

**HUMANITARIAN &  
DEVELOPMENT  
PROGRAMME**

# **HEALTH IN 2016, THE REAL FORGOTTEN CONFLICT**

**By**

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**« GLOBAL HEALTH » THINK TANK**



With the celebration of the New Year, we wish for it to fulfil our hopes and dreams and remember some notable moments of 2016: the attacks in Nice and Brussels and the Olympic games, the arrival of Trump as the American president, Brexit, the Syrian conflict, the migrants, ISIL and the Euro. It is even easier to forget what happened for healthcare—a matter that affects us all. We are reminded – or did we even know? - that in Europe, for the first time since 1969, life expectancy and IQs reduced and alcohol-related deaths increased in 2016.

Perhaps we talk about Europe because we feel more concerned by issues on our continent but diseases have no regard for man-made border. Stateless, viruses and other pathogens have become pandemics and shape the history of mankind. The Spanish plague, which caused more casualties than the First World War or smallpox, typhoid and measles were the real conquistadors to whom we owe the European colonization of the Americas in the 16<sup>th</sup> century.

In 2016<sup>1</sup>, the WHO identified 134 epidemic outbreaks across the globe compared with 55 in 2010.

The ‘Zika’ virus has had a presence in Latin America, avian influenza in Asia, Severe Acute Respiratory Syndrome coronavirus in the Middle East and yellow fever and Lassa in Africa. If the individual starting points of these epidemics are marked geographically, it is clear that, over weeks and months, new cases appear far from the ‘source patient’. The hidden migration of the Zika Virus to the USA in February, the coronavirus that flew to Bangkok in August 2016 and the Lassa fever that ended up in Germany further demonstrates that neither the 21<sup>st</sup> century nor borders protect us from a pandemic.

On the contrary. In order to spread, bacteria, viruses and parasites need a vector, either animal, plant or human. A vector that can increase the risk of large-scale epidemic, further becoming a pandemic, by taking advantage of the increased flow of people and goods across the globe.

The Zika Virus fuelled our fear of pandemics. This year, the Olympic Games in Latin America and the images of microcephaly feeding the media have echoed the psychosis that also led to Ebola the previous year. It took almost two years to see the end of the Ebola epidemic, which ended at the end of 2014, killing more than 11,300 people<sup>2</sup>. Whilst the previous epidemics remained confined, this epidemic crossed borders and made its way through the forests of West Africa before fleeing to new countries (see Nigeria). West African epidemiologists have identified several reasons for this spread: the flow of people on peripheral side-roads, the population density in peri-urban areas, the detrimental false beliefs... and along with this, civil society was alarmed by the slow development of new medicines by the pharmaceutical industry. Everyone was mostly

shocked to find that in the age of Facetime and 3D printers, it still takes 10 years to develop a new vaccine or new therapeutically active molecule. Is this a genuine timeline or just a financial consideration? That was the question and it remains topical.

Let's start with the astonishingly steep bill the pharmaceutical company Gilead has issued to treat hepatitis C in Europe and the United States, which costs €46,988 for 12 weeks of treatment. Generics are already available in some markets globally at 100<sup>th</sup> of the cost.

Whether it is a question of money or not, the fact remains that discovering a new therapeutic molecule is a lengthy and fraught process. Though Antibiotic (ATBs) Revolution contributed by adding 30 years to the life expectancy of Western citizens over the last century, we are now facing its limitations. Resistant strains of bacteria began to emerge in the 1950s. Treated with contempt at a time when it was possible to prescribe another class of antibiotics, it is now a major problem.

Highly simplified protocols, a misuse of ATBs and a lack of competent medical staff in certain parts of the world have led to resistant organisms and antibiotic abuse has given rise to today's multi-drug resistant bacteria (MDR). From health centres where we give third-line ATBs for a simple bronchitis to a trauma centre that welcomes patients carrying MDR... the problem is still the same: reduced treatment efficacy and increased risk of complications. What does 2016 hold? The implementation of the World Health Organization (WHO) global initiative to fight antibiotic resistance. Not just this but also the spread of highly resistant emerging bacteria, which for a few years had only rarely been seen and which is now increasingly taking centre stage. This bacterium has the property of being resistant to the majority of ATBs as its name indicates, but also has been able to pass on its resistance to other bacteria. The carrier patient then sees the end of the line for treatments available, unable to contain an infection that has rapidly turned into septicaemia.<sup>3</sup> This increases the risk of death for the patient, of course, but also the risk of nosocomial infection<sup>4</sup> - an infective risk that sometimes forces the hospital to shut down for a full decontamination with the hope of finally getting rid of this unwelcome guest. This not-so-exceptional procedure significantly reduces access to care for the population and has significant cost implications for the health service. This ATB resistance has become a headache in South Sudan, as a whole generation of children are now resistant to ATBs. But the resistance to ATBs is also a problem in cities: Paris for example, is sometimes forced to close 10 of its 33 intensive care beds for the treatment of burns due to highly resistant emerging bacteria.

During the first Global Week of Action 'towards good use of ATBs'<sup>5</sup>, hard-hitting slogans and education that weren't revolutionary in 2016 will likely be reused in 2017. Having been identified as a priority, the WHO and the Heads of State are committed to a coordinated approach to tackle the root causes of ATB resistance. Coordination and

collaboration: the key words for effective research. This was probably what allowed the rVSV-ZEBOV vaccine to be deemed 'highly effective' against the Ebola virus at the end of December 2016. Good news - as more of this is needed - but it does not allow us to finish the year as well as close the book on immunisation at the same time. A real backbone of public health at global level, vaccination continues to oscillate between success and defeat, infatuation and disenchantment. Nevertheless, it is important to note the eradication of neonatal tetanus in Southeast Asia in 2016. The vaccination campaign for the eradication of poliomyelitis has not been met with the same success, but we have been working towards it for 28 years. We have spent 28 years and 17% of the WHO's total budget. Was it a success? Clearly yes, as we have gone from 350,000 global cases annually in the 1980s to 74 cases reported in 2015. There are also 10 million people who are able to walk when they could have been paralyzed, 1.5 million child deaths avoided and up to 50 billion US dollars saved over the next 20 years for public health in developing countries. But almost three decades later, the same distrust for vaccination remains. Whether it is against poliomyelitis, measles or influenza, some fear sterilization, others are afraid of the aluminium adjuvant in certain vaccines, while others still think they can have a quick word with the virus and thus avoid contamination as well as its spread. Others will talk of conspiracy, but should we really poke fun at this when we know that the US government used a vaccination programme to locate bin Laden in Pakistan in 2011 to 'arrest' him? On the plus side, the Americas have eradicated measles this year and some vaccines could save an estimated 3.2 million more children per year<sup>7</sup> worldwide in the first 5 years of life.

Human evolution, and the world, has moulded us, and today we mould the world - we are immersed in the Anthropocene... How do we survive our very own creation?

The 'New Year's resolutions' of the COP 21 in France and then COP 22 in Morocco<sup>8</sup> gained world media coverage by virtually ignoring the consequences of climate change on human health. The earth will survive; it has always done so. For humans this is less likely. How many years/months will it take for us to realise that climate change is changing the endemic distribution of vectors, such as the malaria-transmitting *Anopheles* mosquito to the more temperate climates? The impact of climate change is becoming increasingly important in our health. A WHO report in the spring of 2016 alarmingly reported that 23% of global deaths are linked to the environment, revealing that 12.6 million deaths per year due to pollution, heat and infectious diseases.

70% of greenhouse gases (GHGs) are generated by cities<sup>9</sup>, at a time when, for the first time, cities are home to more than half of the world's population. There is an urgent need to reconsider the link between health and overcrowding. Developing countries represent the vast majority of this trend towards urbanisation. Individuals are enticed by work, housing or are simply driven by conflict, drought or repeated flooding, towards cities that grow haphazardly and informally. Neighbourhoods are too vast and growing

too quickly for proper planning and growth. The lack of running water, heating and waste management makes it a perfect hub for the spread diarrhoeal diseases, pneumonia and asthma like wildfire.

It is easy to talk about failing primary care in these conditions, and in conditions where people are forced to flee their countries. The shocking images of migrants on Europe's roads allow us to forget that Europe receives only a small fraction of the migrants of this world, and that the majority of the displaced/refugees find themselves in the vicinity of the megacities of the South. Psychological disorders specific to displacement, hopelessness and their repercussions are added to their already existing illnesses. These are neglected illnesses, impacts of which are becoming more and more important. How do you find the energy and hope to rebuild yourself when you are suffering from post-traumatic stress disorder (PTSD)? Depression? Mental health, the truly neglected field of public health, is nevertheless at the crossroads of all disciplines. Today a report shows a return of \$4 for every \$ invested in mental health. It may be insensitive to talk about 'performance' under these conditions, but it is also very likely that this is the way to finally find funding for mental health, as we know of the reluctance of governments to finance health with it being considered a 'cost' rather than an 'investment' for the future.

Our health policies are costly because we have to engage people, train staff, ensure continuity of care and coherence. And despite good will, it sometimes takes us a few decades to recognise our mistakes. The ultra-specialisation of medicine in the 70s saw patient care divided into sectors. The cardiologist took the heart; the endocrinologist took the thyroid, the rheumatologist... who makes the connection between these? Who is trying to scale down this fragmented and time-consuming system, which becomes more a problem than a solution for our elderly? Nowadays, general medicine has difficulty in making the link and finding its place. The aging population of Western societies and the guarantee that this problem will become more widespread in developing countries in the coming decades requires us to re-examine our approach. Especially since this practice of 'silo' medicine is seen at all levels, both in clinical practice and in health policies at the international level. Whilst the role of the general practitioner in the West is questioned, the question in some developing countries is rapidly becoming 'why should I treat my child's malaria if you do not see to the malnutrition that is killing him? Why offer me HIV testing, if you do not allow me to have the treatment?' It is important to rethink our idea of medicine: a patient and not a series of isolated organs, an integrated approach to health and not just offer a water tap here, a bit of antimalarial there. Hygiene and access to water are the fundamental foundations of health. What is the logic in having separate services dealing with the WASH (Water Sanitation and Hygiene Promotion) and health, but not working together? How can improved practices even be considered when the United Nations (UN) Sustainable Development Goals (SDGs) for 2030 make the Good Health and Welfare and Clean Water and Sanitation objectives two separate goals? In fact, the funding allocated and the

entities involved will also be 'separate'. Too bad. Maybe we could start with civil society and integrate these basic rules ourselves, and why not ask our NGOs to add WASH to their environmental health programs?

There is some good news, however, with fewer deaths due to infectious diseases due to an overall improvement in access to water and better management of sanitation and waste. This is further evidence of the need to work in a coordinated manner. The fight against tobacco, which has reached a new stage with new legislation on the neutral packaging of cigarettes. The control of the yellow fever epidemic in Equatorial Africa. Support for universal health coverage that continues to grow. The arrival of the HIV home-test that will potentially allow the 40% of HIV carriers, who in 2016 still do not know their status, in order to stop the spread of the virus. And false beliefs. It would be easy to believe that false rumours are the unique to HIV, but that would be too simple. Regardless of location and social environment, false beliefs are a real barrier to public health and good practice. As we still believe in our 2017 resolutions, now is the time to set right some misconceptions:

- HIV is not a divine punishment against homosexuals, more than 50% of new HIV infections in 2016 have been through heterosexual relationships.
- Your child who has been coughing for 48 hours and whose nose runs clear does not necessarily need ATBs, but a nasal douche 3 times a day and possibly a dose/kilo of paracetamol.
- You are not immune to the Ebola virus by putting salt in your bath.
- You cannot take a double dose of your contraceptive pill when you have forgotten the previous day, but rather should take the morning after pill.
- The removal of the uvula does not cure cerebral malaria.
- Depression is not a weakness, but a pathological illness.
- Applying a slice of a potato does not heal a burn; try 20 minutes under running water at room temperature.
- It is not 'normal' to get beaten by one's spouse.
- It is not necessary to keep one's child out of the sun for the first two years of his life; the child has a higher risk of developing rickets than the 'evil eye'.
- You don't need to be over 65 to spend a week bedridden with flu...yes the flu vaccine is for everyone.

- No, a woman who gets raped regularly does not need a contraceptive implant, but needs to be kept safe.
- No, mosquito nets are not fishing nets or shower puffs.
- Yes, it is necessary to wash your hands between each patient...yes (especially) if you are a doctor/nurse/midwife.
- No, the tablet computer is not a nanny.
- Yes, even if it is a 3-month emergency program, it is important that the medicines delivered through a humanitarian operation are of good quality. This is called ethics, common sense even.
- And no, the big 'H' with a circle around it on the roof of hospitals is not a target!

A multitude of players are required to guide us through this huge set of tasks. Governments, non-governmental organizations (NGOs), civil societies and health professionals, which, frankly, find it difficult to co-ordinate. The WHO is trying to position itself as a leader. Its new Director General, who will be elected in May 2017 and will take office on 1 July, will have major tasks to carry out: a reform that has been underway for some years now with three main priorities: governing, managing, and defining the priorities of the organisation. The budget of the WHO Volunteer base hopes to raise US \$464 million per year from its member states. It is also expected to make up to US \$4,385 billion just by voluntary contributions. How can the WHO gain operationality/credibility and hope to ensure real leadership at the global level when its overall budget does not exceed the overall operating expenditures of a city like Paris? Perhaps we should stop hoping that change will come from above. ■

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