Report from the 'Talking Global Health' Event, University of Sussex, 13 July 2011
The Global Health Development Group*

Background

In recent years, there has been a rapid growth of interest in global health. Health inequalities, the patterns and burden of disease, health and security, global health and development, health and education are but a few of the issues to reach the top of national and international agendas. Interest in Global Health at Sussex University has never been greater. There is clearly a lot of academic activity in this area at Sussex University as well enthusiasm among our students. There is also great potential to collaborate with colleagues at other academic institutions locally as well as with others working in the community. However, there is a feeling that much of this work is happening in relative isolation and that better coordination and connectivity between these stakeholders would be valuable.

Towards addressing this, an event – 'Talking Global Health' – - was hosted by the University of Sussex and sponsored by two of the University of Sussex Research Themes (Global Transformations and Health and Environment). The event brought 70 people together from the Universities of Sussex and Brighton, BSMS the Institute of Development Studies and locally-based non-governmental organisations. The aim was to create an informal environment where people could present their work and make connections, whilst promoting the GH activities of the organising institutions.

'Setting the scene'

The aim of the first session was to encourage interaction among participants by showcasing ongoing activities at the University of Sussex (U of S), Brighton and Sussex Medical School (BSMS) and the University of Brighton (U of B) whilst also providing external delegates with the opportunity to present their work.

The first talk of the session, entitled "*The role of antenatal care for child growth and cognitive development: a comparative analysis in Vietnam, Ethiopia, Peru and India*", was given by Dr Ricardo Sabates (School of Education and Social Work, U of S). The talk focused on the impact of early life interventions on pregnancy outcomes and child development. Reducing social inequalities in health is a social justice issue and health inequalities exist in all countries rich or poor, as recognized in the WHO Commission on Social Determinants of Health Report (http://whqlibdoc.who.int/publications/2008/9789241563703_eng.pdf).

Health and nutritional parameters are strongly associated with school outcomes: for example micro-nutrient deficiencies are known to impact on cognitive development. School health programmes have been shown to be beneficial but children who are not in school do not benefit. The age at which children start school also varies considerably. Better pre-natal care could have a direct positive effect on mother and baby's health and improve mothers' confidence in health services and health care access.

Ricardo presented his project called "Young Lives", a long term international research collaboration which has been studying 12,000 children over 15 years in Ethiopia, India, Peru

and Vietnam. They have been investigating the changing nature of childhood poverty in order to examine the causes and consequences of childhood poverty and how policies can affect children's well being. Households were sampled at sentinel sites and a group of children born in the year 2000 were enrolled. A second cohort of older children who were born in 1994 in each country were also enrolled. The follow-up rates were extremely good by international standards and data were collected on the child's nutritional status, the mother's access to pre-natal care and cognitive development assessed at the age of approximately 5 years. Data were also collected on stunting at 1 year of age. The mother's access to pre-natal care was recorded according to the timing of the first visit, the number of antenatal clinic visits during pregnancy and whether a health professional was present at delivery or not. Generally there were differences in children's cognitive scores that correlated with the standard of antenatal access during pregnancy but there were no differences between children who were stunted or not. The best scores were seen in children whose mother had access to antenatal care and who were not stunted during the first two years of life.

The talk stimulated discussion around the possible mechanism of this effect, whether there might be differences between people who access health care services and those who do not and whether the birth order was relevant.

The next talk focused on the health link between Brighton & Sussex University Hospitals Trust and BSMS with its counterpart teaching hospital and medical school institutions in Lusaka, Zambia. Catherine Butterfield from the Tropical Health and Education Trust (THET) outlined the background that lead to the THET health links initiative. Migration of trained health care professionals out of many countries in sub-Saharan Africa has led to a shortage of approximately 1 million health care workers on the continent. Complex factors underlie these statistics. Lack of training and poor working conditions make it difficult for institutions to retain their staff. THET supports the development of long term voluntary partnerships between UK health institutions and their counterparts in developing countries. The aim is to improve health services in developing countries through reciprocal transfer of skills and knowledge between partners. THET is particularly active in Zambia where in addition to supporting links they are developing medical courses in pathology, psychiatry and anaesthetics. Five schools of nursing in rural areas have recently been opened.

Nita Muir and Jill Durrant (School of Nursing and Midwifery, U of B) described their work with Zambian nursing colleagues that led to a the development of a critical care nursing curriculum in Zambia. The curriculum was written by Zambian educators and approved by the Zambian General Nursing Council and the Ministry of Health this year. This was a major achievement in getting critical care nursing into the curriculum and training for nurses in Zambia. The next area the Link will be working on is strengthening paediatric nursing care. Currently there are no nurses trained specifically to look after children and a recent International Health Links Funding Scheme grant is supporting the development of a paediatric life support training programme for Zambian healthcare workers delivered by Zambians.

The discussion focused on whether other facilities (i.e. buildings) were being developed in parallel and the benefits that the UK partners get from such links. It was felt that these were

numerous and included developing teaching skills, resource management and increased understanding of a different culture.

The third talk of this session was given by Stefan Elbe and Peter Newell (School of Global Studies, U of S). Their talk focused on climate change and global health with each giving their own perspective. Climate change was described as a magnifier of the challenges in global health. There were complex implications of climate change on global health that spanned physical and mental health problems, infectious diseases and nutrition. Vulnerability influenced by social determinants is also magnified. Those who contribute least to global warming suffer the worst effects. 80% of natural disasters occur in developing countries and this is where the burden of increasing disease also lies. Addressing the potential impact of climate change on health could direct resources away from other health issues and there may be negative health impacts of investing in climate change litigation: for example bills could become more expensive increasing poverty in vulnerable populations.

There is currently a bias towards looking at the impact of climate change on health with little emphasis on the effect of health issues on climate change. For example, urbanisation drives climate change so it is possible that improvement of health systems in rural areas could impact on climate change by reducing urbanisation. Likewise, there is scope to reduce carbon footprints by reducing energy consumption by healthcare institutions and limiting air travel to international health conferences.

Discussions focused around off the grid developments, for example solar technology in rural areas that is driving technology delivery and the links with agriculture were highlighted. The role of genetically modified crops was touched upon, for example the development of drought resistant plants. The overriding message was that more interaction between those working in health, climate change and agriculture is required.

There then followed a series of 'snapshot' presentations of work from other delegates who gave short presentation on their work or organisation. Alice Street (U of S) spoke about her work on regulating health systems in fragile states. This is an under-researched area where global health interventions are actually generating new health inequalities and research has tended to be disease specific rather than health systems focussed. She has taken an ethnographic approach to her research and has been working closely with the government and other stakeholders in Papua New Guinea.

Sandra Mutuma (Action Against Hunger, AAH) spoke on integrating the treatment of severe acute malnutrition into national health services for children. AAH works in several countries around the world focusing on under rather than over nutrition which contributes to over one third of childhood deaths.

Hayley McGregor (Institute of Development Studies, IDS) gave an overview of the resources and research programmes at IDS. She described the STEPS programme which links environmental sustainability, poverty reduction and social justice and focuses on making science and technology work for the poor across the three domains of health, agriculture and water. Future Health Systems is a research consortium based at IDS which is working to improve the accessibility, affordability and quality of health services for poor people.

Maria Feelan (Harm Reduction International, HRI) gave a global perspective on harm reduction. HRI works to reduce harm caused by psycho-active drug use and in public health terms this relates primarily to blood born viruses such as HIV and hepatitis C. The organisation aims to make opioid substitution therapy and needle and syringe exchanges globally available, particularly in countries where such resources are currently not available.

Clare Shaw (Target Tuberculosis, TTB) spoke about the organisation's mission to address the health, social and economic impact of the global TB epidemic amongst vulnerable and marginalised groups. TTB works mostly in sub-Saharan African countries and India but also has a project in East Timor. TTB works in partnership with local NGOs and government TB control services to improve access to TB treatment for all by through strengthening community led interventions to control TB. They act as advocates and help strengthen the organisational capacity of their partners.

Stephanie Gill (Tearfund) noted that lack of sanitation and access to clean water is a major contributor to the global disease burden, particularly in children, yet it receives significantly less funding in terms of UK aid than any other area such as health, government and civil society and education. Tearfund works on advocacy, regulation and promotion and is doing research to understand where addressing diarrhoea fits on national priority scales, what influences policy makers in three sub-Saharan African countries and what are the barriers and opportunities within these countries.

Gail Davey (BSMS) spoke about her research on podoconiosis, a neglected tropical disease that results from contact with irritants in volcanic soil in impoverished, barefooted communities. In Ethiopia alone there are estimated to be 1 million sufferers and the disease has huge social and economic consequences. Simple treatment measures are effective and Gail has been working with a number of organisations to bring podoconiosis to international attention. This has included the development of a systematic programme of research linked to a patient association, lobbying across disciplines at national and international level, partnerships with business and direct evidence-based approaches to various organisations.

Keynote addresses

The first keynote talk was given by Peter Aggleton (School of Education and Social Work, U of S) who shared his experience of developing sexual health programme guidance for WHO in a talk entitled 'Sex, sexuality and sexual health'. Peter gave an overview of the key issues in this field, stressing the importance of precision and consensus in the terminology used. He illustrated how definitions have changed over the years, becoming more positive and holistic. He went on to describe a comprehensive programmatic approach that promotes sexual health across five domains: Laws, policies and human rights; Education; Society and culture; Economics and Health systems.
(http://whqlibdoc.who.int/hq/2010/WHO_RHR_HRP_10.22_eng.pdf).

Richard Wilkinson (University of Nottingham) closed the event with the second keynote talk entitled 'The spirit level: why equality is better for everyone', based on his book of the same title. The central thesis to this work is that people living in wealthy countries where the gap between the rich and poor is small are happier, healthier and more successful that those

living in wealthy countries where the gap is large. In addition to happiness, he presented data suggesting that a range of other indicators correlated with the size of the rich-poor gap, including murder and teenage pregnancy rates, burden of mental health problems and obesity.

Round table discussion groups

The afternoon session comprised round table discussions on five topics and delegates were able to attend three groups of their choice. The key points arising from these discussions are summarised below.

Global Health Diplomacy: How can we make global health a greater international priority?

This group discussed the different strategies available for making global issues a greater political priority in the international system. The group noted that internationally there really is no central political institution with the authority to implement global health policies, and that in most countries such policies are still set by national governments. Whilst many countries have a national health care system, there is no international equivalent, and even the World Health Organisation is principally a technical agency serving its member states; it is not an international health care provider. This means that the question of political leadership around global health is often heavily contested in the international system, and marked by a wide variety of different actors and institutions pursuing divergent agendas. This, it was noted, can produce problems of overlap and even rivalry amongst different organisations working in the area of global health.

Another challenge that was identified was how global health issues can command the international attention that they deserve. One prominent strategy pursued over the past decade has been the attempt to rebrand and reposition some health issues as threats to security. This strategy was pioneered in the case of HIV/AIDS where the United Nations Security Council met to consider HIV/AIDS as a threat to international peace and security. Whilst this strategy does have attractions in terms of generating attention and resources for global health, it was also felt to generate new challenges in terms of the overall balance between vertical and horizontal programmes, and also in terms of creating sustainable global health policies that match up well to local priorities of affected communities. The group also noted that all of these questions were particularly pressing given the changing financial climate within which global health is practiced.

Social Determinants of Health: Do we know what really matters to reduce health inequalities?

People need information, knowledge and skills to reduce health inequalities, but they also need to understand why they need to adopt certain health behaviours or change their current behaviours if interventions are to be effective. This demand-led change should also be accompanied by changes to the supply, the way in which goods and services are distributed. The concentration of resources into the hands of just a few individuals will only result into continuing and increasing levels of inequality.

Existing power structures prevent individuals from changing health practices. This is done by oppression and discrimination, such as cultural or gendered power-related structures or by imposition and restrictions, such as economic and political power structures. Changing

structures of power should consider the legal framework and introduce mechanisms to improve transparency and accountability. It is only through individuals in power positions being held accountable for their actions that those oppressed can feel empowered to act.

Community participation and mobilisation is an important factor in leading to changes that would reduce health inequalities, but this gives rise to the question: what motivates communities to mobilise, and how can it be geared towards addressing health inequalities?

Finally, the effect of social environments needs to be considered, rather than just individual risk behaviour. Interventions cannot simply be targeted to individuals for specific improvements, such as targeted programmes to increase access to health services. Support to those in most need must be progressive and holistic, in the area of health, sanitation, education, and living conditions. Dealing with health inequalities is a matter of social justice, and that means strong sense of redistributions to those who suffered from lack of opportunities.

'Empowered communities': political correctness or global health core?

We tried first to define the expression 'Community Empowerment', and this led rapidly to critique of the term and underlying assumptions. Views on current use of the term included "a tired development trope" (using trope in the sense both of a cliché and the older sense as an opposite); "empty language"; and "meaningless idealism" (doubt that a community in entirety can be empowered – certain subgroups will always do better than others).

Participants gave several illustrations of situations in which community empowerment had been compromised, misunderstood, or never really intended. In Romania, a community repeatedly overlooked the needs of the Roma in their midst; an inner-city UK community requesting chiropody services were instead offered an unnecessary but more iconic project. Several examples emerged of funding groups seeming to offer decision making to recipient groups but ignoring decisions that did not fit with the funders' preconceptions. Two participants in separate groups made similar observations, along the lines of "empowerment presupposes the power-holding group being willing to give over power".

All this has clearly got 'Community Empowerment' a bad name, so we went back to look at what the ideas behind the term might originally have been. Pursuit of what the term might originally have been intended to convey included the idea of "grassroots" or "bottom-up" development. Most groups considered these ideas to be worthy, but to badly need another label.

Is the focus of millennium development goal 5 enough to improve maternal health?

MDG5 is worded with a focus on improved maternal health, however the main target is the reduction of deaths. There is little emphasis on health (including mental and emotional) and well being. MDG 5b was recognised as taking a more holistic approach in promoting universal access to reproductive health services however this is widely seen as having been introduced too late.

The underlying issues of the social status of women and their level of power with regard to decision making, which in turn have wider socio-cultural connotations that need to be

considered if maternal health is to be improved, were widely discussed. The need for increased awareness of rights as well as health seeking behaviours and services available was noted. There is a need for wider community involvement in increasing awareness but also in creating demand for services and a sense of shared responsibility for health and health seeking behaviours.

Traditional birth attendants have a role to play in the continuum of care even if this has yet to be fully determined. An underlying concern was that care/health services tend to focus on the delivery rather than the continuum; although it was also recognised that emergency obstetrics care, ante natal care and nutrition programmes are generally increasing and potentially having impact. However, there are many socio-cultural aspects to seeking care at any stage of pregnancy that may be under-considered and therefore have impact on the uptake of services.

Skilled birth attendants (SBAs) were recognised by the majority as being a good idea in principle however some concerns were raised around the "medicalisation" of deliveries and with the promotion of facility-based deliveries which are losing favour in more developed countries. The focus on SBAs may also prevent the effective consideration of other barriers to care, such as transport, infrastructure, availability of equipment and basic hygiene and quality of care. The majority of groups noted the pressure on resources and the challenge of holistic approaches without spreading resources (and potential impact) too thinly.

The lack of support and resources has compromised the ability to improve maternal health. Whilst there has been a recent focus on maternal health (with the Canada G8, the UN summit, UK government focus and African Union declaration etc) is it too little too late? Some groups queried why maternal health does not have an equivalent of the "Global fund" and a single representative organisation providing strong oversight, advocacy and promotion of maternal health.

Depression as the second largest global health challenge – science, social construct or delusion?

Mental Health remains marginal or the Cinderella in Global Health discourses. Greater awareness is necessary to bring Mental Health and the challenges linked to depression to the centre ground. Depression is often defined through a biomedical lens in the Western world. How do we define depression so that it has cultural meaning? People mentioned definitions such as 'pain in the heart' or 'compassion fatigue' as cultural reformulation. Difficulties were acknowledged of biomedically informed Westernised values and how that translates to other cultures. How do we become more culturally sensitive and aware to meet people where they are?

People continue to be silenced by the stigma associated with depression. Treatment of depression should take holistic & inclusive practices into account and thereby move beyond psychopharmacology and therapy to acknowledge the contribution of sport, spirituality & employment etc.

How do we move away from depression seen as located within individuals, to consider how health and social inequalities impact on mental health and wellbeing? How do we

reformulate depression as cultural and social phenomenon to encourage collective responsibility and socially just forms of treatment?

An economic comparison would be helpful of TB/HIV/AIDS/Malaria and depression. Where is depression more prevalent? What is the relationship between social instability, health and social inequalities and social determinants to determine where the best place is to allocate resources?

Conclusions

The Talking Global Health event brought together individuals from diverse backgrounds to discuss and debate a wide range of topics. Feedback after the event suggested the aims - to provide a forum for networking and making new connections and to develop links between academics and those working in GH outside the university setting - were met. Many commented on how useful and interesting it was to meet people from different backgrounds and disciplines that broadened their take on Global Health matters. Presentations and recordings of the talks will be posted at the following site - http://www.sussex.ac.uk/globalhealthpolicy/newsandevents/conferences
A follow-up meeting, 'Doing Global Health' is planned for July 2012.

Acknowledgements

This event was supported by the Global Transformations and Environment and Health Research Themes, University of Sussex. In particular, we thank Deborah Foy-Everrett and Eleanor Marsh for excellent logistical support. We are also grateful to Padmini Iyer and Sue Newport for facilitating discussion groups and contributing to this report.

*Peter Aggleton (Chair), Sarah Lou Bailey, Stephen Bell, Gillian Bendelow, Jackie Cassell (Theme Leader Environment and Health), Gail Davey, Stefan Elbe, Alan Lester (Theme Leader Global Transformations), Nita Muir, Melanie Newport, Ricardo Sabates, Maya Unnithan and Laetitia Zeeman