WHEC UPDATE
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Making A Difference

The population in the United States and the developed world is aging at a rapid pace as the baby boomers turn age 65 years and older is now a familiar news. By 2030, the fastest growing segment of the population in the developed world will be individuals aged 80 years and older. Along with this shift in demographics comes in association of cancer and aging, with a striking increase in cancer incidence, by some estimates, of 67% from 2010 to 2030 in people aged 65 and older. Most of what we know about cancer therapeutics is based on clinical trials conducted in a population younger than those who have the disease. This leaves a major knowledge gaps regarding the risks and benefits of cancer treatment in older adults, particularly those aged 75 years and older. It is clear that a major shift in current research process and priorities is needed to fill these knowledge gaps in an expeditious manner.

We have a successfully aging population. With age comes a greater chance of getting cancer, and because we have an expanding population, the absolute number of people dying of cancer is growing. We have seen that even with an increasing incidence of cancer, the age-adjusted mortality rates, at least the 4 most common cancers (lung, colorectal, breast, and prostate cancer), are plummeting. That's the real news! But the fear factor is there. And we would all agree that avoiding cancer is an important goal. When you consider lifestyle and behavior, it gets simple. *Avoid tobacco products.* That is black and white. *Maintain a healthy body mass index.* Results show us that being a couch-potato is clearly not going to get us anywhere. The public and even other policy makers look to us for guidance about cancer prevention. We need to speak out and promote healthy lifestyle to our patients and in our communities. This means getting our school systems to invest more in physical education, asking companies to promote and allow exercise in the workplace, and making sure our city leaders provide adequate space and resources for exercise at senior centers in the communities.

The disparity in the quality of care must be addressed quickly. We are in the midst of an exceptional increase in cancer incidence, driven largely by an aging population. If asked a few years ago what is the best way to improve evidence and data collection on older adults, we would have said, work with the medical community. This community understands the issues at hand, is immersed in the care in the face of limited data. If the past reflects the future, however, this communication may raise awareness, but it is unlikely to produce the change urgently needed. Other sub-populations that were once under-represented in research have successfully used changes in the law to break through the barriers to participation and close the disparities in medical research.

So what is the next step in cancer and aging? Do we need an act similar to the one developed for women and minorities? Perhaps; The Orphan Drug Act was passed to provide an incentive for the study of drugs in rare diseases. In pediatrics, the Best Pharmaceuticals for Children Act and the Pediatric Research Equity Act were passed by Congress in United States, to provide pediatric market exclusivity to encourage research in pediatric patients and require drug companies to study products in children.

The lesson seems clear: laws can effect change. The Women's Health and Education Center (WHEC) with its partners, is in the forefront for advocating research and clinical trials, for older adults with cancer. We suggest, that for every study proposed, a plan must be developed to recruit individuals who mirror the age distribution of those with the disease. To effect change in medicine, we must speak to power brokers outside of the medical community, convey the urgency and critical nature of the situation, personalize the potential impact of the missing data, and call for legislative change. Now it is clear that change will likely not take place without legislation.

Merging Medicine and Law

Rita Luthra, MD

Your Questions, Our Reply

Do we need the creation of a “Best Pharmaceuticals for Older Adults Act” to provide incentives for the study of drugs and therapies in the population most likely to need treatment? Who should have the authority through an “Older Adult Research Equity Act” to require that novel therapeutics be studied in older adults?

Older Adults and Future Clinical Trials: These may seem like bold, even radical suggestions; however, today’s disparities in cancer and aging are not going to be bridged without concerned physicians, lawyers, and patients and their families working together to advocate for older adults with cancer outside the walls to medicine.

The United States Government funds billions of dollars worth of medical research, and it is appropriate that it does so because of its obligation to fulfill the rights of its citizens to health and to healthcare. In the United States the ***Orphan Drug Act*** has proven to be a successful marriage of government and pharmaceutical companies. The government provides tax incentives and guarantees seven years of exclusivity (after FDA approval) to encourage drug makers to develop drugs that affect fewer than 200,000 people and are generally unprofitable. The result has been, on the whole, positive, despite abuses. The U.S. Orphan Drug Act has been copied, with changes, by the EU, Australia, Japan, and other countries. In the EU, unlike in the U.S., if a drug is "extraordinarily profitable", after five years it loses its orphan drug status, which leads to an abuse, called "salami slicing". Nonetheless, whether one follows the U.S. version or some other, the basic concept has been successful in bringing needed drugs to market. Perhaps something comparable to this, an international orphan drug act can be agreed upon; perhaps governments can subsidize special research on the current World Health Organization list of essential and cancer drugs; perhaps companies agree to fund joint research for cancer drugs for older adults that would not be covered by patents and would be produced and distributed at cost. The actual action taken should be the results of negotiations among all the interested and affected parties.

Areas for future development:

- There should be serious efforts to promote interdisciplinary educational programs in the area of pharmaceutical sciences and patent law. It is also hoped that training of future pharmaceutical scientist will include an effective dose of patent fundamentals. It will enable them to appreciate the strengths and weaknesses of individual patents, which is critical in developing strategies amidst the ongoing tug-of-war between brand-name and generic companies.
- Physicians should feel obligated to provide advice to their patients about the most appropriate care, without being influenced by any profit they might gain through associated commercial ventures. Open communication of information gained from research and experience with medical and surgical procedures is essential if safety and efficacy are to be validated or refuted by colleagues. Scientific freedom of independent investigators (those not employed by the funding organization) should be preserved. Principle investigators should be involved in decisions regarding the publication of data from their trials. Investigators should control the use of their names in promotions. Project funding should not be contingent on results. Once a clinical investigator becomes involved in a research project for a company or knows that he or she might become involved, the investigator, as an individual, should not ethically buy or sell the company's stock until the involvement ends and the results of the research are published or otherwise disseminated to the public.
- Eminent Domain: it was originally designed to facilitate public works projects, such as building roads or schools. The common law tradition, codified in the Fifth Amendment, lets "private property be taken for public use" by the government, as long as "just compensation" is provided. Even if not applied, governmental willingness to use such power could help move the country toward a more fairly balanced intellectual property policy by helping to prevent companies from exerting their patent rights even to the detriment of the public's health.
- The need for a global fund for continuing medical education (a vision for the globalized world). With the turn of century, the global community has recognized that basic health is a prerequisite for sustainable development. It has profound effect on the citizens of the world and political, economic, social systems. Continuing medical education is beneficial to both donor and recipient countries and can engage public and private stakeholders towards common goals. Creating a global fund and partnership for continuing medical education has potential to increase resources to fight infectious diseases in developing countries and to direct those resources to areas of

greatest need. Healthcare providers should support and participate in activities that enhance the community. Care rendered to an individual patient does not take place in a vacuum but rather within a community. Decisions made in one sphere affect those in the other.

- In a free enterprise system governments do not engage directly in production of essential medicines, although they can encourage and promote production through their system of intellectual property protection and their tax system, among others. To the extent that the pharmaceutical industry fails to produce the needed medicines, it is up to governments to ensure that they are produced. Development of international orphan drug plan has potential to increase access of needed drugs, and in the process to help serve the common good.

We invite you to join us on WHEC Global Health Line and Gynecologic Oncology Section of the ***WomensHealthSection.com***

United Nations At A Glance

Burundi at the United Nations

Burundi became the Member State of the United Nations on 10 September 1962.

Burundi, officially the **Republic of Burundi**; French: *République du Burundi*, is a landlocked country in the African Great Lakes-region of East Africa, bordered by Rwanda to the north, Tanzania to the east and south, and the Democratic Republic of the Congo to the west. It is also sometimes considered part of Central Africa. Burundi's capital is Bujumbura. Although the country is landlocked, much of the southwestern border is adjacent to Lake Tanganyika.

The Twa, Hutu, and Tutsi peoples have lived in Burundi for at least five hundred years. For more than 200 years, Burundi was an independent kingdom. At the beginning of the 20th century Germany colonized the region.

After the First World War and Germany's defeat, it ceded the territory to Belgium. The Belgians ruled Burundi and Rwanda as a European colony known as Ruanda-Urundi. Their intervention exacerbated social differences between the Tutsi and Hutu, and contributed to political unrest in the region. Burundi gained independence in 1962 and initially had a monarchy, but a series of assassinations, coups, and a general climate of regional instability culminated in the establishment of a republic and one-party state in 1966. Bouts of ethnic cleansing and ultimately two civil wars and genocides during the 1970s and again in the 1990s left the county undeveloped and its population as one of the world's poorest.

2015 witnessed large-scale political strife as the President opted to run for a third term in office, a coup attempt failed and the country's parliamentary and presidentialhttps://en.wikipedia.org/wiki/Burundian_presidential_election,_2015 elections were broadly criticized by members of the international community.

In addition to poverty, Burundians often have to deal with corruption, weak infrastructure, poor access to health and education services, and hunger. Burundi is densely populated and has had substantial emigration as young people seek opportunities elsewhere.

UN involvement

Between 1993 and 2003, many rounds of peace talks, overseen by regional leaders in Tanzania, South Africa, and Uganda, gradually established power-sharing agreements to satisfy the majority of the contending groups. Initially the South African Protection Support Detachment was deployed to protect Burundian leaders returning from exile.

These forces became part of the African Union Mission to Burundi, deployed to help oversee the installation of a transitional government.

In June 2004, the UN stepped in and took over peacekeeping responsibilities as a signal of growing international support for the already markedly advanced peace process in Burundi.

The mission's mandate, under Chapter VII of the United Nations Charter, has been to monitor cease-fire; carry out disarmament, demobilization, and reintegration of former combatants; support humanitarian assistance and refugee and IDP return; assist with elections; protect international staff and Burundian civilians; monitor Burundi's troublesome borders, including halting illicit arms flows; and assist in carrying out institutional reforms including those of the Constitution, judiciary, armed forces, and police.

The mission has been allotted 5,650 military personnel, 120 civilian police, and about 1,000 international and local civilian personnel. The mission has been functioning well. It has greatly benefited from the transitional government, which has functioned and is in the process of transitioning to one that will be popularly elected.

The main difficulty in the early stages was continued resistance to the peace process by the last Hutu nationalist rebel group. This organization continued its violent conflict on the outskirts of the capital despite the UN's presence. By June 2005, the group had stopped fighting, and its representatives were brought back into the political process. All political parties have accepted a formula for inter-ethnic power-sharing: no political party can gain access to government offices unless it is ethnically integrated.

The focus of the UN's mission had been to enshrine the power-sharing arrangements in a popularly voted constitution, so that elections may be held and a new government installed. Disarmament, demobilization and reintegration were done in tandem with elections preparations.

In February 2005, the Constitution was approved with over 90% of the popular vote. In May, June, and August 2005, three separate elections were also held at the local level for the Parliament and the presidency.

While there are still some difficulties with refugee returns and securing adequate food supplies for the war-weary population, the mission managed to win the trust and confidence of a majority of the formerly warring leaders, as well as the population at large.

It was involved with several "quick effect" projects, including rehabilitating and building schools, orphanages, health clinics, and rebuilding infrastructure such as water lines.

Details: http://www.burundi-un.org/index.asp

Collaboration with World Health Organization (WHO)

WHO | Burundi

Health Situation

The health situation in Burundi remains relatively precarious. The crude mortality rate is 15 per 1000 (2008 Population Census). This situation is associated mainly with the fragility of the health system, the heavy burden of communicable diseases, chronic non-communicable diseases, neglected tropical diseases, the vulnerability of mothers, children and adolescents, and the role of the determinants of health (demographic pressure owing to a density of more than 310 people per km2, and very high rates of acute and chronic malnutrition, 6% and 58% respectively, in children between 0-5). The most prevalent diseases in the epidemiological profile are communicable diseases that particularly affect the health of pregnant women and children, the most vulnerable population groups. The most prevalent diseases in this category are malaria, HIV/AIDS, tuberculosis, diarrheal diseases, vaccine-preventable diseases and acute respiratory infections. Diabetes and high blood pressure coexist in 30% of cases, according to a study done at the Kamenge University Hospital Centre, and are responsible for 73.17% of degenerative complications.

As regards the implementation of international agreements and commitments, very significant progress has been made on Millennium Development Goal (MDG) 6. Moreover, Burundi has just adopted an MDG

acceleration framework for MDG 4 and 5, and with the support of its partners, has committed itself to accelerating all MDGs that still report mixed results. A bill on the Framework Convention on Tobacco Control is under review. The main challenge of this strategic agenda is ensuring universal access to quality health care.

Health Policies and Systems

The national health policy 2005-2015 and the national health development plan articulate the commitments made by Burundi (1) at national level through the Burundi Vision 2025 and the Strategic framework for poverty reduction, and (2) at international level through its adherence to International Health Partnership (IHP+) and the MDG targets. The key areas of the national health plan that are producing increasingly visible results are: (i) decentralization through the establishment of health districts, since 2009; (ii) universal access to health care (approximately 50% of the population) through the free health-care policy for children under 5 and pregnant women, from 2006, and the introduction of the health insurance card for the informal sector; and (iii) the scaling up of the results-based financing approach in 2010. This last component, in conjunction with free health care, is the main incentive mechanism in Burundi and has yielded positive results. Among other things, it has resulted in increased use of health services (from 1.68 consultations in 2009 to 2.2 consultations in 2012 for children under 5), better quality of treatment, strengthening of the health system through private-public collaboration and community engagement, and greater numbers of health workers in peripheral zones. Nonetheless, significant efforts are still needed to address the persistent major challenges associated with the achievement of universal health coverage. It is critical to take account of the determinants of health in national development policies and programmes in order to achieve the best health outcomes possible through coordination of inter-sectoral initiatives, particularly in the areas of nutrition and demographics.

Details: http://www.who.int/countries/bdi/en/

Bulletin of the World Health Organization; Complete list of contents for Volume 93, Number 11, November, 741-816

Collaboration with UN University (UNU)

UNU-WIDER (World Institute for Development Economics Research) *Expert Series on Health Economics:*

Local agency, development assistance and the legacies of rebellion in Burundi and Rwanda

Rwanda and Burundi have both emerged from civil wars over the past 20 years and foreign donors have provided significant contributions to post-conflict reconstruction and development in the two countries. Yet although Rwanda and Burundi share several important characteristics, the social, political and economic trajectories of the two countries have been different. The paper argues that the nature of the ruling parties in Rwanda and Burundi is key to understanding the countries' relationships with donors. Rather than seeing aid as an exogenous factor causing particular development outcomes, the paper shows how local party elites exert considerable agency over the aid relationship. Their agency, however, is influenced and constrained by a number of different local contextual factors, including pre-civil war structures. Thus, the paper provides an analysis of how local context matters in understanding donor-recipient aid relationships, and how the ruling party in Rwanda (the RPF) and in Burundi (the CNDD-FDD) emerged from their respective conflicts with different relationships with international donors.

Despite its past and present human rights violations, the RPF maintained its image as an effective modernizer in the eyes of many international donors, which has only started to be seriously challenged by donors in the past three years. The RPF has consistently emphasized the country's economic accomplishments as an alternative (African) source of internal legitimacy. Paradoxically, while the CNDD-FDD has not been as successful as the RPF in directing donor funds and managing aid relationships, the Burundian state may end up being more robust due to its more inclusive institutions, although the worsening security environment and increasing authoritarianism in Burundi mean that the trajectories of both countries remain uncertain.

It is tempting to attribute Rwanda's relative success to the role of donors and foreign aid. This, however, would be insufficient. Instead, this paper has shown that international donor involvement itself is, in part, a product of very different war-time trajectories. Aid is a consequence of particular relationships, not only a cause, and ruling elites in recipient countries play a critical role in constructing that relationship. Part of the difference between Rwandan and Burundian aid relationships can be explained by the different political contexts leading to the emergence of the RPF and CNDD-FDD, their different internal structures, and the different ways that their civil wars ended. The RPF is a stronger party. This does not necessarily lead to 'better governance', but it has led to more policy autonomy and different patterns of engagement with international donors.

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(Details of the paper can be accessed from the link of UNU-WIDER on CME Page http://www.womenshealthsection.com/content/cme/)

United Nations Girls' Education Initiative (UNGEI)

The Effort to Advance the Global Strategy (Continued)

Burundi: Background

A 12-year civil war between Hutus and Tutsis has ended, and successful presidential elections in 2005 hold the promise of a new era of peace for the nation. UN peacekeeping troops remain stationed in Burundi. About half of the population is under age 18.

Issues facing children in Burundi

- Threats to Burundi's children include rape, child prostitution, child labour, recruitment into militias, internal displacement, kidnapping and landmines.
- Burundi's infant and under-five mortality rates remain among the highest in the world, due in large part to malaria, diarrhea, pneumonia and HIV/AIDS. Burundian women face a lifetime risk of maternal death of 1 in 12.
- Approximately 27,000 children under age 15 have HIV/AIDS. Another 200,000 have been orphaned by the disease.
- The first national nutrition survey conducted in 18 years showed a reduction in malnutrition and an increase in breastfeeding for children under six months, but also revealed high incidences of vitamin A deficiency (28 per cent) in children under age five. Some 60 per cent of primary school–aged children have iodine deficiency.
- Immunization rates for the deadliest childhood diseases have declined in recent years.
- Three quarters of primary schools lack potable water; 38 per cent of schools have insufficient latrines.
- A lingering conflict between the government and Hutu forces in the western provinces continues to threaten civilians. Recruitment of child soldiers is an urgent concern.

Food rations improving female attendance at school

World Vision distributed rations of 3.6 kilograms of vegetable oil to 15,652 school girls from grade four to six in the two provinces of Karusi and Canzuko, Burundi.

The rations are dependent on regular attendance at school. Girls absent for more than 3 days per month are not eligible to take home rations for that month.

Among the 50,334 students of the 41 primary schools of Karusi, less than 8,000 are girls.

Ndindiriza Pierre Claver, a teacher of grade six at Karusi primary school said the incentives provided to girls have already positively influenced their success in schools and their effective participation in class.

The number of enrolled girls in school increased this year, improving from 35 out of 84 students in the sixth grade 2006, to 47 out of 80 this year. Results have also shown that girls are more serious and participate more in class.

Pierre Claver mentioned that in his class the three best performing students are girls.
A 12-year-old female student, said, "I have to work hard and succeed in order to deserve the meals and additional food given to me by World Vision, particularly during this period of hunger in Karusi."
She also confirmed the vegetable oil provided enables her and other vulnerable or child-headed households to eat well-balanced meals.

Details: http://www.ungei.org/infobycountry/burundi.html
To be Continued……..

Top Two-Articles Accessed in October 2015

1. Contraception and Mental Health;
   http://www.womenshealthsection.com/content/gynmh/gynmh015.php3
   WHEC Publications. Special thanks to WHO, NIH and our writers and editors for compiling the review and the physician's board for helpful suggestions.

2. Recurrent Pregnancy Loss; http://www.womenshealthsection.com/content/obs/obs030.php3
   WHEC Publications. Special thanks to our reviewers for helpful suggestions.

From Editor's Desk

Global Financing Facility (GFF) to Improve Maternal and Child Health

Global Financing Facility in support of Every Woman Every Child was developed by **the World Bank Group and the Governments of Canada, Norway, and the United States of America** in response to the Secretary-General's call for expanded cooperation for action. The GFF aims to support the delivery of the Global Strategy for Women's, Children's and Adolescents' Health as an important financing instrument. The overall goal of the GFF will be to contribute to the global efforts to end preventable maternal, newborn, child and adolescent deaths and improve the health and quality of life of women, adolescents and children.

The GFF is already at work in the **four frontrunner countries** of the Democratic Republic of Congo, Ethiopia, Kenya and Tanzania, and we've just announced **eight more countries** who will join: Bangladesh, Cameroon, India, Liberia, Mozambique, Nigeria, Senegal and Uganda.

By blending domestic and international, public and private resources, aligned behind country-led plans, the GFF represents a very different way to grow development finance. This is exactly what we'll need to reach the goals to end preventable maternal and child deaths by 2030 and achieve universal health coverage.

Let's reflect on where we were just over 15 years ago. In the late 1990s, with some 30 million children around the world not immunized, a small group of visionaries started to dare to think differently about

how to tackle the challenge. At that time, there existed in Geneva a modest global partnership for child immunization, with less than $10 million in funding. At a meeting in Bellagio to re-think the status quo, the Rotary Foundation, which had long been playing a leading role in child health, challenged the conventional thinking and proposed that we needed to go from millions to *billions* of dollars in order to expand access to routine child vaccines and immunizations. Many thought that was delusional. But within a matter of months, the world had its first billion dollar global health fund: the Global Alliance for Vaccines and Immunizations (now Gavi).

Soon after that, with the AIDS pandemic raging, another group of out-of-the box thinkers approached the Gavi board to suggest that the world also needed a fund to tackle the three infectious diseases of AIDS, tuberculosis and malaria. That idea also was dismissed by naysayers. But the visionaries prevailed, and at the G7 Okinawa Summit in 2000, the idea of the Global Fund for AIDS, Tuberculosis and Malaria was born. A couple of years later, the Global Fund also became a billion dollar-plus fund. Then, in 2003, US President George W. Bush created the President's Emergency Plan for Emergency AIDS Relief, an unprecedented $15 billion fund.

I affectionately call these funds the *billion dollar babies.* Their establishment has done a massive human good, saving millions of lives and creating hope and opportunity.

But now these billion dollar babies are in their teens. As these funds mature in their second decade, developing countries' economies are growing, so is their health sector spending – and their burdens of disease are changing as well. So the big question looking forward to 2030 is: How do we harness developing countries' growth to mobilize additional domestic resources for health, in order to achieve sustained access to health for all? A major paradigm shift is permeating the conversations in Addis: The majority financier in health is becoming – or in most cases already is – countries themselves. In order to protect and sustain the progress we've made so far in advancing global health, we need to embrace this shift – or risk seeing funding for essential services decline as countries graduate from grant-based ODA. But this is now a *trillion*, not just a billion, dollar challenge.

Details: http://globalfinancingfacility.org/

Words *of* Wisdom

Religions are not for separating men from one another; they are meant to bind them.

– Mohandas Karamchand Gandhi; also known as *Mahatma* (Sanskrit: "high-soul") *Gandhi*
(2 October 1869 – 30 January 1948)

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Monthly newsletter of WHEC designed to keep you informed on the latest UN and NGO activities

http://www.womenshealthsection.com/