# Health Disparities: A Time for Action - A conference of the Consortium of Universities of Global Health

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The theme of this conference, held in New York City from March 16-18, 2018, was based on the observed resource inequality that exists despite global economic growth. This can be a destabilizing force, yet receives little attention, particularly for the 50% of the world population with limited access to modern health services. Given the complexity of subjects and sessions, the emphasis of this report is on key-note addresses, refugee health, research, and application.

## Reducing Health Disparities

In his opening address, Steven Lewis, former UN special envoy for HIV/AIDS and ambassador to the UN, and co-director of AIDS-Free World, Canada, noted that inequality was obvious, with "far too much pain in the world remaining in the poorest countries of the world." Climate change is the "single greatest threat to human kind," due to emerging dislocations serving as a recipe for profound illness, death and despair affecting the poorest parts of the world. This begs the question, "What to do about it?" He highlighted the ongoing problem of HIV and TB, and its effects on the poor. "Marginalized communities at the fragile edges of society are mostly beleaguered, without voice, submerged in feelings of hopelessness... poisoning the anatomy and the soul." He called for identifying and confronting disparity with "crescendos of activism, unrelenting advocacy, and pressure on the governments."

Highlighting the problem of gender inequality and sexual violence, he criticized the United Nations' system, ironically rife with sexual abuse and the absence of effective security council resolutions. There was "energy missing" to implement justice at the government and multi-lateral levels. Interestingly, he called health the "tie that binds" – the one unifying force that engages attention in all sectors. It has enormous appeal. When you concentrate on health, you touch the mind and heart. He then quoted Jesus' service-oriented rallying cry: "In biblical language, 'go forth and do likewise.' The world is worth saving."

A plenary panel discussion followed. Jimmy Volmink, Dean of Stellenbosch University, South Africa, defined resource inequality as *existential inequality* – disparities in dignity and respect – and *vital inequality* – disparities in life chances. A Commission report delineated 8 areas for action: people-centered health systems, health stewardship/ accountability, sustainable financing, essential commodities, epidemic preparedness, training, research, institution strengthening, and enhancing the health workforce. A type of universal health coverage (UHC) which addresses social determinants of health is needed, attending to social and cultural aspects of health by governments.

## Shaping Health Systems to Reduce Disparities

In a plenary session, Rejoice Nkambule, Deputy Director Ministry of Health, Kingdom of Swaziland, listed the main health threats: HIV, TB, NCDs (cancer, obesity, hypertension), trauma/ injuries, and mental health. She called for the imperative of defining national strategy for delivery of health services with a backbone of primary health care (PHC). She suggested nurse-led action with

mentoring of policy-makers from community to national levels, using data for decision making at all levels, and evidence-based health action in other sectors – maximizing technology to reduce disparities. Paulo Ferrinho, Director, Instituto de Higiene e Medicina Tropical, Universidade Nova de Lisboa, Portugal, emphasized closing gaps in quality performance of health work by focusing not just on clinical skills but also providing training in non-clinical capacities such as leadership skills, supervision, incentives, and community health worker (CHW) empowerment. Professor Morten Jerven, University of Edinburgh, noted that population statistics and data were sorely needed, since, "we cannot manage if we do not measure." However, he cautioned on the inaccuracies and political drives for population health statistics.

## Health and Armed Conflicts

Building on the research of the Lancet-American University of Beirut (AUB) Commission on Syria, this panel explored the global health challenges resulting from armed conflict. Ghassan Abu Sitta reported on the development of the Global Health Institute (AUB). The majority of refugees were children and women. 72% worked in agriculture. The Lebanese health care system absorbed acute care but not chronic diseases (NCDs). He highlighted the importance of academic centers being active partners in areas affected by refugees. Samer Jabbour noted that the preliminary report of this new multidisciplinary commission, due September 2018, stressed health care delivery and targeting health facilities used as daily weapons of war, and that one-third of global cases of cholera were in the Middle East (MENA). Global Health Institute was the first and only one in MENA, since North-based institutions were the responders until now.[1] AUB had begun contextualizing global health dialogue/knowledge (in Arabic) through smart learning and informing the world through evidence.[2] Wars have changed: they are more protracted, imbedded, and factional, with more civilian casualties, preferential treatment, and MDR bacteria (65.1%). Conflict never ends in this region, so taking responsibility to have a system of response was imperative. He quoted Kathleen Sebelius, former U.S. Secretary of the Department of Health and Human Services:

> In many ways, human health is the great global connector. It aligns our interests and impacts all of our economies. It compels us to work together and actually punishes us if we drift apart. It calls upon the greatest human impulses for compassion, for health and for love, and it motivates our greatest human capacities for discovering innovation and invention.[3]

## Middle Eastern & Mediterranean Refugee Crisis

Nathan Bertelsen, Assistant Professor of Global Health and Medical Education, Koç University, Turkey, observed that every torture victim was depressed or had PTSD. Their key focus was on symptoms but noted common despair of the future ("I see nothing") as a major problem, noting common features in child labor and child marriage. In 2015, 1 million people migrated through the Mediterranean, and there were thousands drowning in an attempt to migrate through boats. There were three waves of health problems encountered: physical injuries & diarrhea, shelter challenges, then chronic disease management, with mental health problems in all three. This led to a three-part approach to needs: establish safety, hope, and dignity – they needed to restore humanity & identity. [Thus, addressing the first order questions of life: origins, identity/purpose, and destiny were necessary to foster resilience]. Omar Ahmed Abenza, Head of Mission for the North Syria response, Doctors Without Borders (MSF), spoke of the 13.1 M needing humanitarian assistance - 5.6 M refugees, 6.1 M internally displaced. Health disparities were made worse with violations of health rights (granted in 1966 to be impartial, inclusive, accessible, and a

state obligation). But proportionality and distinction were repeatedly violated, and medical missions and hospitals became targets (were weaponized).[4] The forced displacement & torture was compounded by low access to quality care, availability of staff, and little accountability (justice system) or health governance. Capacity building was needed for strategic direction of policy, to correct trends, regulate funds, and enhance accountability. The Syrian tax base was replaced by donors (with some political motivation), and service gaps were filled by NGOs (private actors who didn't manage the public health system). However, there was a lack of coordination and efficiency, and no funding was provided by the Ministry of Health. He emphasized the urgency for primary health care (PHC) emphasis, to tackle NCDs, to rise above politics, to foster more coordination, and to advocate toward warring parties.

Vicki Fumado, Head of Cooperation Unit, Jant Joan de Deu, Basrcellona, Spain, reported 172,000 refugees in 2016 fled to Greece with 38% being children and 21% being women, who primarily needed PHC to treat chronic pathology, malnutrition, psychological/social problems, and vaccinations. She noted difficulties due to language barriers and poor collaboration between NGOs. They conducted a prospective morbidity surveillance over a 2-month period for refugees (75% Syrian) and top health seeking behavior was for respiratory infections and acute malnutrition (16% chronic). Though the study had limitations, children were found to be the most vulnerable, with sanitation, vaccination, and behavioral evaluations being the highest assessed needs. Anna Makenna, clinical researcher on migrant health, Institute of Global Health, University of Barcelona, showed multiple "routes to a better life." Focusing on the Morocco to Spain route, she said that theirs were often long journeys (many from Sub-Saharan origin), with limited water and poor transportation. They were trying to monitor migrant health, but needed more data, a migrant-sensitive health system (training health work force), a policy/legal framework considerate of migration needs, and partnerships and networks. Their goals included better public health policies, access to healthcare, quality of care (defined effective intervention strategies) in order to strengthen capacities for all actors. This included identifying victims of sexual violence, communicable diseases, mental health problems, and cultural mediators, as well as planning data collection and analysis efforts. NGOs had data but not analysis. She highlighted the role of NGOs [which would include faith-based organizations and faith groups], increasingly taking responsibility instead of the state, and providing human resources for collecting data and sharing it between NGOs to enable better strategies in the future. There was a need to mobilize public outcry to take action while fighting media and compassion fatigue. She called for workforce training, empowerment of community health workers to multiply health impact, supporting families to build communities, [creating reflexive therapeutic communities of care through the church might be an example], and "bearing witness" with the NGO. Passion did not publish papers, but data drove public action and policy, giving voice to ones without a voice.

## The Great Global Health Debate: *Is Equity the Defining Objective of Global Health in the 21st Century?*

Sheryl Healton, Dean, College of Global Public Health, New York University, voted *yes*. Health equity is a public good to society, narrowing the gap between groups. She was not against other social determinants of health, but inequity is a destabilizing force, robbing one of hope. Equity is a key social determinant in the SDGs, but is there a political will to view health as a human right? Health, she said, is a societal asset that drives more prosperous economic indicators and is feasible, but it receives the least attention and needs more focus. Health enables people to contribute – giving hope and optimism, as well as more of a tax base leading to overall prosperity. This is an evidence-based,

essential priority but not the only one. She quoted Rev. Martin Luther King, JR, "The arch of the moral universe is long, but it bends toward justice," and called us to, "bend it faster."

Richard Horton, Editor-in-Chief, The Lancet, UK, Professor, London School of Tropical Medicine, voted *no*. He agreed that equity is essential in this wounded world, where the power of the few is exerted over the many, the rich over the poor. But equity is not the defining objective – it is *liberty*, that each could realize their aspiration to self-determination without interference or coercion. This is what it means to be human, and the precursor of a fairer society. Health, he claimed, has an explicit connection to liberty. Liberty is the central objective because of human *dignity*. Humans are not objects tied to the unjust ropes of society. Without dignity there cannot be equity. Those working in global health, therefore, have a duty to hold accountable those governments and sources of power that deprive people of their liberty: authoritarian regimes, military force, religious dogmatists, corporate powers with their tools of exploitation, repression, discrimination, and censorship. Equity without liberty leads us toward oppressive conformity, the death of the human spirit. We need emancipation from enslavement, the "rebirth of the social soul." It leads us, if not to paradise, at least to realizing our full humanity, finding truths about ourselves and the world, embracing a diversity that is welcomed and celebrated.

In his rebuttal, Dr Horton agreed with the moral imperative of equity, but reminded us of the four freedoms expressed by Franklin Roosevelt in 1943: freedom of speech, of worship, from want, and from fear – and this included adequate healthcare. Amartya Sen's book *Development is Freedom* was the signature argument for this view, whereby individuals were seen as active agents of change, not passive recipients of dispensed benefits. Liberty was the clarion call of the enlightenment projects. Maximum flourishing is available in a pluralist social context where there is freedom – to "remove the chains that enslave the human mind," which subjugate us to the oppression of others with unaccounted power which strip away our dignity. In her rebuttal, Dr Healton agreed that liberty was important for social justice, but that liberty and freedom is elusive and illusory. Liberty could mean the freedom to oppress. There should be a 5th freedom – the right to survive. After the debate, a show of hands revealed about an equal number of votes for equity vs. liberty as the defining objective for global health.

## War on Women

Geeta Rao Gupta, Deputy Director, UNICEF, noted that there has been enormous progress in the last 100 years, but still significant gender disparities in health, education, economics, and political power. Sixty-eight countries actually showed an increase in gender gaps, and there is a pushback view which sees women's rights as threatening – a shift in the distribution of power.[5] She evidenced mutual benefit for empowering women and opposing "rigid cultural norms" of masculinity which may lead to dominance, homophobia, accidents, lower life spans, addiction, and violence. There are large gaps in the literature (eg. >1/3 do not disaggregate based on gender). Instead of competing with other movements, she suggested linking with other movements with common goals of equality and social justice. Latanya Mapp Frett, Executive Director, Planned Parenthood Global, eschewed as unjust the Mexico City Policy or "global gag rule" for US foreign aid. She called for WHO to "destigmatize" the issue of provision of "safe abortions" as a "key public health measure" [which implied that those who morally oppose abortion were creating stigma instead of defending the basic human right to life]. Admittedly a contentious issue which divides the UN, there is no moral consensus making it difficult to create a public health policy or for access to abortion to be considered a fundamental human right. Natalie Kanem, UN Population Fund, noted the greatest UN goal is peace – mediated through transmitting facts and sharing knowledge,

but they recently lost $70M in funding, half of which would have been used in humanitarian relief. War on women is literal among victims of gender-based violence in Myanmar (Rohingya), and in Iraq and Yemen where health services and mental health support is also disproportionally low. Calling for "sexual and reproductive rights" as part of universal health coverage, she noted growing coalitions for "abstinence-only" approaches vs "evidence-based decision making" [spoken of as if they were mutually exclusive]. Goals included the "3 zeros": end unmet need for family planning, end preventable maternal deaths, end violence against girls and women (including FGM) toward a world where the inherent dignity of every girl and women is upheld. K. Srinath Reddy, President, Public Health Foundation of India, started by quoting Nobel Laureate Gunnar Myrdal, "Health leaps out of science, and is nourished by the totality of society." It is, he said, the social determinants that determine how health is accessed. In the last 2 centuries, women struggled and gained several rights but there remains active aggression (domestic abuse, FGM, sexual violence) but also passive aggression (denied education, workplace discrimination), reflected over the entire life course – from selective abortion of female fetuses, to neglected underweight girls, to anemic adolescents, to sexually-exploited young women, to preferential access to health services for adult males. The advertising and marketing industries actively target women (eg. tobacco ads), and there is intergenerational inequity: maternal malnutrition affecting the human fetus and particularly the female ova (epigenetic effects). He called for gender justice not through militancy but through liberating women to participate in social transformation in all its dimensions. Women naturally care about next generational nurture. In India, Panchats (village counsels) led by women spent more on education, health, nutrition and sanitation. This movement needs to include women across all levels of the heath care systems, including leadership and research as critical change agents. To see this happen, men also need to be willing to be inclusive with gender equity, and mutual gender respect is needed with common social commitment for a healthier society.

## The Health Implications of Climate Change and Environmental Degradation

Several sessions at the conference focused on how the climate crisis affects all aspects of global health, and the need to be open about our values and pursue evidence-based ways to reduce warming and mitigate these effects. John Balbus, Director, National Institute of Environmental Health Sciences, NIH, noted 2017 was the costliest year for natural disasters due to the increasing power of storms, increased number of wild fires, higher degree of air pollution, limited water supplies, protracted periods of heat waves, all with worldwide distribution, but with a disproportionate effect on low-income countries. Global temperature change from 1890 is approaching 1.5 degrees Celsius. Direct impacts of weather, ecosystem effects, and human system mediation indicate that we can address, adapt to and mitigate effects. Some activities include the Belmont Forum working on a research framework and funding, WHO adding climate resilience to their operational framework, World Bank focusing on Climate and Healthcare Effort, NIH initiating a Disaster Research Response (DR2) program, and developing the Climate Change and Human Health Literature Portal (https://tools.niehs.nih.gov/cchhl/index.cfm).

Madeline Thompson, International Research Institute, Climate and Society, Columbia University, focused on extreme events and children and the needed linked responses to this vulnerable population, having multigenerational impacts. She emphasized the forecasting of climate-sensitive health outcomes with the help of supercomputers and noted the emergence of many environment and health alliances in order to develop enough of a work force to accurately predict and respond while engaging with the local health community for capacity building.

James Hospedales, Director, Caribbean Public Health Agency, overseeing 24 countries (median population of 100,000), indicated that he was a Christian, believing that God made the world and spent a little more time creating the beauty of the Caribbean, but that, as a scientist, he observes "problems in paradise," namely climate becoming hotter, drier with more monster storms and subsequent infectious outbreaks. The physical, biological, social and policy environments are all affected, but "health professionals are sleepwalking." The objective is resilience building by filling big gaps in knowledge, and they are developing a climate roadmap to meet the challenges.

Win de Villiers, Rector and Vice-Chancellor, Stellenbosch University, South Africa, focused on the water crisis in the southern cape. There are 783M without access to clean water globally, and in South Africa, there has been a significant drop in water levels more than typical variations, affecting agriculture and human health. The government announced a day zero "in somewhat apocalyptic terms" when they would run out of water. The response plan: reduce, reuse, and use alternative sources using a multipronged approach, showed a 50% reduction of use at the university and increased understanding of water as a key resource. Kim Knowlton, Mailman School of Public Health, Colombia University, noted there is enough climate change evidence to take action here and now through the power of science, law, and people. Science has proven the human impact, and Natural Resources Defense Council (www.nrdc.org) has sought to educate the public on the localized effects to produce change and use a health-impact framing to enhance "implicit engagement" for action. Health impacts (pain and suffering) and economic effect has been measured in 6 climate events in the US between 2002 - 2009, costing $14B in health costs. Through the Global Consortium on Climate and Health Education, 162 countries have litigated against multiple executive orders, but it is the people who need to express concerns to see change.[6] Health data can be tied in to external factors. She highlighted a need to teach preventive and systems-thinking to medical students (vs individual and curative), integrating climate change and the social sciences into the curriculum, and localizing its impact on migration, conflict (looting), drought, and food price spikes. [Christian movements to address environmental concerns are also emerging such as AROCHA, Renew Our World, and Lausanne Creation Care.][7]

## Discussion with Global Health Leaders

Ann Kurth, Dean and Professor of Nursing, Yale University, noted a lack of *faith* in science/evidence in the general public. Universities are intended to welcome diversity of thought but need to demonstrate their value as producers of the health workforce with innovations needed in availability and pricing. "Meds & Eds" can make a work force accessible (using tools and gifts) and pedagogy (160 courses on global health cataloged on CUGH) to transform health systems. Nick Lemann, Director Global Reports, Columbia University, discussed the power of the pen, speaking truth to power, and how to be better communicators. Journalists and scientists, he said, have common goals – to be independent truth seekers - but face the oldest problem in political theory and is realistically not achievable. Journalists are doing poorly and need to be more scientifically literate, and need to locate real experts in the democratic movements for change. Patricia Garcia, Dean of School of Public Health, Cayetano Heredia University, and former Minister of Health, Peru, highlighted corruption which has led to significant health compromise with "no solutions," but she also highlighted the value of journalism and the need to start addressing new professionals with *ethics* to confront issues like bribes in order to create "new citizens." A more structured education with a scientific basis and peer-review is needed, she said, but can we use other truth-seeking fields, with structured solutions? There is a deep gap in the production of knowledge

being scaled up. Academia is starting to work with greater zeal in translation to the public. She cautioned to avoid the basic science vs applied science dichotomy (privileging one over the other), since innovation truncated from application is a form of waste, and waste is corruption. New knowledge and tools that do not connect with people's lives are useless.

Translational science is next year's CUGH conference theme, and academia needs to focus more on social determinants of health and application, such as upscaling community health workers, training in rural primary care, and enhancing emergency medicine. Transnational products need to be interdisciplinary, locally relevant and regionally impactful. Efforts at governance and social justice in law cannot ignore working with local civic agencies – translating action into communities. Most countries do not have scientific journalists. Social media and stories move behavior, but scientific rigor is insufficient – we need to speak clearly and closely to community leaders and to those who make a difference (legislators). It is said, "If it bleeds it leads. If it thinks, it stinks." Journalists are story tellers, and "narrative imperatives are persuasive." The "scientists as heroes" narrative can be problematic, so we need a "personal narrative" to understand scientific truth. Institutions can better protect those who point out corruption, who might be at risk of death. There has been a democratization of data and citizen activism, but it is also a time of distrust of government or nationalism, and significant suppression of freedom of speech. Corruption is a diffuse and complex problem. Academics can work toward accountability in systems, empowering the community as part of the continuum of health. Free press has not become a global norm. Turkey and India have *regressed* with regard to freedom of the press. Elitism related to academia creates a distance with communities undermining good community of practice in this area: working with communities, local governments, taking a chance to see how things are done in the *real world*. The health department of Peru addressed stunting successfully via evidence-based coordination, commitment, and continuity, working with several actors and different disciplines [including churches as civil society actors]. The business side of medicine is separate from the social enterprise aiming toward health equity. Cooperation with business schools can empower and create capacity to improve, but *financial motivation can undermine community health*. Critical thinking training is essential for a safe clinician but is also a universal outcome in an ideal university, which needs to be careful about "left-wing politics and group think." Wim De Villers' conclusion was to surrender privilege for the sake of others, like giving the 3-Ts (time, talent and treasure) to reduce inequity of privilege.

## Accountability in Academics and Development

There was an interesting discussion on how to evaluate things that cannot be measured like "love". The discussion stated that the overreliance on data may be problematic, so humility is required when dealing with data, knowing its limitations. With the movement toward measuring everything, the numbers become ultimate goals. The first step is to ask what the motivation is for collecting the data. Proxy indicators may miss the mark, such as measures of enrolment in insurance vs. access (outputs vs outcomes). Global donors are beginning to enforce penalties if data are fudged. It is not what we do not know that will hurt us, it is what we *think* we know but actually find to be false. Are SDGs too reliant on figures that computers can read? There are places where it is difficult to count – armed conflict, failed states, fragile states – and social determinants are also hard to measure. Proxies may be good measures, but these are not accepted by governments as a method. Publication has become a requirement for funding a source of accountability.

## Strengthening Governance and Public Health Institutions

In the final plenary session, Chelsea Clinton, Vice Chair of the Clinton Foundation, moderated a panel with Laurie Garrett, Science Journalist; Agnes Soucat, Director, Health Systems and Governance and Finance, WHO; and Willy Mutunga, Former Supreme Court Justice, Kenya. They highlighted a retreat from globalization since 2008, with isolationism and nationalism on the rise countering principles of cooperation. Multilaterals (such as the UN), they claimed, are also declining with shifts in financing to the private sector. Achieving universal health coverage and the SDGs will require political will, primary health care focus, and domestic public financing (85% financing predicted to be able to come from within each country). The stakeholders are a triad of people, market, and government. Freedom of the press is the key element to driving action but is being increasingly restricted in countries such as Central African Republic, Turkey, Mali, Burundi, and Bahrain. Peoples' agency is the key for freedom of information – science anchored in debate as well as action on that information. Profits superseding people's needs corruptly dominate the world. The solution offered is a restoration of more global governance with a scientific basis – "veracity with transparency" – with solidarity between the healthy and the sick, anchored in the social contract, giving agency to those who are excluded. The debates will continue on what UHC looks like – what is covered on the public dole, and what is provided by civil society [including churches and FBOs].

## Conference Reflections

There was excellent content and conversation on some significant global health issues throughout the conference, especially as they related to health equity, justice, and civic action. The emphasis on the importance of research and publication to be of influence for effective policies while also cautioning on being too data driven or enamored with statistics was noteworthy. Evidence-based action was the clarion call, but there was less emphasis on values or narratives which drive the action. There was, conspicuously, no recognition of the importance or language of the faith community. In that 80% of the world population adheres to religious beliefs, narratives that cohere with daily life will be especially critical for translation, localization, capacity-building, buy-in, and community transformation.

Global health goals cannot be accomplished from distant, theoretical, academic platforms, transposed onto communities. Neither health equity nor liberty *fully* describe the best of global health priorities. Rather, through speaking the truth in love to neighbors in need at the community level, speaking truth to failed powers and systems, recognizing the intrinsic dignity of every person and people group, elevating health-promoting biblical values, affirming and mobilizing existing resources, and liberating them from the powers that destroy will be the defining objective for a Christian approach to global health and transformation in the 21st Century.

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