

Global Health beyond the Millennium Development Goals: Visions for public health priorities and the corresponding health research agenda up to 2030
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Consequences

You don't need rocket health science to realize that large segments of the world's population do not enjoy the highest attainable standard of health as one of the fundamental human rights. Newspapers make that painfully clear every day. The Millennium development goals were the global answer to these spectacular inequities but newspapers are still today packed with news about the boring details of poverty. Soon we will have had 15 years with the present MDGs and it might be about time we sat down to look at a new set of MDGs – maybe we could even venture to evaluate the ones we have struggled with up to now and for once try to learn something our experience?

The new MDGs should ideally reflect the changing reality of global health as well as the unsolved issues.

For example: Improve infrastructure in rapidly growing cities without forgetting rural areas, Secure water supply without producing breeding grounds for dengue and malaria epidemics, strengthen mother and child health to reduce perinatal mortality but also to prevent chronic diseases like diabetes.

“In Nature there are neither rewards nor punishments – there are only consequences” said Robert Ingersoll, an American political leader nearly 200 years ago. Let us look at some consequences of what we have done so far and learn from our experience from emerging, and re-merging, problems and solutions in global health:

A terrible example

The introduction of user fees is an example of a disastrous intervention that we are still struggling with the effects of. It was forced on low income countries by international donors and based on very weak evidence. It has increased child mortality and the number of people with catastrophic health expenditure even after its abolishment. We may be heading for a similar disaster with the introduction of male circumcision where we are still to see the long term effects on sexual risk behavior.

The age of generosity

Less than a decade ago, the biggest problem in global health seemed to be the lack of resources available to combat the multiple scourges ravaging the world's poor and sick. Today, thanks to a recent extraordinary and unprecedented rise in public and private giving, more money is being directed toward pressing health challenges than ever before. But because the efforts this money is paying for are largely uncoordinated and directed mostly at specific high-profile diseases—rather than at public health in general—there is a grave danger that the current age of generosity could not only fall short of expectations but actually make things worse on the ground.

Time or numerical targets

But much more than money is required. It takes states, health-care systems, and at least passable local infrastructure to improve public health in the developing world. And because decades of neglect there have rendered local hospitals, clinics, laboratories, medical schools, and health talent dangerously deficient, much of the cash now flooding the field is leaking away without result. Moreover, in all too many cases, aid is tied to short-term numerical targets such as increasing the number of people receiving specific drugs or vaccines, decreasing the number of pregnant women diagnosed with HIV, or increasing the quantity of bed nets handed out to children to block disease-carrying mosquitoes.

Fatal neglect

Few donors seem to understand that it will take at least a full generation (if not two or three) to substantially improve public health—and that efforts should focus less on particular diseases than on broad measures that affect populations' general well-being. Where the water is safe to drink, mosquito populations are under control, immunization is routinely available and delivered with sterile syringes, and food is affordable, children thrive. If any one of those factors is absent, large percentages of children perish before their fifth birthdays. By 2020 chronic diseases will overtake infectious diseases as leading health burdens – probably before – so we might as well prepare for that.

No system in the system

As Tore Godal, who used to run the neglected-diseases program at the WHO, wrote in *Nature*, “There is currently no systemic approach that is designed to match essential needs with the resources that are actually available.” One might add that neither is there such a system that systematically analyses, uses and adapts existing knowledge. Tore Godal called for a strategic framework that could guide both donations and actions, with donors thinking from the start about how to build up the capabilities in poor countries in order to eventually transfer operations to local control—to develop exit strategies, in other words, so as to avoid either abrupt abandonment of worthwhile programs or perpetual hemorrhaging of foreign aid.

Gender:

Treating HIV positive pregnant women with insufficient drug regimens leaves them susceptible to potentially fatal drug resistance and the health care sector is facing huge rises in expenditure because of expensive third line drugs, high-tech lab facilities and specialist hiv doctors – but they have all left for Europe for training and never returned.

Hiv, TB, compliance and resistance:

Hiv does not spread in a vacuum. Lifelong hiv treatment is still the reality but health workers are not trained to maintain compliance in communities with low health literacy. Nobody has yet dared to assess the risk of resistance resulting from impaired adherence or failing drug supplies in low income countries. Why talk about compliance when there are no drugs or the lab is out of blood tubes? The first examples of serious side effects because of shortages in Hiv drug supplies are already published. These are serious problems that we introduced by distributing HIV drugs through unprepared and collapsed health care systems. After having struggled with implementation with little success we have now finally capitulated and instead promoted it to a science: implementation science, because it is too difficult to implement without a better scientific base.

Food for thought

The recent exponential rise in food prices and the economic recession in its tail has forced mothers to sell the only crop they have: their body – resulting in a significant rise in hiv prevalence among women typically single mothers. And crop output is more than halved in farmer families where an adult has contracted HIV. In other parts of the world the struggle is now between using farm land for biofuel for cars in Europe and the US or for food production to China, US, Brazil or India. A recent study from FAO demonstrated that if women had same access to agricultural resources as men they could nearly triple global food production. Research for health is also about linking world economy, food security, gender equity and climate change to survival of individual farmers in low income countries.

Urbanization:

The extremely rapid urbanization process has completely stunned planning possibilities and has created monster cities that are breeding grounds for problems for which we have no solution. The rapid adaptation to city life with high fat food, obesity, smoking, alcohol abuse and no exercise has sent millions of people into a vicious circle towards chronic diseases that require endless numbers of doctors and life long treatment with expensive drugs.

Monitoring and evaluation:

Global fund told recipient countries to monitor their health care sector and setup health information systems. Now the countries feel trapped: you asked us to monitor and now we can see that our hospitals are worse off in terms of quality of care than we anticipated – what can you do to help us with that? Research identifies weaknesses but the international donors try to ignore the consequences of these results. Research fashion dictates monitoring and evaluation but fashion has never had a brain and has never offered solutions to the findings, leaving low income countries puzzled: Donors demanded certain questions to be asked but now they don't want to hear the answers.

Emerging and re-emerging infections:

After SARS and bird flu we monitor the emerging zoonotic infections – but only in high income countries. The countries where most transmission from wild life to human hunters occurs have no capacity to monitor and there are no international investments in these remote areas.

Tuberculosis is married to Hiv and resistant TB is married to weak health care systems. And in Zanzibar they claim: we got rid of malaria – three times! In Sri Lanka malaria re-emerges every time there is armed conflict in the country.

Armed conflicts:

Everybody knows what at war looks like and we know all how to estimate casualties under such conditions. But wars don't appear out of nowhere and then disappear. The chaos of a post conflict organizational vacuum and the long term hidden health effects of armed conflict are still to be described. Public and global interest leaves with the CNN crew and sorry to say so do researchers leaving the civil victims of war now as double victims.

Language barriers are hazardous to your health

I work in a migrant health clinic in Odense. To migrants and refugees language barriers are the biggest problem in their struggle for human security, dignity and health here in Denmark. But somehow language barriers are also at play when it comes to translating research into practice. However, this demands that research output is presented to and adopted by politicians and other decision makers. And this is where it all goes wrong: researches are from Venus and politicians come from Mars and the available interpreters come from Pluto. Researchers won't spend time or money on figuring out how to communicate: politicians should just listen and act.

Politicians on the other hand don't want research – it disrupts their reality and in fact a Danish politician said: “We don't want manipulated data” when presented with data on health status by socio-economic group and ethnicity. The interpreters, typically journalists, only want results and consequences, not pros and cons and long arguments.

As long as researchers and politicians insist on speaking separate languages we are responsible for not reaching goals such as the MDGs and for sustaining inequity in health.

Democracy or research?

We all like democracy, human rights and equity but when it comes to research we tend to promote a completely different ultra-liberal brainless attitude where any idea is brilliant as long as it comes wrapped in a nice looking p-value and is based on and supports all existing knowledge. We become anxious and a little aggressive when isolated researchers try to stir up the cozy middle class research culture by questioning the basics. The web now offers a jungle of open-access journals, discussion forums and blogs that challenge the traditional scientific media and the community behind them. However, the web (and now mobile smart phones) also make knowledge globally and instantly available – even in rural areas of low income countries.

Longitudinal research in low income countries

We need data that evaluate health status and interventions in real life and real time and at the same time offer a data and idea generating system that can train masters and PhDs locally. Longitudinal demographic surveillance sites, organized through the INDEPTH network, have shown us the way to do this and the network offers a healthy research community based in the South for the South.

Millennium development goals

The MDGs gave the globe, in spite of criticism, a common goal. Though the picture was pessimistic initially something has happened over the last 8-10 years especially regarding the heavy MDG no. 4 on lowering child mortality by two thirds. Suddenly a range of countries are on track to reach the goal and we are all smiling again. The only problem is that we haven't got clue why we can smile. Who knows: it could be that the epidemic of urbanization, in spite of everything, has increased access to health care and schooling and markedly reduced malaria risk – three factors that are normally associated with survival. But we can't answer that question because we never setup the information system that could have allowed us to document why we smile today. A somewhat foolish smile....

Social determinants

Social determinants of health are like a 900 pound gorilla that we can't get out of the room. Social determinants of health have been around for so long that we can't even remember a time without them and we have conveniently come to regard them as biological facts of life – maybe because the alternative is too complex – even for researchers.

Fortunately the recent mixed method analyses of social determinants of health by Sir Michael Marmott and colleagues have revitalized research for health and given it a whole new momentum – so maybe we will be able to get the gorilla out of the room if we find more of the same bait.

The right to be counted.....right

If all migrants of the world were joined they would constitute the 5th largest country in the world and if they joined up with the 100 million ultra poor they would become a superpower with a permanent seat in the security council. People of the world have the right to be counted but they also have the right to be counted right. As a Danish politician said: You have the right to your own opinion, not to your own data. To give all human beings on earth a voice, data and documentation is a very good place to start – then we researchers can express opinions and finally we are obliged to try to come to terms with the politicians on which common language to use.

We therefore welcome you to a conference on future needs in health research. The conference aims to take stock of the current landscape in public health research and consider how well it meets the current and emerging needs of individuals, families and communities in developing countries.

The conference organisers hope for open and heated discussions which will help build a strong, positive agenda for the future of public health research, centred on pragmatic actions that could reduce or overcome some of the obstacles we currently face in ensuring that health research contributes as much as it possibly can to human development.

We aim for an immediate output in the form of an opinion piece based on the two upcoming panels but with the ultimate aim that the output will motivate and inform a revision of the existing MDGs building on past experience and not on new fashions.

Researchers are most often wrong in our research questions, assumptions, data collection methods, analyses and conclusions. But that shouldn't hold us back. Scientists are an optimistic breed, and as Professor Peter Aaby once wrote in *The Lancet* the question to all of us is basically: Are we wrong in the right direction?

Wellcome –and let us get started and find out if we are wrong in the right direction - there is no Planet B and we only have two days.

Implementation science

Driven by what has been called “spectacular inequities,” global initiatives have been directed at improving access to effective interventions for AIDS, TB and malaria, and broadening access to vaccines and health information. Deficiencies in health systems and trained personnel are persisting challenges on the ground, but we are also confronted with substantive gaps in knowledge about how to deliver new and proven interventions in impoverished settings – the subject of the emerging field of implementation science – as well the need for more effective tools. Both represent substantial research agendas.

Trends and transitions

We are increasingly confronted with a global convergence of health problems. In large part due to control of childhood infectious diseases, childhood mortality has declined in most regions of the world. As a result, many countries are now undergoing an epidemiological transition, resulting in a marked shift in the global pattern of disease. By 2020 adult conditions such as cardiorespiratory diseases, cancers and other chronic conditions are expected to eclipse communicable diseases as leading health burdens. The global epidemic of type 2 diabetes is indicative of the shift. An estimated 150 million are affected with diabetes worldwide, with the number projected to double by 2025.