Editorial: Health districts model still valid in Africa

25 years ago, the WHO organized an inter-regional meeting in Harare. The meeting, which was about the implementation of primary health care, which followed the Alma Ata conference in 1978, ended with a statement that is known today as the Harare Declaration. By establishing the health district model as a reference strategy to organize and develop health services, this event shaped health systems in many poor countries.

In October 2013, some 20 country delegations and 170 experts attended a regional conference in Dakar, Senegal. They took a fresh look at the role of the local health systems in West and Central Africa. The core objectives of the meeting were to re-assess the health district strategy that puts focus on local health systems and local actors.

The participants came to the conclusion that the changes in African countries resulting from new waves of democratization, the development of more structured civil society or increasing urbanization, to name a few, should be reflected in the district model.

It is indeed most encouraging to see that the subject of health district strategy and its underlying values remain as compelling as they were 25 years ago.

We recommend the related article.

IHF News

Executive Summary for January 2014 International Healthcare Competencies Meeting
Overview of 2014 Agenda

This group convened at the Pan American Health Organization (PAHO) Headquarters in Washington, DC January 15-17, 2014. The group was hosted by Dr. Reynaldo Holder and his team at PAHO. The purpose of this meeting was to determine the core competencies needed for the professionalism of healthcare management worldwide, establishment of a call for action, the role of the consortium and the resulting documents needed to move forward with this work. There were 22 individuals representing 15 different organizations.
Summary of Topics and Consensus Points

Background and purpose.

- The overarching goal of all of this work is to contribute to the profession of healthcare management, to contribute to training and the process of accreditation of organizations and education programs, to certify healthcare managers and give associations tools to accredit within their country.
- The international community needs healthcare managers, both within organizations and across countries.
- There is a global need to professionalize the field of healthcare management.

Core competency group exercise.

- This group worked to pull out the core competencies, from the current competency directory document (developed out of the 2013 meeting), needed for the professionalism of healthcare management

Target audience / focus on the customer.

- Must focus on the competent manager at any level of their career, regardless of their country or care delivery organization.
- Create credibility within this document where the user can see themselves in the document and use it to further themselves and the profession of healthcare management.

Charter document.

- Being developed with the goal of addressing the political process of gaining both traction and support for establishing healthcare management as a profession.
- When done correctly, the reader of this document will realize this matters, the correct people have been involved and this is something that they can support.

Read more at ihfnews.org

IHF participates to activities in support of hospitals in Burkina Faso

Invited by Taiwan Embassy for the 20th anniversary of the diplomatic relations with Burkina Faso, Eric de Roodenbeke, CEO of the IHF participated to an assessment of the activities of the National Hospital Blaise Compaoré and to make a presentation on challenges for healthcare management in an area of IT development. He was along with the Heng-Chang Chen, superintendent from Puli Christian Hospital and Wen-Hsin Chang vice superintendent from Mackay memorial hospital.

The IHF was commissioned in 2009 by Taiwan to assess the project for the National Hospital Blaise Compaoré. This assessment was concluded by a report indicating steps for a successful opening of this facility. View the project
Coming back after four years it was possible to witness the major developments for this hospital. Although not yet fully opened, this facility is offering a solid platform for cost effective referral care.

The current challenge is overall utilization that is still far below the capacity of the hospital, and shortcomings in mobilization of the adequate clinical capacities to make the best use of the equipment. The long term sustainability supported by adequate funding is also a pending challenge.

Absence of a comprehensive development plan for public healthcare in Ouagadougou and the existence of a very dynamic private sector are two major factors explaining this situation. To fully utilize the Blaise Compaoré National Hospital, the authorities will have to take some steps to better rationalize distribution of care between all the public hospitals in OUAGADOUGOU and to develop stronger cooperation with the private sector while considering also more flexibility for the public sector to be more attractive for the most qualified clinicians.

As part of its support to development of this hospital, the Taiwanese cooperation has funded the implementation of process development and computerization of key operating functions for management, ancillary and clinical activities. All this has been possible thanks to a transfer of know-how from Puli Hospital. The whole system is at an early stage but it shows a lot of promises. This is an example of cooperation based on hospital partnership approach. The most advanced hospital share for free its software and helps its customization to the local context.

Read more and follow us at [IHF blog](http://www.ihpblog.org)

**International Relations & Activities**

**22nd International HPH conference in collaboration with IHF**

The upcoming 22nd International conference on Health Promoting Hospitals and Health Services (April 23-25, Barcelona, Spain) with the title “Changing hospital & health service culture to better promote health” will offer an interesting programme with high-level speakers from all over the world. Plenary sessions will deal with hot topics such as improving the health literacy of healthcare services, developing salutogenic workplaces in health care, and better responding to community health needs by fostering collaboration between healthcare and other settings.

In addition to the plenary programme, there will be a rich variety of presentations in oral and poster sessions, which are currently being selected by the scientific committee from over 900 abstracts from submitters in 42 countries.

IHF is one of the conference co-organizers. There will be an IHF symposium on Thursday, April 24, with a focus on institutionalizing health promotion practices, with contributions from Australia, Brazil, Catalonia, Nigeria and the USA.

Take the opportunity to combine the participation at an interesting and informative conference with a visit to the beautiful and romantic city of Barcelona.

The programme is continuously being updated, all relevant information including a link to the online registration option, is available online at [http://www.hphconferences.org/barcelona2014/](http://www.hphconferences.org/barcelona2014/).

For questions about the conference, please contact us at vienna.who-cc@hphconferences.org

**Conference: Transforming Purchaser/Supplier cooperation to improve healthcare efficiency** : a
Global challenge
Save the Date  Paris - 25 & 26 June 2014

Healthcare organizations across the world are quickly reorganizing and pooling their procurement power. In many countries, the procurement function has reached sufficient maturity to take the hospital/supplier relationship to the next level. Hospital purchasers now expect suppliers to work together with them to promote change in the healthcare system.

IAPO attends WHO's 134th Session of the Executive Board
In January, IAPO's Chair, Kin-ping Tsang and IAPO's CEO, Jo Groves attended the World Health Organization's (WHO) 134th Session of the Executive Board. The Executive Board met 20-25 January to discuss the items that will be put forward for a decision at the World Health Assembly in May. It was an opportunity for IAPO to meet with WHO staff and to make interventions on agenda items relevant to IAPO and our members. This year, IAPO call on WHO to strengthen its engagement with non-State actors and to put patients at the centre of national non-communicable diseases (NCDs) action plans.

Read more on IAPO's activities at the Executive Board.

Geneva Health Forum 2014 - April 15 - 17
The Geneva Health Forum (GHF) is a global health conference coupled with an interactive, web based platform (the Global Health Forum Platform), which bring together multi-sectoral representation of global health players including frontliners, catalysts, researchers and policymakers.
Taiwan - Health Promotion Administration Annual Report 2013
The Health Promotion Administration of the ministry of Health and Welfare of Taiwan has just released the annual report 2013.

The Health Promotion Administration, established on July, 2001, has as main goal: to improve health and longevity, reduce health inequality, and allow citizens to live longer and better regardless of wealth, region, gender, and ethnic group.

In the future, the Administration looks to reduce the cancer rate to lower than 20% before 2020 and the early death rate of four major non-communicable diseases to lower than 25% by 2025.

We invite you to download the Report Here

WHO Round Up

Adaptation and implementation of local maternity dashboards in a Zimbabwean hospital to drive clinical improvement
J Crofts et al., Published in Bulletin of the World Health Organization, Volume 92, February 2014
The Commission on Information and Accountability for Women's and Children's Health of the World Health Organization (WHO) reported that national health outcome data were often of questionable quality and “not timely enough for practical use by health planners and administrators”. Delayed reporting of poor-quality data limits the ability of front-line staff to identify problems rapidly and make improvements.

**Approach**
Clinical “dashboards” based on locally available data offer a way of providing accurate and timely information. A dashboard is a simple computerized tool that presents a health facility’s clinical data graphically using a traffic-light coding system to alert front-line staff about changes in the frequency of clinical outcomes. It provides rapid feedback on local outcomes in an accessible form and enables problems to be detected early. Until now, dashboards have been used only in high-resource settings.

**Local setting**
An overview maternity dashboard and a maternal mortality dashboard were designed for, and introduced at, a public hospital in Zimbabwe. A midwife at the hospital was trained to collect and input data monthly.

**Relevant changes**
Implementation of the maternity dashboards was feasible and 28 months of clinical outcome data were summarized using common computer software. Presentation of these data to staff led to the rapid identification of adverse trends in outcomes and to suggestions for actions to improve health-care quality.

**Lessons learnt**
Implementation of maternity dashboards was feasible in a low-resource setting and resulted in actions that improved health-care quality locally. Active participation of hospital management and midwifery staff was crucial to their success.

**From International Organizations**

**Risking your health: causes, consequences, and interventions to prevent risky behaviors**
Damien de Walque, editor, The World Bank - Documents & Reports

A growing share of the burden of disease across the world is associated with risky behaviors by individuals. Drug use, smoking, alcohol, unhealthy eating causing obesity, and unsafe sex are highly prevalent in low-income countries, even though they are traditionally associated with richer countries. Understanding the factors driving those behaviors represents a priority not only from a public health perspective but from a broader development one. This report summarizes the existing evidence about the causes and consequences of those behaviors, as well as about interventions aimed at preventing them from a broad range of sources.

The opening chapter, by Damien de Walque and Sébastien Piguet, presents an epidemiological overview, illustrated by tables, figures, and maps, of the global prevalence and distribution of the risky behaviors that are the focus of this book.

The second chapter, by Mattias Lundberg and Gil Shapira, covers the determinants of health-related risky behaviors in the developing world.

Chapter 3, by Alaka Holla, explores the consequences of risky behaviors, focusing on their direct impact on the individual engaging in them, the spillovers to peers, and the costs that society must bear.

Chapters 4 and 5, by Aakanksha Pande, discuss interventions to reduce the prevalence of risky behaviors.

The findings show that information and regulation interventions can be successful in changing risky behaviors. An important lesson that emerges from this review is that even when interventions are effective, externalities often emerge that need to be considered.

**Sweden has excellent health care but must improve care co-ordination, says OECD**
Published in [www.oecd.org](http://www.oecd.org)
Sweden’s health and elderly care systems deserve their reputation as being among the best in the world. Yet an ageing population with growing chronic conditions and requiring more complex health services are testing Sweden’s ability to continue delivering high-quality care, according to a new OECD report.

The OECD Health Care Quality Review of Sweden says that Sweden has a larger share of elderly people than most OECD countries: 5.2% are over 80, compared to the average of 4.2%. Spending on elderly care is 3.6% of GDP, compared to an OECD average of 1.7%. The country also has the highest number of care workers per capita, and they deliver care where it is generally most wanted – at home. Seven out of ten dependent elderly people receive care in their homes.

The quality of health care in Sweden is generally good. Rates of avoidable hospitalisation for chronic conditions such as asthma (22.2 per 100 000 population) are among the lowest in the OECD (average 45.8) and 90% of people using primary care in Sweden said they were treated with respect and consideration by staff. Sweden’s quality registers, which track the quality of care that patients receive and outcomes for several conditions, are among the most developed across the OECD.

But the co-ordination of care for patients with complex needs is less good. Fewer than half of patients with type I diabetes, for example, have their blood pressure adequately controlled, with an almost three-fold variation (from 26% to 68%) across counties. Only one in six patients has had contact with a physician or specialist nurse after the discharge from hospital for stroke, again with substantial variation across counties.

Hospitalisation for uncontrolled diabetes of elderly people aged over 80 years is among the highest in the OECD, and around 1.5 times higher than in Denmark. Average length of stay in hospital after a heart attack in Sweden is less than 5 days – among the lowest in the OECD, and a sign of efficiency. However, municipalities are often not adequately equipped to manage patients coming out of hospital so soon – only around 20% of primary care doctors in Sweden report that they receive the information necessary to manage a patient within 48 hours after hospital discharge, compared to almost 70% in Germany.

Co-ordination of care between hospitals, primary carers and local authorities is becoming the biggest challenge to the continued excellence of Sweden’s health and social care system, according to the report. Central government will have to set out responsibilities very clearly, by developing standards, building the evidence base and sharing knowledge. For example, central authorities should be given a more defined role in assuring the quality of services by setting out national quality standards. Clear standards are particularly needed to underpin the new intermediate care facilities being developed by municipalities. The information infrastructure must improve by developing new indicators of quality of care provided by GPs and elderly care services. Finding ways to link across different data sources is also necessary, to allow a complete picture of an individual’s care to be built up.

Read the full article

Art of Service Delivery: Learning from Faith-inspired Health Care Providers
Published in http://blogs.worldbank.org/

At a time when many African countries may not achieve the health targets set forth in the Millennium Development Goals, the contribution of faith-inspired providers to improved health care is crucial. A recent World Bank study suggests that, while these providers’ market share and reach to the poor may be smaller than often assumed, they seem particularly good at serving their patients. Indeed, they seem to be experts in the science (or maybe in this case, the art) of delivery, a concept World Bank President Jim Kim has spoken of recently in several keynote addresses on achieving universal health coverage.
The Bank’s study provides illuminating evidence on the market share of faith-based providers, commonly believed to be responsible for a large share of the health services available in Africa. In a number of African countries, data are available on hospital beds provided by Christian Health Associations (CHAs) and the public sector (data on other private sector providers are harder to come by). As a share of the hospital beds provided by the CHAs and Ministries of Health, the CHAs often account for one-third or more of the available beds, which is indeed very large.

But when using data from household surveys, which include all private health facilities as well as traditional healers, chemical stores, pharmacists, and other health service providers, and when including countries where CHAs are not present, the region-wide market share of faith-inspired providers is smaller, of the order of 10%. Still, even if their market share is smaller than often claimed, the contribution of faith-inspired providers clearly remains significant.

Consider next the issue of reaching the poor. It is also often believed that faith-inspired providers reach the poor as a matter of priority, while private, secular providers reach mostly wealthier households. There is truth to this, but data from household surveys suggest that differences in beneficiary incidence between various types of providers are smaller than often believed and that none of the three types of providers (public, faith-inspired, or private secular) serve the poor more than the better off in absolute terms.

Especially for faith-inspired providers, this occurs in part due to a need for some level of cost recovery. As faith-inspired providers often receive only limited support from governments, they have no choice but to charge for care which may make it difficult for the poor to visit. Households often prefer faith-inspired facilities, but they cannot always afford them, even when the facilities make special efforts to make their services affordable.

Consider, finally, the quality of health services, which is arguably the most important issue. Data from household surveys suggests that faith-inspired providers enjoy higher satisfaction rates than both public and private secular facilities. This explains why it is often reported that patients are willing to walk long distances to visit faith-inspired facilities – a finding is supported by both quantitative and qualitative evidence.

Read the full article

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**Hospitals and Services Worldwide News**

**Future Diets**

Should the world go on a diet in 2014?

There has been a dramatic increase in the numbers of overweight or obese people in the past 30 years. Previously considered a problem in richer countries, the biggest rises are in middle income countries and the developing world.

'Future Diets' traces how the changes in diet - more fat, more meat, more sugar and bigger portions - have led to a looming health crisis. It also looks at how policy-makers have tried to curb our eating excesses - with mixed results.

**Key Messages**

- Over one third of all adults across the world – 1.46 billion people – are obese or overweight. Between 1980 and 2008, the numbers of people affected in the developing world more than tripled, from 250 million to 904 million. In high-income countries the numbers increased by 1.7 times over the same period.

- Diets are changing wherever incomes are rising in the developing world, with a marked shift from cereals and tubers to meat, fats and sugar, as well as fruit and vegetables.

- While the forces of globalisation have led to a creeping homogenisation in diets, their continued variation suggests that there is still scope for policies that can influence the food choices that people make.

- Future diets that are rich in animal products, especially meat, will push up prices for meat, but surprisingly, not for grains. This suggests that future diets may matter more for public health than for agriculture.

- There seems to be little will among public and leaders to take the determined action that is needed to influence future diets, but that may change in the face of the serious health implications. Combinations of moderate measures in education, prices and regulation may achieve far more than drastic action of any one type.

Download the report Here
The political origins of health inequity: the perspective of the Youth Commission on Global Governance for Health

Published by www.thelancet.com Vol 383 February 15, 2014

Despite large gains in health over the past few decades, the distribution of health risks worldwide remains extremely and unacceptably uneven. Although the health sector has a crucial role in addressing health inequalities, its efforts often come into conflict with powerful global actors in pursuit of other interests such as protection of national security, safeguarding of sovereignty, or economic goals. This report examines power disparities and dynamics across a range of policy areas that affect health and that require improved global governance: economic crises and austerity measures, knowledge and intellectual property, foreign investment treaties, food security, transnational corporate activity, irregular migration, and violent conflict.

As the world negotiates a post-2015 sustainable development agenda, the global community has a unique opportunity to define a new approach to the future of global health. The report by The Lancet–University of Oslo Commission on Global Governance for Health contributes to this discussion by exploring the challenges of current global governance, and the relation between global governance and health inequities. As members of the Youth Commission on Global Governance for Health we hope to add to the discussion by addressing the philosophical underpinnings, findings, and recommendations of the Commission's report.

The Commission's philosophical framework positions health as a shared social objective, central to all sectors, and a fundamental human right. Although valuable, this approach could be strengthened by drawing upon Amartya Sen's capability approach. This proposes that central to human potential are “capabilities”, defined as the substantive freedoms people should enjoy to lead the lives they have reason to value, including the freedom to lead a healthy life. The capability approach emphasises the collective social responsibility to protect this potential by removing the societal constraints that inhibit an individual's capabilities (e.g., poverty, the deprivation of political rights, a chronic lack of social security, and other "unfreedoms"). Seen through this lens, the health gains that might result from a strengthened global governance system are not just an end in themselves, but part of a range of interdependent processes that combine to improve an individual's freedoms. We believe that viewing the work of the Commission in this way will help guide policy formulation and provide a framework for prioritisation between sectors.

A philosophical framework alone is insufficient to mobilise action. The Commission addresses previously underexplored aspects of global governance, showing that diverging interests and power asymmetries shape policies across all sectors, with the potential to exacerbate health inequities. Furthermore, by identifying five systemic dysfunctions of global governance, the Commission provides a valuable explanation of the current global governance system’s inability to balance power asymmetries and to protect and promote public health in policy making domains outside the health sector.

Download the full article

Africa

Renewing health districts for advancing universal health coverage in Africa

Published in http://www.health4africa.net

Report of the Dakar Conference (October 2013)

Around 20 country delegations and 170 experts — district medical officers, national directors, researchers, technical assistants, social entrepreneurs and innovators — attended the conference. During three days, experts shared their experience and knowledge on organizing primary health care services at local level. A spirit of creative discussion between equals pervaded the keynote speeches, plenary sessions, commissions and debates. Participants highlighted African-grown innovative approaches to local health system coordination and delivery, formulated recommendations to key actors and identified questions deserving further attention in terms of research and knowledge sharing. Due to time constraints and the need to maintain some focus, some important matters — such as financial access to health services, human resources, infrastructure and drugs - have purposely not been covered by the conference.

During the workshop, participants brainstormed on the implications of these contextual changes on the health district strategy. Here are some of their findings:
The greater circulation of people (thanks to transportation and the road network) and the market liberalization will transform health seeking behaviors. We will have to rethink the modalities at first line level of the much needed longitudinal and privileged relationships between people and their health services (e.g. via voluntary subscription of people to a health provider instead of the system whereby providers were responsible for a geographical area). Because of the users’ quest for more advanced diagnostics and medical technologies, one can also expect more and more people to go straight to second level referral hospitals, at the expense of district hospitals; a redefinition of the role and functioning of district hospitals will thus have to take place.

Thanks to democratization, media liberalization and social media, people will be more vocal in sharing their frustrations and stating their preferences. Integrating the many preferences into actual services and interventions will be challenging, as the epidemiological and demographic transition will increase the heterogeneity of the needs and demands. Provider payment mechanisms will become key instruments for the government to control costs.

A challenge for the UHC agenda at national level will be the growing intra-society inequality. The latter could go hand in hand with a fragmentation of risk pooling mechanisms. This would impede the construction of coherent and equitable local health systems.

Download the full report

Europe

The Dutch health care performance report: seven years of health care performance assessment in the Netherlands
Michael J van den Berg et al., published in Health Research Policy and Systems 2014

In 2006, the first edition of a monitoring tool for the performance of the Dutch health care system was released: the Dutch Health Care Performance Report (DHCPR). The Netherlands was among the first countries in the world developing such a comprehensive tool for reporting performance on quality, access, and affordability of health care. The tool contains 125 performance indicators; the choice for specific indicators resulted from a dialogue between researchers and policy makers. In the ‘policy cycle’, the DHCPR can rationally be placed between evaluation (accountability) and agenda-setting (for strategic decision making). In this paper, we reflect on important lessons learned after seven years of health care system performance assessment. These lessons entail the importance of a good conceptual framework for health system performance assessment, the importance of repeated measurement, the strength of combining multiple perspectives (e.g., patient, professional, objective, subjective) on the same issue, the importance of a central role for the patients’ perspective in performance assessment, how to deal with the absence of data in relevant domains, the value of international benchmarking and the continuous exchange between researchers and policy makers.

Background

Although the first examples of the assessment of health care systems performance may be traced back to centuries ago, the first attempts to systematically measure and compare performance of health care systems on a regular basis only started about fifteen years ago. The World Health Organization (WHO) describes Health Systems Performance Assessment (HSPA) as “a country-owned process that allows the health system to be assessed holistically, a ‘health check’ of the entire health system”. Statistical indicators are used to monitor system performance. Although research on specific interventions, programs and sectors is of importance, the system-wide, holistic approach of HSPA has an important added value.
What would it take to eradicate health inequalities?

Testing the fundamental causes theory of health inequalities in Scotland

Scott S et al., NHS Health Scotland, Published in http://www.scotpho.org.uk

Socioeconomic inequalities in mortality are large and increasing in Scotland. These inequalities represent unjust differences in the amount of life lived between the most and least deprived members of society. They are not inevitable. Eradicating this injustice requires us to tackle its root cause. Tackling underlying inequalities in income, wealth and power is likely to be the only way this can be sustainably achieved.

The continued and increasing inequality in morbidity and mortality, across Scottish society from the poorest to the wealthiest, is a gross injustice. That periods of decreasing inequality have previously been observed in the UK and elsewhere suggests that this situation is not inevitable and underlines further the need for urgent action. The current approach in Scotland to reduce inequalities in mortality largely focuses on controlling and reducing immediately visible or proximal causes (such as tobacco and alcohol) and targeting professional support to those living in deprived areas. However, recent work undertaken by American sociologists Bruce Link and Jo Phelan suggests that this approach will ultimately fail to eliminate health inequalities. They have shown that new socially patterned threats to health continually emerge over time to fuel differences in mortality between social groups despite success in controlling prior risks. Phelan and Link propose that this continual reproduction of social gradients in mortality occurs because socioeconomic inequality is itself a root or ‘fundamental cause’ of health inequalities operating through an unequal distribution of multiple resources, including income, wealth and power, which can be variously mobilised to protect and improve health across a range of emergent threats. They hypothesise that if socioeconomic inequality is a fundamental cause of health inequality, there will be smaller mortality gradients where it is more difficult to mobilise resources to protect and improve health, such as is the case where little or nothing is known about how to prevent a cause of death.

We described trends in absolute and relative inequalities for 47 to 50 causes of death for men and women across Carstairs deprivation deciles between 1983 and 1999 and men aged 20-64 years across occupational social classes between 1976 and 1999 to determine whether new socioeconomic inequalities in mortality emerged for certain causes of death whilst declining for others in Scotland during this time. In addition, we tested Phelan and Link’s theory by comparing socioeconomic gradients for avoidable and non-avoidable mortality and assessing whether inequalities in mortality increase with increasing preventability of cause of death.

Building better urban health in England

The Lancet, Volume 383, Issue 9916, Page 488, 8 February 2014

What would encourage you to walk more? So asked the Royal Institute of British Architects (RIBA) in their new report—City Health Check—released last week. The report assesses health and the built environment in the nine most populated cities in England, including London, Manchester, and Bristol. It shows that the areas in these cities with the worst health indicators for physical activity, diabetes, and childhood obesity tend to have substantially less green space and a higher housing density. For example, areas with the highest prevalence of childhood obesity had twice the housing density and a third less green space compared with the healthiest areas. RIBA note that deprivation could play a part; areas with less green space are likely to be less affluent and home to more deprived families. However, they also draw attention to Michael Marmot’s report Fair Society, Healthy Lives, which states that “better health is related to green space regardless of socioeconomic status”. Indeed, a study in The Lancet in 2008 showed that health inequalities corrected for income deprivation were lower in populations living in the greenest areas.

RIBA also surveyed more than 1300 residents in the nine cities about how design could encourage them to walk more in their local area. The top changes noted were safer design of pedestrian pathways and more attractive and safer designed public parks and green spaces. RIBA conclude that it is not only the quantity of green spaces in cities but also the quality that will encourage their residents to make healthier choices.
The report is a welcome addition to the existing evidence from the medical community showing that the way cities and towns are designed, planned, and managed can have an important effect on health. One of the recommendations in the 2012 UCL/Lancet Commission on shaping cities for health called on urban planners to include health concerns in their decision making. RIBA's report also calls for healthy design to be enshrined in planning, and urges developers to create beautiful, fitter, and safer cities. The Lancet supports these recommendations. Together the medical and architectural communities can, and should, lay strong foundations for better urban health in England.

Asia

The state of health in the Arab world, 1990—2010: an analysis of the burden of diseases, injuries, and risk factors

Background
The Arab world has a set of historical, geopolitical, social, cultural, and economic characteristics and has been involved in several wars that have affected the burden of disease. Moreover, financial and human resources vary widely across the region. We aimed to examine the burden of diseases and injuries in the Arab world for 1990, 2005, and 2010 using data from the Global Burden of Diseases, Injuries, and Risk Factors Study 2010 (GBD 2010).

Methods
We divided the 22 countries of the Arab League into three categories according to their gross national income: low-income countries (LICs; Comoros, Djibouti, Mauritania, Yemen, and Somalia), middle-income countries (MICs; Algeria, Egypt, Iraq, Jordan, Lebanon, Libya, Morocco, occupied Palestinian territory, Sudan, Syria, and Tunisia), and high-income countries (HICs; Bahrain, Kuwait, Oman, Qatar, Saudi Arabia, and the United Arab Emirates). For the whole Arab world, each income group, and each individual country, we estimated causes of death, disability-adjusted life years (DALYs), DALY-attributable risk factors, years of life lived with disability (YLDs), years of life lost due to premature mortality (YLLs), and life expectancy by age and sex for 1990, 2005, and 2010.

Findings
Ischaemic heart disease was the top cause of death in the Arab world in 2010 (contributing to 14·3% of deaths), replacing lower respiratory infections, which were the leading cause of death in 1990 (11·0%). Lower respiratory infections contributed to the highest proportion of DALYs overall (6·0%), and in female individuals (6·1%), but ischaemic heart disease was the leading cause of DALYs in male individuals (6·0%). DALYs from non-communicable diseases—especially ischaemic heart disease, mental disorders such as depression and anxiety, musculoskeletal disorders including low back pain and neck pain, diabetes, and cirrhosis—increased since 1990. Major depressive disorder was ranked first as a cause of YLDs in 1990, 2005, and 2010, and lower respiratory infections remained the leading cause of YLLs in 2010 (9·2%). The burden from HIV/AIDS also increased substantially, specifically in LICs and MICs, and road injuries continued to rank highly as a cause of death and DALYs, especially in HICs. Deaths due to suboptimal breastfeeding declined from sixth place in 1990 to tenth place in 2010, and childhood underweight declined from fifth to 11th place.

Interpretation
Since 1990, premature death and disability caused by communicable, newborn, nutritional, and maternal disorders (with the exception of HIV/AIDS) has decreased in the Arab world—although these disorders do still persist in LICs—whereas the burden of non-communicable diseases and injuries has increased. The changes in the burden of disease will challenge already stretched human and financial resources because many Arab countries are now dealing with both non-communicable and infectious diseases. A road map for health in the Arab world is urgently needed.

Download the PDF

International Events

Hong Kong - Hospital Authority Convention 2014
May 7-8, 2014 at the Hong Kong Convention & Exhibition Centre

Since 1993, the Hong Kong Hospital Authority has been organising the convention every year to promote sharing of experience among local and overseas healthcare professionals. The Hospital Authority Convention held in May 2013 was attended by 4,500 clinicians and healthcare professionals, including staff of the Hospital Authority and healthcare managers and executives from Mainland China, Hong Kong and overseas.

This year, we have invited over 80 local and overseas expert to participate and share their knowledge and experience on clinical advances and approaches to modern healthcare service as well as exploration and discussion of contemporary concepts among healthcare professionals and stakeholders.

**Colombia - IV Feria Internacional de la Salud, Meditech 2014**  
Agosto, 12 al 15 de 2014, Bogotá, Colombia

• Conozca la visión de los hospitales del futuro
• Reunase con los representantes de la salud mas destacados
• Obtenga tarifas preferenciales por inscripción anticipada

Lugar: Centro Internacional de Negocios y Exposiciones, Corferias
Tel (57-1) 3810000 Ext. 5322
Email:  mсанchez@corferias.com

**Colombia - XI Congreso Colombiano de Hospitales y Clínicas**  
Agosto 13 y 14 de 2014, Bogotá

Asista y conozca hacia dónde avanzan las Instituciones Prestadoras de Servicios de Salud en el mundo.
Información:  [www.achc.org.co](http://www.achc.org.co)
Tel: (57-1) 3124411 Ext. 110
Email:  atencionalafiliado@achc.org.co - comunicaciones@achc.org.co

**Australia - The Australian Healthcare and Hospitals Association's 2014 Congress**  
September 8-10, 2014, Sydney, Australia

"The Quantum Leap: Innovation - Making Quality Count", in collaboration with the Australian Council on Healthcare Standards

This Congress will focus on quality improvement in the healthcare sector.

More information is available by contacting:  swright@ahha.asn.au

**We welcome the interest and participation of IHF members in this Congress**

**Austria - 17th European Health Forum Gastein**  
October 1-3 2014

The EHFG is the leading health policy event in the EU and takes place annually. It provides a major platform for decision-makers in various fields of public health & health care. With its wide-ranging three-day programme, the EHFG offers an unparalleled opportunity to exchange information about a broad spectrum of contemporary health issues.

[http://www.ehfg.org/home.html](http://www.ehfg.org/home.html)

**Korea - 2014 Korea Healthcare Congress at 63 Convention Center**  
November 12 - 14, Seoul

Organized by The Korean Hospital Association
