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Diplomacy

The diplomacy for a Global Health. The case of Kenya.

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*“All war represents a failure of diplomacy”.*

*Tony Benn*

*“He who has health, has hope; and he who has hope,  
Has everything”.*

*Thomas Carlyle*

### *African melodies of My Heart*

*The sunset*

*Of every day*

*Relives*

*With me as a coloured dawn*

*Full of perfumes,*

*Silences,*

*Sounds buttons.*

*I am still here,*

*In Africa.*

*I feel the hot wind*

*Taste of burnt wood*

*Of the jacaranda and*

*Its colours blend*

*At the delicate frangipane.*

*I am here,*

*In Africa.*

*Africa has taken*

*My Heart.*

*Annita Serventi (my great Mum)*

*My thesis comprehends my prefer topics that are diplomacy, health, and Africa, with the particular reference of Kenya.*

*It was not an easy route. These two academic years were quite difficult.*

*For this reason, I want to thank some people who are really important for me and my life.*

*It will be so FOREVER.*

*To my **parents**.*

*Thanks for all Your Love, understanding, and patience.*

*Thanks You for teaching me to be always determined, even when I did not have more strengths.*

*Thanks **Mum** for giving me the realization that happiness and serenity are the best cures for all diseases.*

*Thanks **Dad**, the first man which I loved and will always love. You are a very special person.*

*Thanks for coaching me strong values, such as loyalty, respect, and love for the others.*

*Thanks because, without You, I would never have had the passion for Africa that I will bring for all my life.*

*To my sister and brothers, **Laura, Giacomo, and Guglielmo**.*

*Thanks for Your Love and Friendship.*

*To You I want to dedicate the following sentence: “I searched my soul, but I could not see it. I sought my God, but my God eluded me. I looked for my sister and brothers and I found all three”.*

*You are and will always be a great example of life for me.*

*I love You.*

*To my super grandchildren, **Alberto and Lapo**.*

*I am the more fortunate aunt because You are two wonderful children, two forces of nature.*

*I wish You the best.*

## **Introduction**

The research of this analysis wants to underline firstly health as a key concern of the global agenda. It wants to underline that there must be the need to consider the link between globalization and health. In fact, globalization of travel, changes in technology, and the liberalization of trade affect seriously the health of all individuals in the world. It is important to understand and contemplate constantly the impact of globalization on health. The process of globalization has also contributed to the connection of much more diseases undermining the all health sectors.

Secondly, the project is focalized on the health situation in Kenya with the principle reference of HIV/AIDS for many reasons: it is the major virus present in the country; Kenya is still the first African country with a bigger percent of the problem in respect to the others; the Kenyan is an outstanding example for the problem constantly present for the management of the global health problems.

Indeed, the thesis continues with the study of the role of diplomacy, its history, process, and methods of action. The health is a problem, both at local and global level. The diplomacy has the duty to be a sort of bridge that unites the international and local interests for the resolution of global health difficulties.

At the beginning, the first chapter of the thesis starts with the definition of the global health and its differences with other two branches of health: international and public health. This part answers to the questions: is the same global, international, and public health? Which are their objects? What about their commitments? These replies are very important for the conclusion that they are different if they are analysed singularly but assembled, they underline the same principle and crucial point that is the health is a right for all individuals.

Then, in order to understand the development of the global health, its social determinants are analysed. In 2003, the WHO suggested that they included, for instance, early childhood development, social exclusion, unemployment, availability of healthy food, and availability of healthy transportation. However, I wanted to focus on economic and policy because they are two social vital elements that mark truly the health sector of a society. In fact, without a global solid and foremost economic and political participation, the global health situation will remain the same. About that, there is chiefly the examination about the relations between economy, policy and health. Hence, the final part of the first chapter refers to global health security and HIV/AIDS, one of the most tragic disease in the world. Regarding the first topic, the lack of health is seen as a

synonymous of insecurity. For this reason, whereas some scholars tend still today to connote health like a private good, health has to be considered like a common resource, a common good. It is essential for the survival and to guarantee equality and development of personality. It is a valuable resource for individuals and societies. Nevertheless, if health is a common resource, is there a common management for this? A paradox exists. The economist Richard Smith argues that health is not per se a global public good (GPG). With national public goods, the government intervenes either financially, through mechanisms such as taxation. However, for global public goods this is harder to do, because no global government exists to ensure that. Hence, the central issue for health-related GPGs is how best to ensure that the collective action necessary for health is taken at the international level. In fact, one of the most important aspect is that a global health requires a collective action between countries but also within them. Initiating, organizing and financing collective actions for health at the global level presents a challenge to existing international organizations. In my opinion, a collective action truly happens when there is a complete consciousness of the problem. In this case, the thought that the protection of health has to be one of the principal goal of every state. Nevertheless, we are considering a global health; consequently, there is the need to establish a global protection. It is difficult to find this or create a health cooperation between states because they have diverse interests and aims.

The second chapter is entirely based on Kenya. Firstly, it gives a demographic, economic, and political overview of the country. Secondly, it evaluates the roles of the World Health Organization (WHO) and Joint United Nations Programme on HIV/AIDS (UNAIDS). How they work? What are their roles and plans about the general health condition of Kenya and in particular on the difficulties caused by HIV/AIDS? In order to respond to these demands, I did a long research in Nairobi and after in Kilifi and Malindi, the two big counties of Kenya. I could see that at a much more international level, some progresses are effectively present thanks to the two organizations just mentioned, but at local level, the badly behaved is still so big. Here the progresses exist but especially, if not only, thanks to the local communities, NGOs, and governments that tried and are trying to improve the condition. It means that the aids are concentrated mostly in the richer parts and not in the poorest ones, like in the other development countries. This is one of the most crucial problem of global health triggered principally by the progress of globalization.

Henceforth, how the government of the African country is reacting to HIV/AIDS? What bilateral or multilateral agreements exist?

What is the role of diplomacy? The third chapter talks about that but, in particular, wants to examine and stress a new type of diplomacy that few individuals, societies, states, governments, institutions know or do not consider that is the health diplomacy.

A health diplomacy, or better saying, a global health diplomacy could be a strong solution for the current global health situation. How? With which methods and practices? When really the health diplomacy was born?

The examination wants to discovery answers to these questions, how diplomacy could eliminate the paradox that could put into discussion the concern of health like a global public good. Moreover, together with the paradox, other problems occur about health like, for example, a global public good. How many of the actions necessary to global health like communicable disease control, generation and dissemination of medical knowledge, public health infrastructure, constitute the global health? Does the concept of health as global health undermine or support concepts of equity and human rights? Answers to these demands are necessary also to better understand how politics effect health.

Nevertheless, there is the requirement to comprehend that health is a foreign policy issue. Some researches highlight the importance of an economic growth linked with an improvement of health. However, politics is essential. The health sector is influenced by economic but also by societal and political factors. Policy measures are required to rectify the adverse effects of globalization on health and strengthen the positive ones. This is a new approach to managing global health issues and initiatives. In particular, policy should be guided by the following principles:

- 1) Policy has to be coherence between economic, social and environment sectors
- 2) Opening up of borders should be gradual and preceded by appropriate protective conditions
- 3) Strong national health policies, institutions, regulations and programs are essential
- 4) The public health workforce must be equipped with the knowledge and skills to engage with partners across sectors and across borders to achieve health and other social goals.

The policies influence and shape the conditions where individuals live and work, and these conditions may have positive or negative consequences for the health of a given population. A policy, program and project has the capacity to change the social determinants of health that are the social and economic conditions of a population. Nonetheless, the protection of health's population represents the principal goal of any nation state. One of the most important approach to do that is health in all policies (HiAP). The rationale of this method is that health is influenced by political, social, environmental, and economic factors. These factors influence the realization of the health's protection and improvement. In order to solve the situation, it is crucial to understand health in a broader societal perspective. In practice, this means integrating health into a broader range of

related policies areas, such as employment and education. It emphasizes the so called cross-border action. Only with this kind of strategy will it be possible to protect and promote the health of all populations in the world, especially those of poor countries. In a world of increasing interconnection and interdependence there is an urgent need to scale up combined activities to improve a global health. It requires a new kind public health workforce with the knowledge and skills to maximize the beneficial effects of globalization on population health status, and minimize the adverse ones. What are national and international policy responses? What health policies are needed to sustain efforts and prevent health crises in the future? One possible solution could be the partnerships between private and public actors, as well as between international level and national-level efforts. Public-private partnerships and international coalitions have been responsible for attracting the attention of policy-makers and placing new health issues on the global agenda. Moreover, the international community should therefore encourage organizations such as WHO to complement health sector programs with multilevel initiatives.

Before the conclusion, there is the consideration of some significant global summit projects and others similar to the first about health like the Global fund to fight AIDS according to which there are four policy recommendations for improving the sustainability of the initiative to control AIDS:

- 1) International cooperation on health should be seen as an issue of global public goods that concerns both poor and rich countries
- 2) National health and other sector budgets should be tapped to ensure that global health concerns are fully and reliably funded; industrialized countries should lead the way
- 3) A global research council should be established to foster more efficient health-related knowledge management
- 4) Managers for specific disease issues should be appointed, to facilitate policy partnerships. Policy changes in these areas have already begun and can provide a basis for further reform.

Finally, the third chapter finishes with a brief analysis of the role and impact of the pharmaceutical companies on health. They are very crucial and stress the importance of the engagements by diplomacy even in this field.



# **Chapter 1 - Visions, determinants, and issues of global health:**

## **Global health, international health, public health**

### **Global health**

Global health is a newer term that has incorporated numerous perspectives and has moved the field away from what was once a mostly clinical or basic science field. Particularly, it reflects the more “globalized” world in which we nowadays live.<sup>1</sup> Hence, there a strong connection exists between health and the development of globalization.

The term *globalization* designates an increasing and global connectivity, integration and interdependence in the economic, social, technological, cultural, political and ecological field.<sup>2</sup>

At first, the globalization was especially of economic type because substantially it consisted in the circulation of capital, goods, services and people. Currently, due to this process, we are assisting at a financial and commercial liberalization that generates positive results for rich countries and multinationals, but not positive results for poor countries. Only the so-called “developing countries” recently are responding sufficiently good to the phenomenon of globalization because they are strengthening financial, physical, and human resources to exploit the opportunities offered.

Hence, the globalization results like an asymmetric process that today is influencing even the health sector. As a matter of fact, it is possible to talk about the “globalization of health”. In this circumstance, the globalization is considered like a crucial determinant of health and for which we talk about *global health*.

According to the Report of the World Health Organization (WHO) on the social determinants of health, the globalization can act on health through its effects on:

- 1) The social and political context, including health policies;
- 2) social stratification and on population movements between the layers;
- 3) exposure, different depending on the social stratum, determinants of disease;
- 4) the different susceptibility to diseases in the various social strata;
- 5) the physical and functional characteristics of the health system.

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<sup>1</sup> Grepin K., *The rise of Global Health: global health vs. international health*

<sup>2</sup> Wikipedia: <http://en.wikipedia.org/wiki/Globalization>

All this state causes entails diverse consequences of the same diseases, which in turn can have critical effects on the societies. Moreover, it causes differences in the outcomes of disease and health provoking inequalities. Henceforth, generally speaking, the globalization has adverse consequences on the health of individuals and populations through mechanisms that lead to increase inequalities between countries and especially within countries, so among the various strata of society.

However, globalization could have, and in part has constructive effects on health. For instance, global policies for the control of infectious diseases, and especially AIDS, may allow the development and distribution of vaccines and medicines in different ways to promote those sectors of the population that most need the access to the primary resources. One of the real problem of the globalization is that it often acts more upstream in order to cancel, or even reverse, these potential benefits. In fact, the globalization increases the vulnerability of women and children with AIDS through mechanisms like the devaluation of national currencies, privatization of services, the liberalization of trade and finance, the imposition of payment for health services and school services.

Hence, it is possible to confirm that the mechanism through which globalization has a negative effect on health is largely related to the increase in inequality. When the inequality for income rises in the countries, economic instability and lack of improvements in the delivery of health services happen<sup>3</sup>.

The trouble is that globalization does not act uniformly. It encourages those countries, and those population or groups of individuals within countries, which already have abundant resources such as raw materials, industry, compact social institutions, and human capital, but it leaves those countries that do not have the capabilities necessary to be in a favorable position. Then, globalization hits heavily the poor countries favoring the rich ones thanks to the power that the latter have in establishing the rules.

From an economic perspective, the globalization does not bring benefits to health. Even development aid can guarantee the decrease of inequalities. Therefore, the worsening of health for large sections of the population is inevitable. This situation occurs not only due to the fact that the majority of the rich countries give in development aid much less than they could or should give; but also because this aid is used in an inefficient and ineffective manner. Hence, the wealthy part of the world is not interested to address the root determinants of health and even to strengthen health

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<sup>3</sup> Labonté R., Schrecker T., *Report of the WHO on the social determinants of health*

systems in a sustainable way. Consequently, more advantaged nations and socio-economic groups have achieved improvements on the health status.

Then, the relationship between globalization and health is constituted by a complex network of causes, interactions and synergies, summarized in two basic connections<sup>4</sup>:

- 1) Direct links consisting in direct impact on lifestyles, health systems, access to services and the health of populations and single individuals.
- 2) Indirect links according to which the forces of globalization act upstream on national economic policies and through these on the living conditions of families and on the health of people.

It is useful to analyse these associations in order to better understand the favourable and unfavourable conditions for the global healthcare system.

After doing this study, it is important to try to explain what it global health, what we mean when we talk about of it.

There are several definitions of global health<sup>5</sup> that reflect dissimilar perspectives on both the scope of the issues that global health should address and the ways in which it should do so.

In 2009, Lancet defined global health like “an area for study, research and practice that places a priority on improving health and achieving equity in health for all people worldwide. Global health emphasizes transnational health issues, determinants and solutions; involves many disciplines within and beyond the health sciences and promotes inter-disciplinary collaboration; and is a synthesis of population-based prevention with individual-level clinical care.”<sup>6</sup> Ilona Kickbush contends that global health refers to “health issues that transcend national boundaries and governments and call for actions on the global forces that determine the health of people.” Koplan offers another perspective suggesting that global health is “an area for study, research, and practice that places a priority on improving health and achieving health equity for all people worldwide.” In addition, Beaglehole and Bonita’s publication give a shorter definition that is “collaborative international research and action for promoting health for all.”<sup>7</sup>

The viewpoint of Ilona Kickbush suggests that global health refers only to problems that cross national boundaries or governments, whereas the other authors do not pose this limit. They speak about “health for all”; otherwise, it would not make sense to talk about global health. Even the World Health Organization maintains, “The health of all people is fundamental to the attainment of

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<sup>4</sup> D. Woodward, Globalization and health: a framework for analysis and action

<sup>5</sup> Marusic A., *Global health – multiple definitions, single goal*

<sup>6</sup> *Global Health Division*

<sup>7</sup> *The Journal of Global Health*

peace and security and is dependent upon the fullest co-operation of individuals and States. The extension to all peoples of the benefits of medical, psychological and related knowledge is essential to the fullest attainment of health”.

It may be appropriate to quote some examples that confirm this supposition<sup>8</sup>:

- Around 10 million children under the age of five die each year
- Cardiovascular diseases are the leading causes of death in the world
- HIV/AIDS is the leading cause of adult death in Africa
- Population ageing is contributing to the rise in cancer and heart disease
- Lung cancer is the most common cause of death from cancer in the world
- Complications of pregnancy account for almost 15 % of deaths in women of reproductive age worldwide
- Mental disorders such as depression are among the 20 leading causes of disability worldwide
- Hearing loss, vision problems and mental disorders are the most common causes of disability
- Road traffic injuries are projected to rise from the ninth leading cause of death globally in 2004, to the fifth in 2030
- Under-nutrition is the underlying cause of death for at least 30% of all children under age five.

Principally, Koplan, Bond, Merson, Reddy, Rodriguez, Sewankambo, and Wasserheit make this two questions: *what is global? Must a health crisis cross national borders to be deemed a global health issue?*

Firstly, it is important to stress the idea of health according the World Health Organization: “Health is a state of complete physical, mental and social well-being and not merely the absence of disease of infirmity”.

Secondly, it is suitable to consider the opinion of the previous authors according to which we should not restrict global health to health-related issues that literally cross international borders. Rather, global refers to any health issue that concerns many countries or is affected by transnational determinants such as HIV infection that is clearly global.

The global in global health refers to the scope of problems, not their location determinants. Moreover, it can focus on domestic health disparities as well as cross-border issues. In particular for

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<sup>8</sup> *Medici con l’Africa – CUAMM, Global Health and International Health Cooperation*

the latter reason, global health is similar to the public health but differs from international health. Indeed, the term “global health” is rapidly replacing the older terminology of “international health.”<sup>9</sup>

Global health derives from international health and public health. They present common characters but also different ones.

## **International Health**

It is possible to maintain that global health is being used recently instead of international health which has been utilized for many decades. The latter is often called and designed in the same way of the first.

On one part, some claims that international health and global health cover the same subjects; on the other, there is the suggestion that they are different.

Firstly, the word “international” is literally defined in terms of national borders, whereas the word “global” encompasses the entire world<sup>10</sup>.

Secondly, from a universal overview, international health has a more straightforward history.<sup>11</sup> For decades, the term *international health* was used for the work in the health sector abroad, with the focus on developing countries and often with a content of infectious and tropical diseases, water and sanitation, malnutrition, and maternal and child health<sup>12</sup>. Hence, international health comprehends a broader range of topics such as chronic diseases, injuries, and health systems. For this reason, many research groups are moving away from the concept that links the international health only to the diseases of the developing world. They stress the fact that international health coincides effortlessly with the content of today’s globalized health practices<sup>13</sup>.

Like for global health, various definitions are present in order to explain the meaning and content of international health.

The *Global Health Education Consortium* describes it as a subspecialty that “relates more to health practices, policies and systems, and stresses more the differences between countries than their commonalities”<sup>14</sup>.

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<sup>9</sup> World Health Organization

<sup>10</sup> M. Peneque [et al.], *International & Public health. Collective Health & Global health diplomacy. Some considerations.*

<sup>11</sup> J. P. Koplan [et al.], *Towards a common definition of global health*

<sup>12</sup> Brown TM, Cueto M, Fee E. *The World Health Organization and the transition from “international” to “global” public health.* Am J Public Health 2006; 96: 62–72.

<sup>13</sup> Brown University International Health Institute

<sup>14</sup> L. Shi, D. A. Singh. *The Nation’s Health.*

The *US Institute of Medicine* referred to international health as "health problems, issues, and concerns that transcend national boundaries, may be influenced by circumstances or experiences in other countries, and are best addressed by cooperative actions and solutions"<sup>15</sup>.

The scholars Paneque, Vinajera, and Torres pressure that the major characteristics of international health are:

- 1) Involvement of countries in the work of international organizations.
- 2) Development of aid and humanitarian assistance.
- 3) The examination of all transboundary and transdisciplinary conditions that affect health.

Merson, Black, and Mills use this definition: "the application of the principles of public health to problems and challenges that affect low and middle-income countries and to the complex array of global and local forces that influence them"<sup>16</sup>.

To resume, the key difference between global health and international health is that the first emphasizes the nations. Whereas, global health is used as a way to recognize the growing importance of non-state actors such as NGOs and internally displaced people and it is also an emphasis on global citizenship.

The latter scholars bring to the same level the international health and public one. However, even global health is compared with public health. Subsequently, it is very important to understand its development and achievement.

## **Public Health**

Public health can be defined as the science of protecting the safety and improving the health of communities through education, policy making and research for disease and injury prevention.

Yet, public health refers to all measures applied to prevent diseases and promote health among the population as a whole. Its activities aim to provide conditions in which people can be healthy and focus on entire populations, not on individual patients or diseases. Thus, public health is concerned with the total system and not only the eradication of a particular disease<sup>17</sup>. This explanation is important because underlines a strong linkage between global health and public health. In fact, the

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<sup>15</sup> *Global Health Division*

<sup>16</sup> Merson MH, Black RE, Mills AJ. *International public health: diseases, programs, systems, and policies*, 2nd edn. Sudbury MA: Jones and Bartlett Publishers, 2006.

<sup>17</sup> WHO

public health field confronts global health issues, such as improving access to health care and controlling infectious disease.

According to the World Health Organization, public health has three main functions:

- 1) The assessment and monitoring of the health of communities and populations at risk to identify health problems and priorities.
- 2) The formulation of public policies designed to solve identified local and national health problems and priorities.
- 3) To assure that all populations have access to appropriate and cost-effective care, including health promotion and disease prevention services.

These report health like a public good and not a private good. In particular, in a strong era of globalization it is crucial to consider health like a global public good (GPG). In this framework, health has to be considered like a common resource. It is essential for the survival and to guarantee equality and development of personality. It is a valuable resource for individuals and societies.

Thus, a global public health is real. It comprehends activities within the health sector that address normative health issues, global disease outbreaks and pandemics as well as international agreements and cooperation regarding non-communicable diseases. It implies ensuring the value of health, understanding it as a key dimension of global citizenship, and keeping it high on the global political agenda. Moreover, public health embodies a new interface between foreign and domestic policies and new forms of sharing of research and proprietary information to resolve common health challenges<sup>18</sup>.

However, some scholars tend still today to connote health like a private good. For instance, the economist Richard Smith argues that health is not per se a global public good. With national public goods, the government intervenes either financially, through mechanisms such as taxation. For global public goods, this is harder to do, because no global government exists to ensure that. Therefore, the central issue for health-related GPGs is how best to ensure that the collective action necessary for health is taken at the international level. In fact, one of the most important aspect is that a global health requires a collective action between countries but also within them. Initiating, organizing and financing collective actions for health at the global level presents a challenge to existing international organizations.

The point is that a collective action truly happens when there is a complete consciousness of the problem. In this case, the thought that the protection of health has to be one of the principal goal of

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<sup>18</sup> Paneque, Torres, Vinajera. *International & Public health. Collective health & Global health diplomacy. Some considerations.*

every state. The consideration regards global health; consequently, there is the need to establish a global protection. It is difficult to find this or create a health cooperation between states.

In order to well understand where it is possible to collocate public health, it is important to remark that global health have a better usage when refer problems extra-continentals. International health should be used when involving a few countries in the same continent. In other hand, public health do not related with geographic area, but it is related with governmental and institutional or group responsibility for health. In a more specific way, public health can be used as an indicator of wellness or sickness, or as an infrastructure measure, within a geographic area. When there are multiple areas from various continents that might be called "global" health.

According to the Association of Schools of Public Health in the European Region (ASPHER), it is possible to coin global health with public one. In fact, the School talks about Global Public Health. It is surely possible if there is a broader consideration of the concept of health.

Therefore, it is essential to unify the concept of public health focused on a local community (village, district, country)<sup>19</sup>, and that of global health based on one community<sup>20</sup>.

	Global health	International health	Public health
Geographical reach	Focuses on issues that directly or indirectly affect health but that can transcend national boundaries	Focuses on health issues of countries other than one's own, especially those of low-income and middle-income	Focuses on issues that affect the health of the population of a particular community or country
Level of cooperation	Development and implementation of solutions often requires global cooperation	Development and implementation of solutions usually requires binational cooperation	Development and implementation of solutions does not usually require global cooperation
Individuals or populations	Embraces both prevention in populations and clinical care of individuals	Embraces both prevention in populations and clinical care of individuals	Mainly focused on prevention programmes for populations
Access to health	Health equity among nations and for all people is a major objective	Seeks to help people of other nations	Health equity within a nation or community is a major objective
Range of disciplines	Highly interdisciplinary and multidisciplinary within and beyond health sciences	Embraces a few disciplines but has not emphasised multidisciplinary	Encourages multidisciplinary approaches, particularly within health sciences and with social sciences

*Table: Comparison of global, international, and public health*

**Figure 1** *Koplan J. P., Differences between Global Health, International Health, Public Health*

<sup>19</sup> Beaglehole R. & Bonita Ruth, *Public Health at the crossroads: Achievements and Prospects*

<sup>20</sup> Lindstrand A. & Rosling H., *Global Health – An introductory textbook*, November 2006



## 1.1 Social determinants of Global Health

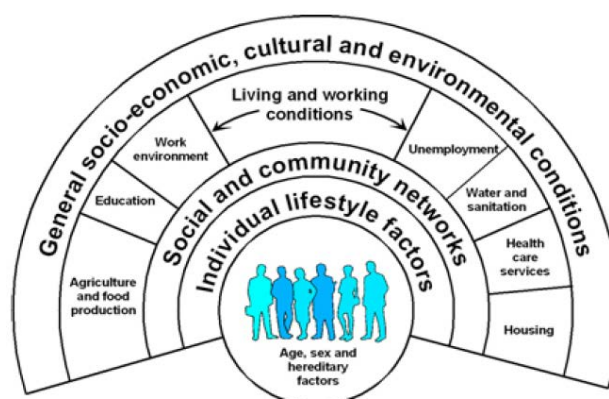


Figura 2 Social determinants of Health - WHO

According to the World Health Organization, the social determinants of health are very important because they have direct impact on health, predict the greatest proportion of health status variance (health inequity), can determine health behaviors, and interact with each other in order to produce a right health for all.

Poor social and economic circumstances affect health throughout life<sup>21</sup>. Poor people usually are subject to serious illness and premature death contrary to richest individuals. Therefore, it is important to understand how a society is structured in order to analyze what it can or cannot offer to its population. On the basis of this consideration, there is the life of expectancy, wellbeing and health. These are three terms strictly correlated, especially the last two.

Amartya Sen, winner of the Nobel Memorial Prize in Economic Science in 1998, articulated the so-called “capability approach” according to which the basic human functionings are what determine individual human wellbeing, and that societies concerning with justice should seek to maximize

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<sup>21</sup> Marmot M., Wilkinson R., *Social determinants of health. The solid facts*, Second edition, WHO

individual capabilities or freedoms to achieve certain functionings. According to Sen, functionings can vary in relation, for example, to health. A person's wellbeing is dependent on its capability to exercise a function. In the case of health, all individuals, without distinction of sex, religion, nationality, etc., are sure to have a strong wellbeing if they can access with assurance to healthcare system.

The philosopher Rawls talks about two types of health care: just and adequate. The first is based on the conception according to which the primary goods are guaranteed at all; the second wants to demonstrate that the health care can be shown to be instrumental in enjoying the set of primary goods defined by Rawls<sup>22</sup>. According to him, primary goods can be natural and social. Health and intelligence belong to the primary category. Rights and liberties, power and opportunities, income and wealth and the social bases of self-respect to the second. The last are at the disposition of the society contrary to previous measured like not the determinants of society. Even if this reflection, it is possible to consider the opinion of the academic about the social primary goods in order to put in light the real social determinants of global health. The scholar argues that the social primary goods are a measure of equality. For instance, inequalities of wages among some countries generate strong differences and their effects can extend to most diseases and causes of death. In turn, these diversities can be influenced by social and structural drivers such as economic arrangements and policy frameworks.

Hence, it is possible to say that a "social gradient of health" subsists, that is health is progressively better if there is a higher socioeconomic position of people and communities. An individual's resources and capabilities for health are influenced by social and economic arrangements, by collective resources provided by the communities of which they are part and by welfare institutions. Economics and politics are the most crucial and influential fields regarding health from a social point of view. Moreover, it is essential to nominate also the technology or the so-called "hi-Tec" that, especially today and with the constant development process of globalization, is dominating the all health sectors. For instance, the modern concept of health care involves access to medical professionals from various fields as well as medical technology, such as medications and surgical equipment. Moreover, technology today could defeat HIV/AIDS without the use of vaccine. The method utilized is HATS – the HIV/AIDS Test Screening Software. It incorporates interactive elements that provide information to patients and providers. HATS automates reporting and can be used to improve delivery of HIV related care. An individual can benefit by easily finding out if they need a test. Institutions can also implement HATS to realize large savings while scaling up testing

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<sup>22</sup> Coogan E.H., *Rawls and Health Care*, Colby College, 2007

services. Without to make large investments to grow testing programs including hiring and training new employees, HATS offers these organizations a rapid low cost alternative. In addition, it can be used to increase the efficiency of existing programs<sup>23</sup>. The problem is the communication: it is not so efficiency especially in development countries and this causes a loss of knowledge about new technological methods that could ensure or establish a better situation.

Nonetheless, it is opportunity to fossilize in the economic piece and political one. Therefore, there is the need to highlight the nexus between economics and health, and between politics and health.

### **Economics and health**

In the era of globalization of economic change, from a universal point of view there are profound impact on people's health and their access to health care. In every part of the planet's health, it is more severely threatened by rising rates of inequality and poverty, which reduce access to education, clean water, health care and accommodation of ever broader layers of the population. The planet's natural resources are being exploited at an alarming rate, causing a global environmental degradation.

All this factors constitute a serious threat to the health of all individuals, especially those of poorest countries<sup>24</sup>.

Economy is a social science to which actions influence and determine the basic and structural components of the society, including the health system. In fact, the so-called health economics exists and it is always beginning more prominent in the last years.

Economics health was born as a branch of political economics after 1970, a period in which the resources for health were no abundant. This type of economics analyzes how the individuals act in order to maintain their own healthiness, and when they enter into contact with the services used for health protection. Health economics is truly suitable because in addition to examine the demand and supply of health care, it tries to comprehend what is health and what is its value. In a global context, it is thinkable to extend the last thoughts globally. Subsequently, a debate rises about global health and its universal significance.

Over the last 30 years, attention has increased with the emergence of new health threats, like the virus HIV/AIDS, and the recognition that health is a key determinant of economic growth and poverty reduction<sup>25</sup>.

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<sup>23</sup> www.medwiser.org

<sup>24</sup> Sala C., *AIDS e salute nell'era della globalizzazione*, LIFEGATE.IT

<sup>25</sup> Dodd R. et al. , *Aid Effectiveness and Health*, Department for Health Policy, Development and Services, Health System and Services, WHO, Geneva, 2007

Regarding the problem of AIDS, it can seriously undermine the economic development of a country, especially in poor districts where the situation is worse for dearth and wars.

According to the United Nations, the HIV/AIDS epidemic can affect the economic in various ways.

The most relevant are the following:

- 1) Slowing of labor force. The degree of the virus hits a skilled labor force that is hard to replace.
- 2) Reduction of the savings and investments of the families for the growing of the HIV/AIDS health expenditures. For instance, in Kenya some private hospitals have adopted a program to combat AIDS in payment. Before, an individual has to prove to be seropositive doing the serological test. After, only if the person has demonstrated the seropositivity enters in the program<sup>26</sup>. Moreover, even the medicines to relieve the virus cost and, sometimes, the hospitals are not able to guarantee them to patients who must procure them alone.
- 3) Slower growth of the gross domestic product. It can happen that foreign and domestic private investment might also decline if potential investors become convinced that the epidemic is seriously undermining the rate of return to investment<sup>27</sup>.
- 4) Increasing poverty in the countries most affected by the virus because its spread tends to make the income distribution more unequal. Hence, HIV/AIDS exacerbates the income inequalities.

However, between the factors reported below, several economists are focused especially on the loss of the human capital. They argue that, at the end, when the prevalence of the epidemic is relatively high, the macroeconomic impact of the epidemic is unclear<sup>28</sup>.

It is clear that the effects of HIV/AIDS are catastrophic. It generates a vicious circle because hits children's education, nutrition, and global health undermining the prospect of the economic growth and development that will decline more and more in the future.

More immediate economic benefits have a positive impact on the health of all individuals. The current economic difficulties in several countries are a reason for action and inaction to improve the health conditions. The economic crisis that is affecting the world demonstrates to be a great challenge even for the health system and not only for the economic fluxes or the society in general. Economic problems reduce investments in health and its social determinants. For example,

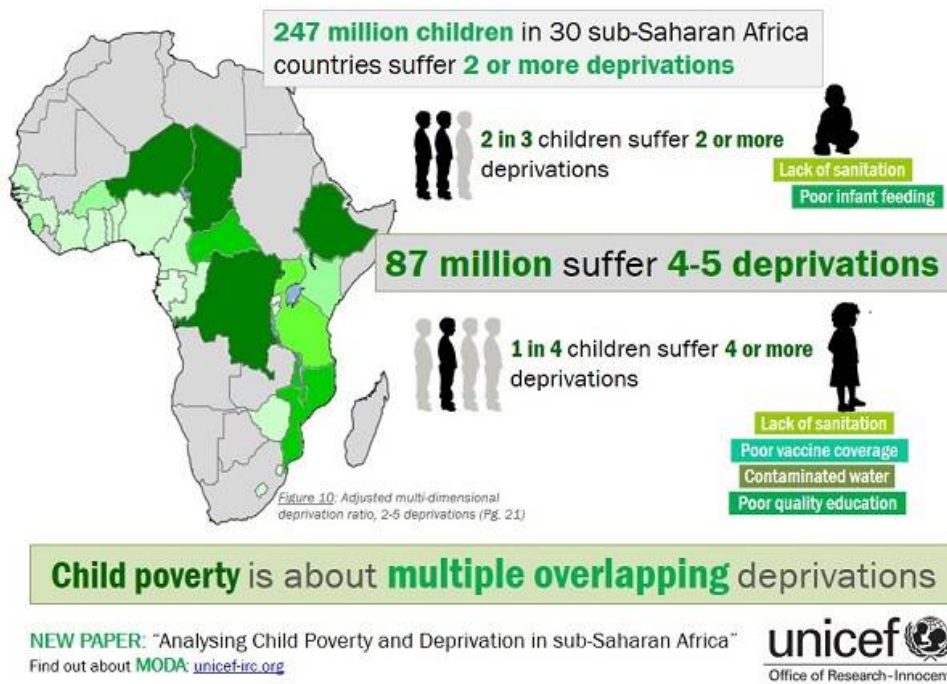
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<sup>26</sup> Sattin G. [et al], *Viaggio nella società dell'AIDS. LA NUOVA PESTE (e la vecchia fame)*, Missioni Consolata, June 2001

<sup>27</sup> United Nations Department of Economic and Social Affairs/Population Division, *The Impact of AIDS*, 2004

<sup>28</sup> Dixon S. [et al.], *AIDS and economic growth in Africa: a panel data analysis*, *Journal of International Development*, vol. 13, 2002

investing in early child development is a very good tool that lays the basis for a healthier future. The poverty in childhood influences health and other outcomes throughout life and it is remaining high in much countries of the world, like Africa.

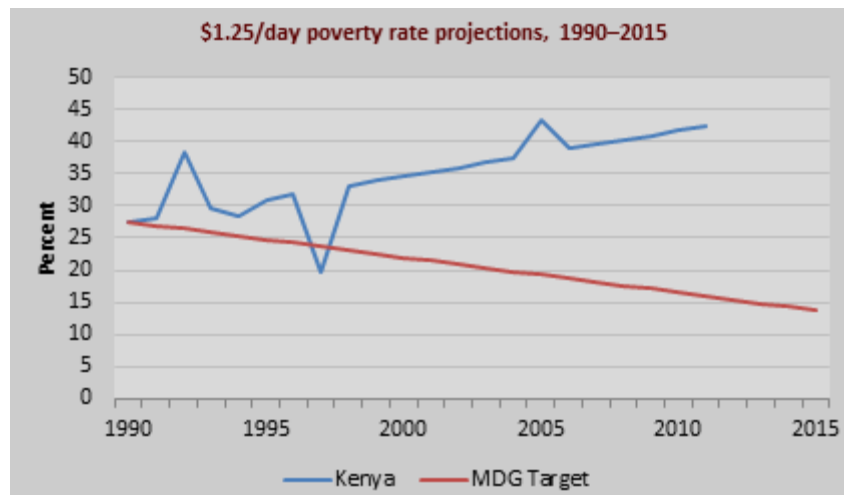


The figure shows, as the absence of sanitation in the earlier age of children is one of the most evident deprivation that marks the child poverty in Africa.

Even if it seems that in all Africa the infant mortality rate is diminished, the general situation needs to be strongly meliorate.

For instance, in 2013 the rate above mentioned, in Kenya was of 42,18/live births, in 2014 was 40,71/live births<sup>29</sup>. There has been a robust decrease; but nowadays, a high poverty still dominates the villages of Kenya. Particularly, a profound divergence exists within the cities. Riches and poor coexist together underlining the differences and increasing the sense of stress and illness.

<sup>29</sup> Index Mundi



Also the value of the Mortality Rate is declined in Kenya: 7,12/1.000 population in 2013; 7/1.000 population in 2014<sup>30</sup>. Despite this, the social conditions is not sufficient good. These circumstances include economy and health. People accuse their harmful status and they suffer. It happens not only in Kenya but in all countries of the world, especially in development ones.

The economic disadvantages tend to accumulate and to have a negative impact on health during the life of individuals. Stressful circumstances make people feel worried, anxious, and unable to cope. They damage to health and generate a premature death especially in the long period. For brief times, it cannot matter; but if people feel tense too often or the tension goes on for too long, they become more vulnerable to a wide range of conditions including infections, diabetes, high blood pressure, heart attack, stroke, depression, and aggression<sup>31</sup>.

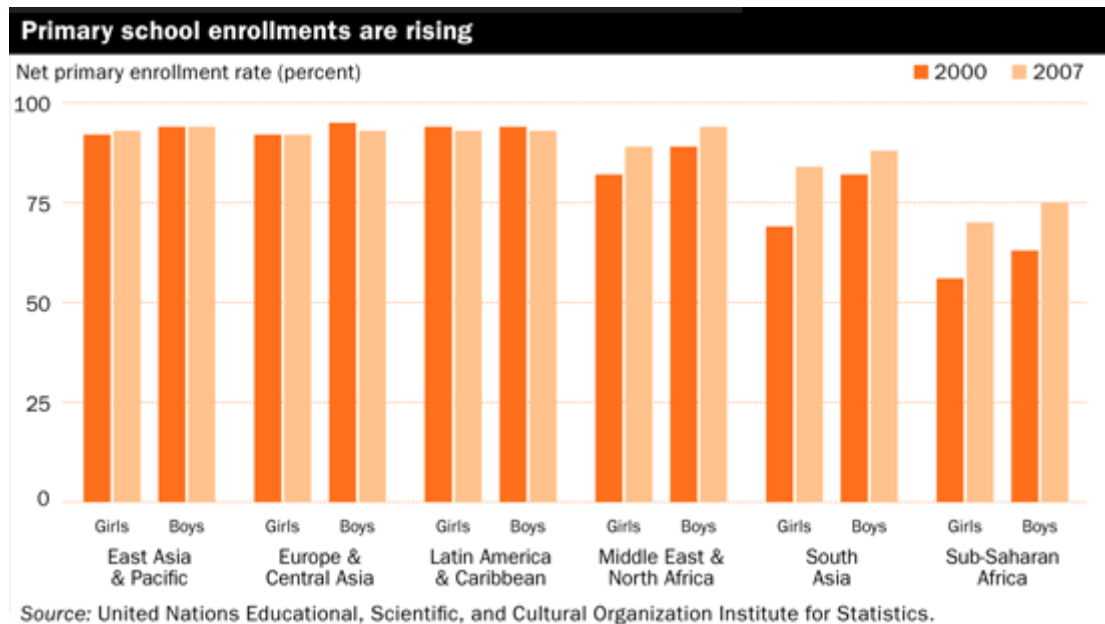
A good start in life means a cycle of journeys without tense surroundings then, instead, with good opportunities for childhood. In fact, the highest priority for all countries is to ensure a good start to life for every child. This requires adequate social and health protection for women, families, and to make significant progress towards a universal and high-quality child care system and education.

Many researches demonstrate that a powerful correlation between education and health. According to Callahan, new variables are much more present in respect to the past in order to strengthen the sanitation and diminish the mortality rate. These variables are economic conditions and instruction. In those development countries like Africa and India where there is still a low rate of schooling, a high mortality rate arises. The causes are numerous, but the major are that the schools are constructed inadequately without giving to children the access of core structures like bathrooms and canteens with food staples; or the government do not invest enough to ensure the necessary

<sup>30</sup> Index Mundi

<sup>31</sup> Marmot MG, Stansfeld SA., *Stress and heart disease*, London, BMJ Books, 2002

resources for a good school organization. Another negative factor regards the fact that the schools are located far from the villages where children live. This involves long walks with a scarce quantity of food and water. In all the cases, children get sick; they do not attend school and are unable to build a strong foundation for their future.



The figure shows that, with the course of years, the demand to enrol children in school raised globally in 2007. It did not transpire in an amazing manner for Sub-Saharan Africa. The state is the same formerly.

It is essential to stress that economic crises or an inadequacy effectiveness of economic agents like banks or private companies, generates a series of complications that contribute to worse the health condition of a society. Some of the more constant troubles provoked by the economic decreases are unemployment and low-paid works. In fact, occupational position is important for people's social status and social identity, and threats to social status from job instability or job loss affect health and well-being.

Levels of unemployment across the world are high and vary substantially by country, age, sex, migrant status and educational level. They have recently risen considerably in the countries most affected by recession and the economic crisis. There is a comprehensive scientific evidence on increased health risks resulting from precarious occupation. It proves that employment and high-quality work are critically important for population health and health inequalities in several

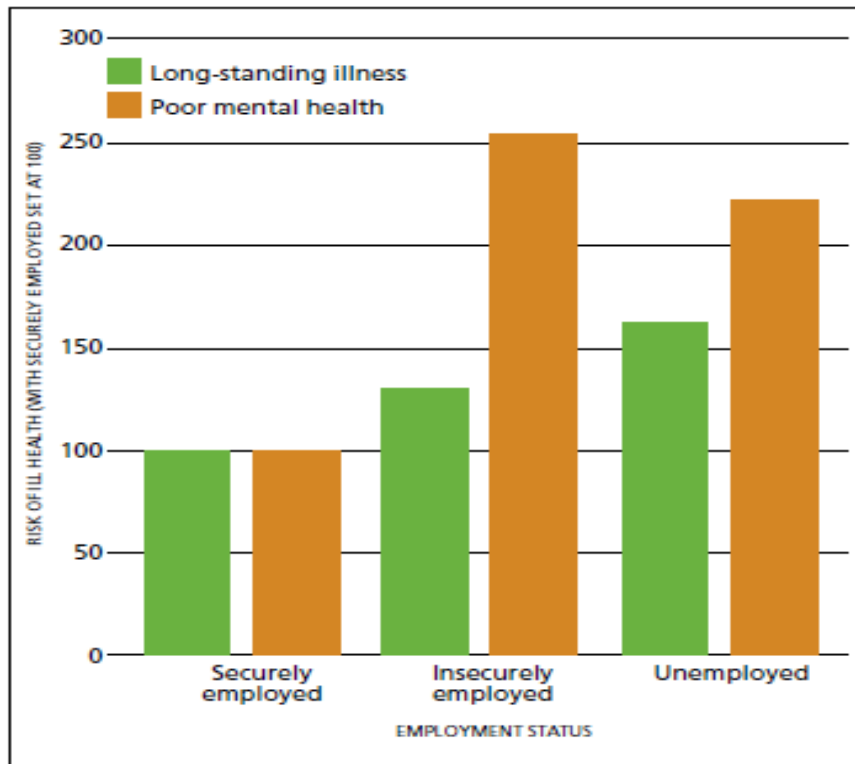
interrelated ways. One of these is the participation in or exclusion from the labor market, regular wages and salaries that can determine a wide range of healthy life. People on low incomes are fewer possibilities to have the means and resources to mitigate the risks and effects of health threats and to overcome the obstacles posed by economic disadvantages to securing less hazardous conditions and access to opportunities. In particular, people who live in areas of higher scarceness of incomes are more likely to be affected by destructive features for health such as tobacco smoke, biological and chemical contamination, air pollution, sanitation and water scarcity<sup>32</sup>.

Job security increases health, whereas higher rates of unemployment cause more illness and premature death. The health effects start when people first feel their jobs are threatened, even before they become unemployed. In addition, the hierarchical disparities within a job context can aggravate the mental stability of an individual and, in turn, heighten its health.

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<sup>32</sup> Mackenbach J et al., *Socioeconomic inequalities in health in 22 European countries.*, New England Journal of Medicine, 2008, 2468–2481.





**Figure 3 Effects of job insecurity and unemployment of health - British Medical Journal**

Inequities in the distribution of power and economic arrangements, globally, are of key relevance to health equity. Our main fears with health equity must be part of the global community balancing the needs of social and economic development of the completely global population.

Health equity may be the aim and result of economy and all social policies.

Economy and policy are rigorously correlated. In reality, the first lacking a correct guidance of the second, is not able to sustain suitably the society. The same is for politics because it needs to a truthful functioning of economic arrangements to put in practice its values.

Economic growth can give the opportunities to provide resources to invest in improvement of the lives of a certain population. Nevertheless, growth by itself, without appropriate social policies to ensure reasonable social policies to ensure reasonable fairness in the way its benefits are distributed, brings little assistances to health equity. Poor and unequal living conditions are the consequence of poor social policies and programs, unfair economic arrangements, and bad politics. It means that actions on health must involve economy but similarly politics.

For this reason, it is essential to analyze the influence and action of government with the local communities, civil society, global fora, and international agencies.

## Politics and health

Similar to the economy, the policy has the equal importance in order to better and purely ensure health equity and sanitation for all.

The implementation of policies can contribute to the development and protection of health.

Economy and policy are strictly interrelated in the sense that they define the social context of a society. There is not a rule about who actions at first and who in a second moment. Generally, the economic ranks are those that primarily determine the social position of an individual. A poor family cannot have the same benefits of richest one. The circumstance of the first is caused by itself but especially for the governmental apparatus that demonstrates to be incapable of generating the effectiveness of actions towards the people in health difficulties.

However, a damaging social position can originate diseases that comport social consequence influencing negatively the life of individuals. Especially at this moment, the policy start to act.

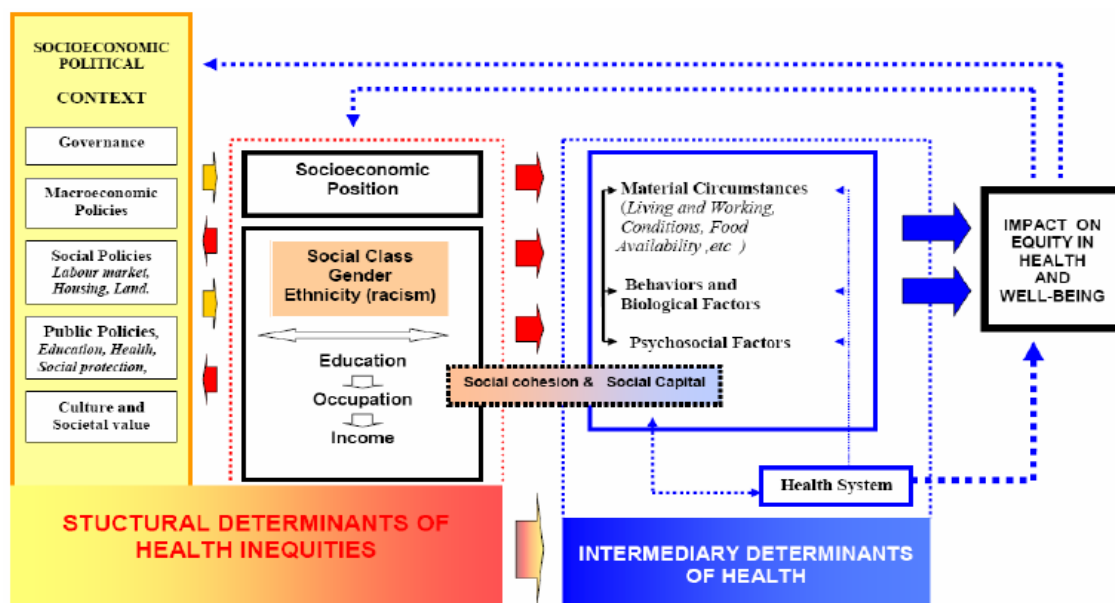


Figure 4 Framework of the major categories and pathways of determinants – WHO

Agreeing with the WHO and taking into consideration the globalization environment, the actions of the public policy stay at the macro level; whereas, at the mesa level there is the community and at the micro level the individual interaction. In this sort of pyramid, the policy and in particular public policies, are situated at the first and most impact place embracing the roles to reduce inequalities,

exposures of disadvantages people to health-damaging factors, vulnerabilities people in trouble, unequal consequences of illness in on social, economic and health terms<sup>33</sup>. Furthermore, it is clear by the figure that also local people and communities need to be involved in defining the problem, agreeing solutions and implementation approaches.

A particular range of policymaking subsists regarding health and this is the so-called health policy. It can be defined as the "decisions, plans, and actions that are undertaken to achieve specific health care goals within a society." An explicit health policy can achieve several things: it defines a vision for the future; it outlines priorities and the expected roles of different groups; and it builds consensus and informs people<sup>34</sup>.

Many categories of health policies exist, as well as personal health care policy, pharmaceutical policy, and policies related to public health such as vaccination policy, tobacco control policy or breastfeeding promotion policy. They may cover topics of financing and delivery of health care, access to care, quality of care, and health equity<sup>35</sup>.

Therefore, many topics in the politics are evident and they can influence the decision of a government.

Health is increasingly recognized globally as a critical economic and political asset. Government has a serious role in determining the conditions through which health governance and health equity are achieved.

Policy refers principally to governance. Governance for health comprises "the attempts of governments or other actors to steer communities, whole countries, or even groups of countries in the pursuit of health as integral to well-being through both a whole-of-society and a whole-of-government approach"<sup>36</sup>.

The whole-of-government approach integrates equity within the health in all policies approach as:

- 1) Providing a way of achieving the multiple benefits that accrue to sectors through the shared priorities outlined above;
- 2) Ensuring equity is integrated into policy across all parts of government and society.

"Governance for health" concerns policies, expenditure and decision-making related to responsibility for health outcomes across the whole of government and society at all levels, including those that result from activities outside the health sector.

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<sup>33</sup> WHO Commission, Closing the gap in a generation: Health equity through action on the social determinants of health

<sup>34</sup> World Health Organization, *Health Policy*, 2011

<sup>35</sup> Harvard School of Public Health, Department of Health Policy and Management About Health Care Policy, 25 March 2011.

<sup>36</sup> Kickbusch I., Gleicher D., *Governance for health in the 21st century*, WHO Regional Office for Europe, 2011

“Governance for health” is linked to well-being like a central building block of good governance. It is guided by a value framework that includes health as a human right, a global public good, a component of well-being and a matter of social justice.

In particular, it is important to stress the first point that is health is a global human right. Medical care is a right of all people.

Martin Luther King said that “all forms of inequality and injustice in health care are the most shocking and inhumane”. Health outcomes are not equal for people throughout the world and this is avoidable and unacceptable.

The Universal Declaration of Human Rights, adopted on December 10 1948 by the General Assembly of the United Nations, defines health like a right “at the highest possible level of physical and mental health”. Chiefly, UDHR Article 25 declares that "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, illness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control."

The UNESCO’s guidance of human rights stresses that, according to the United Nations, the basic health services that function to ensure adequate protection to the health community should include:

- Assistance to mothers and children especially in developing countries where, for example, the 99% of maternal deaths occurs.
- Prevention and control of infectious diseases.
- Sanitation and access to water.
- Health education.
- Health in the workplace<sup>37</sup>.

According to the scholars Kickbusch & Gleicher, a good governance for health has to warrant these requirements and correspondingly govern through collaboration, citizen engagement, a mix of regulation and persuasion, independent agencies and expert bodies, adaptive policies, resilient structures and foresight.

Additionally, even the worldwide human rights organization Amnesty International has focused on health as a human right, addressing chiefly inadequate access to HIV drugs and women's sexual and reproductive rights including wide disparities in maternal mortality within and across countries<sup>38</sup>. However, at this time the method *Health in All Policies* (HiAP) is becoming increasingly like one

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<sup>37</sup> AIDOS NGO

<sup>38</sup> The Lancet, *Half a century of Amnesty International*, 2011

of the most popular governmental strategy to improve population health by coordinating actions across health and non-health sectors.

The term was used for the first time in Europe during the Finnish Presidency of the European Union in 2006, with the aim of collaborating across sectors to achieve common goals. This strategy comprehends a variety of initiatives that frame health determinants as the bridge between policies and health outcomes.

In the context of the 8th WHO Global Conference on Health Promotion, HiAP has been defined as “an approach to public policies across sectors that systematically takes into account the health implications of decisions, seeks synergies, and avoids harmful health impacts, in order to improve population health and health equity.”

The method improves the accountability of public policy makers for health impacts at all levels of policy making; includes an emphasis on the consequences of public policies on health systems, determinants of health, and well-being; contributes to sustainable development<sup>39</sup>.

HiAP was thought especially to underscore the point that health and equity are highly valued elements of population well-being in all countries<sup>40</sup>. They are intrinsic goals in expansion that aim to improve societal well-being and happiness of all individuals in the world. Therefore, health, equity, and development processes are much interconnected.

In particular, it is possible to take advantages from the interconnectedness between health and development in order to realize additional gains for societal well-being, and avoid or decrease losses in the health sector. This effort requires the efficient help of public policies that have to be coherence and transparency. At the same time, they have to consider their inferences in other sectors like labor and environment that, in turn, can have influence on health. Moreover, public policies provide the framework for all activities in society, including those of private households, the private sector and civil society organizations.

Hence, the Health in All Policies approach aims to enable all sectors to realize gains for health, well-being and development. It requires the participation of all actors in the society. It is feasible and refers to practical governance instruments and analytical tools.

Governance instruments include parliamentary intersectoral committees, interdepartmental committees, budgetary analyses, and tools for public and civil society organizations, private sector and media.

Analytical tools include different policy impact assessment tools, such as health impact assessment, health lenses, and health equity analysis guidance.

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<sup>39</sup> Freiler A. et al., *Glossary for the implementation of Health in All Policies (HiAP)*, 2013

<sup>40</sup> Action:SDH, *Health in All Policies Definition Consultation*

Health in All Policies entails the knowledge on determinants of health, health outcomes, health systems functioning and their distribution aspects on the one hand, and the potential effects of policies across sectors on those, on the other. It calls for skills to prioritize and strategically think through the key health concerns in relation to other sectors and the ability to understand their agendas and priorities. Finally, it requires abilities in reaching out to other sectors to facilitate intersectoral dialogue and in contributing to intersectoral activities led by other sectors.

The approach is useful also for understanding the governance's expenditure for health care. According to the WHO, 100 million of people probably are pushed below the poverty line every year as a result of health care expenditure.

Access to and utilization of health care is vital to good and equitable health. The health-care system is itself a social determinant of health, influenced by and influencing the effect of other social determinants. Gender, education, occupation, income, ethnicity, and place of residence are all closely linked to people's access to, experiences of, and benefits from health care.

Without health care, many of the opportunities for fundamental health improvement are lost. With partial health-care systems, opportunities for universal health as a matter of social justice are lost. The ensuring of a right health care to all is a global core issue. The problem is that health-care systems are yet weak in many countries, with massive unequal access and use between rich and poor.

Many countries have an explicit policy to ensure and support access for all of its citizens in the health care system. Many governments around the world have established universal health care, which takes the burden of health care expenses of private businesses or individuals through pooling of financial risk. Health care is an important part of health systems and therefore it often accounts for one of the largest areas of spending for both governments and individuals all over the world. Many countries and jurisdictions integrate a human rights philosophy in directing their health care policies. The World Health Organization reports that every country in the world is party to at least one human rights treaty that addresses health-related rights, including the right to health as well as other rights that relate to conditions necessary for good health<sup>41</sup>.

Health care has to be considered universally like a common good, not a market commodity. Generally all high-income countries organize their health-care systems around the principle of universal coverage according to which everyone within a country can access the same range of good quality services according to needs and preferences, income level, social status, residency, jobs of individuals and their possibility to use these services.

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<sup>41</sup> United Nations, *The Universal Declaration of Human Rights*

Numerous types of health policies finance the health care services through taxation, mandatory, voluntary or private insurance<sup>42</sup>.

The debate is ongoing on which type of health financing policy results in better or worse quality of health care services provided, and how to ensure allocated funds are used effectively, efficiently and equitably<sup>43</sup>.

The government spending on health care is essential for the accessibility and sustainability of health care services and programs. It is sometimes used as a global indicator<sup>44</sup> in order to: build health-care systems based on principles of equity, disease prevention, and health promotion; strengthen public sector leadership in equitable healthcare systems financing, ensuring universal access to care regardless of ability to pay; invest in national health workforces, balancing rural and urban health-worker density; act for the focus on investments in increased health human resources and training and bilateral agreements to regulate gains and losses.

In a global context, it is essential to talk about “global health policy” which encompasses the global governance structures creating policies concentrated on public health throughout the world. In addressing global health, global health policy implies consideration of the health needs of the people of the whole planet above the concerns of particular nations.

It is important to take a distinction from international health policy based on agreements among sovereign states; comparative health policy like an analysis of health policy across states; global health policy characterized by institutions consisting of the actors and norms that frame the global health response.

Hence, the access to health for all represents one of the most relevant global problems that have to be solved especially by the governments. In this prospective, it is important to underline the concept of governance intended like a process and not an entity. It is able to find valid solutions for global difficulties<sup>45</sup>.

Many governments and agencies include a health dimension in their foreign policy in order to achieve global health goals. Promoting health in lower income countries has been seen as instrumental to achieve other goals on the global agenda that are the promotion of the:

- Economic development including the economic effect of poor health on development, pandemic outbreaks on the global market place, and also the gain from the growing global market in health goods and services.

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<sup>42</sup> Bhavasar, V., Bhugra, D., *Globalization: Mental health and social economic factors*, Global Social Policy, December 2008

<sup>43</sup> Petrusek M., Rapin L., *The mental health paradox*, Benefits Q, 2002

<sup>44</sup> Svorney S., *Licensing Doctors: Do Economists Agree?*, Economist Journal Watch, 2004

<sup>45</sup> Ferrara P., *Oltre l'aritmetica del potere mondiale. Governance globale e democrazia deliberativa*

- Social justice for the reinforcement of health as a social value and human right.
- Global security linked to fears of global pandemics and the spread of pathogens;

The last objective is crucial important especially today were we are assisting always more to big humanitarian conflict that advantage to the spread of tragic infections.

Many talk about global security but, whit this, is opportunity to mention global health security.

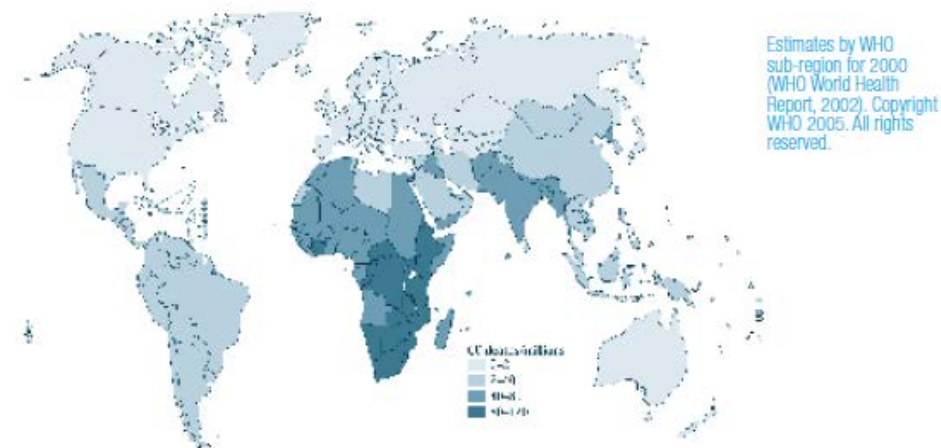
## 1.2 Two essential issues of global health: security and HIV/AIDS

### Health Security

General speaking, health security refers to a threat for the state and society. The WHO is based specifically on global health security and divides it in three broad categories:

- 1) Infectious diseases and knew variants of these that pose new dangers.
- 2) Food safety, in particular risks arising from the industrialization of agriculture exacerbated by the global nature of the food industry.
- 3) Catastrophes that represent clear limits for future generations affecting the natural environment. For instance, climate change has profound implications for the global system. It can affect the way of life and health of individuals, expressly in greater in low-income countries and among vulnerable subpopulations.

**Figure 6.1: Deaths from climate change.**



Reprinted, with permission of the publisher, from WHO (2005e).



The figure demonstrates how climate change constitutes a global serious problem and the fact that it is concentrated in a maximum level in the development countries. The reason for that is non due to a loss concentration of, for example, pollutions in rich countries; but the fact that the latter are additional developed to react more efficiently to environmental change. Contradictory, the richest countries can be those that cause problems at the nature but they suffer less for these.

However, it is possible to affirm that the debate about climate change continues to be priority even because it can produce health inequities.

Climate change, urbanization, rural development, agriculture, and food security are intertwined determinants of population health and health equity. For this reason, there is the need to social policy responses to climate change and other environmental degradation, which can interference health equity<sup>46</sup>.

Henceforth, nowadays it is well to consider health security globally because it is affected in particular by the three categories. They are wider properly for the motive that grow in all countries and represent a threat for them. For this reason, global health security generates a strong collective international public health action in order to build a safer future for humanity<sup>47</sup>.

Indeed, the World Health Organization describes global health security in terms of actions in the logic that it embodies some activities required to minimize vulnerabilities to acute public health events that endanger the collective health of population living across geographical regions and international boundaries.

For some scholars, such as Bolzacq and Vuori, the term security is utilized not to describe a condition but to increase awareness and encourage action for change by adding a symptom of urgency and importance<sup>48</sup>. Therefore, health security commonly is allied to human security.

The UN first drew global attention to the concept in its 1994 Human Development Report (HDR) according to which human security encompasses everything that constitutes freedom for all individuals.

Moreover, human security is focused on individuals. The last characteristic is different to that of national security based on defending borders from external military threats.

Human security uses non-coercive approaches centered on preventive diplomacy, conflict management, state capacity, and the promotion of equitable economic development<sup>49</sup>.

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<sup>46</sup> Campbell-Lendrum D & Corvalan C, *Climate change and developing-country cities: implications for environmental health and equity*, Journal of Urban Health, 2007

<sup>47</sup> WHO, 2007

<sup>48</sup> Rushton S. & Youde J., *Routledge Handbook of Global Health Security*,

<sup>49</sup> UNESCO, *Human Security: Approaches and Challenges*, 2008

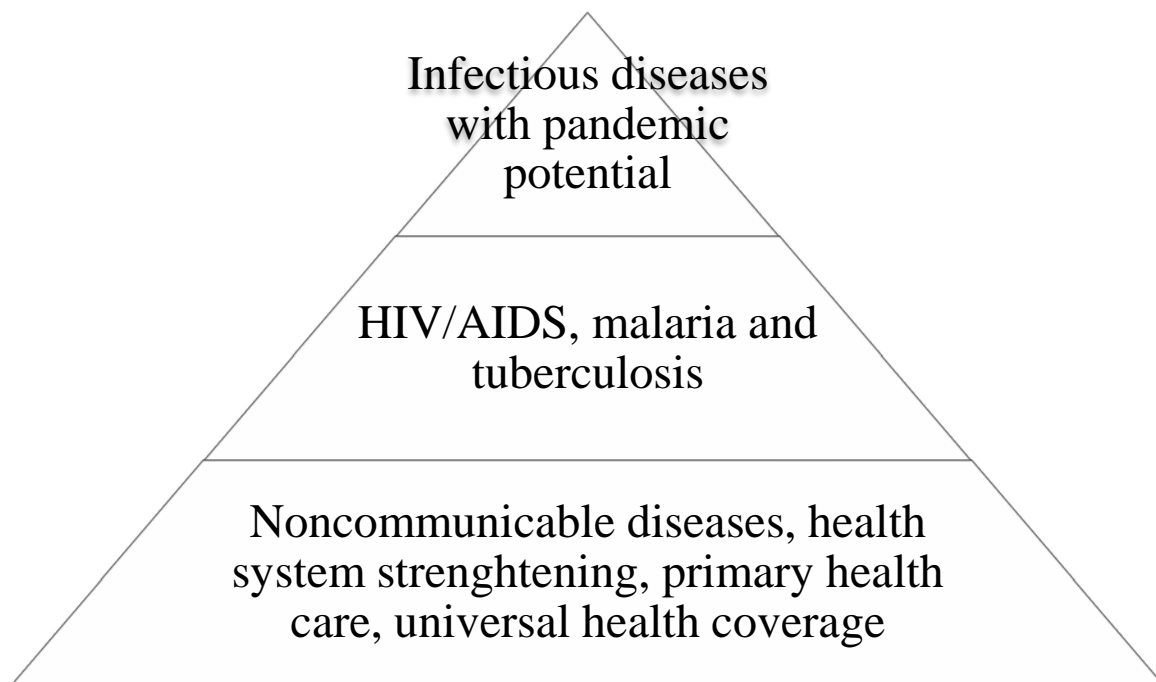
Global health security can be conceived as a mix of these two and stresses the inconvenient that secure states do not automatically mean secure peoples. It is concerned with health promotion on a global scale. It is motivated by the belief that risks to public health have been globalized and they required a fast response to individual states.

The primary goal of the global health security is the well-being of population in the face of health threats. So, in this prospective, perhaps is much more accurate to sustain that the global health security is firstly linked with the human security because both privilege individuals.

In reality, many scholars tend to precise that the global health security was formed, at the beginning, with the union between national/international security and health one.

The term global health security appeared for the first time in 1990 with the speech of some WHO's seniors. Since this moment, a development of the concept occurs and now it can be considered like a governance and sociotechnical apparatus that conjoins human actors, objects, and statements. The intentionality of the World Health Organization was to implement a global surveillance system with the capacity to detect and respond to the outbreaks of the various diseases. It is a complicate aim to achieve due to the expansion of new diseases or the constant progress of the existent illnesses.

For this reason, the global governance has to focalize what are the urgencies to consider for diminishing the varies problematics around health.



In the pyramid are shown the priorities to be considered with the global health security.

At the top, there are emerging infectious diseases because they are an important public health threat and infections with pandemic potential that are a major global risk. Pandemic preparedness remains a political and scientific challenge. A need exists to develop trust and effective meaningful collaboration between countries to help with rapid detection of potential pandemic infections and initiate public health actions. The cooperation between countries should encourage equitable collaborative research partnerships and the focus of pandemic awareness should include upstream prevention through better collaboration between human and animal health sciences in order to enhance capacity for the identification of potential pathogens before they become serious human threats, and to prevent their emergence where possible.<sup>50</sup>

At the down, some crucial issues are present and they are the basis to understand and to find a solution for the others of the pyramid. Non-communicable disease (NCD) is a medical condition that is non-infectious or non-transmissible. It can refer to chronic diseases which keep for long periods and it can cause rapid deaths. In fact, non-communicable diseases kill 38 million people each year and 28 million occur in low and middle income countries<sup>51</sup>. There are four main types of NCDs: cardiovascular diseases, cancers, chronic respiratory diseases and diabetes. These continue to be persistent in all part of the world and, for this reason, the World Health Organization and World Bank Human Development Network have identified the prevention and control of NCDs as an increasingly important discussion item on the global health agenda. In particular, in May 2008 the 193 Member States of the WHO approved a six-year plan to address non-communicable diseases, especially in low- and middle-income countries. During the 64th session of the United Nations General Assembly in 2010, a resolution was passed to call for a high-level meeting of the General Assembly on the prevention and treatment NCDs with the participation of heads of state and government. The resolution also encouraged UN Member States to address the issue of non-communicable diseases at the 2010 Review Summit for the Millennium Development Goals. Even the Food and Agriculture Organization demonstrated its preoccupation stressing the importance to reduce the globalization of unhealthy lifestyles like the levels of salt in foods, inappropriate marketing of unhealthy foods to children, harmful alcohol use, etc.

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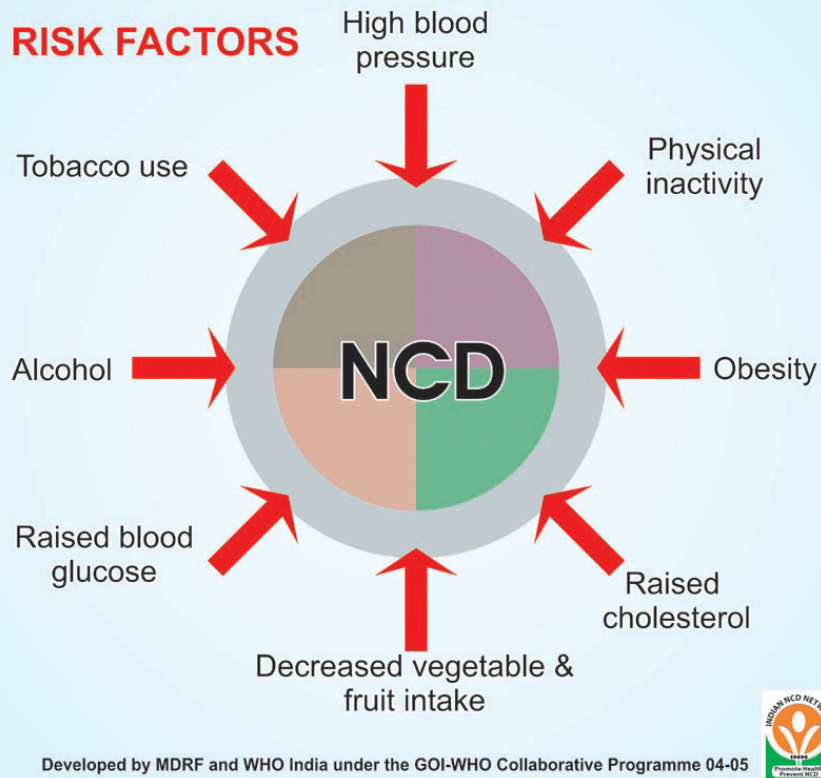
<sup>50</sup> McCloskey B. et al., *Emerging infectious diseases and pandemic potential: status quo and reducing risk of global spread*, 2014

<sup>51</sup> WHO

## NON COMMUNICABLE DISEASES (NCDs)

### NON COMMUNICABLE DISEASES INCLUDE

- **Cardiovascular disease (CVD)**
- **Diabetes Mellitus (DM)**
- **Chronic obstructive pulmonary disease (COPD)**
- **Cancer**



Together with the reduction of the NCDs, there is the aim to strengthen the health care system and primary health care system. In addition, the last is essential in order to have a universal health coverage.

The Primary health care (PHC) refers to essential health care, which make universal health care globally. It is focus on health equity-producing social policy.

According to the WHO, the decisive goal of primary health care is better health for all. The organization has identified five key elements to achieving that goal:

- 1) Reducing exclusion and social disparities in health (universal coverage reforms);

- 2) organizing health services around people's needs and expectations (service delivery reforms);
- 3) integrating health into all sectors (public policy reforms);
- 4) pursuing collaborative models of policy dialogue (leadership reforms);
- 5) Increasing stakeholder participation.

The expression “primary health care” broke out for the first time during the Declaration of Alma-Ata in 1978. It was the first international declaration advocating primary health care as the main strategy for achieving WHO’s goal of “health for all”. Thirty years on, primary health care is still firmly on the agenda at the World Health Organization.

While there have been huge improvements in areas such as childhood immunization coverage and access to safe water and sanitation, there have been obstacles in order to offer equitable access to essential health care worldwide. Health system constraints including financial barriers and health worker shortages, combined with challenges such as the HIV epidemic, have hampered progress towards achieving health for all.

The virus HIV/AIDS stays at the centre of the pyramid with tuberculosis and malaria. They are considered like the most hurtful disease in the development countries, especially Africa. Indeed, in 2000, AIDS, tuberculosis and malaria together killed approximately 6 million people a year. As of 2012, the number of deaths related to these three diseases had decreased by 40 percent <sup>52</sup>.

For this reason, in January 2002 there was the creation of the Global Fund. It is an independent and no-profit foundation that operates as a financing instrument in order to fight AIDS, tuberculosis and malaria. Its role consists in to provide the financial support needed to ensure effective programs of prevention, treatment, and care. Many of them have been made like the intensification of health campaign, the development of medicines, treatment of diseases, and the strengthening of health structures<sup>53</sup>. For instance, with access to treatments, millions of HIV-positive people are living healthy, but one out of two persons do not know their status. In fact, the three maladies still alive especially like global public health threats.

Currently and contrary to the previous decades, the tools and diffusion of the problem exist but there are not abundant efforts to fight completely AIDS, tuberculosis, and malaria.

The serious tricky is that if a fast defeat does not arise, the risk is that the illness will resurge in new and more powerful forms which the governance, economic arrangement and others will not have the trappings to combat the three big epidemics. They are epidemics because have spread and are

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<sup>52</sup> The Global Fund

<sup>53</sup> Massarenti J., *AIDS e Tubercolosi, una coppia mortale*, Vita.it, 2006

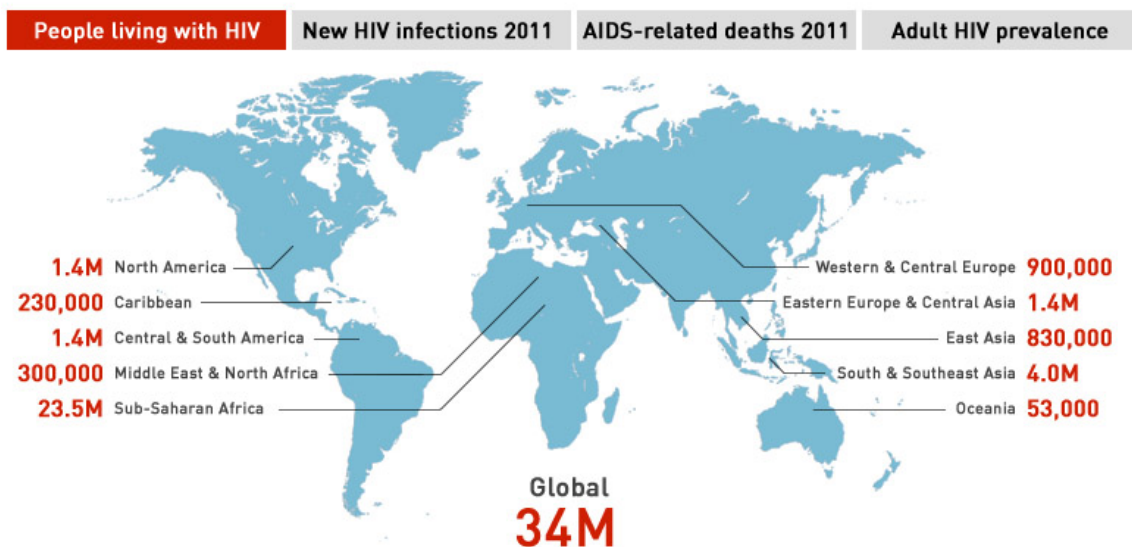
expanding around the world, although with less frequency but with more irregularities, particularly in the developing countries.

The three diseases mentioned above all have a great impact on the national and international level. Globally, it is possible to say that AIDS is crucially a central issue. In fact, with malaria, it covers the sixth Millennium Development Goal according to which there is the need to combat HIV/AIDS, malaria and other diseases.

However, AIDS is predominantly vital from a global point of vision and it can cause, in turn, malaria and in particular tuberculosis. In fact, for instance the populations of the developing countries contract tuberculosis more easily because often have a compromised immune system due to the high rates of AIDS<sup>54</sup>. It will be analysed in more detail in the following chapters.

### **The virus HIV/AIDS**

According to the World Health Organization, in 2014 36.9 million people were living with HIV in the world. Hence, it is not so difficult to comprehend why the virus is strongly and alertly associated with global health security.



*Figura 5 HIV/AIDS in the world – CBC news*

The figure 4 shows how the virus HIV/AIDS was the most severe epidemic during 2011. In this year, there were 1.7 million AIDS-related deaths and 2.5 million new HIV infections around the

<sup>54</sup> S.D. Lawn et al., *Tuberculosis*, Lancet, 2011

globe. Even if the UN notes that, there were more than half a million fewer deaths in 2011 as compared with 2005, HIV continues to spread<sup>55</sup>.

AIDS (Acquired Immunodeficiency Syndrome) is a disease caused by HIV, a virus that attacks the human immune system. In people with AIDS, the immune system is no longer able to defend the body against disease and the degenerative process continues until the patient's death due to infections. There is no cure or a vaccine to eradicate HIV<sup>56</sup>, like for malaria but not for tuberculosis. According the Joint United Nations Programme on HIV/AIDS (UNAIDS), the AIDS epidemic is declining globally, but new cases of this continue to rise in some regions and countries of the world. Important progresses have been made in combating the disease locally. Some of these are the increase in funding and access to care, and the decrease of HIV prevalence among young people. Nonetheless, AIDS remains a strong threat to global health. It represents to be also one of the major cause of the infant mortality.

According to the United Nations Children's Fund (UNICEF), 2.5 million children under 15 years are living with the virus and 16,6 billions of children became orphans due to this tragic disease.

In the last cases, it is important to underline that the infant mortality for HIV/AIDS is strictly correlated to the maternal mortality caused always to the viral epidemic.

UNAIDS stresses the undesirable aspect that structural inequalities continue to fuel the virus in all societies with an increasing concentration of it in the most poor and marginalized parts of the society. Without a doubt, the primary cause of the HIV/AIDS diffusion is due to the worsening of the spread of the economic, social and cultural spread disparities. In addition to the Global Fund mentioned above, even the World Bank provides the necessary funds to combat against the difficult advancement of HIV/AIDS. In particular, the international financial institution, born in July 1944, collaborates intensely with UNAIDS in order to better achieve their goals.

Moreover, the biggest UN Programme against HIV/AIDS, collaborates also with other agencies of the United Nations: United Nations Children's Fund (UNICEF), United Nations Population Fund (UNFPA), International Labour Organization (ILO), United Nations Educational, Scientific and Cultural Organization (UNESCO), World Health Organization (WHO), World Food Programme (WFP), United Nations Development Programme (UNDP), Commission on Narcotic Drugs (CND).

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<sup>55</sup> CBC news

<sup>56</sup> UNICEF

Name	Role
<b>World Bank</b>	provision of the necessary funding for UNAIDS
<b>UNICEF</b>	aid to HIV-positive children and their parents
<b>UNFPA</b>	protection of the population seriously affected by HIV/AIDS
<b>ILO</b>	prevention of the HIV/AIDS transmission in the workplace
<b>UNESCO</b>	development and distribution of information on HIV / AIDS
<b>WHO</b>	coordination of doctors in the areas most affected by HIV/AIDS
<b>WFPA</b>	food aid to patients already debilitated by HIV/AIDS
<b>UNDP</b>	economic development programs for the countries most affected by HIV/AIDS
<b>CND</b>	prevention and treatment of the HIV/AIDS transmission among drug users

The upstairs table summarizes the roles played by the UN principle organizations that work together with UNAIDS about the HIV/AIDS management. They prove to be organisms at a high level to meet the challenge of disease<sup>57</sup>.

This march is factual imperative because strains the global advance and exploit of the virus. Therefore, it can be evident its role on the global health.

As reaction, some countries point more on treatment than on prevention. It occurs because the health care system that many countries have inherited from the era of colonialism is more directed towards the treatment of disease, and not to prevention. Robust prevention programs are essential to reduce HIV infections globally, but the changes needed to push the health care system in this direction are huge and difficult. Lack of funds is the most obvious difficulty, even though there is the will to distribute humanitarian aid to countries in the developing world with many HIV/AIDS. These problematics happen especially in the African countries.

There are still many problems and it is necessary to increase the planning, support to governments and long-term loans. In fact, the goal of universal access to prevention, care and support against the epidemic, still far away.

According to the United Nations, the global epidemic AIDS could be ended as a public health threat by 2030 if new plans to prevent infections are implemented extensively.

Expanding treatment to 90 percent of people with HIV by 2020 from 38 percent now will help reverse the epidemic, preventing 21 million deaths and 28 million infections in the following

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<sup>57</sup> United Nations



decade. Maintaining current treatment levels would enable the epidemic to rebound, jeopardizing years of progress.

Studies have shown that treating those infected with anti-HIV drugs as early as possible, instead of waiting for their immune systems to deteriorate to certain levels, suppresses the virus to a point where it is almost impossible to transmit. Expanding condom use, education and male circumcision programs in Africa will also help to reduce infections, saving \$24 billion in health care costs<sup>58</sup>.

As mentioned earlier and now, Africa is the continent most widespread by the virus.

The African mainland is plagued by a lack of medical infrastructure; rampant corruption both by the governments and by the agencies in charge of distributing aid; doctors of other countries that are not plentiful able to find and start a coordination with local governments.

The UNAIDS Executive Director Peter Piot argues, "The therapies are technically possible in every part of the world. Even the lack of infrastructure is not an excuse. I know of no place in the world where the real reason is that the HIV/AIDS treatments are not available and there is a lack of health infrastructures. The barrier is not knowledge. The barrier is the lack of will by the politicians. "

Hence, according to Piot the principal problem is provoked by the governance or rather by a global inefficiency of global political action.

For instance, new anti-retroviral treatments are present today in Africa, like in Kenya. They are important because can slow or even reverse the progression of HIV infection, delaying the onset of AIDS for at least 20 years. The problem is that only a few people living in Africa, generally speaking in developing countries, who need the medications cannot afford them. It should be one of the key task of the government to assure the various pills.

During my research in the AIDS center of the International Hospital of Malindi, a little town of Kenya and the largest urban midpoint in Kilifi County, I can note that one of the big cause of HIV/AIDS is the lack of medicines, health care, financial aid, and support from the state, especially by Nairobi.

Nairobi is the capital and largest city of Kenya. The city and its surrounding area also form Nairobi County<sup>59</sup>. The city, from an economic point of view, can be almost compared to one of rich countries. According to the African Development Bank and the International Monetary Fund, the economy of Kenya is raising of 6,5%. In 2014 the situation was different because it was growing of 5,3%<sup>60</sup>.

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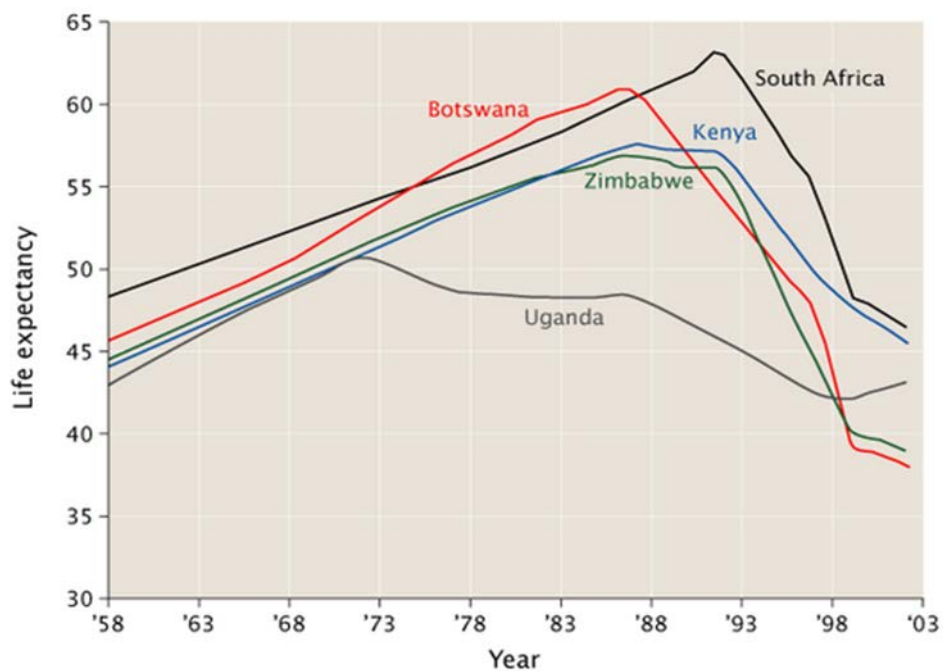
<sup>58</sup> Bennett S., *AIDS Could Be Ended as Threat to Global Health by 2030*, UN Says, Bloomber, 2014

<sup>59</sup> Wikipedia

<sup>60</sup> Africa e Affari, *KENYA: PREVISTO UN 2015 DI FORTE CRESCITA ECONOMICA*, June 2015

Therefore, it is a good result but not for the villages and the tiny cities near to Nairobi. It would seem that the Kenyan capital thinks strongly to itself development and it would be concentrated in business cooperation with other richest countries. In this way, it does not put on the primacy the cardinal points of the third sector like health and problems linked to this, such as HIV/AIDS.

The fact of Nairobi is crucial because it is a valid illustration of how internal differences exist between the center and periphery of a country and how this can constitute a serious problem that has brutal and social repercussion on health.



*Figure 6 The diffusion of HIV/AIDS in Africa - Wikipedia*

As we can see in the Figure number 5, the spread of HIV/AIDS in South Africa is estimated to be the highest in the world. In fact, according to the African Medical Research Council the disease is the principal cause of death in the country. This because the government's response to the contagion was insignificant and superficial.

In 2013, 5.6 million people live with the virus (more than 10% of the population). Each year, there are approximately 300,000 new infections and 170,000 deaths related to AIDS. The 70% of South Africans living with HIV are also contract with other tragic diseases like tuberculosis. A third of pregnant women have AIDS and they transfer the virus to the baby during the pregnancy.

The problem in South Africa is that for years, high-level representatives of the African National Congress seem to have preferred to deny the spread of HIV/AIDS and to neglect the search of the best way to combat it. The civil society organizations tried and are trying to combat the situation especially with media campaigns.

According to the National Department of Health of South Africa and professionals of private health the conditions currently are not so desperate. During the passing years, three different approaches have been adopted and have helped to contain the spread:

- 1) The provision of antiretroviral therapy by the government and donor agencies.
- 2) A better treatment of patients with tuberculosis who also tend to contract the HIV virus.
- 3) An expanded program of prevention transmission of the virus from mother to child.

These remedies have reduced the rate of new infections. But, the total number of people living with HIV continues to grow, especially in the population between 15 and 49 years old<sup>61</sup>.

There has been a progress made, but it was not so high and able to stop it.

Conversely, the recent successes demonstrate that with the political will a big obstacle can be defeated. This can be considered like a lesson not only for South Africa but also for other countries, such as Kenya.

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<sup>61</sup> Akunyili T., *La battaglia contro l'AIDS che il Sudafrica può vincere*, Il Sole24 Ore, 2013

## Chapter 2: Case-study of HIV/AIDS in Kenya

### 2.1 Demographic, economic, and political hints of Kenya

#### Demography

Kenya, together with Tanzania, is one of the biggest countries of East Africa.

In fact, the population of Kenya continues to grow with high rates. The current population is 46,748,000<sup>62</sup>.

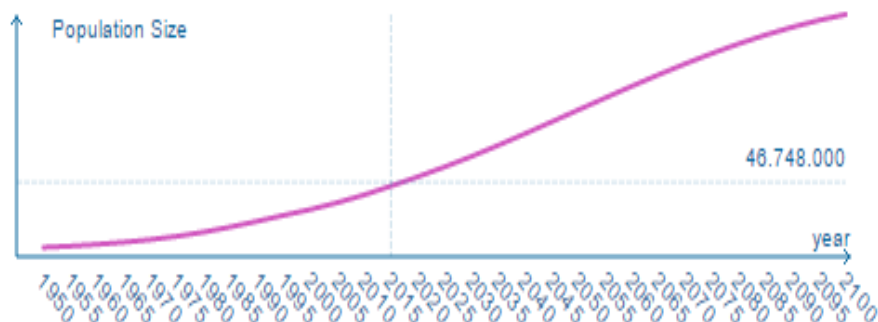


Figure 7 Population of Kenya 2015

<sup>62</sup> Countrymeters

In the figure 6, it is possible to see the constant increase of the Kenyan population. According to this, the andment will be always high. Some experts argue that Kenya is knowing a big primate if there is the consideration, for instance, of 2009 when the Republic was populated by 38,610,097 people. For this reason, Kenya is considered like the 30th largest country in the world in terms of population numbers and the 140th most densely populated country on earth.

The huge density of Kenyan population derives also from the varius ethnicities present of the State. Indeed, the population is divided into more than 70 ethnic groups. The most present of these is the Kikuyu ethnicity which embodies the 21% of population.

However, from a demographic point of view a sophisticated advance of the population is not so good for the country. In fact, according to Malthus the population growth would push to cultivate less fertile lands causing an unrest of economic development. The scholar argues that the population tends to grow in geometric progression, that is faster than the availability of food, which would grow instead in arithmetic progression<sup>63</sup>.

The Maltus's theory is surely true and its magnitudes are awful from a social and health issue. More individuals and less goods of sussistance generate emargination and deaths.

For instance, in 2014 the infant mortality rate in Kenya was of 40,71/1000 live births. A little better in comparison to 2013 when it was of 42,18/1000 live births<sup>64</sup>. Despite its miglioramente which is still rising, the problem exists and is very serious.

According to the UNICEF organization, the principle causes of the infant deceases are:

- 1) HIV/AIDS, malaria, and other terrible diseases
- 2) Illiteracy
- 3) Wars and environmental disasters
- 4) Shortage of drinking water and basic needs
- 5) Lack of hygiene and vaccinations

These problematics are present more in the Kenyan rural village rather in the cities because in the latter the situation is wealthier. However, it is a global disorder present in all development countries. For this reaseon, it is a strong meneace for the global health.

The reasons of a high infant mortality rate in Kenya, but also in the poor countries, are in turn generate by the loss from the part of governance. In fact, when the poverty rules the State is not able to reassure immunizations and basis health care systems. The big problem, always caused by the

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<sup>63</sup> T. R. Malthus, *An essay of the principle of the population as it affects the future improvement of society*, 1978

<sup>64</sup> IndexMundi

supremacy, is the absence of information. Often communities and families ignore the vital importance of vaccinations and they do not recognize the symptoms of the diseases.

To combat these forms of “ignorance health”<sup>65</sup>, it is fundamental the education of women and mothers. A girl who has attended a few years of school is able to better assist and cherish your baby, can know how to read the instructions of a health care and dose a treatment in a rightful way. Instead, an illiterate woman can not do this. In fact, many children in Kenya, but worldwide, die each year because their mothers too dilute the medicine or milk powder. Moreover, unfortunately there are occasional state welfare programs that, instead, they could really important in order to defeat or diminish the various disease that every time kill billion of children, such as AIDS/HIV.

Equally serious for the health of children but also for every individual are the consequences of the lack or inadequacy of sanitation, sewerage and infrastructure for waste disposal, which touch more people in Kenya and on the planet.

All of these are serious complications that the state, governance, diplomats of the world have to reduce until to destroy.

However, the Kenyan government, contrary to the past years, is taking much more awareness for the strengthening of the health care system<sup>66</sup>. For instance, in June 2015 it has chosen as a strategic partner in the field of dialysis, the Italian company Bellco. The project, called Managed Equipment Services, is completely financed by Kenya through its Ministry of Health. Its aim consists into ensure the continuous improvement of health services health for 46 million Kenyans citizens and increase the access of the same to great quality healthcare system.

The MES provides a total investment of 420 million dollars over the next 10 years, with particular attention to 5 strategic sectors of the Kenyan health system: dialysis, operating room, instruments and machinery sterilization, intensive care unit (ICU), radiology.

Bellco, with the cooperation of its local partner will provide for the supply of equipment dialysis, osmosis equipment, and supplies for each of the 47 centers involved. In addition to provide technology and dialysis machines, Bellco is also strongly committed to supporting training and educational programs aimed at increasing local expertise. This last policy is real strategic and it is linked to the fact that a scarce information can provoke serious problem to the sanitation, nationally and globally.

## **Economy**

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<sup>65</sup> UNICEF

<sup>66</sup> Bussini O., *Politiche di popolazione e migrazioni*, Morlacchi, 2015

Kenya obtained the independence in December 12<sup>th</sup> 1963. From this moment, the country has adopted a liberal economic system type and, despite the problems caused by the instability of the last year, remains the heart of the finance and communications in East Africa<sup>67</sup>.

Compared to neighboring countries, Kenya has some considerable economic potentials. Currently, the Kenyan economy is based especially on exports of agricultural products such as bananas, tea, coffee, etc., and tourism.

Agriculture is the backbone of the economy of the country and employs over 80% of the population. Even the industries determine the production of the agricultural needs. As well as in the other part of the world, the agriculture is focused on the periphery of the country. Regarding Kenya, the agricultural districts are present in the villages. So, it would mean that they could be very rich if there is the consideration that agricultural products are those major invested. In reality, a sort of exploitation exists by the Kenyan riches and the most powerful in the world like China. For instance, in May 2014 the Chinese President Li Keqiang meet the Kenyan President Uhuru Kenyatta to build a railway between Nairobi and Mombasa<sup>68</sup>. It is still available and the second phase of its construction will be start during 2017 extending throughout Uganda, with branches to West towards Kisangani in the Democratic Republic of Congo, to South towards Rwanda and Burundi and to North towards South Sudan<sup>69</sup>. All the African countries involved in this plan are demonstrating to be prepositives considering it like a big chance to became a tangible global power. However, continuously for a lack of real information, it is not tangible the environmental impact of a similar construction. In fact, this can have a serious and negative consequences in the health of Kenyan people.

According to UNESCO, the daily conditions in which individuals live have a strong influence on health equity. As a consequence, the protection of the natural environment represents to be one of the most essential key to ensure health for all the country.

A big inconvenient of Kenya, like for the development countries in the world, is that there is a big discreprancy between cities and rural villages. The development of economy is concentrated in Nairobi, the capital of Kenya. Only in recent times it is happening for the other little cities but the process is still far away. Instead, for the villages it seems that a similar growing is never happened. The result in Kenya is that currently only 2% of the population can enjoy a stable well-being, while about 50% live below the poverty level.

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<sup>67</sup> ItalAfrica Centrale

<sup>68</sup> GBTIMES

<sup>69</sup> LookOut News

An example of a financial expansion only for few Kenyan parts that it can be considered like a monetary private sector, is the imprenditorial mission organized by Promos, the Special Agency of the of Milan Chamber of Commerce for the internationalization in collaboration to the Private Sector Liaison Officer Network of World Bank, and African Development Bank<sup>70</sup>.

Hence, it is possible to affirm that the economic diplomacy is helping Kenya to maintain its credit market firmly positive but, at the same time, it is not truly favouring the possibility for which all the products in the commerce are accessible for all, rich and poor.

## **Policy**

Kenya is an independent Presidential Republic since December 1963. In the last three years the country has undergone a major political transformation both internally and internationally.

On August 27 2010, the new Constitution was approved and it replaced that adopted by the Declaration of Independence. The elections of March 2013, established the final changeover to the Presidential pure system, articulated on a statual system in which the local governments find ample space, in response to the need to give adequate representation to the complex ethnic-tribal mosaic of Kenya<sup>71</sup>.

Uhuru Muigai Kenyatta was elected as the new president of the Republic of Kenya on March 26 2013 replacing the seat of Mwai Kibaki.

The new government, from the beginning, was called to solve the challenge represented by the structural and infrastructural deficiencies that limit the growth capacity of the country. In fact, the new President in his inaugural address stressed his willingness to continue the national development plan initiated by his predecessors and called this plan "2030 Vision". It is an ambitious project aimed to ensure a real economic expansion and the growth of the quality of life through industrialization, improvement of the infrastructures and the welfare system, the fight against corruption and the spread of the scourge of HIV<sup>72</sup>.

The Kenyan Vision 2030 underlines that, apart from the economic sector, there is the need to provide also other policies in order to achieve greater social cohesion and stability in an environment still characterized by a high disparity in wealth distribution. In particular, the political pillar vision for 2030 is "a democratic political system that is issue-based, people-centered, result-oriented and accountable to the public". An issue-based system is one in which political differences are about means to meet the widest public interest. "People-centered" goals refer to the system's

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<sup>70</sup> Ministero degli Esteri

<sup>71</sup> Info Mercati Esteri

<sup>72</sup> Di Liddo M., *Terrorismo, conflitti etnici, instabilità: le sfide del Corno d'Africa*, CeSI, Osservatorio di Politica Internazionale, n. 91, Marzo 2014



responsiveness to the needs and rights of citizens, whose participation in all public policies and resource allocation processes is both fully appreciated and facilitated. A result-oriented system is stable, predictable and whose performance is based on measurable outcomes.

However, in the Kenyan population a deeply rooted sentiment of ethnicity exists that feeds claims based on historical disparity in access to political power and the public wealth among the different ethnic groups. In Kenya there are about 40 different ethnic groups, widely different in language and culture. The 96% of the population is composed especially by Bantu and groups who speak Nilotic and Cushitic. A third of the population is Christian, a third Anglican Roman Catholic, and a fifth is Muslim. The religion is an important factor that can cause many teething troubles in Kenya.

Currently, the coastal region is considered the area where the stronger social discontent is fueling for the dissatisfaction caused by the absence of incisive political development and power.

The internal security is another crucial point to be considered because it is taking problems to Kenya from a political, social and economic point of view. It is given by the frequent and violent incidents of crime in some urban areas, and tribal clashes around rural zones of the country. For example, the most frequent terroristic outbreak was against the catholic school campus at Garissa in the Eastern Kenya. The attack was claimed by the group of Al Shabaab. Moreover, it is important to remember the conflict amongst Somalia and Kenya that probably is the most reason of instability and global fear for the Republic of Kenya. In fact, Somalia is the greatest factor of external criticality for Kenya, which accuses Al Shabaab terrorists from the infringement of their economic interests and their own internal security.

However, Kenya presents a strong regional integration especially within the East African Community (EAC). Furthermore, Kenya has special relations with the United States, Israel and other key countries such as China, India and South Africa even in the sphere of military cooperation. Kenya maintains also a successful dialogue with the EU, especially in the economic and commercial development.

About health sector, the Kenyan policies pursue to ensure a significant reduction in the general ill health in the Kenyan population by achieving reductions in deaths due to communicable diseases by at least 48 per cent and reducing deaths due to non-communicable conditions and injuries to below levels of public health importance without losing focus on emerging conditions. This would translate to a 31 per cent reduction in the absolute numbers of deaths in the country, as opposed to only a 14 per cent reduction<sup>73</sup>.

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<sup>73</sup> Republic of Kenya, *Ministry of Health, Kenya Health Policy. Towards attaining the highest standard of health*, Nairobi, 2014

Future projections indicate that, if the current policy directions and interventions are effectively implemented, the overall annual mortality will decline by 14 per cent by 2030. The contribution to the annual mortality by disease domain would be different: communicable diseases would decline to 39 per cent and non-communicable and injuries conditions will increase to 47 per cent, and 14 per cent respectively. This represents a 48 per cent reduction in absolute deaths due to communicable conditions, but a 55 per cent increase in deaths due to non-communicable conditions and a 25 per cent increase in deaths due to injuries and violence. In fact, although Kenya has been considered a country internally stable in the past, the growth of social tensions, the enlarged crimes and the poor state of the economy are all contributing to the worsening of the political situation.

## **2.2 International health partnership: Kenya, WHO, UNAIDS**

Kenya's vision for health is to provide "equitable and affordable health care at the highest affordable standard" to the citizens.

The country wants to ensure significant improvements in overall status of Kenyan health in line with the Constitution of Kenya 2010 and the mission "Vision 2030".

Particularly, the country is trying to implement some complete policies that have to be focus on the two key obligations of health: the contribution to economic development as envisioned in Vision 2030; the realisation of fundamental human rights including the right to health as preserved in the Constitution of Kenya 2010.

In accordance with the Constitution, the policies have to embrace the principles of protection of the rights and fundamental freedoms of specific groups of persons, including the right to health of children, persons with disabilities, youth, and minorities, the marginalised and older members of the society. The health is considered properly like a fundamental right and the state of Kenya has to guarantee this at the population. For instance, the article 70 of the Constitution acknowledges the right to life and physical integrity. The comma 1 argues that "No persons shall be deprived of his

life intentionally save in execution of the sentence of a court in respect of a criminal offence under the law of Kenya of which he has been convicted”.

A lack of access to health services is regarded as a deprivation of life and therefore a lack of right. Even if the governance of Kenya wants to demonstrate a positive task for the health globally, the problems exist also because today the Kenyan legislation has not been perfectly adequate to all provisions. In 1972, the International Covenant on Civil and Political Rights was signed and ratified ensuring the implementation of major fundamental rights in favour of the Kenyan citizens. Nevertheless, it did not entail significant innovations in the field of civil and political rights. For this reason, the Constitution presents provisions disregarded and the most relevant for the health sector are:

- Equal rights between men and women. It should be clearly stated and articulated in the Constitution, which, however, still does not mention it. This equality is not only a synonym of fairness in the enjoyment of the rights provided for by law, but also the elimination of all harmful traditional practices to mental and physical health for the women.
- The obligation to establish special securities to child protection: the right to social protection of children is not yet required by the Kenyan Constitution.
- The non-accession to the Optional Protocol of Kenya which authorizes the Human Rights Committee to receive and resolve the complaints of violation of fundamental rights from the single individuals<sup>74</sup>.

The first two points are the most important in order to better understand and analyse the health situation in Kenya and how the governance and the international organizations operate to meliorate the situation.

The third MDG is to promote the gender equality and empowerment of women. Therefore, there is a global discrimination and inequality for women that is undermining the all societies in the world, especially in those countries where the female figure appears to be the backbone of the family.

In Kenya, but commonly also like in Africa, the woman has a crucial role from a social and economic point of view. The problem is that women have few rights but several duties.

First of all, women in Kenya need to protect not only their political and economic rights, but also the rights to health and reproductive life. In this way, the women's empowerment could become a reality. They carry out all the activities of the field and have to ensure the education of their children without a support of their husbands or companions. Kenyan women cannot give their

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<sup>74</sup> Decarli G., *Tra diritto e tradizione. Riflessioni sulla circoncisione femminile in Kenya*, 2007, Università di Siena

opinions or try to improve the circumstances still nowadays dramatic for the sanitation and education.

One of the main causes of women's oppression in Kenya is the traditional division of roles between the sexes, especially in the rural areas where women demonstrate to be the pillar of the all agricultural works. The isolation of women to the domestic tasks is due, also, by the inability to access to property rights, despite the family income is largely supplemented by female labour. In the country, the woman is 78% of the agricultural labour force, but the economic value of her work is not recognized.

Furthermore, the inequality in Kenya is strongly linked to the access of education. The last represents one of the most essential key of the development. In the Kenyan country, inequalities increase with the level of education. The limited turned to education and training does not allow women to be competitive in the labour market and this can create serious problems for the other social aspects. In fact, education would also lead to improvements in health. Women's work is closely linked to economic growth<sup>75</sup>.

According to the journal Economist "Women are now the most powerful engine of global growth"<sup>76</sup>. The fact is that they are able to put in practice this connotation specifically, if not exclusively, in the richest countries whereas in the poorest countries the situation is much more difficulties. This is the consequence of the economic, social, political, and cultural inequalities that, in turn, generate violence against women. Sexual violences and other forms of gender-based violences continue to occur on a massive scale throughout Kenya. Mistreatments within marriage are the most public, particularly the spousal rape, which is not considered a crime by law in Kenya. In large urban areas of the country, where most of the population lives in informal settlements named slums the status of women worse like that of the rural areas. Women and girls from the slums of Nairobi live in constant threat of being subjected to violence and, for this reason, they waive often to come out from their quarters also to use the toilets and public baths. They are so forced to resort to "flying toilets", envelopes plastic causing diseases. In fact, although it is registering an improvement in all of Kenya, the gender gap in the health sphere, increased by the trend towards privatization of care services, it is still large. Gender dynamics in the epidemic of HIV/AIDS see greater female vulnerability to the virus, which affects women more than men for different cultural origin and social factors, such as less access to education and employment. The risk of getting sick is determined by many factors such as poverty, malnutrition and lack of protection of sexual activity of teenagers forced into prostitution. The socio-economic consequences

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<sup>75</sup> Donzellini V., *Genere e povertà in Kenya*, Revue Quart Monde, n. 223, October 2012

<sup>76</sup> Speroni D., *Womenomics, l'economia al femminile*, 2008

of HIV/AIDS are very serious. In Nairobi, the risk of contracting the virus is 90%. But, the problems occur especially for small farmers. When in a family, whose income depends on the work in the fields, her mother falls ill, which generally provides for food, it decreases the viability of the entire family.

Then, the protection of girls and women from the virus HIV means to safeguard them from gender-based violence and discrimination and to promote their economic independence for the benefits of the all family.

In many families affected by HIV and AIDS, girls are the first to be removed by the school and the first to take on the increase the responsibility of the family. Some data suggest that girls suspected of being HIV-positive are more likely than boys to be excluded from education and assistance health care<sup>77</sup>. Girls orphan AIDS are particularly vulnerable to loss of property and inheritance rights.

They are also more exposed to discrimination in extended family and other types of accommodation hospitality. They may face abuse or exploitation sexual into domestic service, early marriage, or taken advantage in other ways.

According to the updated data by the CIA World Factbook, in 2014 Kenya was the African country with the major number of individuals affected by HIV/AIDS. The number expected was to 1,646,000 and more than half was made by women. Indeed, more than three quarters of young people with HIV are women and young women between 15 and 24 have a three times greater risk of infection than men.<sup>78</sup> To better understand that the Kenyan percent of individuals with the virus is really tragic, it is useful compared it with the other of African countries. For example, always in 2014 Ethiopia was characterized by an amount of 758,600 individuals with HIV/AIDS, Sudan 260,000, Sierra Leone 57,700, and Senegal 42,800<sup>79</sup>.

The current situation is not so different, even if there have been some improvements but they are not enough.

For this reason, I choose to analyse in particular the virus HIV in Kenya because it represents to be the most evident and influential in all regions of the Republic.

Within this catastrophic disease, a vicious circle exists in the sense that at the basis of the problem there is a lack of some important elements, like the sexual education and prostitution, that attack women and, in turn, they are linked to the life of children. For instance, in 2005 48 billions of

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<sup>77</sup> Engender Health, *No Missed Opportunities: Engender Health Response to HIV/AIDS*, New York, 2003, pp. 1–4.

<sup>78</sup> UNAIDS, *2006 Report on the Global AIDS Epidemic*, 2006

<sup>79</sup> Index Mundi

orphans occurred due to the deaths of their mother caused by AIDS. This number upsurge of 60% since 1990.

Today, 8 out of 10 children are orphans for the AIDS of their mums. Even in places where the HIV rates have stabilized or are declining the number of orphans will continue to rise or remain high for the next years. This fact demonstrates that the problem is still alive and there is a huge intervention by the Kenyan governance.

The level of orphans in Kenya is so elevate because when one parent is HIV positive, there is a higher probability that the other partner is infected and that, in the end, both will die. The so called "double orphans" are children who have lost both mother and father and they are particularly vulnerable to poverty, exploitation and abuse<sup>80</sup>.

HIV and AIDS affect virtually every aspect of child development and threaten the enjoyment of the children's rights. They endanger the health and schooling, reinforce exclusion and deprivation, and they upon on the shoulder of children the burden of loss, fear and adult responsibility.

For the reasons given above, there is the need to stimulate national governments and the global community. Chiefly, a guide with a wide national and global basis is essential to develop the capacity of families and communities for the dismantling of the disease. This guide must unite politicians, governments, NGOs, civil society, media, religious organizations, academics, women's groups and human rights activists, children and young people, because only together it is impossible to combat the damage inflicted by HIV and AIDS to children, their families and communities.

In 1999, the Kenyan government established the National program for orphans in partnership with some organizations operating at local and private sector. The program aims to the definition of interventions, including an examination of the involvement of the government in child protection; to develop and strengthen institutional capacity; to provide social welfare services; to support the initiatives of communities and to monitor and evaluate various activities. The program also includes a national database registration of orphans. Plans like the last are really important in order to facilitate a more efficient decision-making and allocation of resources. The problem is that, in many cases, the political will has been insufficient, as well as that of the government leadership and the coordination between the various ministries<sup>81</sup>. For this reason, it is essential to promote a strong leadership against the virus HIV/AIDS at national level but with major sustain at international level.

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<sup>80</sup> Unicef, *Prendersi cura dei bambini colpiti da HIV ed AIDS*, Centro di Ricerca Innocenti, 2006

<sup>81</sup> UNICEF, *National Response to Orphans and Other Vulnerable Children in Sub-Saharan Africa: The OVC Programme Effort Index 2004*, 2004

Firstly, it is crucial to reaffirm the political commitment of national governments towards individuals affected by HIV and AIDS with a particular attention to women and children. Secondly, there is the necessity to translate this support into concrete actions.

The partnership of the international community, which already it plays a key role, should be expanded in order to focus the interests especially of children.

The focus on children must be part of national plans supported by international initiatives.

Central to the success of these efforts is a collective and collaborative response. This means that not just a single answer is useful to remove the crisis that complicate enormously the life of children, families and communities affected by HIV/AIDS. All partners must join in the effort to prevent and stop the devastation caused by the epidemic. The action in the family and in the community, supported by policies, programs and national and international resources, is indispensable to respond effectively and provide adequate assistance, protection and support to the millions of man, women, and children orphaned by AIDS.

Kenya has trodden a similar path to many African countries in the struggle to come up with an HIV/AIDS strategy and policy guidelines for effective response to the pandemic. Kenya's participation and ratification of many recommendations for finding appropriate, relevant and responsive interventions to the HIV/AIDS pandemic are well known. However, like most other African countries the shock of that came with the discovery of the first case of HIV/AIDS sent many stakeholders looking for medical solutions to the pandemic first and foremost. The fact that HIV/AIDS is a multi-faceted, multi-sectoral problem was not understood and appreciated in the initial responses to the pandemic. It was much later that the need for a comprehensive policy was recognised and addressed seriously.

The first AIDS case in Kenya was diagnosed in 1984. In 1985, the government established the National AIDS Committee to advise the MOH on matters related to HIV/AIDS control. In 1986, the MOH formulated policy statements and guidelines on safe blood supply. The First Medium Term Plan was developed in 1987.

Because the government viewed AIDS primarily as a health issue, it did not then see the need for a comprehensive policy.

The rate of infection peaked among urban dwellers in the mid 90s and the overall HIV prevalence among the adult population peaked in the late 90s. A 1991 government-led review of the accomplishments of the First Medium Term Plan found government officials and donors seriously concerned about the lack of a national policy and clear guidelines on HIV/AIDS. The National AIDS Control Programme and the Kenya AIDS NGO Consortium (KANCO) made efforts to increase senior officials' understanding of the 12 Analysis of HIV/AIDS Policy Formulation in

Kenya seriousness of the epidemic and its multi-sectoral nature. The Ministry of Planning and National Development initiated efforts to integrate HIV/AIDS into national planning efforts.

The Kenyan process was characterized by substantial technical input from experts and a high degree of multi-sectoral participation in the review of the draft policy. Although it took some time to get the process organized, policy development moved quickly and smoothly once technical subcommittees were established. By the time the Sessional Paper reached Parliament, it had undergone a thorough review. As a result, Parliament approved the paper quickly and with little dissent. The Sessional paper was passed in 2005 and with its passing came a new enthusiasm to undertake long term planning. The government ministries most actively involved in HIV/AIDS programmes were ready for sector specific HIV/AIDS policies for their ministries, departments and institutions.

As is evident from this review, Kenya was slow to come up with proper guidelines and considerable time was lost with many stakeholders using the approach that HIV/AIDS is a medical programme, thus failing to recognize the need for a policy to guide the national response. Auspiciously, the education sector took the initiative to lead the way to the development of a sector-specific HIV/AIDS policy. The sector embarked on the process of developing a sector policy on HIV/AIDS issues as they affect the whole education and training areas in 2004 and the policy was launched in July 2005.

Kenya reported a decline in the rate of infection among adults from the high rate of 10% in the 90s to a significant reduction to 7% in 2003. Kenya is only the second recorded case in Sub-Saharan Africa where a sustained decline in infections has been achieved. The most noticeable drops in HIV prevalence were recorded among pregnant women in Busia, Meru, Nakuru and Thika where HIV prevalence plummeted from approximately 28% in 1999 to 9% in 2003. Other significant declines were reported in the towns of Garissa, Kajiado, Kisii, Kitui, Nyeri and the capital city Nairobi. There is evidence in Kenya's case that behaviour change has contributed significantly to the decline of the rate of infection. In 2003 about 24% (23.9%) of the population said, they used condoms.

Nevertheless, it is worth noting that Kenya moved very fast in the implementation of HIV/AIDS education programmes across the board. The last decade has seen many school based and community based education and training programmes in Kenya. Kenya was also among the first African countries to adopt a multi-sectoral approach to dealing with the HIV/AIDS pandemic in Africa.

In fact, Kenya has been slow in providing the medical treatment and care and support interventions but quick in putting in place and implementing educational programmes.



The other problem Kenya has had is quality control in HIV/AIDS programmes. With so many NGOs and CBOs, participating in the implementation of a large diversity of community-based programmes, quality and accountability has been an issue. Accountability has been a problem at all levels and aspects of programming in the quality of outputs and outcomes and in the utilization of available resources.

At the school level, Kenya has invested in a national HIV/AIDS curriculum. The HIV/AIDS curriculum was launched in 2000. Since 2000 all the primary and secondary schools were expected to implement the curriculum through infusion method. Teachers were expected to infuse HIV/AIDS messages as they teach their regular subjects. In 2004 the Kenya Institute of Education revised the national curriculum.

The HIV/AIDS curriculum was integrated in the revised curriculum for both primary and secondary schools. All the teachers are expected to teach using the revised curriculum. Arguably as they teach the integrated curriculum they are going to pass the HIV/AIDS messages. In order to effectively teach the integrated curriculum the teachers should have been in serviced.

The MoE made efforts to provide in-service training to teachers for the revised curriculum but these have largely been unsuccessful, mainly because of the very large numbers of teachers that needed training before the commencement of the implementation, which gave only a very short timeframe. In service, training is thus being done in phases. The Quality Assurance Directorate and KIE (the curriculum development centre) are charged with the responsibility of ensuring that teachers are adequately trained. KIE has an ambitious teacher in-service programme that is expected to reach at least three teachers per school for all the schools in the country.

The majority of the respondents in this study agreed that although the Kenya Government and its development partners have invested in a diversity of programmes, there is still serious weaknesses, particularly in disseminating the education policy to schools. One of the priorities must be to make a set of comprehensive and all-inclusive policy guidelines at the national level. The formulation of such a policy should be multi-sectoral, and the processes should capture the divergent issues facing society in relation to the HIV/AIDS pandemic. The focus should be on the prevention of infection through behaviour change among all Kenyans, especially youth in the 11-25 age bracket where high prevalence of infections occur, as Kenya's youth are the foundation as well as the future of the

nation. However, equal attention must be paid to young adults in the 26-39 years age bracket, who are the most economically as well as the most sexually active and hence at highest risk<sup>82</sup>.

The main colossal structures of the ONU, WHO and UNAIDS, tried and are trying to put in practice these objectives. In particular, they are addressing urgently the current catastrophe of HIV and AIDS providing even more serious consequences in the coming years due to the disintegration of families and society, the economic crisis and the high rate of orphans. The World Health Organization and the Joint United Nations Programme on HIV/AIDS, want to stress the importance to be ready to face this challenge with appropriate measures for the protection of the rights and future of millions of individuals whose lives are in danger due to the tall and constant persistence of the disease.

### **World Health Organization (WHO)**

The World Health Organization (WHO) is one of those international organizations at universal base that in the Art.57 of the Charter of the United Nations are defined as "specialized agencies, established by intergovernmental agreement and having, in compliance with their regulations, wide international responsibilities in the economic, social, cultural, educational, health fields and others." WHO is an intergovernmental and independent organization with a permanent character, an open structure, its own governing bodies, its budget and Secretariat.

The founding Treaty came into force on 7 April 1948. It argues, "The health of all peoples is a fundamental condition for the realization of peace and security and depends on the full cooperation between individuals and states." The enjoyment of the highest attainable standard of health is defined as "one of the fundamental rights of every human being", and the concept of Health is reconnected to those of peace and security, the overall objectives of the United Nations system<sup>83</sup>.

The Conference for the establishment of the Treaty was long. It held its first meeting in New York on June 19, 1946 with the participation of 64 states, the Allied Control Authorities in Germany, Japan and Korea and 10 international organizations. On 7 April of every year, there is the celebration of the "World Health Day" in memory of the Constitution, which was dedicated to a particular theme or topic. For instance, on April 23 2015 there was the World Health Day having like subject the malaria where the WHO calls on the global health community to urgently address significant gaps in the prevention, diagnosis and treatment of the disease<sup>84</sup>. Again, on March 17 2015 the World Tuberculosis (TB) Day took place like an opportunity to raise awareness about the

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<sup>82</sup> CfBT Kenya, *An analysis of HIV/AIDS policy formulation and implementation structures, mechanisms and processes in the education sector in Kenya*, July 2006

<sup>83</sup> Basic Documents, Forty Second Edition, Geneva, 1999

<sup>84</sup> WHO

burden of TB worldwide and the status of TB prevention and control efforts. During this day, the WHO calls on governments, affected communities, civil society organizations, health-care providers, and international partners to join the drive to roll out this strategy and to reach, treat and cure all those who are ill now<sup>85</sup>.

The World AIDS Day was celebrated on November 28 2014 but it is convened every year on 1 December as an opportunity to harness the power of social change to put people first and close the access gap. According to the World Health Organization, ending the AIDS epidemic by 2030 is possible, but only by closing the gap between people who have access to HIV prevention, treatment, care and support services and people who are being left behind. Closing the gap means empowering and enabling all people, everywhere, to access the services they need. In reality, World AIDS Day was first conceived in August 1987 by James W. Bunn and Thomas Netter, two public information officers for the Global Programme on AIDS at the World Health Organization in Geneva<sup>86</sup>.

In its first two years, the theme of World AIDS Day focused on children and young people. While the choice of this theme was criticized at the time by some for ignoring the fact that people of all ages may become infected with HIV, the theme helped alleviate some of the stigma surrounding the disease and boost recognition of the problem as a family disease<sup>87</sup>.

Nonetheless, all the World AIDS Day campaigns are centred on a specific theme chosen with the consultation of UNAIDS, WHO and a large number of grassroots, national and international agencies involved in the prevention and treatment of HIV/AIDS. For each World AIDS Day from 2005 through 2010, the theme was "Stop AIDS. Keep the Promise", designed to encourage political leaders to keep their commitment to achieve universal access to HIV/AIDS prevention, treatment, care and support by the year 2010. As of 2012, the multi-year theme for World AIDS Day was "Getting to Zero: Zero new HIV infections. Zero deaths from AIDS-related illness. Zero discrimination." The US Federal theme for the year 2014 is "Focus, Partner, Achieve: An AIDS-Free Generation". The next World AIDS Day will be in December 1, 2015<sup>88</sup>.

The themes are not limited to a single day but are utilized year-round in international efforts to highlight HIV/AIDS awareness within the context of other major global events including the G8 Summit<sup>89</sup>.

However, among the 16 specialized agencies WHO can be considered like one of the most "extensive."<sup>90</sup>

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<sup>85</sup> WHO

<sup>86</sup> U.S. Centers for Disease Control and Prevention, *World AIDS Day Co-Founder Looks Back 20 Years Later*, 12 December 2007

<sup>87</sup> Speicher S., *World AIDS Day Marks 20th Anniversary Of Solidarity*, Medical News Today, 19 November 2008

<sup>88</sup> <http://www.worldaidsday.org/>

<sup>89</sup> Minnesota Department of Health

Hence, the World Health Organization (WHO) is a specialized agency of the United Nations concerned with international public health. It was established on 7 April 1948, headquartered in Geneva.

The WHO is a member of the United Nations Development Group. Its predecessor, the Health Organization, was an agency of the League of Nations. The constitution of the World Health Organization had been signed by 61 countries on 22 July 1946, with the first meeting of the World Health Assembly finishing on 24 July 1948. It incorporated the Office International d'Hygiène Publique and the League of Nations Health Organization. Since its creation, it has played a leading role in the eradication of smallpox. Its current priorities include communicable diseases, in particular HIV/AIDS, Ebola, malaria and tuberculosis; the mitigation of the effects of non-communicable diseases; sexual and reproductive health, development, and aging; nutrition, food security and healthy eating; occupational health; substance abuse; and driving the development of reporting, publications, and networking. The WHO is responsible for the World Health Report, a leading international publication on health, the worldwide World Health Survey, and World Health Day (7 April of every year).

WHO addresses government health policy with two aims: firstly, "to address the underlying social and economic determinants of health through policies and programmes that enhance health equity and integrate pro-poor, gender-responsive, and human rights-based approaches" and secondly "to promote a healthier environment, intensify primary prevention and influence public policies in all sectors so as to address the root causes of environmental threats to health".

The organization develops and promotes the use of evidence-based tools, norms and standards to support member states to inform health policy options. It oversees the implementation of the International Health Regulations, and publishes a series of medical classifications; of these, three are overarching "reference classifications": the International Statistical Classification of Diseases (ICD), the International Classification of Functioning, Disability and Health (ICF) and the International Classification of Health Interventions (ICHI)<sup>91</sup>. Other international policy frameworks produced by WHO include the International Code of Marketing of Breast-milk Substitutes adopted in 1981, Framework Convention on Tobacco Control (2003) and the Global Code of Practice on the International Recruitment of Health Personnel (2010).

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<sup>90</sup> Scudeller P., *L'Organizzazione Mondiale della Sanità*, Università degli Studi di Pavia, 1999/2000

<sup>91</sup> Madden R. [et al.], *World Health Organization. Family of International Classifications: definition, scope and purpose*, WHO, 2007

In terms of health services, WHO looks to improve "governance, financing, staffing and management" and the availability and quality of evidence and research to guide policymaking. It also strives to "ensure improved access, quality and use of medical products and technologies"<sup>92</sup>.

The central objective of the Organization, briefly outlined by Article 1, is that all individuals in the world have to achieve the highest possible level of health.

According to the Preamble of the World Health Organization, health is "A state of complete physical, mental and social and not merely the absence of disease or infirmity."

An irregular development in different countries in the field of health promotion and disease control is considered a common danger of international society and, as such, requires the adoption of adequate health and social measures by all governments, who have a responsibility for the health of his subjects. In addition to the responsibility of governments it is also recalled the active cooperation of the public and the need for informed public opinion because the extension to all peoples of the health knowledge is recognized as an indispensable tool for achieving the objectives of the Organization.

In particular, even the so called health cooperation is essential in order to prevent and eliminate some tragic diseases like the virus HIV/AIDS to which the WHO gives a great importance especially in those countries wherever its feast is very high, such as Kenya.

Indeed, the World Health Organization is trying as much as possible to improve the access to HIV services in the African country in order to close the gap caused by the infection.

The WHO has a regional office also in the capital of Kenya, Nairobi. During my research done in July, I had the opportunity to better understand how the Organization works in order to resolve problems linked to HIV/AIDS and the relations established with the Kenyan government.

According to the Dr. Brian Pazvakavambwa, HIV/AIDS and Hepatitis Team Leader for the WHO, Kenya has made impressive progresses in attracting people into HIV services. Principally, he says that Kenya is one of the top four countries in Africa that has benn able to realize real and good evolutions but there is the need to do still much with a particular attention for those poor areas that are not considered in a accurate manner. In fact, Pazvakavambwa argues that only together is really possible to close the gap of HIV/AIDS, and it is not one approach alone that makes the difference but the right combination. Early antiretroviral treatment keeps people healthy and prevents HIV transmission to partners and children, but there is still a requirement to attract more people into HIV prevention and treatment services. Mostly, the World Health Organization stresses the importance that everyone requiin Kenya res to learn about HIV. In fact, many campaigns have programmed in

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<sup>92</sup> WHO, *Programme Budget 2012-2013*, March 2012

order to divulgate the knowledge of the problem. One of the most big movement is the so called “Global ALL IN” against adolescent infection and death by HIV-AIDS kicked off with calls to listen. It involves and includes young people in efforts to reduce AIDS-related deaths and new HIV infections. Additionally, it aims to achieve reductions in AIDS-related deaths by 65% and new HIV infection by 75% by 2020<sup>93</sup>.

Instead, according to the Dr. Michael Kiragu, Senior Technical Officer HIV Prevention, the government of Kenya has shown a good leadership especially for HIV prevention, by launching a new “HIV Prevention Revolution Roadmap”. It aims to further scale-up access to a range of interventions from early antiretroviral treatment, condom use and prevention of mother-to-child transmission, to male circumcision and post-exposure prophylaxis.

This Road Map is a product of extensive stakeholder consultation led by the Government of Kenya through the National AIDS and STI and Control Programme (NAS COP) in partnership with the National AIDS Control Council (NACC) and other partners. The process included a review of globally accepted evidence of effective prevention strategies, the current status targets and milestones for HIV prevention in Kenya. This Road Map aims to revolutionise HIV prevention and drastically reduce new HIV infections and HIV related deaths. The HIV prevention goals are aligned to the Kenya Vision 2030 blue print, including five-year milestones. Furthermore, the Road Map addresses the gaps in the current HIV response and seeks to catalyze HIV prevention in Kenya. It is neither a formal guideline nor standard operating procedure for service delivery, nor is it intended to replace existing programming guidelines. Rather, the Road Map, based on current knowledge of effective interventions and expected funding for the response, aims to dramatically strengthen HIV prevention, with the ultimate goal of reducing new HIV infections to zero by 2030. Thanks to some researches completed by this work, it has been put in evidence that Kenya is achieving significant progresses in preventing the transmission of HIV through the implementation of evidence based interventions. In fact, in 2015 there has been the achievement of 50% reduction of new HIV infections. But, at the same time, the advancements are not enough and two goals exist that are the reduction of 75% of HIV spread in 2020 and 100% in 2030.

The problem is that constant gender disparities are still present with higher prevalence amongst women at 7.6% compared to men at 5.6% . This represents the grave gap that characterized the HIV/AIDS epidemic in Kenya and for which the World Health Organization is trying to remove. The connection to these inequalities is the upraise number of women that practice the sex work

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<sup>93</sup> WHO

without condom and with men who use drugs. According to the Road Map, 21% of new adult HIV infections occur among young women aged 15-24 every year and 14,1% of these are sex workers.

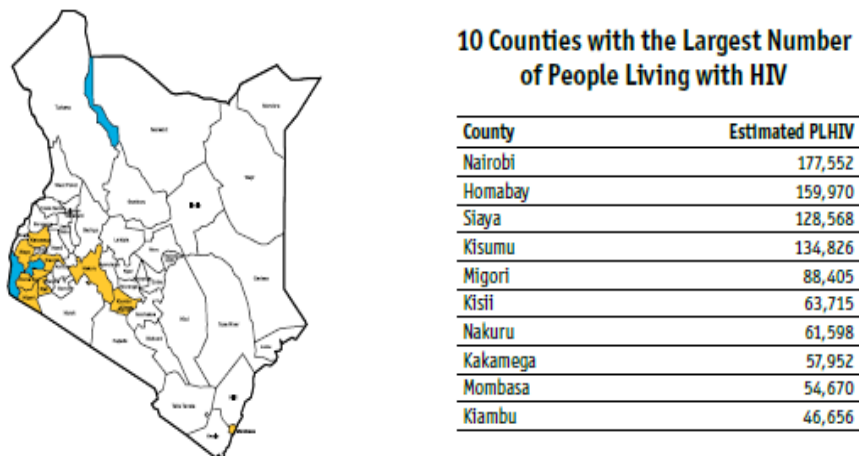


Figure 8

The figure 7 shows the feast of HIV in the counties of Kenya. It is interesting to note that the largest number of people living with the virus stays in Nairobi, a big city compared almost like New York for the quantity of inhabitants. The point is that in the capital of Kenya many shacks exist and the life here is very tragic. The families live in deprived and disastrous conditions where the majority of children result to be HIV positive. During the research, it has been possible to interview a child HIV positive. She is daughter of a woman who died of AIDS and she is orphan. The child explains that she is treated in a hospital of Nairobi with therapies based on vitamins and antibiotics. She lives in a little community managed by a church of the city. It is only one of the several cases present in Nairobi, like in Mombasa, the two biggest cities of Kenya. The difficulty is always the same: the Kenyan government does not give the exact importance to these realities of marginalization. The World Health Organization is properly focalized on this fact and it wants to resolve it. In particular, it emphasizes the key groups affected by the virus HIV in Kenya, as well as orphaned children, sex workers, and the higher prevalence of women affected by the virus contrary to the number of men:

- 1) Men who have sex with men (MSM), in 2010, HIV prevalence among MSM was an estimated 18.2 percent<sup>94</sup>. In the city of Mombasa, one study found that up to 24.5 percent of MSM were living with HIV<sup>95</sup>. The trouble here breaks in the fact that sexual relations between men are illegal in Kenya and can carry a prison sentence of up to 21 years.

<sup>94</sup> IOM, *Integrated Biological and Behavioural Surveillance Survey among Migrant Female Sex Workers in Nairobi, Kenya*, 2010

<sup>95</sup> Sanders E.J., *HIV-1 infection in high risk men who have sex with men in Mombasa, Kenya*, 2007

Homosexuality is "largely considered to be taboo and repugnant to the cultural values and morality"<sup>96</sup> of Kenya. This position leads to high levels of stigma and discrimination towards MSM deterring them from seeking the HIV services they need.

- 2) People who inject drugs (PWID), representing the 18.3 percent of people that live with HIV. The majority of them are concentrated in Nairobi and Mombasa.

The country, thanks especially to the support of WHO but also UNAIDS, has adopted a number of strategies including provider initiated testing and counselling. However, even if annual testing rates have increased, there remains a significant disparity between men and women. In 2008/9, 22.8 percent of men and 29.3 percent of women aged 15-49 reported having an HIV test in the previous 12 months<sup>97</sup>. In 2012, 35.8 percent of men had a HIV test in the previous year compared with 47.3 percent of women. As a result, there has been a concerted effort to increase testing rates among Kenyan men with community-based testing programs.

The World Health Organization collaborates with the National AIDS Control Council (NACC) that is the body responsible for coordinating the multi-sectoral response to the HIV epidemic in Kenya. They aim to coordinate a comprehensive combination of HIV prevention, treatment, care and support services in the country. Moreover, a common association exists also with the Kenyan government regarding the distribution of condoms. The latter has actively promoted their use since 2001, and in that year, announced intentions to import 300 million condoms by the end of 2002<sup>98</sup>. In 2004, 10 million condoms were being distributed annually; by 2013, this had increased to 180 million.

In reality, many people still find condoms difficult to acquire. According to Peter Cherutich, Head of HIV Prevention at Ministry of Health-National AIDS/STD Control Programme in Kenya, this happens specifically in the rural areas where the distribution of condoms result to be real critical due to the poor road network and even because the government guarantee the availability of condoms and health facilities much more in the richest areas of the country.

However, it is thinkable to confirm that there is a strong bilateral affiliation between the World Health Organization and the government of Kenya. In particular, WHO ensures the assistance to the Kenyan administration to improve the health services; promote the prevention and advancement of progress in all matters connected with the health sector; propose conventions and regulations; make

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<sup>96</sup> United Nations, *International Covenant on Civil and Political Rights: List of issues to be taken up in connection with the consideration of the third periodic report of Kenya*, 2011

<sup>97</sup> Kenya National Bureau of Statistics (KNBS), *Kenya Demographic and Health Survey 2008-09*, 2010

<sup>98</sup> BBC News, *Kenyan condom imports to rise*, 11 July 2011



recommendations on international and global health; safeguard the protection of health of mother and child; give boost for researches, information and professional trainings about HIV/AIDS.

In addition to these functions put in practice for the virus in Kenya, the Organization has the task to operate like an authority of direction and coordination.

The latter is held in compliance with another essential agency of the UN, that is the UNAIDS.

### **Joint United Nations Programme on HIV and AIDS (UNAIDS)**

It is a member of the United Nations Development Group and is the main advocate for accelerated, comprehensive and coordinated global action on the HIV/AIDS epidemic.

The mission of UNAIDS is to lead, strengthen and support an expanded and prolonged response to HIV/AIDS that includes preventing transmission of HIV, providing care and support to those already living with the virus, reducing the vulnerability of individuals and communities to HIV and alleviating the impact of the epidemic.

In particular, UNAIDS has ten goals:

- 1) Reduce sexual transmission of HIV by 50% by 2015
- 2) Prevent HIV among drug users by 50 % by 2015
- 3) Eliminate new HIV infections among children by 2015 and substantially reducing AIDS-related maternal deaths
- 4) Reach 15 million people living with HIV with lifesaving antiretroviral treatment by 2015
- 5) Reduce tuberculosis deaths in people living with HIV by 50% by 2015
- 6) Close the global AIDS resource gap by 2015 and reach annual global investment of US\$ 22-24 billion in low- and middle-income countries
- 7) Eliminate gender inequalities and gender-based abuse and violence and increase the capacity of women and girls to protect themselves from HIV
- 8) Eliminate stigma and discrimination against people living with and affected by HIV through promotion of laws and policies that ensure the full realization of all human rights and fundamental freedoms
- 9) Eliminate HIV-related restrictions on entry, stay and residence
- 10) Eliminate parallel systems for HIV-related services to strengthen integration of the AIDS response in global health and development efforts<sup>99</sup>.

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<sup>99</sup> UNAIDS

As it is possible to remind, the major aims of UNAIDS are equal to those of WHO. Indeed, the two big work places of the UN collaborated often together realizing papers and projects.

For instance, in April 2009 they underlined, in collaboration with the United Nations Human Rights, the percent of disable people with HIV present in Kenya where the latter are not considered. Particularly, children who present disabilities are relegated by the Kenyan society due to lack of knowledge and fatalistic terms, disability is often seen as divine punishment. For these reasons, WHO and UNAIDS wanted to highlight the relationship between HIV and disability introducing a Policy Brief. It discusses the actions needed to increase the participation of persons with disabilities in the HIV response and ensure they have access to HIV services<sup>100</sup>.

Prophylactic treatment is another plan joint by WHO and UNAIDS. According to them, this action with cotrimoxazole can potentially enhance essential HIV care programs in Africa by preventing several secondary bacterial and parasitic infections in people living with HIV/AIDS<sup>101</sup>.

Hence, the aim of UNAIDS is to help mount and support an expanded response to HIV/AIDS, one that engages the efforts of many sectors and partners from government and civil society.

Established in 1994 by a resolution of the UN Economic and Social Council and launched in January 1996, UNAIDS is guided by a Programme Coordinating Board with representatives of 22 governments from all geographic regions, the UNAIDS Cosponsors, and five representatives of nongovernmental organizations (NGOs), including associations of people living with HIV/AIDS.

Peter Piot was the first executive director of UNAIDS. He served from its inception in 1995 until 2008, when he departed to lead the Institute for Global Health at Imperial College London<sup>102</sup>. On 1 January 2009, Michel Sidibé became the new executive director of UNAIDS<sup>103</sup>.

The United Nations Declaration Commitment on HIV/AIDS provides the guiding framework for UNAIDS action. Promoting partnerships among various stakeholders is reflected within the leadership section of the Declaration of Commitment.

In the case of Kenya, it calls for complementation of government efforts by the full and active participation of civil society, the business community and the private sector through:

- 1) Establishing and strengthening mechanisms that involve civil society, private sector, and people living with HIV/AIDS at all levels.

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<sup>100</sup> United Nations Human Rights, WHO, UNAIDS, *Disability and HIV Policy Brief*, April 2009

<sup>101</sup> World Health Organization/UNAIDS, *PRACTICE POINTS: Provisional WHO/UNAIDS Secretariat Recommendations on the Use of Cotrimoxazole Prophylaxis in Adults and Children Living with HIV/AIDS in Africa*, Geneva, October 2000

<sup>102</sup> UNAIDS, *Biography of former UNAIDS Executive Director Dr. Peter Piot*, April 2013

<sup>103</sup> UNAIDS, *Biography Mr. Michel Sidibe*, April 2013

- 2) Encouraging and supporting local and national organizations to expand and strengthen regional partnerships, coalitions and networks for the full participation of people living with HIV/AIDS considering in particular vulnerable groups and people mostly at risk like women and young individuals.
- 3) Addressing issue of stigma and discrimination.

UNAIDS works to promote partnerships between the diverse and broad range of non-state entities. This calls for increases in both the number of new actors, as well as in innovative ways of working, to facilitate increased capacity of non-state entities to respond effectively to the epidemic at all levels.

In engaging non-state entities in an expanded response to the epidemic, the UNAIDS Secretariat fosters and supports global, regional and country level partnerships which include connections amongst civil society, private sector, philanthropy, media, and with particular attention to organizations of people living with HIV/AIDS. It supports the Kenyan government in developing partnerships with non-state entities. This includes support for approaches intended to increase participation, improve connectedness of efforts and strengthen the various participants' capacity for action.

On July 2013, the leaders of the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the Global Fund to Fight AIDS, Tuberculosis and Malaria went to Nairobi to sign a strong partnership in order to defeat infectious diseases including HIV and TB.

Mark Dybul, Executive Director of the Global Fund, and Michel Sidibe, Executive Director of UNAIDS, met with leaders in Kenya's new government, as well as Civil Society Organizations and other partners. At a signing ceremony in Nairobi, two new grant agreements demonstrated a commitment to work together with partners. The grants, worth US\$27 million, will support programs implemented jointly by the Ministry of Finance of Kenya and by AMREF, a civil society organization that has been working improving the health of African communities for over 50 years. According to the Dr. Dybul, the most effective prevention in Kenya often comes by reaching those most vulnerable to infection and the missions against HIV/AIDS can be most effective when all partners are moving in the same direction.

Yet again, the reflection has been that Kenya can have a profound effect on the AIDS response if it continues to lead in a people-centered approach to health. If all people in Kenya can access essential health services with dignity and without fear, then surely this country can tip the balance of the epidemic in Africa.

The UNAIDS Country office spent \$420,000 since 2010 with a focus on supporting the governance and oversight of the Kenya Coordinating Mechanism, as well as through technical support for the development of future grants and unblocking barriers in the flow of funds. UNAIDS' technical support helped to ensure the successful agreement between the Government of Kenya and the Global Fund for the implementation of its Round 10 grants of US\$483 million.

In fact, UNAIDS and the Global Fund are working closely to support the Government of Kenya to eliminate new HIV infections among children and keep their mothers alive.

Mainly, in 2008 UNAIDS was asked, together with the Global Fund, to carry out a new, root-and-branch assessment of funding and bottlenecks.

Some basic problems identified were the Country Coordinating Mechanism (CCM), a multi-sectoral national body, was isolated and not integrated with any national structure. Stakeholders had little involvement and the CCM exercised poor oversight of grant implementation. There were few performance reviews, which meant there was no way to identify and analyze bottlenecks and take informed decisions.

For this reason, UNAIDS supported some major reforms that had two main objectives:

- 1) Improve overall governance and accountability for a lasting solution to the management issues, along with the development of a stronger mechanism for stakeholder engagement
- 2) Improve the flow of existing resources and the capacity to develop proposals for leveraging new funds.

In turn, within these objectives UNAIDS provided technical support that focused on four areas:

- 1) Strengthen stakeholders' engagement and reinforce their oversight role
- 2) Unblock barriers to existing grants and make the money flow
- 3) Improve monitoring, accountability and reporting on grants
- 4) Strengthen Global Fund grant development processes.

In compliance with these actions, a key structural change was the introduction of the Kenya Coordination Mechanism (KCM), a mandate with the aim to attract funds from The Global Fund for the HIV and AIDS, Tuberculosis and Malaria programs, and coordinate, monitor, evaluate and

support the implementation of the Global Fund grants. It is responsible for ensuring that the Global Fund proposal is country owned and implementation is country driven<sup>104</sup>.

However, UNAIDS assisted in the development of guidelines and supporting documents, including a governance manual and a code of conduct to prevent conflict of interest among committee members, along with strategies for communication and resource mobilization. Over two years, UNAIDS invested some US\$ 470 000 and this support was important to reform the Country Coordinating Mechanism that transformed and organized the Kenyan civil society<sup>105</sup>.

So, according to the Executive Director of UNAIDS, a good governance, accountability and stronger

consultation have become the symbols of the management of Global Fund resources in Kenya. If the second stage of reforms goes through, Kenya could be one of the first countries in Africa to demonstrate a dual track approach of more money for health and more health for the money<sup>106</sup>.

Conversely, even if both WHO and UNAIDS demonstrate their valence to combat HIV/AIDS stressing the fact that this virus is the greatest challenge to human hubris, the pharmaceutical and research communities, and international global health governance, they represent some weakness.

Firstly, it has not been highlighted the world's disastrous response to it. In fact, Thomas Frieden, Director of the U.S. Centers for Disease Control and Prevention (CDC) since 2009, stresses that, regarding the AIDS pandemic, governments and the populations in general, almost always proved more interested in attacking the subpopulations at greatest risk for the disease than in fighting the virus itself. For instance, children infected by HIV-contaminated blood transfusions were banned from schools, the homes of hemophiliacs were burned, masses of gay men died with little attention from the heterosexual communities around them, female prostitutes were imprisoned or denied access to health care, and many medical and dental providers refused to allow HIV-positive individuals access to care unrelated to their infections<sup>107</sup>.

In a certain sense, if there we compare AIDS with other tragic disease like Ebola, we can affirm that there has been and, unfortunately, a constant ignorant, inept, and cruel response to AIDS continues to be present. Yet during the 1980s, the World Health Organization failed to recognize the importance of HIV/AIDS. Inside its Geneva headquarters, some experts exhibited as much

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<sup>104</sup> The Global Fund, *The KCM Constitution. Kenya coordinating mechanism for Global Fund to fight AIDS, Tuberculosis and Malaria*, Republic of Kenya, February 2011

<sup>105</sup> UNAIDS, *How UNAIDS supported Kenya in the Global Fund grant process. Case study Kenya 2008-2013*, 2013

<sup>106</sup> Michel Sidibé, Executive Director UNAIDS

<sup>107</sup> Garrett L., *Ebola's Lessons. How the WHO Mishandled the Crisis*, Foreign Affairs, August 18, 2015

prejudice against the populations at great risk for AIDS, especially homosexuals, like for the public in general.

The years have passed, but the story is maybe the similar because poor nations are unable to perceive new diseases quickly and bring them quickly under control. On the contrary, rich nations show only marginal interest in outbreaks until the microbes seem to directly threaten their citizens. Governments look after their own interests, cover up outbreaks, hoard scarce pharmaceutical supplies, prevent exports of life-saving medicines, shut borders, and bar travel.

Therefore, the global response to the rise of new pathogens and causes of HIV/AIDS continues to be limited, uncoordinated, and dysfunctional.

The global health infrastructure is showing itself to be not so strong in these problematics. However, positive features exist based by strong and still existence surveillance helps that generate a public response to HIV, help target prevention activities and plan responses, and monitor the success of the national response<sup>108</sup>.

To sum up, it is possible to say that the weakness of WHO in agreement to those of UNAIDS in Kenya are the following:

- Current systems rarely track the risk behaviors that provide warning signs for the spread of HIV
- Useful information from other sources is often ignored
- Surveillance resources are often targeted in the general population where little infection exists, while at-risk sub-populations are neglected
- Systems have difficulty explaining changes in levels of HIV infection in mature epidemics or in countries where therapy exists.

The WHO and UNAIDS must to work yet hardly in order to resolve the problematics mentioned above.

## **2.3 Local health condition: Kilifi County**

Other the research completed in Nairobi, there has been the possibility to do another one in Kilifi, one of the big County of Kenya.

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<sup>108</sup> WHO , UNAIDS, *Guidelines for Second Generation HIV Surveillance*, 2005

In particular, the research was developed in the so-called Kituo Cha Huduma Toshelezi, the Comprehensive Care Centre of the Malindi General Hospital strictly linked to Kilifi. The work carried out was truly profitable and confirmed all the techniques, data, and difficulties stated by the WHO and UNAIDS.

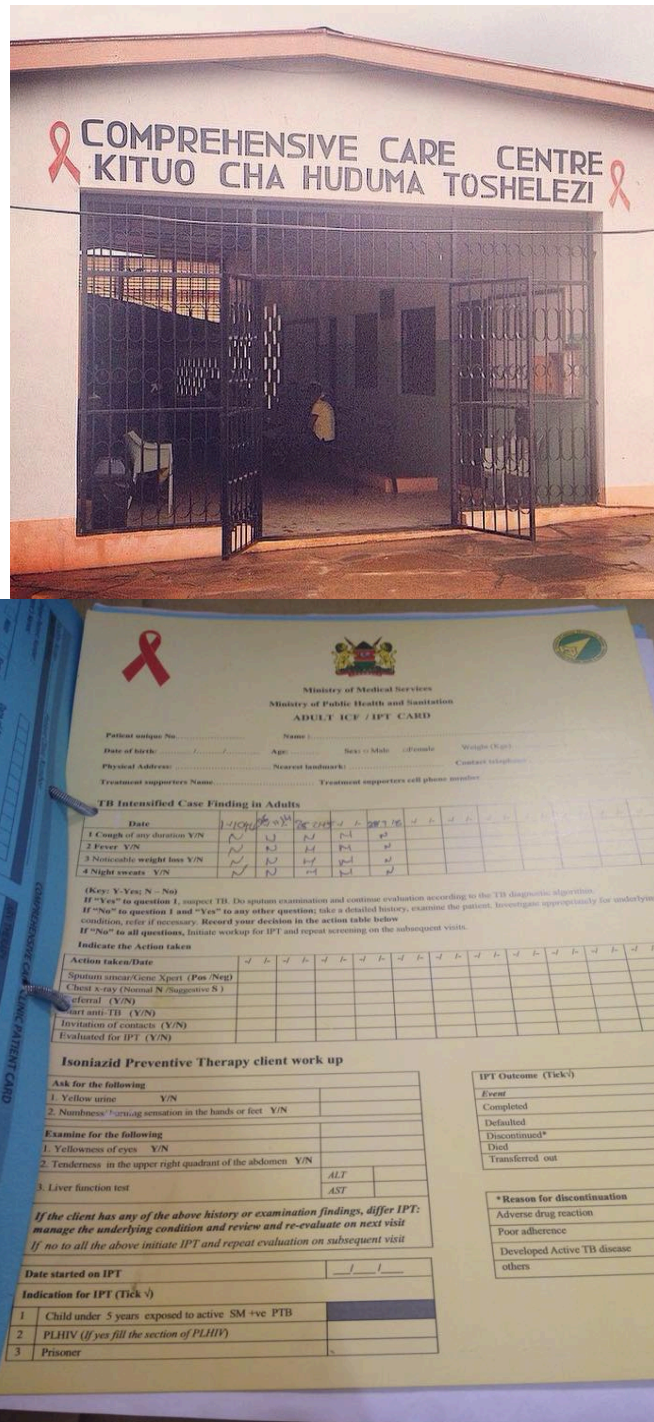
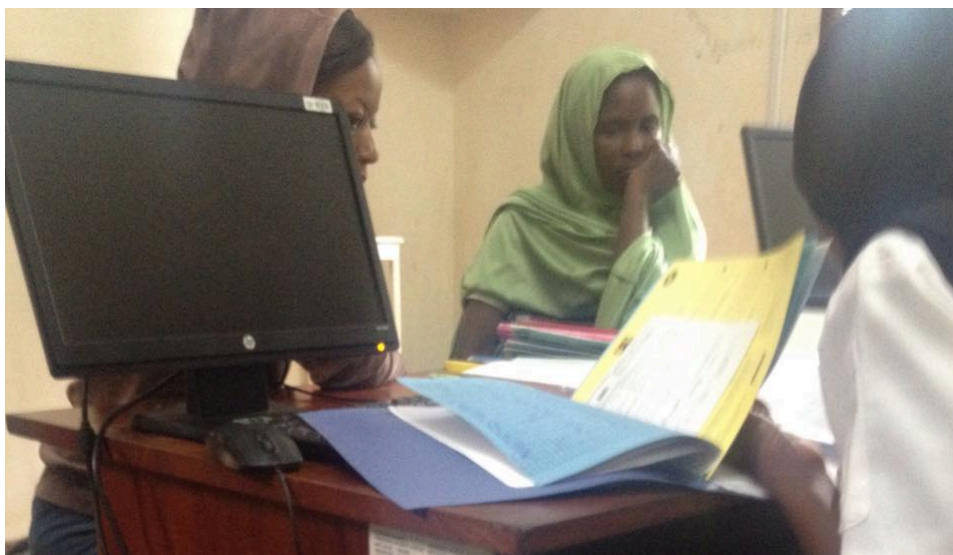


Figure 10







**Figure 12**

Instead, in the figure 11 is depicted a counseling at two girls affected by the virus HIV/AIDS. In that morning, many persons went to the midpoint and the major of these are women with a maximum age of 40 years. Few men had gone and one of this was homosexual. Therefore, there was a problem to understand really the symptoms and the causes of the disease because he feel ashamed. The boy had started to cry too. This confirms the status of homosexuals in Kenya but, in reality, also many women do no capable to explain effectively of the problem. Indeed, a big number hides its real age and sometimes do not take the medicines necessary for the cure. The last case happened during the research where a woman had come a month late on the care because she would not agree to have AIDS. It happens to another young girl but here the problem was that she had to keep her baby and the village where she live was too far from the hospital. Another case has been of a woman who did not take the medicines regularly for lack of information. Again, from the project made by the center of the hospital, results that the major of women had not been accompanied by their respective husbands or companions.

Hence, the examples explained demonstrate and endorse the most continuous problems linked to the virus HIV in Kenya. Deficits that the local government, Nairobi, and big officialdoms like the World Health Organization and UNAIDS are trying constantly to resolve.

In addition, the County government of Kilifi is determined to improve access of health services to the population including ensuring the principle of equity through focused interventions which will enable the health sector contribute to the realization of the Economic Recovery Strategy, Vision 2030, Public Service Reforms and the Millennium Development Goals.

As part of the transformation agenda in taking Kenya forward, the state department of health in Kilifi County has therefore concluded its strategic and investment plan 2013-2018.

The strategic plan has been developed to assist the Department of Health and its partners in defining and executing the Health strategic objectives, policies and programs to address the numerous challenges the Kilifi County health sector faces. These initiatives are aimed at reducing Kilifi county's morbidity and mortality rates, increase life expectancy and improve health care delivery, there by transforming the county's health sector and contribute to Kenya as a country to achieve the aspirations of National Health Sector Strategic Plan III, Vision 2030 and the Millennium Development Goals. This strategic initiative also aims to improve the County department of Health institutional and human capacity and to create a conducive environment for both staff and patients.

The development of the strategic plan was based on consultations with the national level, World Health Organization and other international stakeholders.

The Strategic and Investment Plan is an important tool developed to systematically guide the health agenda for the next five years. It is an overall framework into which sector priorities in the county will be implemented, provide guidelines for action and ensure quality service delivery to citizens.. It highlights the strategic health direction and actions the government of Kilifi County. The service delivery priorities in this plan are focused on the health sector strategic objectives of the national health agenda namely; Eliminate communicable conditions, Halt, and reverse the rising burden of non-communicable conditions, Reduce the burden of violence and injuries, Provide essential health care, Minimize exposure to health risk factors and Strengthen collaboration with health related sectors.

To enable the county government achieve its strategic goals, all departments are required to align their functions to the overall County corporate strategy. It is for this purpose that this plan was developed for the Health Department to ultimately contribute to the socio-economic transformation of the country.

Kilifi County has a total of 95 public health facilities categorized as follows; 5 sub county hospitals, 12 health centers and 77 dispensaries distributed in various sub counties.

Of the sub County Hospitals, Kilifi, Mariakani and Malindi Hospitals are the main referral facilities in the County. The other hospitals are Bamba and Jibana, which were upgraded from Health center status in the recent years but are to function as full hospitals.

Kilifi County covers a total area of 12,609.7km<sup>2</sup> with an estimated population of 1,246,296 in 2014/15 according to KNBS projections 2009. The population is projected to rise to 1,440,689 by the year 2018 with an annual population growth rate of 2.9% as shown in table 2.1.1 below. The

male to female ratio about 1:1 with 52.1% female, Male 47.9%. Women of reproductive age comprises of 23.2% of the population. A significant proportion of the population is composed of <15 years (47.5%) with the youth making up 19.4%, the age group 25-59 years making up 28% and the elderly comprise 5% of the population. Children under one year make up 3.6% and those less than 5 years 17.3% of the population. The life expectancy of the county is 56 years<sup>109</sup>.

The Health status of the population in Kilifi cannot be described as optimal as is faced with various health problems, common among them include HIV, Tuberculosis, pneumonia, Diabetes, hypertension, Malaria among the adult population. Among the children under 5 years, diarrhea, Respiratory system diseases, Pneumonia, skin diseases. However, the main present still today is HIV/AIDS both in adults and in children.

Some of the health risk factors affecting the population include poverty, poor hygiene and sanitation, alcohol consumption, negative cultural practices, and low literacy levels.

Indeed, Kilifi County has some of the poorest social economic indicators in the country. With a poverty rate of 72 % and a relatively high literacy level, exposes a significant proportion of the population to various health risk factors. Hence, efforts to improve the health status of the population must be backed by a broad based multi- sectoral approach to address the social determinants of health and disease within the county.

Kilifi County strategic and investment plan, just as the Kenya Essential Package for Health, KEPH, has defined health services and interventions to be provided for each policy objective, by level of care and cohorts (Pregnancy/newborn, childhood, children/youth, adults, elderly) where applicable. Specific interventions have been defined in each policy objective for attainment, and services around which the interventions are clustered to guide the implementation level and communities on what needs to be provided.

The number of units currently providing services according to the six strategic policy objectives vary according to level of care and the type of services to be offered as per the policy objectives. In general, 59 community units, 102 primary care units and 10 Hospitals are offering these services according to the Policy Objectives.

Kilifi County has substantial health investments gaps in health workforce and infrastructure, which this plan aims to bridge within the plan period. This will be done through recruitment, capacity building and progressive upgrading of the existing structures and building of new facilities.

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<sup>109</sup> De Agostini Geografia

Health care service delivery is very dynamic and a heavy investment area, whose success and effectiveness is dependent on a mix of critical inputs ranging from qualified health workforce, good infrastructure, availability of health products to health systems management and leadership.

The Kilifi County Health System is faced with various challenges that include inadequate health workforce, inaccessibility of health services due to poverty and long distances because of uneven distribution of health facilities in the county. Some of the existing health facilities are dilapidated and need some improvements and expansion.

Other challenges affecting health service delivery include, low literacy levels, ignorance which has led to poor health seeking behavior, cultural practices and beliefs which do not promote health. With 72% of poverty levels in the county, this is a major obstacle to the population's socio-economic development.

Over the last 10 years, positive trends on different health indicators have been observed, with a decreasing under-five Mortality and Infant Mortality rates. Other positive improvements have been in the coverage of childhood immunization and vitamin A supplementation. On the contrary, almost 30% of children under-five are anemic and are stunted.

Factors influencing the positive trends include sustained high coverage of vaccination and other effective interventions such as Vitamin A supplementation. Up to 75% of health facilities in the county are providing immunization services. The Integrated Management of Childhood Illnesses (IMCI) was adopted in the country in 2002 as a key strategy for reduction of under-five mortality and presently only about 30% of the facilities are implementing IMCI. More effective prevention and treatment of malaria are likely to be important contributors to improved health, especially in reducing infant and under-five mortality. This notwithstanding, there remains a substantial urban-rural, regional and socio-economic differences. Rural poor families are more likely than their urban counterpart to die and when they survive, they are more likely to be malnourished. The three main causes of death are HIV, pneumonia and Tuberculosis.

The maternal mortality ratio is estimated at 484 per 100,000 live births. More than 50% of women aged 19yrs are either pregnant or already mothers, increasing their vulnerability to sexual and reproductive health problems. Micronutrient deficiencies and chronic energy deficiency during pregnancy increase the risk of maternal mortality and poor outcomes for infants, including preterm delivery, fetal growth retardation, low birth weight, increased risk of dying, impaired cognitive development and increased risk of non-communicable diseases later in life.

The Department of Health of Kilifi has a Mandate in order to undertake the Provision of healthcare services and the management of public health. Its principle goal consists in attaining the highest possible health standards in a manner responsive to the population needs. It has the vision to ensure

a healthy and productive population in Kilifi County, but also like in Kenya in general. Its mission is to provide effective leadership and participate in the provision of quality health care services that are accessible, acceptable, sustainable and equitable to the population of Kilifi County and beyond. This task will contribute to the broader County government mission thus sustainably improve living standards of the people of Kilifi County through provision of equitable quality services and conducive environment for development.

The County Department of Health is headed by a County Executive Member for Health (Minister) who is responsible for the overall coordination and management of County Health Services. The County Chief Officer for Health (COH), is the Chief Accounting Officer for the Department while the County Director for Health (CDH), is the technical Head, who provides the overall technical guidance on Health Matters in the County. The CDH is expected to exercise his/her functions through six technical directorates: Clinical & referral services, promotive & preventive care services; family health services, administration & finance, standards quality assurance and regulatory services, planning and monitoring and evaluation.

A County Health Management Team (CHMT) will be constituted, headed by the County Director of Health and made up of; Heads of the 3 Directorates in the County Department for Health assisted by various officers constituting the different functions of the health departments and Medical Superintendents of all County hospitals within the County

This team's main responsibility will be to follow up on implementation of the County Health Strategic Plan and Operational Plan. It will meet monthly, and its operations guided by Terms of Reference. It will define areas of responsibility for each County and Sub-county Referral Facility based on allocation of all the County locations / sub locations. The County Health Management Team will plan, supervise, coordinate, and monitor service delivery in this area. The county health service delivery will be managed by the county health management team with the leadership of the county executive member for health as the executive arm. The chief officer of health will be the accounting officer of the health department and will oversee service provision at the county level. He/she will directly be answerable to the county executive member for health who will also be directly answerable to the Governor.

The county health management team will coordinate health services at the county level and will have an implementing arm at the sub - county level to oversee service provision in all levels at their respective sub - counties. Hospitals will have hospital management teams to supervise health service provision and ensure that services offered are of the highest attainable standards. Primary health care facilities will be headed by technical staff. Service provision at the community level will

be overseen by community health extension officers who will supervise the community health workers.

For Governance and social accountability to the community, hospitals will have health management boards and primary health facilities will have facility management committees. Service provision at the community level will be overseen by community health committees. Their main responsibility will be to represent the community at the various tiers of service provision ensuring the rights based approach in health care delivery is realized. They will oversee implementation of activities and approve budgets and assist in resource mobilization for health services.

To facilitate operational provision of health services, this strategic plan proposes the following organizational structure based on the County functions for health outlined in the Fourth Schedule of the Constitution, the health policy objectives and orientations, and the need for clearly demarcated areas of responsibilities. The proposal also takes into account the need to have a lean structure based on functionality and integration of services at the county level.

The Kenyan health sector is important for sustainable growth and development of the country. The Right to Health is enshrined in the Constitution of Kenya 2010. One of its major responsibilities is to ensure that all citizens have access to and receive the services they need. The way in which health sector institutions are structured within the county has an impact on how effectively they can deliver services to citizens. Effective organizational structures in the health sector matter to the Kilifi population, the national and county governments, health sector organizations, and the individuals employed in those organizations.



Classical diplomacy was bilateral, linked to the representation of nation-state governments to one another and to exchanges between them<sup>111</sup>. The classical diplomats were drawn from the aristocratic ranks of the societies they represented, and the substance of communications between states was treated as a hermetically sealed world to be left to this professional elite. Diplomacy thus consisted almost exclusively of privileged dialogue among official agents, far from the public gaze, and ambassadors routinely enjoyed direct personal access to heads of states.

Yet, diplomatic processes and practices evolved steadily throughout the eighteenth and nineteenth centuries and became more complex as a response to the development of more complicated governing structures in human societies, and the consequently more complicated issues they undertook to negotiate with each other<sup>112</sup>.

At the beginning, there were different opinions on the role and actual effectiveness of diplomacy. For instance, some scholars did not have a good vision of diplomacy. Kant said that “diplomats justify whatever the sovereign states decides to do”<sup>113</sup>. The philosopher was referring to a new international order inaugurated with Peace of Westphalia (1648) thanks to which the concept of state sovereignty took on great importance. Hence, the state was the principle and the supreme subject. It was independent and had an absolute supremacy in respect of other juridical form. In particular, sovereignty presupposes that the state is a territorially bounded unit with an inside and an outside. Internally, the sovereign state is conceived to be an entity that can exercise supreme authority within its own territorial boundary. Thus, a state is sovereign because it is acknowledged that there is no external organization that can exercise authority within the territorial boundaries of that state. Externally, a state must be recognized by the other sovereign states and identified as an equal member of the international society. Putting internal and external considerations together, it follows that sovereign states have an international obligation or duty to abide by the norm of non-intervention. Put differently, sovereignty requires all states to acknowledge that they have no right to intervene in each other’s domestic affairs<sup>114</sup>.

On the other hand, since the 1960s the potential for states to maintain their sovereign status was called into question with increasing frequency. This trend accelerated in the 1990s with the growing

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<sup>111</sup> Pigman G. A., *Contemporary Diplomacy. Representation and Communication in a Globalized World*, United Kingdom, Polity Press, 2010, p. 18

<sup>112</sup> Hamilton K., Langhorne R., *The Practice of Diplomacy. Its evolution, theory and administration*, Second edition, New York, Routledge, 2011, p. 1

<sup>113</sup> Kant I., *Perpetual Peace: a philosophical essay*, 1975

<sup>114</sup> Little R., *Sovereignty*, *ENCYCLOPEDIA OF INTERNATIONAL RELATIONS AND GLOBAL POLITICS*, 2005, ed. M. Griffiths. London: Routledge, pp. 768-769



belief that the forces of globalization had the capacity to erode sovereignty<sup>115</sup>. Chiefly, the consequences of the two World Wars were tragic. The political and economic of the Second World War were huge, but the deaths of civilians were appalling. In a world that was changing slowly, such situations were no longer acceptable. In fact, there was the need to establish new persistent pressures and demands for the promotion of democratization and to engage in humanitarian intervention at the expense of sovereign states in the so called “Third World”.

The Cold War marked a new chapter in the evolution of diplomacy. According to author Daryl Copeland, the “balance of terror” amongst the Western and Soviet blocs established clear rules for diplomatic practice<sup>116</sup>. Henceforth, in the post-World War II era, the nation-states have been effectively curbed in their individualistic pursuit of goals and payoffs by the proliferation of International Organizations and regimes and the internalization of international norms and rules by domestic societies.

Perceptibly, even diplomacy changed. From a collaborative public diplomacy in the Westphalia era, it became a “reflexive” diplomacy as a radical alternative to violence and power-based relationships<sup>117</sup>. Moreover, a “civilian power” has developed. It is the combined force of women and men across the government, who practice diplomacy, implement development projects, strengthen alliances and partnerships, prevent and respond to crises and conflict, and advance security, prosperity, universal values (especially democracy and human rights) and just international order.

To sum up, there is the idea that foreign policy should be at the service of development and not the contrary.

Therefore, also the diplomacy itself is changing. Particularly, diplomacy is changing from within<sup>118</sup> and it is possible to emphasize four major transformations in diplomacy:

- 1) Weberian revolution, where the agents represent to be the main feature. The diplomat itself was a different person, chosen not from aristocracy as happened before, but from the bourgeoisie, according for instance to academic preparation.
- 2) Wilsonian turn, after WWI, with the culture like the principle objective. The first point of Wilson’s 14 points was claiming for the end of “secret diplomacy” and thus started “public diplomacy”. It can be considered like a democratic evolution of diplomacy. Secret

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<sup>115</sup> Vaughan M., *AFTER WESTPHALIA, WHITHER THE NATION STATE, ITS PEOPLE AND ITS GOVERNMENTAL INSTITUTIONS*, School Of Political Science & International Studies, The University Of Queensland, 29 September 2011

<sup>116</sup> Richard L. C., *Diplomacy in the Twenty-First century: Change and Evolution*, University of Ottawa, 15 September 2011

<sup>117</sup> Hussein Banai

<sup>118</sup> Pasquale Ferrara

diplomacy means diplomacy carried on by kings, presidents and other rulers, without the knowledge or consent of the people and behind closed doors. Through secret diplomacy the kings, presidents and other rulers, intent to pursue the goals of foreign policy through effective means of compromise, persuasion, and threat of war<sup>119</sup>. Instead, regarding the concept of public diplomacy there is more complicated because there is not a unique definition of public diplomacy. But, despite this, in a broader sense it is possible to define public diplomacy as the a particular communication with foreign publics to establish a dialogue designed to inform and influence.

- 3) Vertical extension with the actors at the core of analysis. Diplomacy is not only a relation between governments or between public officials, but it is also a relation among states actors and non-state actors such as religious groups and non-governmental organizations (NGOs).
- 4) Horizontal expansion according to which a diplomat has to deal with different issues, such as military ones. Today the diplomats should also understand the environmental changes, economic and social developments, health problems, etc.

Hence, rethinking these four points, it is possible to confirm that we are assisting to a “trans-national diplomacy” characterized more and more by non-state actors and it is focused on the inclusion of civil society. The role of diplomats is strongly changed. They must increasingly negotiate or interact in contexts characterized by complexity, both in terms of structural factors and of participating actors. A good example to take into consideration for the new diplomatic evolution is the “eDiplomacy” or “Digital diplomacy” defined as the use of the Internet and new information communication technologies to help achieve diplomatic objectives<sup>120</sup>. Almost, communication is one of the central functions of diplomacy and, for this reason, they must have familiarity with latest communication technologies. Principally, diplomats must have the proficiency in intercultural communication with which they demonstrate to be sensitive so socio-cultural differences.

It is not only the vastly larger numbers of actors involved that adds complexity to the management of the new diplomacy, but also its much wider scopes and many more policy levels that it has to entail. Indeed, the latter are local, domestic, national, bilateral, regional and global. Chiefly, all diplomats must have a keen interest in global issues.

So, with the development of new global actors, the role of diplomacy has widened and, in turn, that of foreign policy.

Initially, some scholars tend and want to underline the difference between “club diplomacy” and “network diplomacy”. The first, is characterized by few players, a hierarchical structure and low

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<sup>119</sup> <http://definitions.uslegal.com/s/secret-diplomacy/>

<sup>120</sup> Hanson F., *A Digital DFAT: Joining the 21st century*, Lowy Institute, November 2012

transparency. It is presented mostly in a written form and its main purpose is the signing agreements.

In the "club model" of diplomacy, diplomats meet only with government officials among themselves. By and large, they restrict themselves to fellow members of the club, with whom they also feel most comfortable<sup>121</sup>. On the contrary, the second is structured by many players, a flatter structure, written and oral form, and high transparency. Its main aim consists in to increase bilateral flows.

The following figure reassumes the differences between the two types of diplomacy just explained.

	<b>Number of players</b>	<b>Structure</b>	<b>Form</b>	<b>Transparency</b>	<b>Main Purpose</b>
<b>Club Diplomacy</b>	Few	Hierarchical	Mostly written	Low	Sign agreements
<b>Network Diplomacy</b>	Many	Flatter	Written and oral	High	Increase bilateral flows

**Figure 14 Club versus Network Diplomacy**

Also to these two particular categories of diplomacy, next to the classical diplomacy, there is the so-called economic diplomacy with the principle aims to protect the economic interests abroad in public administrations and foreign other subjects of importance to this purpose, for the protection and promotion of the growth economic and employment of the interesting country<sup>122</sup>.

Hence, economic diplomacy deals with the connection between power and wealth in international affairs. It does not only promote the state's prosperity but also manipulates its foreign commercial and financial relations in support of its foreign policy.

Accordingly, economic diplomacy is a major theme of the external relations of virtually all countries<sup>123</sup>. Hence, diplomacy is frequently referred to as the art and practice of conducting negotiations.<sup>124</sup> It is usually still understood to mean the conduct of international relations through the intervention of professional diplomats from ministries of foreign affairs with regard to issues of

<sup>121</sup> Heine J., *On the Manner of Practising the New Diplomacy*, The Centre for International Governance Innovation, Working Paper No.11, October 2006

<sup>122</sup> Frattini F., *La Diplomazia Economica: nuove sfide e nuovo approccio*, SIOI, 2011

<sup>123</sup> DiPLO

<sup>124</sup> Berridge GR., *Diplomacy. Theory and practice*, London and New York: Palgrave, Macmillan 2005

"hard power", initially war and peace, and - as countries compete economically - economics and trade. But in recent years there has also been an increase in the number of international agreements on "soft issues", such as the environment and health; it is now recognized that some of these issues have significant "hard" ramifications on national economies.

However, other new important forms of diplomacy are existent and one of these is the health diplomacy. In a certain logic, it could be possible to argue that health diplomacy is a consequence of economic diplomacy. In fact, the constant threats causing by the spread of ancient and new diseases increased the awareness of the link between health and economic development<sup>125</sup>.

The concept of medical or health diplomacy was introduced during 1978 by Peter Bourne, special assistant to the president for health issues during the Carter administration. He argued "the role of health and medicine as a means for bettering international relations has not been fully explored by the United States. Certain humanitarian issues, especially health, can be the basis for establishing a dialogue and bridging diplomatic barriers because they transcend traditional and more volatile and emotional concerns".

Before, health issues have traditionally resided in a "low politics" position in foreign policy practices. After and in recent years, certain health issues have received political attention at the highest levels of international politics such as the virus HIV/AIDS. This change occurred because many foreign policy-makers arrived to the conclusion that the health is linked to other crucial aspects of a society like security, education, economy, human dignity, and so on<sup>126</sup>. For the fact that the health groups a series of social and global issues, the concept developed and matured with the route of decades until policymakers and researchers became to use the term "global health diplomacy", still in progress.

The global health diplomacy is characterized by three different categories of interaction around international public health issues:

- 1) Core diplomacy, formal negotiations between and among nations. A bilateral negotiation between two nations is the most traditional form of core diplomacy. It involves high-level negotiations between national representatives, who may be health officials or other technical experts, and whose outcome may be a signed agreement resulting in obligations on the parties.

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<sup>125</sup> Alleyne A. O. G., Cohen D., *Health, Economic Growth, and Poverty Reduction*, WHO, April 2002

<sup>126</sup> Fidler P. D., *Reflections on the revolution in health and foreign policy*, Bulletin of the World Health Organization, March 2007

- 2) Multistakeholder diplomacy, international negotiations between or among nations and other actors, not necessarily intended to lead to binding agreements. The actors involved work together to address common issues.
- 3) Informal diplomacy, interactions between international public health actors and their counterparts in the field, including host country officials, nongovernmental organizations, private-sector companies, and the public<sup>127</sup>.

The use of the term global near to the health diplomacy is because the accelerated process of globalization has determined variations in diplomatic purposes and practices. Health issues have become increasingly preeminent in the evolving global diplomacy agenda. Indeed, more leaders in academia and policy are thinking about how to structure and utilize diplomacy in pursuit of global health goals.

An important part of global health diplomacy still takes place within the World Health Organization. According to the latter, global health diplomacy gets together the disciplines of public health, international affairs, management, law and economics and focuses on negotiations that shape and manage the global policy environment for health. This because improving the health care system within any country requires many decisions by many people. So, the decisions that are needed have to be the result of several individuals working together, facing an endless stream of problems and negotiating an infinite stream of decisions<sup>128</sup>.

Under the Constitution of the World Health Organization, it works with its members towards the attainment by all peoples of the highest possible level of health. The context in which WHO and its members pursue this goal has radically changed since 1946. The interdependence produced by globalization has broken down traditional ways of conceptualizing and organizing the medical, economic, political and technological means to improve health. Nowhere is this transformation more apparent than in the rise of health as a foreign policy concern<sup>129</sup>.

WHO's work on trade and health policy coherence reveals increasing country-level commitment to, and sophistication about, strategies to promote trade and protect health in ways that are politically feasible, economically attractive, epidemiologically informed and ethically sound. Through these efforts, health ministries are identifying how they can best inform pre-negotiation trade positions, provide input during negotiations, analyse the health costs and benefits of proposed compromises and monitor the health impacts of trade agreements.

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<sup>127</sup> Katz R. [et al.], *Defining Health Diplomacy: Changing Demands in the Era of Globalization*, The Milbank Quarterly, September 2011

<sup>128</sup> Drager N. [et al.], *Negotiating Health Development: A Guide for Practitioners*, Conflict Management Group, World Health Organization, 2000

<sup>129</sup> Drager N., Fidler D.P., *Foreign policy, trade and health: at the cutting edge of global health diplomacy*, March 2007

WHO is collaborating with its members and other international organizations to advance this integrated approach to foreign policy by developing a new trade and health diagnostic tool. This tool is being designed to help health and trade ministries more systematically assess trade and health issues, to empower health ministries to give better advice to their trade counterparts and to enhance health policy input into the trade community's pursuit of integrated frameworks, trade policy reviews and aid initiatives to bolster trade capacities in developing countries.

Moreover, the World Health Organization stresses that in the 21st century, health is a shared responsibility, involving equitable access to essential care and collective defense against transnational threats. Both elements of this statement, that are a shared responsibility for equitable access to essential services, and a shared responsibility for collective defense against transnational health threats, require global leadership, sustainable and scalable resources, collaboration, and mutual support among states, businesses, philanthropy, and civil society. Hence, a global partnership and the sufficient and effective provision of aid and financing are essential.

Additionally, global health urgently requires enhanced global health governance.

A coherent system of global health governance can be built, founded on the common interests of states and their partners. All states have self-interests in fostering global health governance as a collective defense against transnational health threats, containing infectious diseases where they emerge and avoiding the international spread of health hazards. States also have self-interests in ensuring equitable access to essential health systems.

Ensuring essential health services and goods makes all countries safer, more secure, and more prosperous, and a foreign policy based on global health improvement is an effective form of diplomacy.

The relationship between health, foreign policy and trade is at the cutting edge of global health diplomacy. There are two goals of this unit: the support of the development of a more systematic and pro-active approach to identify and understand key current and future changes impacting global public health; the creation of the capacity among member states to support the necessary collective action to take advantage of opportunities and mitigate the risks for health.

In a globalized increasingly complex and interdependent world health has been found to be a critical factor for success in foreign affairs.

In order to understand better what mutual benefits Global Health Diplomacy brings to the world of international relations it might be helpful to look at the origins of the term. Global Health Diplomacy has been defined by Ilona Kickbusch, professor at the Graduate Institute for International Development studies and one of the most prominent scholars in that field, as the

“multi-level and multi actor negotiation processes that shape and manage the global policy environment for health”.

The implementation of health as a key element of foreign policy was reinforced by the Oslo ministerial declaration – global health in 2007, which was written by the seven ministers of foreign affairs of Brazil, France, Indonesia, Norway, Senegal, South Africa, and Thailand. It aims at “broadening the scope of foreign policy”, more precisely it emphasizes that “life and health are our most precious assets.” Then it states: “There is a growing awareness that investment in health is fundamental to economic growth and development. It is generally acknowledged that threats to health may compromise a country’s stability and security.”

The process of globalization has led to an increase in interdependencies and helped bring this approach to the overarching field of foreign affairs with its various policies. The signing countries of the Oslo declaration have realized that most health threats do not stop at political borders and play a crucial role in all policies and sectors of society, including security.

Particularly, in 2007, the foreign ministers of seven countries issued the Oslo Declaration identifying global health as “a pressing foreign policy issue of our time” [1]. The declaration was not the start of recent interest in health and foreign policy, but reflects a decadal trend in which health has become more prominent in global policy agendas. During this contest, the term of global health diplomacy broke out.

Political instability can cause health disasters but moreover a fragile public health situation can be a hazardous threat to stability of countries and regions. A vivid example is the devastating effect of the HIV/AIDS epidemic that destroys whole communities and destabilizes huge areas in sub-Saharan Africa.

Foreign policy can endanger health when diplomacy breaks down or when trade considerations trump health; health can be used as an instrument of foreign policy in order to achieve other goals; health can be an integral part of foreign policy; and foreign policy can be used to promote health goals. These approaches cannot always be sharply differentiated and are better visualized as a continuum<sup>130</sup>.

The gap into global health diplomacy provided by the trade and health relationship reveals controversy, but also increasing efforts between those in trade and health ministries towards coherent policies within and among countries.

Critical to global health diplomacy is the relationship between health and foreign policy. Even though much of what affects health today is transnational in nature, countries remain essential

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<sup>130</sup> IFAIR, Global Health Diplomacy, March 7, 2013

actors that must reorient their health and foreign policies in ways that align their national interests with the diplomatic and ethical realities of a globalized world. This alignment involves governments adjusting to globalization by overcoming fragmented policy competencies in national governance systems.

At the basis of the global health diplomacy there is the consideration according to which securing health's fullest participation in foreign policy does not ensure health for all, but it supports the principle that foreign policy achievements by any country in promoting and protecting health will be of value to all.

For this reason, the financing for global health financing has increased intensely in recent years. It demonstrates how the health issue is rising within the foreign policy. Indeed, a big number of governments have issued specific foreign policy statements on global health and the new term, global

health diplomacy, has been coined to describe the processes by which state and non-state actors engage to position health issues more prominently in foreign policy decision-making<sup>131</sup>.

The international community has made progresses in addressing these challenges.

For instance, the Paris Declaration on Aid Effectiveness and the Accra Agenda for Action, demand for clearer targets and indicators of success for harmonization among partners, alignment with country strategies, and mutual accountability for development results. The International Health Partnership and related initiatives seeks to put these principles into practice. The Global Fund to Fight AIDS, Tuberculosis and Malaria is driven by country demand and receives funding proposals from inclusive Country Coordinating Mechanisms, whose members include government officials, civil society, development partners, and the private sector.

In the meantime, both domestic and international health investments have increased. From 2000 to 2007, governments in sub-Saharan Africa increased their health sector spending from 8.7% to 9.6% of their budgets. Official development assistance for health increased from \$7.6 billion in 2001 to \$26.4 billion in 2008.

Together with the all international aids and project, it is important to underline that Global health has been a core issue on the G8 agenda ever since the G8 Kyushu-Okinawa Summit in 2000, which led to the establishment of the Global Fund to Fight AIDS, Tuberculosis and Malaria. The aim is still in act of ensuring that the G8 nations take effective action in tackling the global health issues central to the United Nations Millennium Development Goals<sup>132</sup>.

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<sup>131</sup> Labonté R., Gagnon M.L., *Framing health and foreign policy: lessons for global health diplomacy*, Globalization and Health, 2010

<sup>132</sup> Health and Global Policy Institute



At present, many speeches, projects and so on are spent each year to support healthcare provision and measures against infectious diseases, like HIV/AIDS, in developing countries, with by far the greater part of this funded by the G8 nations. With the aim of securing the continued contributions of G8 nations despite the ongoing global economic slump, Health and Global Policy Institute took the proactive measure of organizing the Global Health Summit Project.

### **3.2 The Global Health Summit Projects**

The Global Health Summit Project is a mechanism to take common initiatives in the G8 chairing country to promote global health on the G8 agenda and to maintain continuity across G8 countries. The latter are Canada, France, Germany, Italy, Japan, Russia, the United States, the United Kingdom and the European Union.

The G8 mainly serves as a forum for consultation and coordination between the most developed countries that share objectives and basic principles. In the case of health, ensuring a global access to health. Contrary to G7, which is characterized mostly for its procedure of financial cooperation, the G8 has progressively expanded the range of its powers as political issues<sup>133</sup>, even if with some problematics.

As the largest donor and most influential decision-making body, the G8 has consummate capacity in the global health arena. Health has long received attention from the G8 but it is important to understand how well the G8 has governed.

In a broader sense, the G8 has been a relatively effective center of global health governance.

According to Thomas Fue, the G8 is no longer in a position to coordinate world economic policy and to deal with global challenges adequate. In this sense, it is important to leverage on the big institutions and international organizations like the International Monetary Fund, World Bank, and World Health Organization.

Since its start, the summit has done little to help its leaders directly manage their domestic politics and policy on health.

The health-related decisions making of G8 present some gaps. They are concentrated on the core issues of HIV/AIDS, multiple diseases, medicine, polio, malaria, the Global Fund to Fight AIDS, Tuberculosis and Malaria. It has also reacted to health outbreak events, such as severe acute respiratory syndrome (SARS) in 2003 and avian influenza in 2006. Nonetheless, the G8 has given

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<sup>133</sup> F. Pasquale, *Oltre l'aritmetica del potere mondiale. Governance globale e democrazia deliberativa*

very little attention to children's and maternal health<sup>134</sup>, the core issue of the global health condition.

Hence, the principle aim of the Global Health Summit Project is to maintain global health as a key G8 priority. The Project emphasizes it because the global health is no longer guaranteed within the G8 agenda due to economic crisis and slowdown, inflation, high energy prices, the climate change and other environmental problems that can affect the health globally, and the food emergency.

To achieve the goal of maintaining global health as a key G8 priority, the Project takes three innovative approaches:

- 1) Engagement of top decision makers
- 2) Involvement of multi-stakeholders
- 3) Community building and domestic follow-through.

Organized in cooperation with The World Bank, the first Global Health Summit was held on February 16, 2008 in Tokyo, with 100 of the most influential leaders on health issues from Japan and overseas gathering to debate the challenges and shape the priorities of the global health agenda. In 2008, Japan hosts the G8 Summit, presenting an excellent opportunity to show the world Japan's leadership in combating the widespread problems affecting global health. In 2000, when Japan previously hosted the G8 Summit, the Okinawa Infectious Diseases Initiative was taken up as a worldwide policy challenge. In the same year, the United Nations adopted the Millennium Development Goals, which ranged from reducing poverty to halting the spread of infectious diseases. 2008 represents the halfway point to the Millennium Development Goals' target year, and it is time to take action.

However, the Global Health Summit has to convene every year to improve the dialogue on global health issues among governments, the private sector, and international organizations. It has the support of The World Bank, the Ministry of Foreign Affairs, the Ministry of Finance, the Ministry of Health, Labour and Welfare, and other partner organizations.

As a global leader nation, Japan is expected to play a valuable role in ensuring a healthier and more productive global community. The Global Health Summit advocates and contributes to continuing discussion and collaboration on global health issues to map out a path to a better future for all.

Instead, on February 13, 2009 The Global Health Forum was held in Rome like the second Global Health Summit, following the first Summit in 2008 to bring together stakeholder leaders from

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<sup>134</sup> Kirton J., Guebert Jenilee, *Health Accountability: The G8's Compliance Record from 1975 to 2009*, December 28, 2009

government, parliament, business, civil society, academia, and media in Italy to help shape and build momentum around a global health agenda.

The meeting was chaired by Italian Economy and Finance Minister Giulio Tremonti, and the G8 sherpa, Giampiero Massalo, and other G8 secretariat teams led the G8 discussions. The event successfully convened leaders from diverse stakeholders, including government, international organizations, civil society/NGOs, academia, the private sector, etc., to facilitate constructive dialogue on various global health issues.

Italy, which has been a major player in establishing the Global Fund to fight AIDS, Tuberculosis and Malaria and supporting a number of new financing mechanisms, is now pushing for the harmonization of global initiatives and their alignment with the beneficiaries' management systems. The Global Health Forum contributes to maintaining focus and momentum on recent international trends, including the G8's endorsement of the Toyako Framework for Action on Global Health.

For many years, the G8 was a great place for global health. In 2010, the G8 committed to US\$ 5 billion for maternal, newborn and child health that grew into the US\$ 40 billion Global Strategy on Women's and Children's Health. In 2007, G8 members made a \$1.5 billion pledge to reduce the gaps in maternal and child health care and voluntary family planning. In 2005, leaders agreed to provide universal access to anti-HIV drugs in Africa. Not all the pledges were met, but the meetings kept the attention on key global health issues and played some role in mobilizing aid agency responses. On balance, this consistency paid off – health aid quadrupled between 1992 and 2009, with G8 members providing more than 75% of all bilateral aid for health in 2009<sup>135</sup>.

However, while the G8 has received particular critics, some reasons still exist in order to keep alive the G8 because it:

- 1) Collects a significant number of major international players
- 2) Is able to achieve common positions
- 3) All its members have the capacity and the political will to take their responsibility in order to address global problems and issues like the global health
- 4) Is not bound by rules of law
- 5) Has a composition relatively small that allows more informal and immediate discussions among its members.

For these five principle reasons, in a certain way the G8 is considered better in confront of G7. The latter is a forum created in 1999 after a succession of financial crisis to encourage the progress of the international economy taking into account the new developing economies. It congregates the 19

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<sup>135</sup> Glassman A., *What Happened to Health at the G-8?*, Center for Global Development, December 2012

most industrialized countries (the G8 in particular) with the European Union. The representatives of its member countries are the finance ministers and the governors of their central banks.

The G20 represents two thirds of the world's population and trade, as well as more than 90% of GDP<sup>136</sup>. The G20 has a membership extremely heterogeneous and this can create problems to act on the international scene.

Together to the Global Health Summit Project, there is also The Global Centre for Healthy Workplaces “Global Healthy Workplace Awards & Summit” (GHW Awards) annual event, the first global awards program recognizing healthy workplaces and brings together leaders in global health and well-being from around the world. This Summit underlines three crucial points:

- Importance of company health programs
- Emerging better practices and innovations for health services
- Capacities to reproduce health opportunities around the world

In May 2015, there was the third GHW Awards Summit at Florianopolis, Brazil. The topics discussed were the following:

- Strengthening the investments for a much more stout health system
- Improvement the mental well-being of employees through some particular comprehensive approaches
- Evidencing that physical disabilities and mental health issues are interdependent, underling the crucial link between employee safety and employee health and well-being.
- Stressing that there are single chances to improve employee health and safety in emerging markets
- Necessity of a strong leadership support for rightful health and safety programs
- More measurement of health promotion program outcomes
- Consideration that engaging women in the workplace is an essential measure for higher productivity, equitability, and wellbeing<sup>137</sup>.

Once more, a Framework Convention on Global Health (FCGH) has been create because it could ensure a right to health governance framework. It would be a global health treaty based on the right

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<sup>136</sup> G20.org

<sup>137</sup> Global Center for Healthy Workplaces, *3<sup>rd</sup> Global Healthy Workplace Awards & Summit*, May 2015

to health and with the aim to close the national and global health inequities. It would provide standards to ensure health care underlying determinants of health, such as clean water and nutritious food, for all individuals. It would establish a transformative understanding of the right to health to create the accountability now missing and adapt the right to our globalized world. It would establish pathways towards national and global health equity, with a special concern for marginalized populations, and further inclusive and democratic decision-making on health and related concerns, domestically and internationally. The FCGH would clearly define extraterritorial obligations, while ensuring that policies in other sectors are responsive to public health needs, including by elevating the status of health and demanding adherence to the right to health in other international legal regimes, such as trade and investment<sup>138</sup>.

Hence, the basic goals of the FCGH are the achievement of:

- 1) Equitable and sustainable health systems defining areas of cost effective investment to meet basic survival needs and create incentives for scientific innovation for affordable vaccines and essential medicines.
- 2) A concrete financing for health because domestic and international health financing is insufficient, with health and development financing targets largely unfulfilled. Resources that could be devoted to health and development are lost to inequitable and ineffective tax systems, corruption, mismanagement, and weak international financial regulation and enforcement. International financing responsibilities are particularly ill defined. Such funding is insufficient and often fails to meet local priorities, to respect country ownership, and to utilize national and community knowledge, processes, culture, and other capacities.
- 3) National and global governance for health due to the fact that in the non-health sectors, global rules and national policies frequently fail to promote health. Hence, a solid and durable global governance, organized with the cooperation and in particular health cooperation, is required to safeguard the world's population.
- 4) Human rights implementation and enforcement globally. In particular, the international community could dramatically improve prospects for the rights of good global health.

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<sup>138</sup> FCGH Platform, *Platform for a Framework Convention on Global Health: Realizing the Universal Right to Health*, May 2014

These four tasks are the same of the global health or rather are essential in order to ensure and enlarge the health systems worldwide.

However, even if the FCGH demonstrates to be positive, some scholars have individuated three main limitations:

- 1) The duplication of efforts in the sense that FCGH would create a conference of parties that would function similarly to the World Health Assembly, the plenary governing body of WHO, and could over time compete with it or even displace it.
- 2) Lack of feasibility because the FCGH proposals are considered expensive and difficult to achieve.
- 3) Questionable impact for the length of time needed for it to become effective and the lack of consideration about some crucial challenges in global governance for health such as the institutional fragmentation and the democratic deficit in global decision-making.

On the other hand, even if currently the most powerful actors and institutions, like the Global Fund to Fight AIDS, Tuberculosis and Malaria, the Bill and Melinda Gates Foundation, and the World Health Organization perceive the proposed FCGH as a threat to their strategic interests, the latter influence positively the national and international health and foreign aid budgets, realizing health rights, and reorganizing global governance for health. In fact, the UNAIDS Secretariat's recently argues that, contrary to the other organizations, the FCGH proposals demonstrate support among some key constituencies<sup>139</sup>.

The FCGH would reimagine global governance for health, offering a new, post-Millennium Development Goals vision. Indeed, the United Nations is revising the Millennium Development Goals (MDGs) and, according to the UN Secretary-General, the FCGH would reimagine global governance for health, offering a new post-MDG vision<sup>140</sup>.

Hence, Framework Convention on Global Health (FCGH) is considered as a global health treaty stranded especially for the right to health with the central objective of reducing the huge internal and global health inequities. As well, it could serve as a vigorous global governance instrument to reinforce the United Nations post-2015 Millennium Development Goals (MDGs). It would ensure for all people the three essential conditions for a healthy life that are public health, health care, and the positive social determinants of health. To do that, the FCGH attempts to advance good

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<sup>139</sup> A. Palmer, [et al.], *Does ratification of human-rights treaties have effects on population health?*, The Lancet 373/9679, 2009, pp. 1987-1992

<sup>140</sup> Gostin L. O., *A framework convention on global health: health for all, justice for all*, May 2012

governance in particular around health disadvantages for marginalized populations. Moreover, it raises health in other legal regimes, and improve people's ability to achieve their rights<sup>141</sup>.

The most recent global summit on health is the so-called *Global Strategy for Women's, Children's and Adolescents' Health* launched on 26 September during the UN Sustainable Development Summit. In reality, this project was firstly presented by the United Nations Secretary General Ban Ki-moon in September 2010 underling that the global community could and should do more to save the lives and improve the well-being of women and children.

The Global Strategy has been repeated during the September 2015 to ensure that the acceleration of the progress in reducing newborn, child and maternal mortality becomes a reality for women, children and young people around the globe.

Ban Ki-moon states "The Global Strategy for Women's, Children's and Adolescents' Health, which I am proud to launch today, will help to build resilient and healthy societies. We have shown that our partnership can yield concrete results. I, and the entire UN system, remain dedicated to saving and improving the lives of the most vulnerable amongst us."

The vision of the strategy is to have, by 2030, a world in which all woman, child and adolescent in every situation realizes their rights to physical and mental health and well-being, has social and economic opportunities, and is able to participate fully in shaping prosperous and sustainable societies. The objectives and targets aligned with the Sustainable Development Goals (SDGs) are:

- 1) Ensuring really health and well-being with, for instance, the universal access to sexual and reproductive health-care services and rights. This is a good and crucial plan to reduce HIV/AIDS especially in those countries where its percentage is very high, such as in Kenya.
- 2) Ending preventable deaths.
- 3) Expanding enabling environments like the elimination of all harmful practices of discrimination and violence against women and girls.

In order to achieve these three goals, the project underlines some vital action areas like country leadership, individual potential, community engagement with the promotion of laws, policies, and norms, accountability, multisector action, and innovation. Regarding the last point, it has been stressed its importance because there is properly the need to have new methods supported by innovative and sustainable financing mechanisms such as the *Global Financing Facility*<sup>142</sup>. It has the principle task to contribute to the global efforts to end preventable maternal, newborn, child, and

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<sup>141</sup> Waris A., [et al.], *Towards a Framework Convention on Global Health*, Georgetown University Law Center, 2013

<sup>142</sup> Every Woman Every Child, *THE GLOBAL STRATEGY FOR WOMEN'S, CHILDREN'S AND ADOLESCENTS' HEALTH (2016-2030)*, Sustainable Development Goals, 2015

adolescent deaths and, at the same time, to improve their health and quality life. It is estimated that this type of financing could help to prevent a total of 4 million maternal deaths, 107 million child deaths, and 21 million stillbirths between 2015 and 2030 in 74 high-burden countries<sup>143</sup>.

Hence, the Global Financing Facility (GFF) is a key financing platform of the UN Secretary-General's Every Woman Every Child Global Strategy 2.0. It is a country-driven financing partnership that brings together, under national government leadership, stakeholders in reproductive, maternal, newborn, child and adolescent health, to provide smart, scaled and sustainable financing in order to accelerate efforts for the end of avoidable maternal, newborn, child and adolescent deaths by 2030. The GFF was launched at the Third International Conference on Financing for Development in July 2015.

According to the World Bank, healthy women and children enable healthy economies, political stability and forward momentum. They are our smartest investment, when we invest wisely.

### **3.3 Corporate social responsibilities in global health: the role of multinational pharmaceutical firms**

Businesses and corporations in many sectors are initiating programs and strategies aimed at enhancing social welfare, protecting the environment and defending human rights. There is evidence worldwide of the growing importance and impact of corporate social responsibility (CSR)<sup>144</sup>.

While there is an extensive published literature on CSR and its international development, the literature on CSR and global health is limited. Moreover, the CSR is characterized by a multitude of definitions. On one side and in a broader sense, CSR has been defined as “the overall contribution of business to sustainable development”<sup>145</sup>.

On the other side, there is the study adopted the European Commission's definition of CSR as “the responsibility of enterprises for their impacts on society.” The European Commission further recommends that firms put in place processes “to integrate social, environmental, ethical, human rights and consumer concerns into their business operations and core strategy in close collaboration with their stakeholders”.

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<sup>143</sup> The World Bank, *Global Financing Facility in Support of Every Women, Every Child*, September 2015

<sup>144</sup> Porter ME, Kramer MR, *The competitive advantage of corporate philanthropy*, Harv Bus Rev. 2002

<sup>145</sup> United Nations, *CSR and Developing Countries: What Scope for Government Action? Sustainable Development Innovation Briefs. Policy Integration and Analysis Branch of the Division for Sustainable Development*, February 2007



Corporate social responsibility differed for each firm particularly with respect to how CSR is defined, organizational structures for managing CSR, current CSR activities, and motivations for CSR.

The common CSR activities are differential pharmaceutical pricing, strengthening developing country drug distribution infrastructure, and targeted research and development. Primary factors that motivated CSR engagement are reputational benefits, recruitment and employee satisfaction, better rankings in sustainability indices, entrance into new markets, long-term economic returns, and improved population health.

CSR activities were always supported by partnerships involving local and international partners, which were prominently featured on the firms' websites. Firms described partnerships with telecommunications companies for their health initiatives, banks for micro-loan schemes to increase patient purchasing power, and community-based organizations to encourage local buy-in and participation.

The decision-making process behind initiating specific CSR activities varied across the included firms but was often determined by the presence of existing in-country networks, cooperative local government, alignment with company expertise, and the ability to make health impact in an area that was not over-saturated they could meaningfully contribute to.

Therefore, multinational company involvement in global health issues has been evolving since the late 1980s/1990s, with the introduction of compulsory competitive tendering for services such as catering, cleaning and facilities management services. For some companies, this formed the springboard for involvement in formal public-private partnerships for capital projects. However, in these two phases, the multinational companies were more likely to be service, property and finance companies, rather than health care companies. More recently, healthcare multinationals have started to become involved in public health care systems as providers of health care.

In general, the multinational companies are strongly criticized because they tend to manipulate the laws of the countries in terms of health, in order to avoid regulation or legislation to soften it, seeping through investments in non-governmental organizations and health agencies with the clear intention of distorting the results of research and to gain political favours.

Pharmaceutical companies are special cases because their business decisions have a direct impact on human health, making CSR efforts particularly important. There are some positive considerations for which, at least in part, during the past two decades pharmaceutical companies have significantly increased CSR efforts. At the same time, other thoughts are negative. In fact, these firms have been criticized for specific behaviours such as setting prohibitively high prices and

sluggishness in responding to demands to provide access to life saving drugs for poor populations<sup>146</sup>.

Moreover, the most crucial epidemiological and demographic shifts, notably the HIV/AIDS pandemic, have magnified pressures to actively work to promote societal well-being. Regarding the virus of HIV, own in these days the scandal of the antiviral Daraprim broke. It is a valued drug for AIDS patients. Martin Shkreli of 32 years and a young American entrepreneur has bought the patent of the medicine by Turing Pharmaceuticals raising (a big biopharmaceutical company) steeply its price from 13 dollars a pill to 750. The medication, in trade for 62 years, has increased by more than 5000% in one day sending hundreds of patients in crisis because they cannot buy it for its so high price.<sup>147</sup> However, it is not the first time that in the pharmaceutical market American the drug prices rise suddenly. Hence, also taking into consideration the last example, the pharmaceutical companies can be critiqued also for using CSR to repair compromised reputations or to reverse public beliefs about their commercial endeavours being unethical.

The actions of the pharmaceutical companies represent to be a global problem. Therefore, the global health diplomacy has to act with the elaboration of a common health policy on drugs, and raise the profile of the pharmaceutical industry's actions. Specifically, there is the need to have a global legislation that excludes in the strongest terms the participation of companies from the circuit in charge of health to prevent collaboration with governments and multinationals and prohibit any form of direct funding or not in the field of health research.

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<sup>146</sup> Leisinger KM, *The corporate social responsibility of the pharmaceutical industry: idealism without illusion and realism without resignation*, Bus Ethics Q, 2005

<sup>147</sup> Betti I., *Martin Shkreli compra il brevetto del farmaco Daraprim per i malati di Aids e ne alza il prezzo del 5000%.* "È l'uomo più cattivo d'America" (TWEET), HUFFPOST, September 2015

## 4. Conclusions

The first preamble of Art. 25 of the 1948 Universal Declaration of Human Rights said, “Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control”. Instead, according to the second preamble “Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection”<sup>148</sup>.

From these statements, it is crucial to highlight two issues. Foremost, a strong link between health and wellbeing exists. Health is synonymous of well-being; without the former, the latter cannot occur completely. For instance, an ill health can keep the individuals from going to school or to work, or from participating fully in the activities of our community. The tricky is that this relation often is not considered. For this reason, the role of governments is important because the policies have to support and enhance a culture of healthiness and wellbeing.

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<sup>148</sup> <http://www.un.org/en/documents/udhr/index.shtml#a25>

Contrariwise, the first statement regarding the fact that health is a fundamental part of human rights and understanding of a life in dignity for all individuals in the world. Hence, as such, it must be guaranteed to all. For this reason, it is better to talk about global health like, in a certain sense, a goal responding to human rights and to common interests.

Especially in the most recent years, a particular type of global society is building up more and more opposed to the project of a world society based on the idea of the hegemony of the nation-states. There is a global context where constantly many fluxes of diverse ideas, individuals, cultures, religious born and they are interconnected with each other. The particular aspect of these interconnections is that, at a certain point, they meet like in a unique block. The spirit of globalization is this. It wants to create a world more and more as a unique social system.

Before to arrive at a total conclusion about the relation between globalization and health in order to understand if effectively it produces benefits or not for the health in general, it is opportunity to understand the positive and negative aspect of the process of globalization.

In an optimistic view, living in a more globalized world means and involves new opportunities and choices whenever all individuals in the world stay in a precise moment. Globalization is a multi-dimensional process that generates free flows of goods, ideas, technologies and social practices across national borders. They can eliminate the negative aspects of national differences increasing a major knowledge and tolerance for different cultures. From an economic opinion, the route of globalization creates a single global market where countries help each other, or at least they should. In fact, as it has been said before, the negative facets do not lack to the globalization. The most critical and evident are the loss of identity and the intensification of social and economic disparities among rich countries and poorest ones. The latter represents to be a countersense because the globalization has the aim to amplify the global economic, political, social, and cultural relations but, at the same time, it contributes to the formation of new dimensions and new dividing lines in the relations between dominant and dominated, wealth and poverty, religions, peripheral cultures and central cultures.

Hence, it is possible to say that the globalization is a good process particularly, is not only, in a brief period. Whereas, it can create serious problematics in the long run.

Globalization is itself a paradox for the reason that it produces a sole and separated world. A disparity and controversy comparable to this is present also for the health. The problem is that globalization does not act uniformly and this has consequences in the health status of all individuals. In particular, the globalization acting firstly on the economic plan, it creates a solid affiliation between the economy and health sector.

Generally, richer nations and socio-economic groups have a better health condition contrary to other poorer. For instance, it is useful to take into consideration the life expectancy. It is a statistical indicator that shows the average number of years of life of an individual from a certain age in the population index. It is strictly correlated with the mortality rate. Indeed, the lengthening of life expectancy at birth may be the result of the reduction in infant mortality rates due to improved sanitation and hygiene. The life expectancy is a real good demographic and statistical indicator because represents and underlines the social and health status of a population. Many countries of Africa continue to have a low life expectancy due to the constant diseases and medical problems. This situation is very different respect that of Japan which has the highest life expectancy in the world, followed by Spain and Switzerland. Henceforth, even here it is possible to perceive a huge discrepancy in sanitation amongst rich and poor countries. The key causes are always the same: increase in income inequality, economic instability, lack of improvements in the distribution of health services. Having a global scenario that has vital effects on the global health, primarily there is the need to leverage on the economy for the promotion of a:

- 1) Social and economic development based on the approach of human rights, giving priority to low- and middle-income and disadvantaged population groups, in line with the Development Goals Millennium and with those of Agenda post-2015.
- 2) Universal access to quality health services in order to meet the health needs without incurring financial difficulties to pay them.
- 3) Strengthening of health systems with a universalistic view oriented to ensure reforms on equity, solidarity and social inclusion.

Then, together to these three main goals more centred in an economic prospective, there is the action with everything is related to the politics like diplomacy and government. In particular, a specific branch of diplomacy subsists, the so-called health diplomacy. It has to collaborate with politicians, institutions, and organizations in order to indorse the:

- 1) Role of the World Health Organization as a guide and coordinating authority for the government of the global health.
- 2) Coherence between policies of development cooperation and others that have an impact on the growth of the partner countries.
- 3) Donor coordination for the support of national health plans made by the authorities of the partner countries in accordance with the needs of the population and individual rights.

- 4) Integration of global health initiatives and global partnerships in national health plans taking into account the priorities of countries partners and aligning their modalities of programming, implementation, monitoring and evaluation to the local systems.
- 5) Policies for the financing of social and health spending in partner countries within the international forums.
- 6) Coordination of policies, programs and interventions in health among territorial partnerships.
- 7) Development of appropriate skills of those working in global health.

Hence, the politics has a crucial role in health. Rather, the strong economic performance is only possible with a good policy, both in a national and international approaching.

Above all, in a world increasingly interconnected for the process of globalization, there is the necessity to strong global health policies able to combat the new and challenging collective action problems such as global poverty, global economic crisis, climate change, human security, and so on, that have tremendous impact on global health. It is better to focus on policy rather than governance because policy generally relates to the creation of guidelines or principles deemed necessary to achieve specific governance outcomes.

However, it is important to distinguish between *global governance for health* that is the starting point for the social, economic, and political determinants of health. The latter is considered in the context of global organizations in other sectors. *Governance for global health*, the starting point for global health strategies. It stays at national and regional levels in support of global health agendas. Finally, there is the *global health governance*, the starting point for health equity and disease control. It is a type of governance of dedicated health organizations and their interference. They are powerfully interconnected.

In the current global health contest, the first global governance outcome has to be the realization of a real common solution by all countries in the world. The states and economic authorities cannot longer consider health as a single problem; it is common to the entire hemisphere.

There is the need to the implementation of a global health shared strategy firstly towards the poor countries, those really have an urgent necessity to improve their sanitation. Secondly, for richest nations. In fact, another problem is evident. Often, also the big organization like the WHO, fail to separate the priorities.

Regarding the World Health Organization, the preamble of its 1946 Constitution of the World Health defines health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”. The preamble further states that “the enjoyment of the highest

attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.”

From the technical point of view, the WHO have surely improved the health situation over the last 20 years. Together with other major agencies like UNAID, it has developed operational protocols that can prevent the most egregious errors and facilitate the initiation and development of activities. However, especially the World Health Organization has been criticized because it seems that it often comes when disaster has already taken place. So, its effectiveness is in the short term reducing only the damage. Another damaging constituent is that when an epidemic is finished it is put aside like the governments had finished their tasks.

In reality, when a health problem is ended, specifically in a development country, is in that moment the political and economic aid must grow in order to support the country to give itself a base sanitation formed by a right structure.

All the local and international governments, institutions, and organizations have to understand that the difficulties stay at the base and it will continue to be so if they do not implement a comprehensive action to boost awareness of the problem.

Governments are responsible for the health of their peoples; they can cope with this responsibility, taking only the necessary health, economic, and social practices.

We are assisting an evolution so strong and durable that the challenges cannot longer be effectively addressed only within the health sector and at the national level. In fact, the World Health Organization cannot be the sole manager of intergovernmental challenges relating to the governance of global health. There is the requirement of political will and the willingness of states and other priority actors in the fields of health.

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