Year of the Nurse and the Midwife. It is also the 200th anniversary of the birth of Florence Nightingale, as well as the publication of the first report on the State of the World's Nursing. Indeed, the global Nursing Now campaign to raise the status and profile of nursing to improve health globally, has created the Nightingale Challenge. This tasks every health employer around the world with providing leadership and development training for a group of their young nurses and midwives during 2020.

The world is waking up to the importance of nurses and midwives. Now, it depends on what actions we, nationally and internationally, can take to ensure that they are valued and that their potential to deliver healthcare to people at risk of being left behind is realised. As Lord Nigel Crisp, Chair of Nursing Now, said: "Nurses are an unrecognised, massive asset that we should be developing so that they can have an even bigger impact". Let that impact be for UHC. ■

ABOVE:

1. Nursing and midwifery students prepare for their class to start at Garden City University College in Kumasi, Ghana.
2. A nurse cares for a child recovering from meningococcal meningitis at Wenchi Hospital in Ghana.
3. A healthcare professional writes notes in a patient's chart at a South African hospital.
4. A health worker holds an infant just after birth in Ghana.
5. A registered nurse checks on a patient's IV drip in ward in a state facility in KwaZulu-Natal, South Africa.

"In order to realise the huge nursing dividend, nurses need to be at decision-making tables and have a say in influencing policies that matter."

Global nurse retention and ethical recruitment

Professor Kathleen McCourt, President of the Commonwealth Nurses and Midwives Federation, looks at strategies to fill the acute shortage of nurses across the Commonwealth, including international health worker mobility and the ethical recruitment of nurses between countries.

Professor Kathleen McCourt,
President, Commonwealth Nurses and Midwives Federation

"Is it ethical for countries with high nurse and midwife density to recruit nurses and midwives from countries with low nurse and midwifery density?"

The year 2020 has been designated by the WHO as the International Year of the Nurse and Midwife. The first ever State of the World's Nursing report will be released alongside the third State of the World's Midwifery report. They are likely to reinforce what we already know: that there is an estimated seven to nine million shortfall in nurses and midwives globally, and that there is also an unequal distribution of these health workers, with South East Asia and Africa facing the greatest shortages.

The focus on nursing and midwifery in 2020 gives countries an incentive to evaluate the number, distribution and status of their own nursing and midwifery workforce and to determine whether it is fit for purpose.

Across the Commonwealth, there are vast differences in the density of nurses and midwives per 1,000 population, both across and within regions. In high-income Commonwealth countries (Australia, Canada, Cyprus, Malta, New Zealand and the UK), the density of nurses and midwives is 9.94 per 1,000 population across the six countries, but in African Commonwealth countries (18 countries), it is 1.58; in Asia (eight countries) it is 3.36; in the Pacific (nine countries) 3.06; and the Caribbean (12 countries), 3.10.

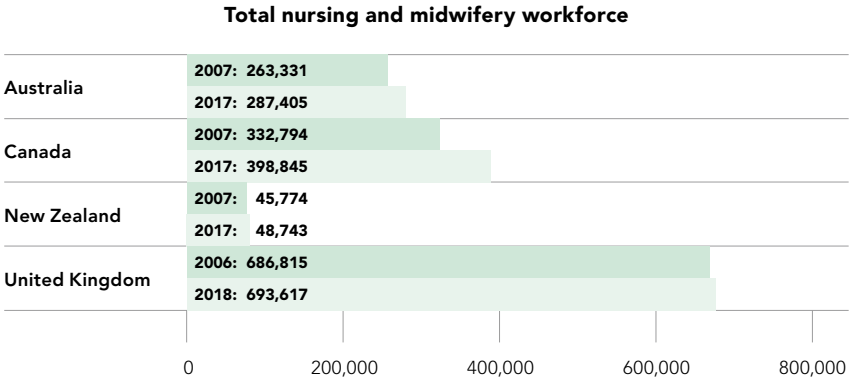
Within regions, density ranges dramatically. According to 2019 WHO data, in Africa, the density is 35.17 in South Africa, compared with just 4.13 in Tanzania. In Asia, the density in Singapore is 72.14 while in Bangladesh, it is only 3.07. In the Pacific, in the tiny country of Nauru, density is 61.95 while in Papua New Guinea, it is 5.13. In the Caribbean, density ranges from 60.27 in Barbados down to 11.4 in Jamaica.

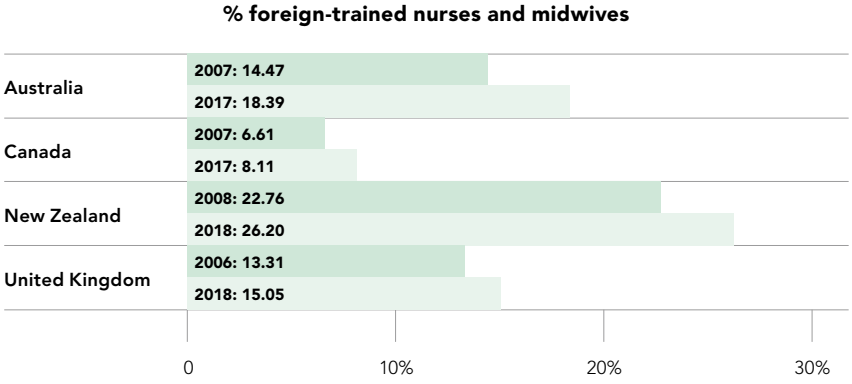
So what can Commonwealth countries, particularly those in Africa, do to address their nursing and midwifery shortages? In 2019, the International Council of Nurses International Workforce Forum proposed a range of actions to foster positive and supportive working environments, including fair pay, safe staffing levels, decent working conditions, professional and career development and the absence of violence, bullying and harassment.

In their 2019 British Medical Bulletin review, Drennan and Ross suggest that there are a broad range of factors influencing nurses' decisions to stay in or leave a particular job, including:

- Individual characteristics: skills and interests, career plans, family responsibilities and financial responsibilities.
- Job characteristics: remuneration and other financial benefits, hours, type, volume and intensity of work, level of responsibility or autonomy and clinical, managerial and professional support.

Nurse and midwife workforce size and percentage of foreign-trained workers in selected high-income Commonwealth countries (OECD, 2019)





- Organisational characteristics: employer reputation, type and size of organisation, infrastructure to support employees and access to professional and career development.
- Location: urban, suburban or rural, and proximity to family and other services such as schools.

The WHO Global Strategy on Human Resources for Health: Workforce 2030 and the report of the UN High-Level Commission on Health Employment and Economic Growth, Working for Health and Growth: Investing in the Health Workforce, note that health worker mobility is both increasing and becoming increasingly complex. The High-Level Commission report, while calling for countries to do more to achieve greater self-sufficiency and sustainability in their domestic supply of nurses and midwives, emphasises that the international mobility of health workers, if appropriately governed and any adverse effects addressed, can deliver numerous benefits. Questions remain, however: how is the international mobility of health workers to be governed on a global level between sovereign states;

"The international mobility of health workers, if appropriately governed and any adverse effects addressed, can deliver numerous benefits."

how and by whom are adverse effects to be identified and addressed; and where is the benefit, and to whom?

Drennan and Ross say that one of the consequences of high levels of demand or shortages is that nurses have choices about their employment, both within their own country and in other countries. This raises another important issue. Commonwealth high-income countries such as Australia, Canada, New Zealand and the UK, all rely on importing nurses from other countries to meet their workforce shortages (see chart on previous page). Where are these nurses and midwives to come from? Is it ethical for countries with high nurse and midwife density to recruit nurses and midwives from countries with low nurse and midwifery density?

The Commonwealth broke new ground in 2003 when health ministers of member states endorsed the Commonwealth Code of Practice for the International Recruitment of Health Workers. This was the driver of and forerunner to the subsequent 2010 WHO Global Code of Practice on the International Recruitment of Health Personnel. WHO member states are 'encouraged' to complete a voluntary self-assessment tool on their implementation of the code every three years. In the first round of reporting, 56 countries submitted national reports; 74 countries submitted national reports in the second round of reporting; and 80 in the third round. Fifty-four of the 80 countries that submitted reports in the third round acknowledged that they had taken steps to implement the code, and of these 54, 34 identified laws and policies consistent with the code that had been introduced or were under consideration. However, despite the long existence of both the Commonwealth and these global codes, the ability to enforce sovereign states to adhere to them is limited.

Thirty-nine of the 80 countries reported using bilateral, regional or multilateral arrangements for the international recruitment and migration of health personnel, with 33 of the 39 identifying that the WHO Global Code's recommendations were incorporated in these arrangements. Altogether, nearly 100 agreements were identified – including those voluntarily submitted by countries and others from the World Trade Organization Integrated Trade Intelligence Portal – which contained health worker mobility clauses. It is worth asking, however, when trade agreements are being negotiated, how much input is had by the countries' nursing and midwifery leadership?

The Commonwealth led the way in developing a Code of Practice for the International Recruitment of Health Workers. At a time of acute shortages of health workers globally, perhaps the Commonwealth can also lead the way in assessing bilateral, regional or multinational health worker mobility provisions, for consistency with the WHO Global Code, and develop standard clauses for countries to use when trade agreements are being developed. ■

NATIONAL UNIVERSITY OF LESOTHO

A Vibrant African University, Nurturing Thought Leaders

Our Faculty of Health Sciences was established in 2001, and comprises Nursing, Nutrition, Pharmacy and Environmental Health departments. Through its training, the Faculty ensures the availability of competently trained, professional healthcare workers for Lesotho. The aim is to prepare knowledgeable health workers, who will tackle the country's prevailing health problems and therefore improve the overall health of our communities.

Human resources remain the backbone of any health system globally and, unless the development of manpower is at sufficient levels for a nation, the health needs of its people and environment become compromised. Wherever this is the case, the population generally underachieve, both socially and economically.

To address this, our programmes are designed to train the future nurses and midwives, pharmacists, environmental health specialists, nutritionists and food scientists of Lesotho from undergraduate through to postgraduate level.

Our 'Master of Nursing Science' programme started in January 2019 and prepares professional nurses as specialists in four different areas:

MIDWIFERY
Our students are specially trained to counter and reduce the currently high maternal and neonatal mortality rates found within Lesotho.

MEDICAL SURGICAL NURSING
Our nurses are taught to deal with the specific burdens of infectious diseases, non-communicable diseases, as well as conditions such as diabetes and high blood pressure caused by unhealthy lifestyles.

PSYCHIATRIC MENTAL HEALTH
Social conditions can cause emotional or psychiatric problems within the population. As such, we are increasing the number of mental health specialists available within the country to combat this.

COMMUNITY HEALTH
We train community health nurses and environmental health specialists to deal with public health issues.

Furthermore, our future pharmacists are trained to ensure there is an adequate supply and distribution of the drugs which are needed on daily basis for the prevention and treatment of diseases and lifestyle conditions. In addition to providing healthcare to patients, the pharmacists are also taught to play a greater role within drug regulation and the quality control of medicinal substances. Lastly, our nutritionists are taught the skills necessary to be the frontline in addressing the dietary issues among the people of Lesotho.

LIFELONG LEARNING
The importance of lifelong learning is inculcated into the minds of all our future health professionals during their training with us. Offering such opportunities assists practitioners to acquire up-to-date knowledge, best practice and new skills, enabling health professionals to continually develop within their areas of interest, as well as to maintain their registration with professional and regulatory bodies.

SUSTAINABLE DEVELOPMENT GOALS
Our training of health specialists and professionals contributes directly towards achieving the Sustainable Development Goals by 2030, especially SDG 3, and by producing greater numbers of health professionals for Lesotho we will increase health levels for all in the country.

www.nul.ls

Prof. Beatrice Ekanjume-Ilongo
Acting Pro Vice Chancellor, National University of Lesotho

The critical role of the pharmaceutical workforce in achieving UHC

Victoria Rutter, Executive Director of the Commonwealth Pharmacists Association and Dr Catherine Duggan, CEO of the International Pharmaceutical Federation, together assert that Commonwealth countries must advance the capacity and capability of the pharmaceutical workforce to ensure the safe and effective supply and use of medicines, that is essential to achieve universal health coverage.

Victoria Rutter,
Executive Director,
Commonwealth Pharmacists Association (CPA)
Dr Catherine Duggan,
CEO, International Pharmaceutical Federation (FIP)

"Top on the list of challenges preventing the achievement of universal health coverage among Commonwealth member states are issues of medicines access, safety and quality."

Medicines are the most common healthcare intervention and account for expenditure in a health system second only to human resources. The 'double burden of disease' facing low-and middle-income countries in the Commonwealth – an increasing burden of long-term conditions on top of the ongoing burden from infectious diseases – means that medicines-related problems are particularly pertinent. While there is a need to increase investment in all disciplines and areas of healthcare, the shortfall in the pharmaceutical workforce is arguably one that requires urgent attention.

Top on the list of challenges preventing the achievement of universal health coverage (UHC) among Commonwealth member states are issues of medicines access, safety and quality. These may include falsified or substandard medicines, and suboptimal use of available medicines.

Pharmacists are well-placed – both as medicines experts and because of their situation within communities – to address medicines-related issues and so improve health outcomes. The importance of the pharmaceutical workforce is recognised in the third Sustainable Development Goal (SDG 3), in which the density of pharmaceutical personnel (alongside physicians, nurses, midwives and dentists) is one of the indicators of success in meeting the overall goal.

There is a great deal of evidence to support investment in the pharmaceutical workforce as a cost-effective way of tackling medicines-related problems. Besides playing a key role in ensuring the safe and effective supply and use of medicines, pharmacists also have demonstrable benefits in delivering preventative care and public health promotion.

In many countries, pharmacists are the most accessible healthcare professionals, and thus, are a key channel for the delivery of healthcare services. Their unique position within and across communities allows for effective involvement in primary care, including managing and supporting patients living with chronic conditions. Targeted intervention from pharmacists also has the potential to enhance therapeutic outcomes for patients with long-term diseases. In areas where there is a high pharmacist to population ratio, positive outcomes have been demonstrated in reducing length of stay in hospital and a reduction in

medicines-related adverse events. These gains are seen regardless of the income status of the country.

Investment in a country's pharmaceutical workforce is valuable and cost-effective, with far-reaching gains seen in healthcare outcomes. Yet, to build up the gains that we need, we must ensure the presence of a competent, trained and equitably distributed pharmaceutical workforce. To achieve this, there needs to be progress made towards developing the pharmaceutical workforce in each country.

In 2016, the International Pharmaceutical Federation (FIP) published a set of thirteen Pharmaceutical Workforce Development Goals (PWDGs) that span the development of academic capacity and capability, essential in the education of pharmacy undergraduates, through to the development of the profession and the individual professional. The aim was to facilitate the development of the pharmaceutical workforce through a 'series of measurable, feasible and tangible goals', to provide a standardised basis from which to measure country level progress towards developing the pharmacy workforce, and to identify future workforce needs.

The Commonwealth Pharmacists Association (CPA) is an affiliated organisation of the Commonwealth, representing over one million pharmacists through the national pharmacy associations of the Commonwealth. A registered charity, the CPA works with its members to improve health and wellbeing throughout the Commonwealth. It has a strategic partnership with FIP and a shared vision to strive for development in the pharmacy workforce and implement the PWDGs. These goals serve as a key starting point for addressing issues relating to pharmaceutical workforce supply, retention, education and training capacity. With a focus on the Commonwealth, the CPA partners with the FIP in its global mission to provide resources and bring people together to advance global pharmacy education and workforce.

The PWDGs are grouped into three broad areas relating to academy, professional development and systems. To ensure a competent pharmaceutical workforce, progress needs to be made in all of these key areas.

Academy goals

While many Commonwealth member states have developed schools of pharmacy, there needs to be an ongoing review and evaluation of the undergraduate and postgraduate curricula to ensure alignment with changing health priorities. The population of the Commonwealth is young, with over half of people aged under 25 years old. Strategies to ensure the recruitment and retention of young pharmacists in the workforce are needed, particularly within rural communities.

Examples of successful programmes in the Commonwealth have involved mentors and leadership frameworks to support early pharmacist career

development. At a national level, countries need to invest to ensure there are roles with vacancies for pharmacists upon graduation.

Programmes already underway to build academic capacity include the UNITWIN programme, a unique partnership between FIP and UNESCO, whereby colleges that have capacity 'twin' with those with very little capacity. This has led to the establishment of the FIP UNESCO-UNITWIN Centre for Excellence in Africa (CfEA), a network of pharmacy schools across Ghana, Kenya, Malawi, Namibia, Nigeria, Uganda and Zambia. CfEA represents the first multi-country effort to develop a strategic programme for transforming pharmacy education and workforce to meet country and regional health needs.

Among other things, partnerships (for example between Kenya and Nottingham, UK – part of the UK aid-funded Strategic Partnerships for Higher Education Innovation and Reform (SPHEIR) programme) aim to reinvigorate the content of outdated chemistry and pharmacy courses, and create a globally competitive and adaptive workforce to meet the requirements of a rapidly industrialising economy.

"In many countries, pharmacists are the most accessible healthcare professionals, and thus, are a key channel for the delivery of healthcare services."

Professional development goals

Professional development systems vary widely between Commonwealth member states, with some countries having mandatory continuing professional development (CPD) to ensure ongoing pharmacist registration, while others have no formal system in place. There is an opportunity to review how CPD is evaluated and assessed in each country.

A needs-based assessment and care delivery approach should be adopted to ensure that CPD goals reflect local health needs and that the care delivered by pharmacists meets the current health priorities of the local population. CPD systems need to reflect the rate of change in healthcare evidence, and be adaptable and feasible for engagement by pharmacists as part of their everyday practice.

Systems goals

As the role of the pharmacist advances in each Commonwealth member state, regulations must exist to define their role and support the development of expanded roles such as pharmacist-led screening and monitoring of long-term conditions in the community, and to support local manufacturing to ensure timely and cost-effective access to medicines.

Innovative systems approaches such as the development of health partnerships between high-income Commonwealth countries and low- and middle-income countries, have shown success in highlighting the value of the pharmacy workforce in achieving health outcomes. In 2018, the CPA received funding from the UK Department of Health and Social Care's Fleming Fund, together with the Tropical Health and Education Trust (THET), to develop the Commonwealth Partnerships for Antimicrobial Stewardship (CwPAMS) programme. As well as enhancing antimicrobial stewardship capacity, the programme provided opportunities to champion pharmacists as medicines experts, and highlight the added value they can bring to the healthcare team. ■

For further information on CwPAMS, please see the article co-authored by Victoria Rutter, Executive Director of the CPA and Dame Sally Davies, UK Special Envoy on Antimicrobial Resistance.

The authors would also like to thank Dr Amy Chan, Professional Development and Research Lead, CPA, for her assistance with this article.

LEFT:
Catherine Duggan and Victoria Rutter sign a MOU to define how the CPA and FIP can work synergistically to develop the pharmacy profession to advance public health.

Investing in health professional education

Dr Vanessa Kerry, CEO of Seed Global Health, calls on Commonwealth governments to invest in transforming and scaling up health professional education to help address the shortage of health workers and enable skilled health professionals to better meet the needs of the populations they serve.

Dr Vanessa Kerry,
CEO, Seed Global Health

"Health professionals are the heart of the health system and the most important levers of change within it."

Despite making significant advancements in addressing global health challenges over the last three decades, there is still much to be done. There is no panacea for fixing the health problems we face – healthcare delivery is ultimately, at its core, a human-centred intervention. To effectively tackle the challenges, we must invest in people.

The WHO estimates that a global shortage of skilled health professionals will increase to 18 million by 2030, and the impact of this is further worsened by the fact that the distribution, competencies and experiences of the available physicians, nurses and midwives are often inadequately suited to the health needs of the populations they serve. Recognising that health challenges are increasingly complex, we need to reimagine pre-service education and in-service training for students and practitioners.

The 2014 Ebola outbreak in West Africa is a chilling and dramatic example of why health workers matter. In late 2013, a two-year old boy in Guinea – the index case of Ebola – presented to a health facility. Through no fault of their own, the health workers there were ill-equipped to recognise and contain what later became a global $53 billion USD catastrophe, with over 26,000 people infected and 11,000 lives lost over three continents. Many of those who died were health workers. Following the outbreak, equally painful was that more children were estimated to have died from measles than Ebola, because there weren't enough health workers to administer routine measles vaccinations.

The contrasting experience of Ebola in Uganda confirms the value of investing in health professionals. In the wake of an Ebola outbreak in the north of the country between 2000 and 2001 that killed over 200 people, including 13 health workers, Uganda trained and retained health workers capable of addressing viral hemorrhagic fevers (VHFs). As a result, repeated subsequent outbreaks of VHFs have been contained with minimal fatalities, even before some of today's more advanced therapies became available.

Despite tangible examples of success, there remains a harmful hesitancy to invest in health professionals (and a diverse and well distributed workforce) in settings with some of the greatest health needs. For some, the investment feels like it will take too long, be too complicated or unsustainable, or the power of technology is emphasised for bridging gaps in care. This is a two-dimensional view, however. While technology is important for improving efficiency and can be an incredible leverage, it cannot replace


A.


B.


C.


D.


E.


F.

ABOVE:

A. Medical students at Mbarara University of Science and Technology in Uganda during a training exercise.
B. First responders demonstrate the treatment that should be given to an accident victim during a mass casualty simulation in Uganda.
C. Dr Jimmy Atyera, one of the medical students trained by Seed Educators, in the surgical ward during his internship at Mbale Regional Referral Hospital in Uganda.
D. Students at the Hubert Kairuki Memorial University in Tanzania.
E. Nursing students from Muni University in Uganda during a birth simulation.
F. Nurses at Kamuzu Central Hospital in Malawi consult with each other before doing ward rounds.

the power of the human provider on the frontlines of responding, providing dignity and humanity. Technology is only as good as the user in whose hands it lies and their ability to identify where it can be best applied, both now and in the future.

Investing in people is often deemed too costly, but we argue that it is too costly not to do. Without enough well-skilled health workers in the right places to address diseases early, to detect the first case of Ebola, or to treat every day traumas, millions of preventable deaths will burden economies and undermine communities. Data shows that NCDs could cost the global economy $47 trillion USD by 2030 and that a child who loses his or her mother is more likely to be socially and economically disadvantaged over its lifetime.

Health professionals are the heart of the health system and the most important levers of change within it. Ensuring their place at the frontlines, providing comprehensive and appropriate care, is intensive but necessary – and possible. Building the cadres starts with planting the seeds of change early, by transforming health professional education. Pre-clinical advancements must then be coupled with targeted training and clinical teaching to equip both students and professionals to consistently deliver high quality care.

The final, critical step? Working with governments to ensure reliable and durable support for health professionals after their training, to enable them to stay in their communities. The result is a stronger pipeline with trained, local professionals who are empowered to teach their successors as well as other health workers in the system. Importantly, this in-situ learning increases the number of health professionals and workers who are locally trained and locally rooted, and best able to address the specific health needs of their communities.

Malawi offers a powerful example of the deep need to prioritise training. Data suggests that one in five patients here presents in primary care with a condition that is associated with a mental illness, and this is crippling an already burdened health system. Stigma, lack of knowledge and a scarcity of mental health professionals mean limited access to much needed services at the primary and specialty care level. Further, very few institutions are able to train specialised mental health professionals or provide mental health services. Service delivery can clearly improve through the prioritisation of training of mental health workers and the integration of mental health diagnosis, prevention and management skills into the training of all cadres of the workforce, particularly at the primary care level. Such a programme could also offer an important model for others.

"Investing in people is often deemed too costly, but we argue that it is too costly not to do. Without enough well-skilled health workers in the right places, millions of preventable deaths will burden economies and undermine communities."

One of the key challenges in Uganda is the lack of emergency medicine and appropriate nursing faculty to provide training and leadership in this area. Despite a population of 43 million, there are only three specialist doctors trained in emergency care in the country, and limited training programmes for emergency care specialists. Seed Global Health has collaborated with the government, ministries of health and education and academic institutions, to train more emergency physicians to address the wide range of common medical, surgical and obstetric conditions that burden communities and cause nearly half of current deaths.

Through deep and long-term partnerships in Malawi, Uganda and elsewhere, Seed is helping to build a complete and strong health workforce that can deliver quality care, provide ongoing education, problem solve and ensure that health systems are not ravaged by health crises, but proactively respond to them. Empowered by their expertise and experience, these health professionals can serve as agents of change in their countries' health systems, resulting in the systemic transformation needed to save lives and continuously improve health. While daunting, comprehensive, sizable and long-term investment is a prerequisite to closing the enduring gap in standards of care around the world.

It is also worth it. If each of the 16,000 health professionals that Seed has helped to train over a five year period see only a mere three patients a day, the cost is $1 USD per patient to receive higher quality care that day. Over the years, the cost reduces to fractions of a cent.

A 2018 study by the High-Level Commission on Health Employment and Economic Growth found that health workforce investments, coupled with the right policy action, can unleash enormous socioeconomic gains in quality education, gender equality, decent work, inclusive economic growth and health and wellbeing.

Healthcare is not just about providing a quick fix, it's about empowering generations and investing in people – our human existence – so that we can live longer, healthier lives and, in turn, invest in our countries. The evidence and need for it are clear. We must act urgently to make the required investments today, to bring an essential impact for tomorrow and the subsequent years to come. ■

This article has been co-authored by the Seed Global Health Country Directors for Uganda and Malawi, Dr Bonaventure Ahaisibwe and Dr Bridget Malewezi.

Digital health education: Addressing our 18 million health worker shortfall

Josip Car and Josh Quah at the WHO Collaborating Centre for Digital Health and Health Education, focus on the enormous potential of digital education technologies to address the global shortfall in health workers and consider the application of interactive and immersive modalities to deepen digital competencies of the health workforce.

Associate Professor Josip Car, Founding Director, and **Josh Quah**, Research Associate, WHO Collaborating Centre for Digital Health & Health Education, Centre for Population Health Sciences, Lee Kong Chian School of Medicine, Nanyang Technological University

"Digital health education represents a more effective way to empower the health workforce than traditional education."

18 million. 18 million could seem like any number on a dry statistical report and too big for one to reasonably comprehend. But if you read next that, according to the WHO, 18,000,000 people is the number of health workers required to meet our global health needs by 2030, suddenly this previously-incomprehensible figure takes an immediate human context.

And faces – like your family's access to timely hospital services. Or your community having adequate healthcare personnel to serve its needs. Or the capacity of those same workers to be equipped with the latest training and education. Discussing the health needs of populations simply cannot be relegated to the realm of snappy television soundbites or dusty institutional white papers.

The WHO and the Commonwealth Secretariat both recognise this looming reality; it is one of the biggest challenges facing the UN in achieving its Sustainable Development Goals (SDGs), in particular its mission to bring good health and wellbeing to all people (SDG 3). Every waking day in the WHO Collaborating Centre (WHOCC) for Digital Health and Health Education, we are reminded about these 18 million faces that the world needs to stave off an impending global health crisis. At the same time, we are also acutely aware that we are in a real position to help shift the needle on this awful statistic.

As a WHOCC located in Singapore, we wholeheartedly support the Commonwealth Secretariat working towards the WHO's goal of universal health coverage (UHC) to reach SDG 3 and other SDGs. This is no easy task and one that first requires the competencies of the health workforce to be brought up to speed. Countries can add more people to health workforces, to a limit. The key also lies in how health systems can continually grow their most important resource – humans – to help them to be even better at what they already do.

Thankfully, the silver linings are clear. We believe that one of the most promising solutions to this global problem can already be found in the present, tapping into something that we as a Commonwealth are already good at – innovating digital solutions to bring clarity to complexity. Using digital education technologies to train health workers and populations – we term this simply as digital health education – represents a more effective way to empower the health workforce than traditional education.

For one, think of the issue of scale. Traditional education and vocational

ABOVE:
Digital health education modalities like mLearning can reach health professionals wherever and whenever they need.

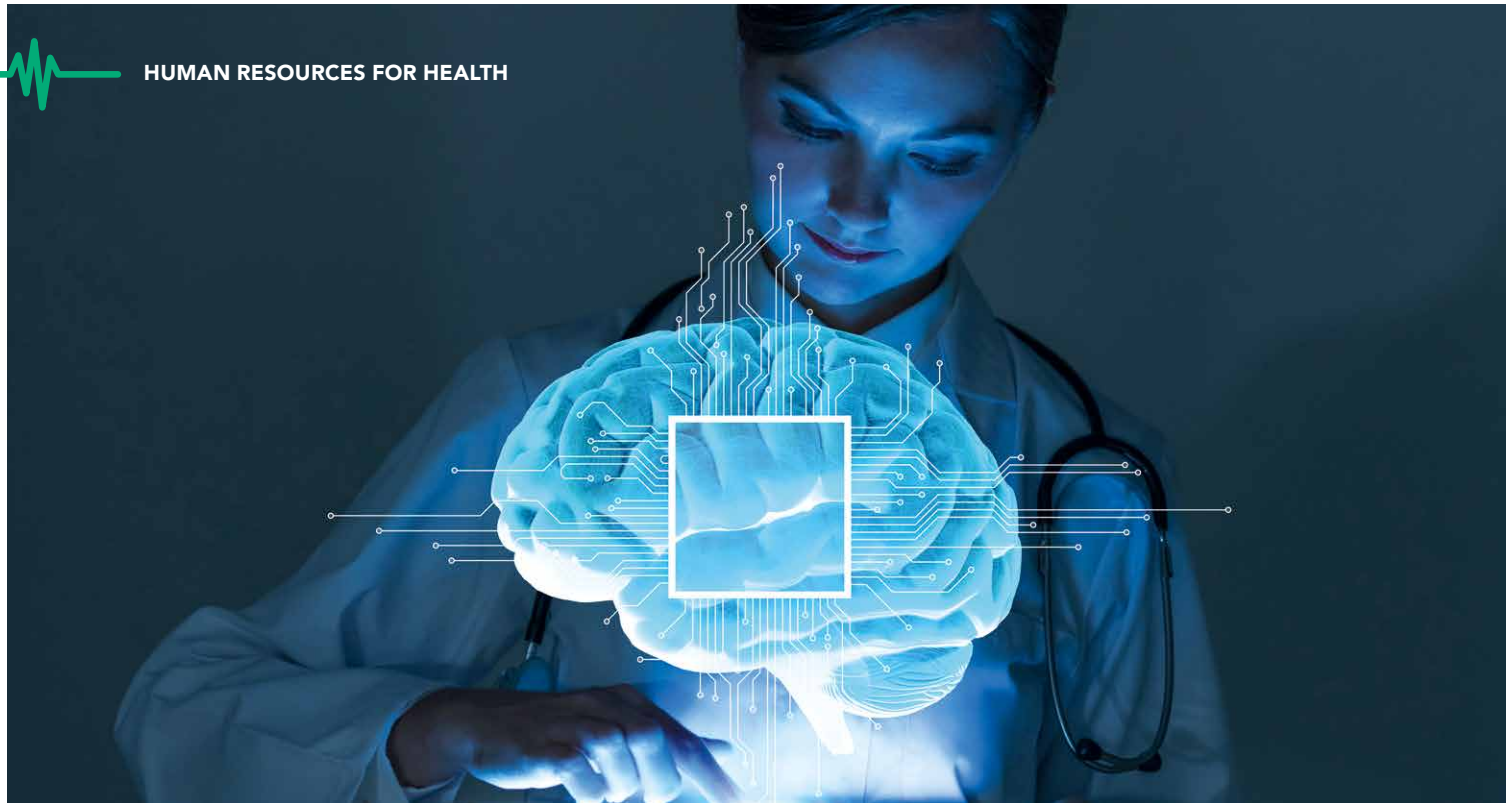
training still largely operate on bricks-and-mortar models, so course intake is limited by the size of physical teaching facilities and the number of educators. What cross-platform digital solutions are showing us today is that this knowledge transfer can be equally, if not better, facilitated by one item commonly found in pockets across the Commonwealth – our mobile devices.

With smartphone ownership at 80 and 82 per cent for developed and developing countries respectively, it is surely no exaggeration to say that mobile devices have found their way into the lifestyles and livelihoods of people around the world. Organisations like Learn, by Canadian company QxMD and the Singapore-developed Bot MD app for doctors, have smartly stepped into this space to deploy on-demand mobile learning (or mLearning) for health professionals, delivering content straight to their mobile devices, wherever and whenever the user needs it. No bricks-and-mortar confines; mLearning can reach learners across time and space in a way that our chalky blackboards and ivory offices simply cannot.

Along with scalability, technology can also bring greater cost-effectiveness. Besides the visceral wow factor of technology, like Imperial College London's foray into hologram lectures for instance, the other valuable takeaway was that the technology (developed by Canadian company Arht Media) had been cost-optimised to a point where it could now be adapted for wider use in education. Although the hindsight of time will always give us a more accurate verdict, the more mundane truism of economies of scale still applies here. The more widely adopted digital health education becomes, the better the distribution of costs across its users, which ultimately benefits the public funding bodies that typically take on the burden of research and development.

These arguments are not particularly new. Where digital health education can bring something genuinely original to the table, however, is in its application of interactive and immersive modalities to deepen the digital competencies of the health workforce. For instance, the Bot MD app breaks down medical training content in a way that can be delivered as specific responses to search queries, alongside more instructional formats, allowing for informal learning that fits seamlessly into one's daily patterns.

The recent launch of the Commonwealth Digital Academy, in collaboration with the International Institute of Health Sciences, a Sri Lankan organisation and member of the Association of Commonwealth Universities, will be delivered via the institution's E-Incubator arm, bringing online learning for the continuous professional development of nurses in Commonwealth countries. In Singapore, the Lee Kong Chian School of Medicine at Nanyang Technological University, folds digital technologies



into its blended learning programmes. The development of virtual and augmented reality learning mobile apps, as well as an ongoing project with IBM for an algorithmic 'cognitive tutor', have complemented its unique team-based pedagogy, winning recognition from the country's healthcare community. If anything, they show that treading new digital waters is far more than just hot bluster at conferences, but real solutions meeting the demands of modern day learners, effecting real outcomes for the Commonwealth and beyond.

Yet, the technology is only one side of this story. A robust health system, willing to take on risk in the mobilisation of resources towards digital health education, must be the glue holding together the pages of this ongoing chapter. It requires a profound awareness that health systems cannot be siloed along geopolitical or institutional lines. Deep collaborations are required, from which a wellspring of shared thought, research and resources can flow. The 2018 launch of the Commonwealth Centre for Digital Health is a firm step forward, taking hold of its mission to 'transform the scaling up of sustainable health systems and solutions' across member states, and in particular, those of lower income.

As we begin the knotted process of systemic change, it also demands our own change in perspective. Future Commonwealth health reports may be able to better inform policymakers, for instance, if they include analytics not often found in typical 'state of healthcare' reports, such as mobile penetration rates, digital health consumption patterns or even digital media habits across population categories. Just as health systems cannot be silos, we should recognise that the field of health itself is, but part of a larger whole, interdependent with other societal ecosystems.

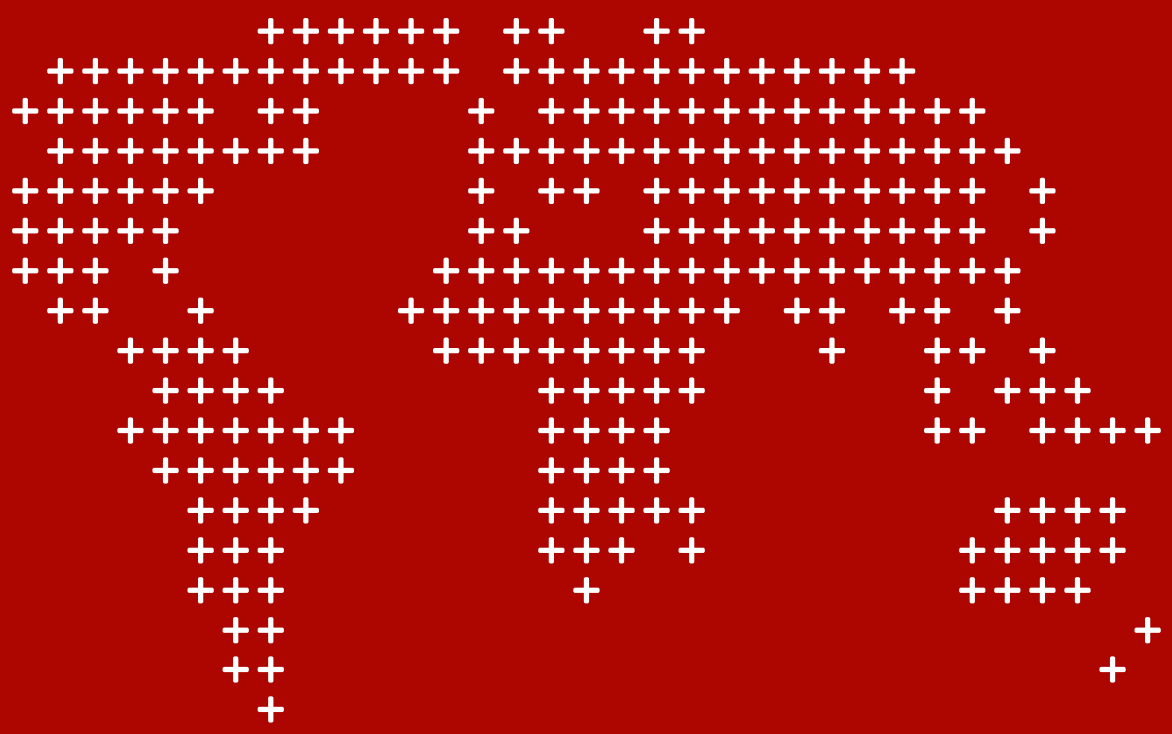
Therefore, as we rightfully celebrate these advancements, let us do well to remember the values that thread through our cultures and countries. The Commonwealth Charter was laid down on a backbone of humanistic principles and a mutual recognition to help one another. In a time where protectionism, isolationism and even xenophobic self-interest have gained populistic currency, we must hold fast onto what brought us together in the first place. So, it is critical that we do not stop here. There is room for more inter-government collaborations, more research synergies, more technological breakthroughs. We still have a way to go to close the 18 million-wide gap, and we are all needed in the fray, together.

ABOVE:
The continuing professional development of health workers is critical for meeting population health needs. Digital health education can be a powerful vehicle to reach these goals.

Across the Commonwealth, we have more in common than we may think. How we bring these things together will be the legacy that we leave behind for generations to come. ■

"A robust health system, willing to take on risk in the mobilisation of resources towards digital health education, must be the glue holding together the pages of this ongoing chapter."

SPECIAL FEATURE: Health tech



How tech can improve healthcare worldwide

Malcolm Johnson, Deputy Secretary-General of the International Telecommunication Union (ITU), looks at the enormous potential of information and communication technologies to improve healthcare and explains how the ITU is helping Commonwealth countries leverage technological advancements.

Malcolm Johnson,
Deputy Secretary-General,
International Telecommunication Union

"Nearly half the world is still not using the internet. There will only be universal health coverage when everyone is connected."

Information and communication technologies (ICTs) underpin today's digital economy – throughout the Commonwealth and throughout the world.

This is especially exciting in the healthcare sector because of its potential to improve and even save lives.

From remote surgery to better diagnoses, to an ever-widening array of mobile health applications, technology is making us healthier every day. Artificial intelligence (AI)-powered technologies, such as skin-disease recognition, could even be deployed on some six billion smartphones in the next few years.

The potential is enormous and the ITU – the United Nation's specialised agency for ICTs – is ready to help lead the charge.

AI for Health

ITU has pursued several important 'AI for Health' initiatives, including partnering with the WHO to establish a Focus Group on AI for Health. The group is working towards the standardisation of a framework for the performance benchmarking of AI for Health algorithms to address health issues such as breast cancer, Alzheimer's disease, vision loss and skin lesions. The objective is to provide regulatory bodies with the information necessary to determine whether or not AI algorithms have proven themselves accurate enough to enter clinical settings – similar to national health regulators' approval of new pharmaceuticals and medical devices.

The Focus Group on AI for Health is also improving our understanding of how to best navigate the challenges surrounding access to health data and the appropriate use of that data. It has developed a data handling policy enabling the initiative to accept both open data and undisclosed test datasets.

One problem that has been recognised is the lack of interoperability between different databases used in hospitals, even within the same country.

ITU international standards are developed specifically to help provide for such interoperability and to create a worldwide market that reduces costs through economies of scale.

The importance of standards

It is important that the technology used in the health sector complies with international standards to ensure interoperability and security, and that radio equipment operates in harmonised radio-frequency bands to avoid harmful interference.

This encourages and protects critical investment and enables cost advantages by reducing the price of equipment and user devices, thereby enabling affordable services. This key work helps ensure more people across the world are connected and able to benefit from the widening range of

digital health services offered via wireless communication.

Every ITU standard relies on the participation of key stakeholders, and ITU benefits considerably through its large and rapidly growing private sector membership of over 600 companies and more than 160 universities. It is these experts that drive the work and produce the output, mainly in the form of international technical standards.

We are looking to members to develop further standards that can improve both access to care and the quality of care.

Sometimes, however, the ICT solutions for health are far simpler.

Since 2013, for instance, ITU and the WHO have been working on the Be He@lthy, Be Mobile initiative in 11 countries, using mobile technologies for the prevention and control of noncommunicable diseases. Tens of thousands of people in Commonwealth countries such as India and Zambia can use mobile phone applications to help manage their diabetes, cervical cancer and tobacco use.

It all starts with connectivity

Of course, people will only be able to benefit fully from these developments if they have access to broadband communications.

Nearly half the world is still not using the internet. There will only be universal health coverage when everyone is connected.

ABOVE:
The potential for digital technology to improve healthcare is enormous.

BELOW:
The ITU and WHO Be He@lthy, Be Mobile initiative uses mobile technologies for the prevention and control of noncommunicable diseases.


Credit: Chris J. Ratcliffe/Bloomberg via Getty Images.

"ITU will continue to cooperate with the Commonwealth to nurture a digital future where technology is accessible, affordable, safe and trustworthy."

The good news is that there are some groundbreaking initiatives underway to help provide affordable internet access to today's unserved rural and remote communities.

Small satellites, satellites with all-electric propulsion and low-Earth orbiting (LEO) satellites are among these game-changing innovations, opening new use cases such as the backhaul for 5G and the Internet of Things, and enabling a range of solutions from digital financial services to better healthcare and smarter cities. These trends also offer new and more economical solutions to connect the unconnected, who are mostly in rural areas.

In addition to satellite-based technologies, new stratospheric-based radio systems, referred to as High Altitude Platform Stations (HAPS), are being developed specifically to provide affordable broadband connectivity and telecommunication services in underserved communities in rural and remote areas, including mountainous, coastal and desert areas.

ITU manages the only international treaty on the use of the radio-frequency spectrum and satellite orbits – the Radio Regulations. This treaty was updated in late 2019 at the ITU World Radiocommunication Conference in Egypt. A new globally harmonised spectrum will be found for these new advances – among many other decisions.

These decisions will pave the way to achieving ITU's mission to connect the world, which will bring so many benefits to so many people, including progress toward universal health coverage.

Working together, across the Commonwealth and beyond

Of course, we recognise that we must all work together to leverage ICTs to improve healthcare and accelerate sustainable development more broadly.

Collaboration, coordination and cooperation between national, regional and international organisations – and between the public and private sectors – is now more important than ever. It is also more challenging since there is an increasing number of organisations using the technology for their own purposes.

We have to ensure that we bring our own specific competencies to the table, avoid duplication of effort and work for the common good.

For our part, ITU will continue to bring its core competencies to the table and we are very keen to further strengthen our cooperation with the Commonwealth so as to nurture a digital future where technology is accessible, affordable, safe and trustworthy.

In the past, ITU has collaborated on many Commonwealth initiatives, for example the Commonwealth Cybercrime Initiative by the Commonwealth Secretariat, which led to the Commonwealth Cyber Declaration, the world's largest and most geographically diverse intergovernmental commitment on cybersecurity cooperation.

With 2019 marking the 70th anniversary of the modern Commonwealth, I believe it is increasingly relevant as a compelling force for good in the world, and an effective network for promoting development.

At the last Commonwealth Heads of Government Meeting, Her Majesty the Queen referred to the Commonwealth's generosity of spirit. May this spirit guide our work as we strive to create a common approach to promote the digital economy. And may it continue to bring the Commonwealth, the Commonwealth Telecommunications Organisation, ITU and all the other players determined to achieve this, closer together. ■

Using the power of technology to fight infectious diseases

Dr Ngozi Okonjo-Iweala, Board Chair of Gavi, the Vaccine Alliance, discusses the huge potential of technology to break down barriers to development, and provides examples of new innovations being used to tackle infectious diseases in hard to reach communities across the Commonwealth.

Dr Ngozi Okonjo-Iweala,
Board Chair, GAVI

"If we are to continue to make progress, we have to find new ways to reach those missing out, including the millions hiding in plain sight in our cities."

Over the last two decades, we have made encouraging progress in tackling some of the biggest challenges in global development, improving the health, wealth and quality of life for millions of people across the Commonwealth. Fewer people live in extreme poverty and more children are getting the quality schooling they need to unlock their intellectual and economic potential. Child mortality rates have dropped dramatically, as have deaths due to infectious diseases. And women and girls are increasingly closing the opportunity and empowerment gap between them and their male counterparts.

One key reason for this unprecedented progress was a collective commitment by world leaders to devote more resources, energy and ingenuity to big, seemingly insurmountable global problems, first through the Millennium Development Goals and now through the 2030 Sustainable Development Goals. However, global trends, such as climate change, urbanisation, human migration, fragility and conflict, are presenting new challenges that now threaten to make such efforts even harder, potentially undermining further progress.

This is particularly the case with communicable disease. Today 86 per cent of the world's children – more than at any point in history – are protected from a range of deadly and debilitating infectious diseases through routine immunisation. And yet, population growth, human migration and the rising number of people living in cities increase the ease and speed at which infectious diseases can spread. In theory, living in an urban setting should improve one's access to health services, but because of the speed and scale at which this demographic transformation is taking place, in too many countries urban development cannot keep up and the inevitable happens: we get slums.

The lack of sanitation and limited access to clean water in these slums can create conditions that are ripe for many diseases – and the insects that can carry them – to spread, making the growing risk of outbreaks and epidemics a real concern. This means that if we are to continue to make progress, we have to find new ways to reach those missing out, including the millions hiding in plain sight in our cities.

The good news is that we now have a powerful weapon to help us in this task – technology. Although limited

RIGHT:
A Zipline drone delivers blood products to a hospital in Muhanga, Rwanda.

access to technology has traditionally been a factor that has held many low-income countries back, we're now seeing the deployment of a huge influx of highly innovative technological solutions helping them to leapfrog former obstacles, particularly in Commonwealth countries.

One prime example of this is the use of drone technology. In both Rwanda and Ghana, we now have fleets of autonomous drones delivering life saving medicines, including vaccines, to communities across both countries. Developed by California-based tech company Zipline, and with support from the UPS Foundation and Gavi, the Vaccine Alliance, of which I am Board Chair, these networks are supporting millions of people, increasing the reach of health services and reducing waste at the same time. However, this is just the beginning. In my home country, Nigeria, authorities are exploring whether the same technology can be used within densely populated urban settings too, such as in Lagos.

Similarly, digital identity technology, such as biometrics, is also helping to improve access to immunisation. A mammoth issue for many children around the world is a lack of formal identity. One in four children have no legal record of their birth, and in Africa, it's closer to one in two. This can render them disenfranchised for the rest of their lives and limit access to education, health, work and even the right to vote. With more children having vaccination cards than birth certificates, for many years these have ended up serving as de facto identity cards. But in order to reach those that are still missing out, we need to move beyond such paper-based systems.

One solution being used in Tanzania is the Electronic Immunisation Register, which is helping healthcare workers to keep track of children who may have missed vaccinations. After they are registered on the system at birth, it stores their entire medical history, which is then digitally available to all healthcare workers across the region. This means that when a mother brings the child to a clinic, or when healthcare workers do outreach in the community, they know precisely what the child needs. It has proved immensely useful in boosting vaccination rates, particularly with

"We're now seeing the deployment of a huge influx of highly innovative technological solutions helping to leapfrog former obstacles… In both Rwanda and Ghana, we have fleets of autonomous drones delivering life saving medicines, including vaccines, to communities across both countries."

Credit: Karel Prinsloo/Gavi/Arete

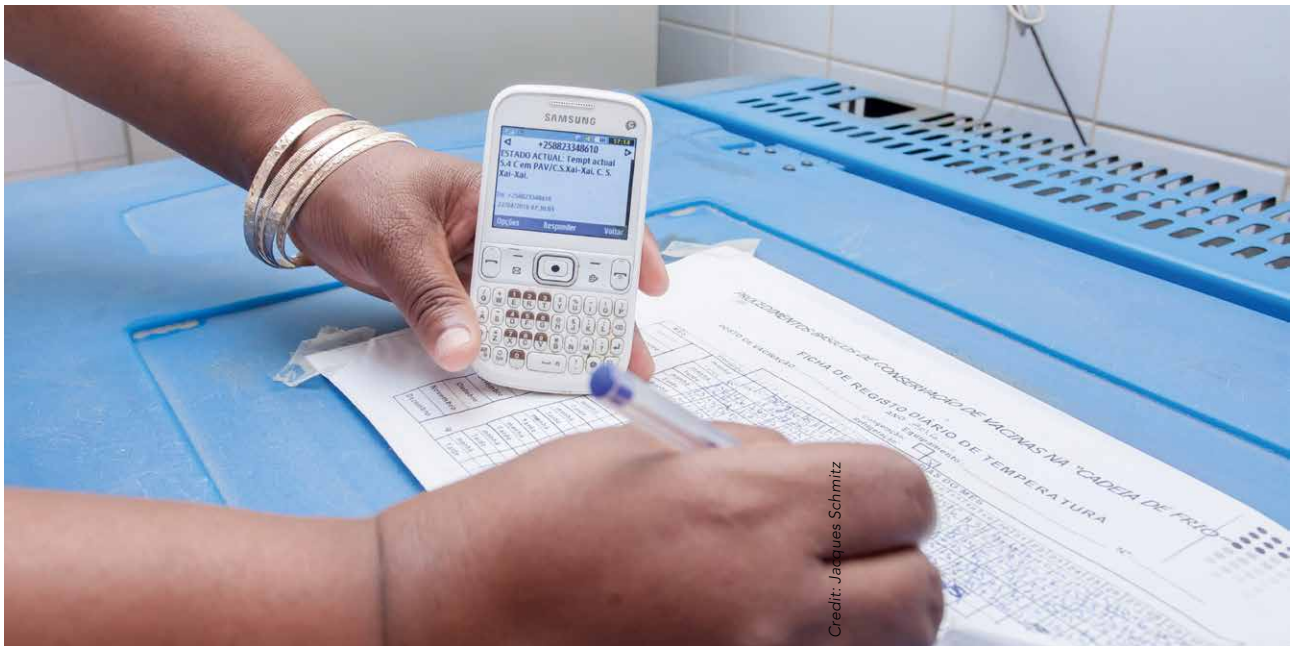
nomadic people like the Maasai, who may not always return to the same clinics. This would not be possible with paper records. And similarly, in urban settings, where we often see migrant communities moving to different districts to follow the work, it can help ensure that children don't slip between the cracks.

Arguably, the biggest digital identity system in the world is India's Aadhaar biometric ID system, which currently has more than 1.2 billion people enrolled. This system, which combines a unique ID number, much like a social security number, with a biometric scan of a fingerprint or iris, gives citizens a formal identity that opens up the potential for access to health and other human services that were previously elusive, no matter where they lived. Gavi has also brought together UK social enterprise Simprints and Japanese tech company NEC to pilot the use of infant biometrics to build a vaccination record for children in Bangladesh and Tanzania.

Data systems are also helping to close the gap. For example, Gavi has worked with Nexleaf Analytics, in collaboration with Google.org, to use data from wireless temperature sensors and build a cloud-based platform to improve vaccine delivery. This platform allows countries like Kenya to monitor the temperature at every critical point in the refrigerated 'cold chains' that keep vaccines safe and effective, from the point they leave the factory, to the point that they reach the children who need them. We are now working with other sensor technology companies to scale this effort. Companies like Zenysis Technologies are using artificial intelligence platforms to carry out analysis of the often fragmented information systems that exist within countries, to help decision-makers identify where children are missing out on vaccinations.

Given the SDG agenda of leaving no one behind by 2030, this is vitally important, because these groups are not just the last to be reached, they are also the hardest to reach. Technology will not always offer a solution, and even when it does, we need to make sure that it is safe and secure. But, in the face of new challenges, it has huge potential to offer new and highly innovative solutions to help overcome such obstacles, and in this, Commonwealth countries are leading the way. ■

"The biggest digital identity system in the world is India's Aadhaar biometric ID system, giving citizens a formal identity that opens up the potential for access to health and other human services that were previously elusive, no matter where they lived."



Credit: Jacques Schmitz

BELOW:
Wireless sensors and cloud-based platforms allow temperature monitoring of vaccines through every critical point in the refrigerated 'cold chains' that keep them safe and effective.

Using data science to improve the health of the world's most vulnerable

Dr Naveen Rao, Senior Vice President of Health at The Rockefeller Foundation, argues that using data to improve health is a moral imperative and we must all ensure that the benefits of new technologies are used to build a healthier, more prosperous future for everyone.

Dr A. Naveen Rao,
Senior Vice President of Health,
The Rockefeller Foundation

"It is crucial to ask this question: how much more could be achieved if the latest technologies were also used to lift up the poorest and most vulnerable?"

These days, it seems that you can't turn on the nightly news or check social media without hearing how advances in data science are improving human health.

To take just a few recent examples, Apple is adding new health features to its smartwatch, allowing users to track their heart rhythms and menstrual cycles. Google and a leading hospital are joining forces to leverage artificial intelligence to improve medical research. Microsoft said it will work with a pharmaceutical company to apply machine learning to accelerate new drug development.

In total, by the end of 2019, investors poured billions of dollars into the digital health sector.

If data science is the next big thing in health, it is crucial to ask this question: how much more could be achieved if the latest technologies were also used to lift up the poorest and most vulnerable? While data innovations may be revolutionising healthcare for people who can afford to pay, they are not yet benefitting everyone, including many across the Commonwealth.

When we broaden our lens, we find far greater need – and far greater potential – for data science to improve health for all.

Worldwide, the most prevalent causes of death for young children are diseases that are almost entirely preventable: pneumonia, diarrhoea, malaria. Every year, however, millions of children, mostly in poorer communities, die before their fifth birthday. Similarly, for women of childbearing age, one of the most dire health risks is becoming pregnant without access to proper care. Each day, more than 800 women lose their life while pregnant or giving birth.

These statistics are tragic because they are avoidable and also because they are not improving nearly fast enough. Despite decades of progress in reducing child mortality overall, countries have struggled to reduce newborn deaths, that is deaths during the first 28 days of life, when children are at greatest risk of dying. Newborns and their mothers urgently need our attention.

Data science could be transformative in addressing the health challenges facing the most vulnerable people. New data-driven tools could unlock the power to identify individuals and communities who are at high risk for poor health but lack adequate resources, so the right care can be directed to the right people and places at the right time.

Imagine a world where we could dramatically reduce maternal and infant deaths by using satellite imagery to predict high-risk births based on

ABOVE:
Precision public health delivers the right care to the right people at the right time. #DataSavesLives

factors like access to electricity and roads. Imagine being able to save lives during an infectious disease outbreak by combining data on sanitation with weather patterns. Imagine empowering frontline health workers by providing them with real-time insights about which families and houses to visit first.

Actually, we don't have to dream about these scenarios as many of the capabilities already exist and have begun to be tested in small pilot projects. Now, it is time to work together to invest in deploying digital health tools at the scale needed to make a lasting difference.

That is why The Rockefeller Foundation has decided to focus our health efforts for the next decade on leveraging data science for health, an approach we call Precision Public Health. By 2030, we aim to save the lives of at least six million mothers and children by working with a range of partners to identify, test and bring to scale data-driven applications for health.

Our work is beginning in India and Uganda, two Commonwealth countries with more than two million frontline health workers combined. These countries are prioritising efforts to use data to provide the intelligence needed for frontline health workers to better prevent, identify and triage health issues in their communities, setting an inspiring example for others.

The ultimate goal is to create a global movement. In order to fully leverage the power of data to improve health for all, we need to address fundamental inequities in the availability of data and the capacity to use it.

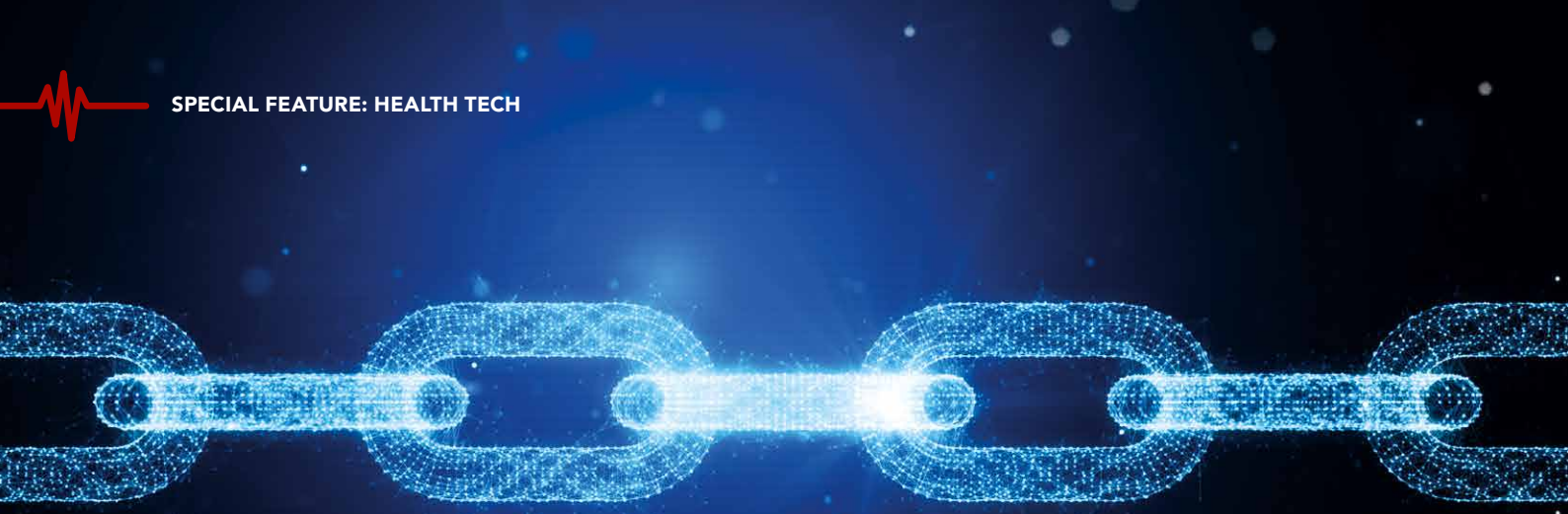
Many low-income countries have serious gaps in the quality of their data about health, as well as data about the broader social factors that influence health. In addition, while stakeholders in these countries are interested in using data analytics to inform health policy decisions, they often lack the skilled personnel to interpret large datasets and perform statistical analysis. Legal frameworks to protect the privacy and security of sensitive health data are generally underdeveloped and underenforced.

Every sector has a role to play. Global health agencies can direct funding and research to data science initiatives. At the country level, ministries of health should work to best understand how people live, move and seek care, and their insights must inform new, tailored data solutions.

Technology companies have the expertise to help define best practice for the sharing, analysis and protection of health data. Most importantly, as the crucial link between health systems and families, frontline health workers and their managers can embrace more targeted and user-friendly solutions to make their work more effective and efficient.

Using data to improve health is a moral imperative. Data is quickly becoming a new currency that separates the haves from the have-nots. We face a choice: allow the benefits of data science to accrue to just some, or use new technologies to build a healthier, more prosperous future for everyone. ■

"Many low-income countries have serious gaps in the quality of their data about health, as well as the broader social factors that influence health."



Blockchain in healthcare

Malta's Deputy Prime Minister and Minister for Health, Chris Fearne, explains the potential of blockchain technology to transform health systems across the Commonwealth, and illustrates how it has measurably improved health outcomes and patient safety in Malta.

Hon Chris Fearne,
Deputy Prime Minister and Minister for Health, Malta

"Although no single technology can transform a health system overnight, blockchain can powerfully disrupt and improve healthcare in a myriad of ways."

Imagine a network of interoperable healthcare systems in a utopia of minimal waiting times, affordable medicines and clinical research; where the best possible patient safety and quality of care is offered.

Blockchain technology makes all this achievable once healthcare providers appreciate its value and potential beyond cryptocurrencies; once they fully recognise how this innovative, disruptive technology, and the ethos behind it, can transform and significantly improve the delivery of healthcare through a revolutionary approach to the storage and sharing of electronic personal patient data.

Malta, aka the 'Blockchain Island', has indeed understood the enormous potential of Distributed Ledger Technology across sectors and applications, and has been a trailblazer in this regard. The country is a global leader in legislating for its regulation, a model which can be proudly shared across the Commonwealth.

Although no single technology can transform a health system overnight, blockchain can powerfully disrupt and improve healthcare in a myriad of ways.

Within current systems, medical records are mostly owned by the caring institutions and healthcare providers, with patients being required to ask to be granted access to them. In the past, before the institution of data protection measures, practically everyone working in a hospital would have had access to this personal data, bar the patients. This is unacceptable, since the data should belong to the patient. Blockchain technology can reverse this.

Without it, data collection from clinical episodes over a person's lifetime may be fragmented and not immediately accessible from differently operating systems, introducing delays and possibly serious implications. This becomes more significant when it comes to cross-border care, where quick decisions may be required, and timely consideration of a person's full clinical history could be a critical factor in accurate diagnosis and effective treatment.

Electronic patient records in Malta are accessible from all public sector health centres, apart from those generated by the 20 per cent or so of private sector services. The government has recently also implemented a web-based platform to allow patients and their private doctors (registered in Malta) to access public health records online, even when requiring treatment abroad. This is essential for us to be able to provide our patients with continuity of care.

Blockchain technology allows patients to have access to all of their medical data using key cryptography and then to share this with a doctor abroad if they need to. This actively places the patient at the helm of their health and wellbeing, enhancing safety and optimal healthcare delivery.

The technology allows each clinical episode to be chronologically recorded in a transparent, confidential, secure, tamper-proof manner, that is less vulnerable to theft. Patients have full ownership and instant, safe and secure access and control over their own medical data. They can selectively share their medical records with healthcare providers anywhere across the globe, through a single portal, without breaching trust or privacy.

Blockchain empowers patients to use their own health data. Given the implicit sensitivities, confidentiality concerns are often the reason that many patients feel reluctant to consent to the sharing of their clinical data for research purposes, as in the case of clinical trials. Blockchain can be a game-changer in this respect since it allows for improved medical research methodologies and transparency through the tracking of interactions, addressing privacy concerns and improving trust between research and patient communities. Patients can control and choose if, how, when and for how long, to share access to their personal data. Facilitating greater participation in clinical trials will translate into less costly research into new technologies and medicines.

The cost of innovative medicines is a challenging area which has my close attention and personal interest. As minister for health and a trained doctor, I am eager to see blockchain bringing down the prices of medicines. Counterfeit medicines hold a growing market share for counterfeit goods globally – estimates suggest that ten per cent of all medicines supplied globally are falsified. The costs run into billions annually with considerable financial impact and negative effects to public health and the individual patient receiving ineffective or contaminated medicines. The current system for the regulation of falsified medicines in Europe is a complicated, labour-intensive one, where each medicine is given a unique barcode to allow product authentication across the manufacturing and supply chain until it reaches the patient. Blockchain can considerably improve the logistics of end-to-end product authentication and traceability and harmonise the regulatory framework – a most useful tool in the global fight against falsified medicines.

Blockchain's system automation processes maximise human resource productivity potential, saving time and performance costs related to data reconciliation and administration. The recording of real-time changes to patient data improves the quality of care and removes the necessity and cost of storing voluminous outdated records by healthcare providers, and possibly insurance companies.

Of course, blockchain does also have its challenges. It is costly to create and implement, requiring political commitment and investment, and broad collaboration by technical experts and all stakeholders, as well as a conviction and willingness to radically change the current modus operandi. Potential users must be convinced that a system revolutionised by blockchain will be far better than the current one, translating into improved patient experience and positive health outcomes. Digital health literacy and equity issues must be addressed to ensure that no one, especially the most vulnerable, is left behind.

Clearly, the standardisation and handling of sensitive patient data recorded by various healthcare providers requires a legal basis and a regulatory framework that safeguards its users and ensures compliance by industry. Malta's parliament has recently approved a legal framework for blockchain regulation, including three new laws enabling blockchain-based businesses. Our visionary leadership in blockchain research and development is drawing international and local attention from various sectors. The healthcare industry will undoubtedly follow.

Digital health advances, including the application of artificial intelligence and the role of big data, have shown promise for the improvement of health systems and the achievement of universal health coverage in the context of Agenda 2030 and the Sustainable Development Goals.

Blockchain is not just another technology, and is not just about cryptocurrencies. It will save lives. It is set to revolutionise the way healthcare is delivered in Malta and across the Commonwealth, and is an opportunity that should not be missed.

Malta, like several other Commonwealth states, may be small and have somewhat limited resources, but we have a track record of resilience when faced with rapid change and can adapt well to changing landscapes. I am confident that taking this forward will be no exception. ■

"Blockchain is set to revolutionise the way healthcare is delivered in Malta and across the Commonwealth, and is an opportunity that should not be missed."

Promoting leadership and frugal innovation in digital health

Professor Vajira HW Dissanayake, President of the Commonwealth Medical Association and Chairman of the Commonwealth Centre for Digital Health, looks at health systems strengthening in the digital era through developing capacity for leadership and frugal innovation in digital health.

Professor Vajira HW Dissanayake,
President, Commonwealth Medical Association and Chairman, Commonwealth Centre for Digital Health

"We have committed to making sure that the power of digital technologies is harnessed and made to work for the poorest and the most vulnerable, not just the rich."

In the digital world in which we live today, healthcare workforces are increasingly called upon to deliver care through new clinical pathways that use digital technologies. They are expected to engage positively with and take leadership in directing the future of digital technologies in healthcare, and use these tools effectively in the delivery of people-centred, quality services. To empower healthcare workforces to do this, it is essential to invest in their capacity development.

Capacity development of the healthcare workforce on digital technologies should not be confined to training them on using these technologies. It must also extend to developing core competencies in biomedical and health informatics. This enables the more competent, innovative and entrepreneurial among them to play a leadership role with teams comprising all categories of healthcare workers collaborating with information and communication technology engineers to design, develop and deploy appropriate digital health solutions. Such capacity development should also enable 'frugal innovation', in other words, cost-effective, scalable, sustainable innovations that are custom built to meet local needs on open source software platforms and conform to open standards that safeguard interoperability.

This is not an aspiration and is achievable. One of the best examples is found in a Commonwealth country, Sri Lanka, which is developing a sustainable digital health ecosystem through in-country capacity development. Since 2008, Sri Lanka has invested heavily in creating a generation of digital health leaders through graduate programmes in biomedical and health informatics aimed at doctors and dentists. There are now plans to extend this to other categories of healthcare workers. Today, Sri Lanka has over 150 biomedical and health informaticians in its health services and is only the second country in the world, after the USA, to have recognised health informatics as a medical specialty. The foundation for its digital health ecosystem was laid through low cost, highly effective, scalable innovations that were locally conceived and implemented by these graduates to meet the country's specific needs. Due to this pool of biomedical and health informaticians, Sri Lanka's Ministry of Health now has the capacity to create and sustain any digital health solution in-house. Its innovations have been internationally recognised at the highest level, including the District Nutrition Monitoring System – a mobile solution

ABOVE:
Sri Lanka's award-winning District Nutrition Monitoring System tracks malnourished children in the community to enable personalised intervention.

that tracks malnourished children in the community to enable personalised intervention – that won the first prize in the health and wellness category, among submissions from 178 countries, at the World Summit Awards in 2016.

The Commonwealth is home to nearly two billion people living in mostly emerging economies spread across the world. The digital transformation of their health systems is dependent on investment coming through international development banks and international development partners. Such investment is under threat of fragmentation due to lack of digital health leadership capacity in these countries. As such, there is an urgent need to globalise experiences, such as that of Sri Lanka, to develop national digital health leadership capacity in all countries of the Commonwealth.

In June 2019, the Commonwealth Centre for Digital Health (CWCDH) worked in collaboration with the University of Southampton, building on the Commonwealth Systems Framework for Healthy Policy, to establish a Digital Hub. The aim was to create a common good for securing a healthy planet for all with the development of a digital framework and platform for Universal Health Systems for Planet, Place and People, learning from Sri Lanka's experience and supported by a rotating team of Sri Lankan Commonwealth Digital Health Fellows. Other Commonwealth countries and organisations have now expressed an interest in partnering with the Hub. The Commonwealth Digital Health Fellowship Programme will enable health informaticians from the global south to experience digital health systems in the global north. It is expected that these fellows will contribute to digital health development activities aimed at strengthening health systems in emerging economies across the global south, through collaborative partnerships established by the CWCDH.

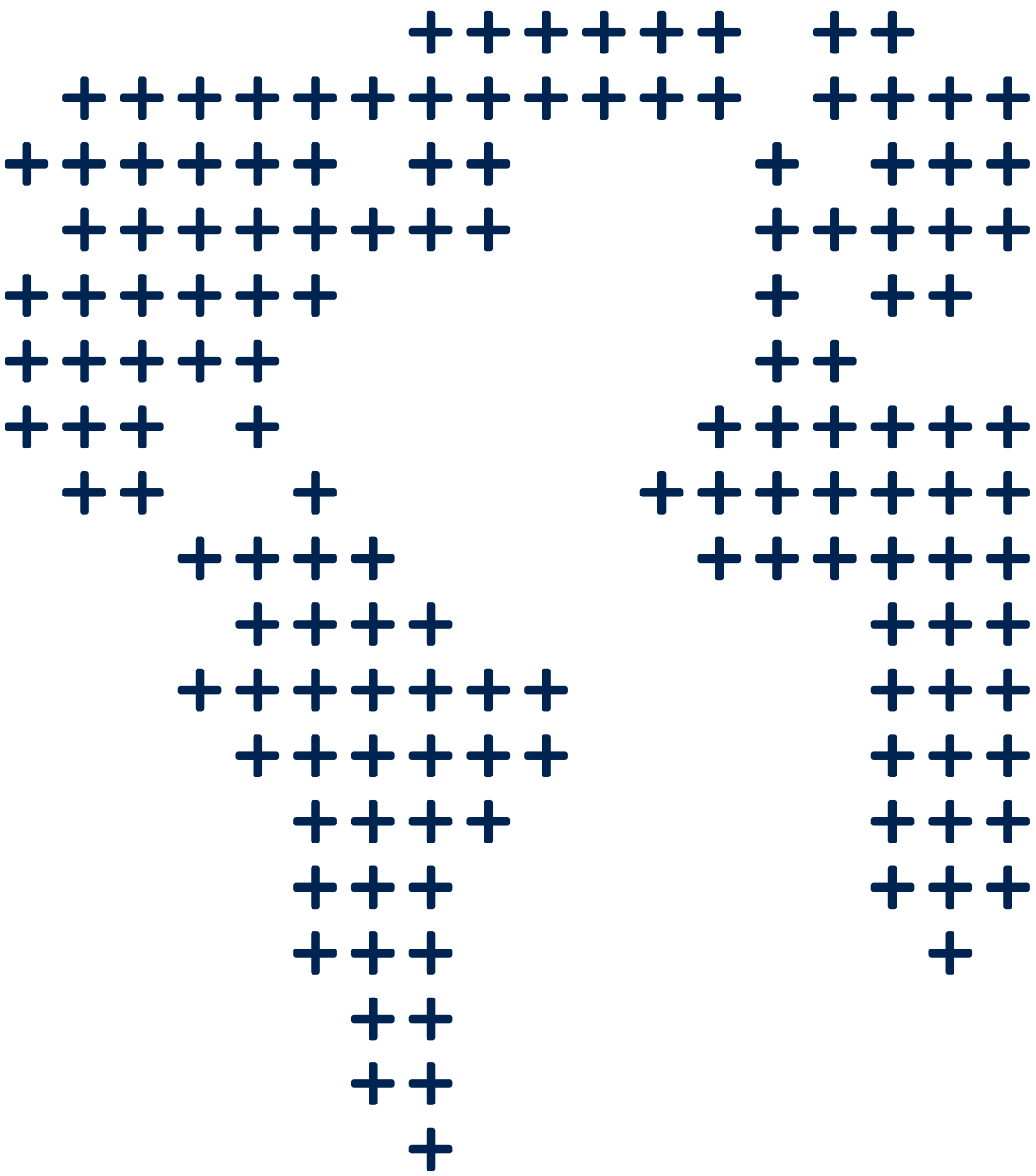
Today, all around us, we can see the transformational change that healthcare services are undergoing through adoption of digital technologies. It is incumbent on us to ensure that everyone benefits from that transformation and no one is left behind. We have therefore committed to making sure that the power of digital technologies is harnessed and made to work for the poorest and the most vulnerable and not just the rich, thereby creating a healthier, safer and more equitable world. ■

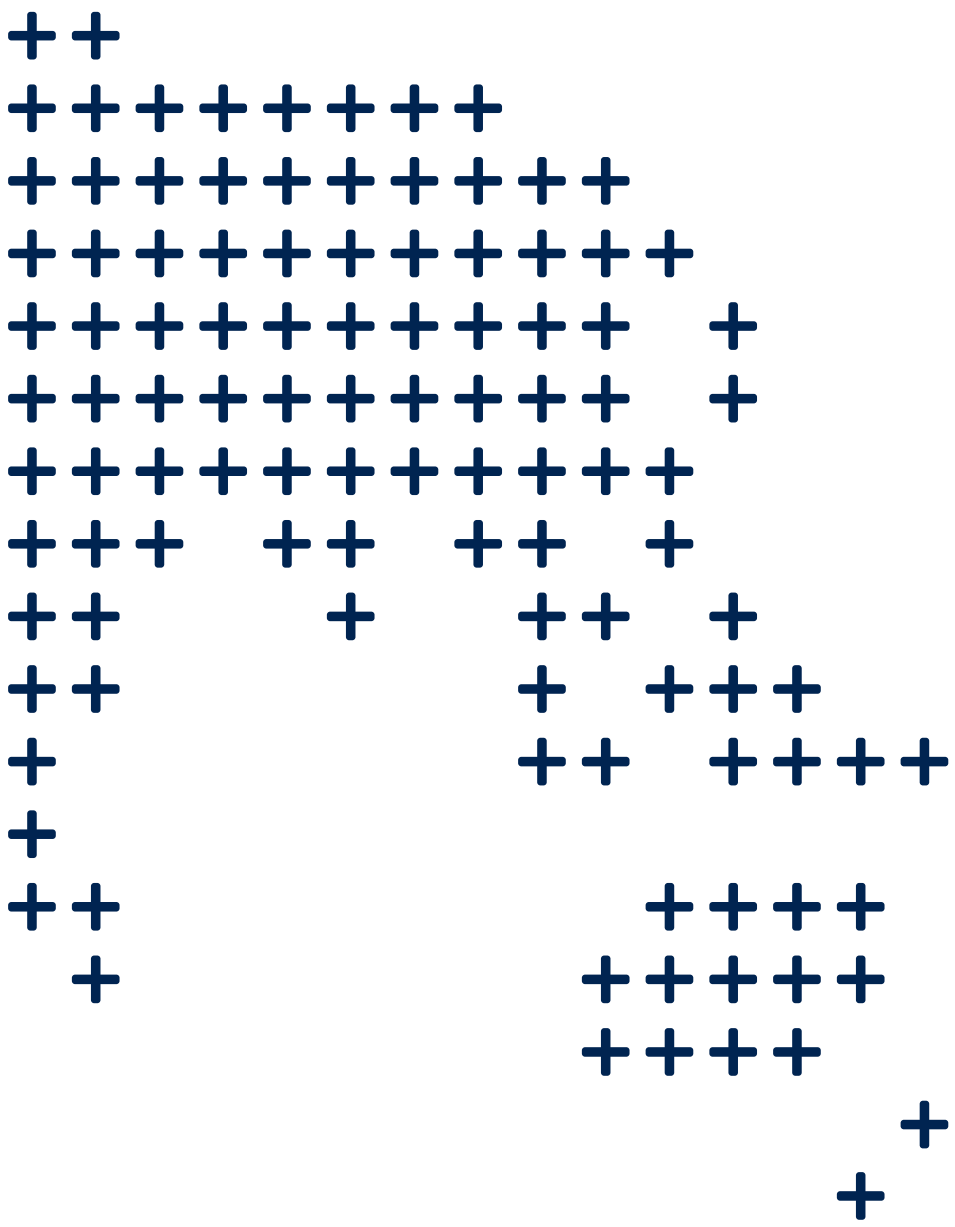
Commonwealth collaboration in action for the digital health era:

May 2016: At the Commonwealth Health Ministers Meeting (CHMM) in Geneva, Ministers adopted a Commonwealth Systems Framework for Healthy Policy with a view to creating a flexible health policy framework that can be applied across the Commonwealth and beyond, to strengthen the sustainability of delivering universal health coverage.

October 2016: During the 24th Triennial Conference of the Commonwealth Medical Association (CMA), health professional associations representing doctors, dentists, nurses, midwives and pharmacists that form the Commonwealth Health Professions Alliance (CHPA); the health ministry and intergovernmental agency representatives from across the Commonwealth that comprise the Commonwealth Advisory Committee on Health (CACH); and over 300 delegates from 38 countries, deliberated on the role of Digital Health for Health and Wellbeing. Their commitment to working collaboratively to create a healthier world was captured in the Colombo Declaration and its accompanying plan for collaborative action was issued at the end of the conference.

May 2017: At the CHMM in Geneva, Ministers approved the Commonwealth Policy Brief on Digital Systems for One Health that articulated the Commonwealth's vision for strengthening of health systems in the digital era.The CMA, through the Commonwealth Centre for Digital Health that was launched during the Commonwealth Heads of Government Meeting in April 2018, aims to take that mandate forward in the years to come.





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representing 54 nations
across six continents,
one-fifth of global trade
and one-third of the world's population.