abstract of

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PERSPECTIVE

On famine crimes and tragedies.
de Waal, A.

Photographs for freedom.
Martin, C.

Ogobara Doumbo: building capacity for malaria research in Africa.
Pincock, S.

WORLD REPORT

Drug abuse in older US adults worries experts.
Boddiger, D.

New director elected for WHO’s Western Pacific region.
Cheng, M.H.

ARTICLES


Best-practice interventions to reduce socioeconomic inequalities of coronary heart disease mortality in UK: a prospective occupational cohort study.

The role of welfare state principles and generosity in social policy programmes for public health: an international comparative study.
Lundberg, O., Monica Aberg Yngwe, Maria Kolegård Stjarne, Jon Ivar Elstad, Tommy Farrarini, Olli Kangas, Thor Norström, Joakim Palme, and Johan Fritzell.

Melhuish, E., Jay Belsky, Alastair H Leyland, and Jacqueline Barnes.

Effect of a fall in malaria transmission on morbidity and mortality in Kilifi, Kenya.

WHO’s budgetary allocations and burden of disease: a comparative analysis.
Stuckler, D., Lawrence King, Helen Robinson, and Martin McKee.

HEALTH POLICY

From Mexico to Mali: progress in health policy and systems research.
Bennett, S., Taghreed Adam, Christina Zarowsky, Viroj Tangcharoensathien, Kent Ranson, Tim Evans, Anne Mills, and Alliance STAC.

Addressing social determinants of health inequities: what can the state and civil society do?
Blas, E., Lucy Gilson, Michael P Kelly, Ronald Labonté, Jostacio Lapitan, Carles Muntaner, Piroska Ostlin, Jennie Popay, Ritu Sadana, Gita Sen, Ted Schrecker, and Ziba Vaghri.

Globalisation and health: the need for a global vision.
Schrecker, T., Ronald Labonté, and Roberto De Vogli.

Global health equity and climate stabilisation: a common agenda.
Sharon Friel, Michael Marmot, Anthony J McMichael, Tord Kjellstrom, and Denny Vagero.

PUBLIC HEALTH

Sustainability science: an integrated approach for health-programme planning.

Closing the gap in a generation: health equity through action on the social determinants of health.
Michael Marmot, Sharon Friel, Ruth Bell, Tanja AJ Houweling, and Sebastian Taylor.

VIEWPOINT

Strengthening clinical and research ethics in Nigeria—an agenda for change.
Anya, I., and Rosalind Raine.

Placing the individual within a social determinants approach to health inequity.
Forde, I., and Rosalind Raine.

Recommendations for action on the social determinants of health: a Canadian perspective.
Johnson, S., Sylvia Abonyi, Bonnie Jeffery, Paul Hackett, Mary Hampton, Tom McIntosh, Diane Martz, Nazeem Muhajarine, Pammla Petrucca, and Nazmi Sari.

Strengthening capacity for health research in Africa.

SERIES


CASE REPORT

Trapped in bed (after 32 years of a blocked nose).
Imtiaz, K.E., Asyifah Zaki, Chris Scales, Caroline Ross, and Gajanan Niranjan Nirodi.

Not only coughs and sneezes.
O’Connell, R.L., Amjid A Riaz, Barry Morgan, Elliott Smock, and Johnathan G Hubbard.

REVIEW

Effect of exposure to natural environment on health inequalities: an observational population study.
Mitchell, R., and Frank Popham.
PERSPECTIVE

The small town of Kailak lies on the southern slopes of Darfur’s Jebel Marra massif that rises from the surrounding savanna to a height of 10’000 feet. It was once a prosperous if modest market town, where farmers sold millet and fruit to merchants from the nearby city of Nyala. But for 8 weeks in 2004, Kailak achieved the ugly distinction of becoming the site of a massacre by starvation. Militiamen and soldiers torched the surrounding villages, forcing 17’000 people to flee to the town. Then the armed men surrounded the makeshift camp and stopped anyone leaving.

Disposable People: Contemporary Global Slavery At the Royal Festival Hall, Southbank Centre, London, UK, until Nov 9, 2008, then touring throughout the UK in 2009, for details of venues see http://www.southbankcentre.co.uk/visual-arts/hayward-touring/current/contemporary-global-slavery

One day towards in the late 1960s, a doctor came to visit a small village in eastern Mali where the young Ogobara Doumbo and his family lived. He asked the 10-year-old what he wanted to be when he grew up. “I said, ‘I am planning to be a doctor like you’”, Doumbo recalls. “He was very surprised for a small child to be so convinced he wanted to be a doctor.” Considering Doumbo’s father and grandfather were both traditional healers, perhaps his response was not really so surprising. From that year, Doumbo began travelling with his grandfather to other mountain villages, absorbing his strongly ethical approach to treating ailments ranging from infectious diseases to breast inflammation.

WORLD REPORT

Experts monitoring illicit drug use in the USA have noticed a shift in substance abuse patterns in recent years. Although studies show reductions in abuse in young adults, health officials are concerned about continued abuse in older populations. David Boddiger reports.

A Korean, Shin Young-Soo, had just won a close fought election for director of WHO’s Western Pacific region—a region in which member states have very different health challenges, from the health risks of climate change to epidemics of type 2 diabetes. Margaret Harris Cheng reports.

ARTICLES

A large proportion of the malaria burden has been alleviated in The Gambia. Our results encourage consideration of a policy to eliminate malaria as a public-health problem, while emphasising the importance of accurate and continuous surveillance.

Our results suggest that current best-practice interventions to reduce classic coronary risk factors, if successfully implemented in both high and low socioeconomic groups, could eliminate most of the socioeconomic differences in coronary heart disease mortality. Modest further benefits would result if the classic coronary risk factors could be reduced to primordial levels for the whole population.

The ways in which social policies are designed, as well as their generosity, are important for health because of the increase in resources that social policies entail. Hence, social policies are of major importance for how we can tackle the social determinants of health.

Children and their families benefited from living in SSLP areas. The contrast between these and previous findings on the effect of SSLPs might indicate increased exposure to programmes that have become more effective. Early interventions can improve the life chances of young children living in deprived areas.


Sustained reduction in exposure to infection leads to changes in mean age and presentation of disease similar to those described in multisite studies. Changes in transmission might not lead to immediate reductions in incidence of clinical disease. However, longitudinal data do not indicate that reductions in transmission intensity lead to transient increases in morbidity and mortality.


Decision makers at Bamako should consider the implications of the present misalignment of global health priorities and disease burden for health research worldwide. Funds allocated by external donors substantially differ from those allocated by WHO member states. The meeting at Bamako provides an opportunity to consider how this disparity might be addressed.

HEALTH POLICY


In 2004, the ministerial summit in Mexico drew attention to the historic neglect of health policy and systems research (HPSR) and called for increased funding, investment in national institutional capacity for HPSR, and resources for selected priority research topics. On the basis of meeting discussions, published reports, and available data from research funders and organisations in low-income and middle-income countries, we discuss how HPSR has evolved since the summit in Mexico. Funding for HPSR, particularly in low-income countries, is mainly supported by international and bilateral organisations.


This Health Policy article, we selected and reviewed evidence synthesised by nine knowledge networks established by WHO to support the Commission on the Social Determinants of Health. We have indicated the part that national governments and civil society can play in reducing health inequity. Government action can take three forms: (1) as provider or guarantor of human rights and essential services; (2) as facilitator of policy frameworks that provide the basis for equitable health improvement; and (3) as gatherer and monitor of data about their populations in ways that generate health information about mortality and morbidity and data about health equity.


The reduction of health inequities is an ethical imperative, according to the WHO Commission on Social Determinants of Health (CSDH). Drawing on detailed multidisciplinary evidence assembled by the Globalization Knowledge Network that supported the CSDH, we define globalisation in mainly economic terms. We consider and reject the presumption that globalisation will yield health benefits as a result of its contribution to rapid economic growth and associated reductions in poverty. Expanding on this point, we describe four disequalising dynamics by which contemporary globalisation causes divergence: the global reorganisation of production and emergence of a global labour-market; the increasing importance of binding trade agreements and processes to resolve disputes; the rapidly increasing mobility of financial capital; and the persistence of debt crises in developing countries.


Although health has improved for many people, the extent of health inequities between and within countries is growing. Meanwhile, humankind is disrupting the global climate and other life-supporting environmental systems, thereby creating serious risks for health and wellbeing, especially in vulnerable...
populations but ultimately for everybody. Underlying determinants of health inequity and environmental change overlap substantially; they are signs of an economic system predicated on asymmetric growth and competition, shaped by market forces that mostly disregard health and environmental consequences rather than by values of fairness and support.

**PUBLIC HEALTH**


Planning for programme sustainability is a key contributor to health and development, especially in low-income and middle-income countries. A consensus evidence-based operational framework would facilitate policy and research advances in understanding, measuring, and improving programme sustainability. We did a systematic review of both conceptual frameworks and empirical studies about health-programme sustainability. On the basis of the review, we propose that sustainable health programmes are regarded as complex systems that encompass programmes, health problems targeted by programmes, and programmes' drivers or key stakeholders, all of which interact dynamically within any given context.


The Commission on Social Determinants of Health, created to marshal the evidence on what can be done to promote health equity and to foster a global movement to achieve it, is a global collaboration of policy makers, researchers, and civil society, led by commissioners with a unique blend of political, academic, and advocacy experience. The focus of attention is on countries at all levels of income and development. The commission launched its final report on August 28, 2008. This paper summarises the key findings and recommendations; the full list is in the final report.

**VIEWPOINT**


Training to be a doctor in Nigeria a decade ago included little more than cursory attention to either clinical or research ethics: a single hour-long lecture on ethics and professional practice, delivered close to the final examinations, sufficed. As a house officer at a major teaching hospital, it was not unusual to be instructed to take samples for a research project without any research protocols or consent forms being provided. Ethics committees were weak or non-existent at most hospitals.


The Final Report of the WHO Commission on Social Determinants of Health is a welcome challenge to governments. It sets out the core conditions that have to be met to give everyone a fair chance of leading a healthy and flourishing life.


Health disparities are widely prevalent within and between countries, and Canada is no exception.1,2 Although historic efforts to address such disparities have not been successful and Canada’s provincial and territorial health goals have been only partly achieved,3 we are now well positioned to understand and address health disparities at the global, national, and local levels. The global resurgence of interest in addressing health disparities in the 1990s and 2000s through various movements, such as the WHO Commission on the Social Determinants of Health and their final report with evidence-based recommendations,4,5 have provided momentum to countries around the world to re-engage in dialogue at the national and international levels for this vitally important issue.


Research has a key role in the development of low-income and middle-income countries. There are several current initiatives that have greatly contributed to capacity strengthening of health research in sub-Saharan Africa, including those supported by WHO and Tropical Disease Research (TDR), the Swedish International Development Agency (SIDA) and Department for Research Cooperation (SAREC), the European Union, the Bill & Melinda Gates Foundation, the International Clinical Epidemiology Network (INCLEN), the Fogarty International Centre, the National Institutes of Health (NIH), and the Wellcome Trust.
SERIES


Diseases remain the major causes of morbidity and mortality in China despite substantial progress in their control. China is a major contributor to the worldwide infectious disease burden because of its population size. The association of China with the rest of the world through travel and trade means that events in the country can affect distant populations. The ecological interaction of people with animals in China favours the emergence of new microbial threats. The public-health system has to be prepared to deal with the challenges of newly emerging infectious diseases and at the same time try to control existing diseases.


China has experienced an epidemiological transition shifting from the infectious to the chronic diseases in much shorter time than many other countries. The pace and spread of behavioural changes, including changing diets, decreased physical activity, high rates of male smoking, and other high risk behaviours, has accelerated to an unprecedented degree. As a result, the burden of chronic diseases, preventable morbidity and mortality, and associated health-care costs could now increase substantially.

CASE REPORT


In April, 2008, a 60-year-old man was admitted to our hospital, with paraesthesia and progressive weakness of all four limbs. He had longstanding asthma, recurrent chest infections, and a facial rash; although he had attended a dermatology clinic, the cause of the rash had never been identified. He also had nasal polyps, and a weak sense of smell—32 years before, as his wife vividly recalled, he had been unable to smell a gas leak. In 2006, he had had a septoplasty, and endoscopic sinus surgery, to relieve nasal blockage.


In February, 2008, a 57-year-old man developed diarrhoea and abdominal pain, and saw his general practitioner. Stool samples contained no Escherichia coli, salmonella, shigella, or campylobacter; microscopy showed no ova, cysts, or parasites. Gastroenteritis was diagnosed. 5 weeks later, the patient came to our emergency department with a swollen abdomen, after 3 days of absolute constipation. He had no history of inflammatory bowel disease, and had not recently been abroad.

REVIEW


Populations that are exposed to the greenest environments also have lowest levels of health inequality related to income deprivation. Physical environments that promote good health might be important to reduce socioeconomic health inequalities.