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Our Health in Our Hands



819 – MAY 2022

REFLECTIONS FROM THE PANDEMIC

Interview with
Alain Berset –P.5

WHO / UNEP

Tobacco and plastics
pollution –P.18

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–P.22

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–P.45



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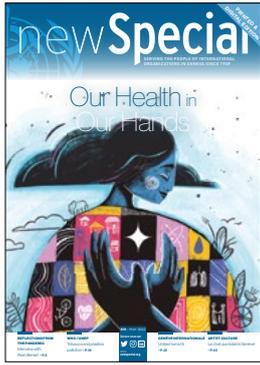
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Our health – creating societies focused on well-being

It is fair to say that health has become one of the key global issues in the last couple of years. The pandemic is still on in many parts of the world, continuing to distract economies, lives, and well-being. But the world also reflects on what has just happened to all of us and what we have learned from this experience.

In this issue, we focus on that reflection. What has been the experience of Switzerland in pandemic management, and what does an ideal future look like? How can we reimagine health systems, hospitals, and future creations of societies focused on well-being? What is the role of new types of media, such as podcasts and other digital health tools, that could dramatically improve our health?

Several articles bring global health stories from international Geneva and from the field, we do hope you will enjoy reading this issue. Especially as we have highlighted the creation of Unitaid fifteen years ago, which developed a unique operational model to target key global health issues, such as HIV/AIDS, tuberculosis, malaria, and most recently, the COVID-19 pandemic. Its record during its existence is very impressive! Over 100 million people in low- and middle-income countries were provided with access to life-saving products at affordable prices.

Enjoy the reading and stay healthy! ■

Notre santé – créer des sociétés concentrées sur le bien-être

Il est juste de dire que la santé est devenue l'un des principaux problèmes mondiaux au cours des deux dernières années. La pandémie est toujours en cours dans de nombreuses régions du monde, au détriment des économies, des vies, et du bien-être. Mais le monde réfléchit également à ce qui vient de nous arriver à tous et à ce que nous avons appris de cette expérience. Dans cette édition, nous nous concentrons sur cette réflexion. Quelle a été l'expérience de la Suisse dans la gestion de la pandémie, et à quoi ressemblerait un avenir idéal? Comment réimaginer les systèmes de santé, les hôpitaux, et les futures créations des sociétés tournées vers le bien-être? Quel est le rôle des nouveaux types de médias, tels que les podcasts et autres outils de santé numériques, qui pourraient considérablement améliorer notre santé?

Plusieurs articles évoquent la santé mondiale au sein de la Genève internationale et sur le terrain. Nous espérons que vous apprécierez la lecture de ce numéro. Ainsi, nous soulignons la création, il y a quinze ans, d'Unitaid qui a développé un modèle opérationnel unique. Son action vise à cibler les principaux problèmes de santé mondiaux, tels que le VIH/sida, la tuberculose, la malaria, et plus récemment, la pandémie de COVID-19. Son bilan est très impressionnant! Plus de 100 millions de personnes dans les pays à revenu faible ou intermédiaire ont eu accès à des produits vitaux à des prix abordables.

Bonne lecture et restez en bonne santé! ■

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Alain Berset

Learning from the past and preparing for the future

newSpecial had the opportunity to interview Alain Berset, vice president of Switzerland, and head of the Federal Department of Home Affairs. The interview was conducted by Lisanne Hopkin.



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LISANNE HOPKIN

Mr. Berset, could you tell us a bit about yourself, your career and engagement in the Swiss political arena?

After gaining political experience at both communal and cantonal level, I was first elected to the Federal Assembly in 2003. I spent eight years in the Council of States before being elected to the Federal Council in December 2011. I was given the home affairs portfolio, which covers public health, social insurance and culture. This experience was very valuable during the pandemic, especially in view of the uncertainties we were constantly faced with.

The preamble to our constitution states that the strength of a society is measured by the condition of its weakest member; this is a fundamental marker, which has always guided my political actions. Seeking solutions, being pragmatic and balanced. That has always been my approach, together with the Federal Council, when responding to the major issues related to the health of the population, but also to safeguarding the interests of the economy and of civil society.

When you started working on health-related issues at federal level, did you imagine you would face such an event as a pandemic? What was your experience during the first couple of

years? Has it changed over this period, in terms of how you approach it now?

Yes, this was clearly a possible scenario. The SARS epidemic in 2003 unfortunately showed that this kind of disaster could also affect us. And it prompted Switzerland to react. Parliament got down to work and in 2013, voters adopted the Epidemics Act by a clear majority. That proved to be incredibly useful right from the start of the crisis in March 2020. We also had a pandemic plan, which instructed the cantons, health institutions and citizens to stock up on masks, so that they would be ready in the event of an outbreak...

We now have to analyse what went well and what didn't go so well so we can avoid making the same mistakes and, above all, to make progress. Because a crisis such as the one we have just been through can happen again. That's also why the Federal Office of Public Health is already preparing a revision of the Epidemics Act. So that will keep us busy for quite some time!

Over the last two years, what has been your proudest achievement? What has been your biggest challenge?

If I had to pick just one thing, then it would be the vaccination campaign. As early as March 2020, my teams identified the companies that, only a few months later,



© WHO/Christopher Black

Swiss Federal Councillor Alain Berset and WHO Director-General, Dr Tedros Adhanom Ghebreyesus

were able to offer the best, safest and most effective vaccines. This was also our biggest challenge: we realised very quickly that we would not get through the pandemic without a vaccine. Together with the cantons, we were able to offer protection to the most vulnerable very quickly. This was a great relief. And it must be emphasised that it is thanks to the immunity provided by the vaccination that we have been able to emerge from the crisis, despite a variant that caused tens of thousands (!) of infections a day in our country.

If you were to pick one issue or one approach which was key and important for Switzerland, which would that be and why?

Politics is about offering choices to citizens, who must be free to make their own decisions. This is a fundamental line that we have always followed within the Federal Council and which corresponds entirely with our political DNA. Moreover, we have never deviated or changed our strategy. This has enabled us to be well understood by our citizens, who have largely supported our decisions. Twice the

Swiss population has supported our policy in popular votes, which is probably unique in the world. We have sought to limit the constraints on the population, the economy and culture as much as possible by adopting a liberal policy, as shown by the various comparative studies carried out at international level. An example that illustrates this quite well are the ski resorts. In contrast to other countries, they were never closed.

Are there any strategies, lessons, experiences you will take with you in order to prepare for the next possible pandemic?

Of course. Even if we were reasonably well prepared, we are always smarter after the event. Several no-holds-barred analyses are currently under way. These steps are very important. In the meantime, we have already put in place procedures that we will follow over the next few months. In short: with the return to normality, the cantons are resuming their role and are therefore responsible for preparing and coordinating themselves for this autumn, should the pandemic return. This includes organising

a possible vaccination campaign and increase the capacity of their hospitals. For its part, the federal government has already purchased and ordered the vaccine doses and is monitoring the circulation of the virus and its effects. One of the key elements will be to measure the development of general immunity among the population.

Is there anything else you would like to add?

It is particularly important to stress my very strong attachment to International Geneva. Over the past two years, we have worked very closely with the WHO, which has played a key role in the crisis. We cannot overcome a pandemic by going it alone, without joining forces at international level. The Federal Council is therefore in favour of strengthening the WHO and its capacity to act. This includes a budget that corresponds to the importance of the task at hand. At present, it is equivalent to the budget of a large hospital in Switzerland, which is obviously very inadequate. Let's be more ambitious! We are therefore convinced that only a strong and reformed WHO, positioned

at the heart of global health governance, can play its leading and coordinating role. This is essential if we are to successfully tackle future crises. ■

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Behind the scenes of the *Global Health Matters* podcast

The *Global Health Matters* podcast, launched in 2021, provides a forum for discussing the most important health topics of the day, with a focus on sharing perspectives from low- and middle-income countries.

MAKIKO KITAMURA, TDR, WHO

The following is an interview conducted by TDR Communications Manager Makiko Kitamura, one of the producers of the podcast with the podcast host, Dr. Garry Aslanyan, Manager of Partnerships and Governance at TDR.

So Garry, tell us about yourself: What's your background, and what led you to choose a career in public health?

I trained in dentistry, but quickly realized that I didn't want to spend the rest of my life in somebody's mouth. At this time, the late 1990s in Canada, where I'm from, there were a lot of health issues such as tobacco control, homelessness and the HIV/AIDS epidemic, which drew me to a career in public health. So I started volunteering for the Ontario Public Health Association, which was part of my training in health policy and systems. I then worked for the Canadian Government and moved to Geneva to support Canada's relations with WHO, which then led to my current position at TDR, the Special Programme for Research and Training in Tropical Diseases, an infectious diseases research programme hosted at WHO.

What prompted you to start this podcast?

I've felt that public health tends to be siloed. For example, people

who work in non-communicable diseases sometimes don't know what's happening in infectious diseases, and there needs to be more connections made with other sectors as well.

I've personally used podcasts as a way to keep up with developments in various areas, and I listened to one by Tenfold that was about "Why Public Health Should Do More Podcasting" – that was the first inspiration. When we looked more closely, we saw that there isn't really a lot of global health podcasting going on, or many have come and gone quickly. I didn't see any that were bringing voices and perspectives from low- and middle-income countries, and that is where we think we're filling a gap. The pandemic was also a major impetus for this project. Pre-pandemic, I was traveling regularly to meet with various stakeholders, and the podcast platform provided an opportunity to do that virtually. It also erased geographic and time zone barriers to engaging in global conversations.

Tell us about setting up the podcast. What were some of the challenges and new skills that you had to bring in to produce the podcast?

I've never worked in radio, and there was a lot of learning that we all had to do. We had to procure the right recording equipment and

find the right recording platform. There have been challenges in terms of guests' internet connections in some countries, getting good quality audio and accommodating different time zones.

But actually, the timing may have been helpful because the pandemic had forced people to start using new communications tools. So by the time we reached out to Muna Abdi in Somaliland and Dissou Affolabi in Benin for our first episode on "Research in the time of COVID-19," they weren't shocked that they would be using these remote interviewing tools.

Can you describe the team that you assembled and a bit about their roles?

Before starting the podcast we had to do a lot of research. We needed to find really good topics and match them with compelling guests. We needed to have someone who works on content production who was also a health expert. We were lucky to have found Lindi van Niekerk who was also interested in podcasting.

So the production team in terms of the content is Lindi and of course Maki and myself. Then we have someone who has experience with recording and editing and all of the other technical aspects of the podcast. That's Obadiah George. He's the only

one on our team who had any previous experience in podcasting. Izabela Suder-Dayao manages the podcast web pages on the TDR website, Christine Coze oversees transcripts of episodes and Elisabetta Dessi is responsible for all podcast-related contracts. We've also engaged graphic designers and social media experts to help promote the episodes.

What makes a good episode and what has been your personal favourite from Season 1?

I think what makes a good episode is a topic that grabs the listener, having a really good discussion with the guests and between the guests as well. And perhaps most importantly, a good episode inspires the listener – someone in Brazil might learn from a speaker in the Philippines who says something relevant and useful for their own work.

The episode on COVID-19 in Africa was an interesting topic because there was very little being said about how previous outbreaks such as Ebola and H1N1; pandemics like HIV, TB and malaria; and polio eradication really helped Africa to deal with this differently. I think our episode unpacked that to those who had not worked in African public health systems, especially to people in high-income countries who may not have



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understood the swift and organized response to this disease.

What topics will be covered in Season 2, and how did you select them?

In Season 2 we've been a bit more systematic in the way we have selected topics. We had suggestions from our listeners emailing us topics they felt were important,

and a research journalist scanned scientific literature, news and other sources to see what the hot topics people are discussing in global health.

Access to medicines is a topic that is not new, but even in the process of producing this episode, we've had a tremendous change in overall global policy and

discourse, from discussions at the WTO such as waiving IP rights to COVID-19 vaccines, to the establishment of a technology hub for LMICs in South Africa, that were not on the table even a year ago. Science diplomacy, corruption in health, migration and health, and diversity in global health are some of the other topics that will be addressed in Season 2

What key lessons have you learned that you can pass on to others about producing a podcast?

I think the key lesson is not to get discouraged as it takes time to build an audience. Fortunately, we reached 10,000 downloads in Season 1, reaching people in more than 130 countries.

Sometimes I look at the analytics data showing the people listening to the podcast, and I think, my gosh, who are these eight people in that small city in Yemen who listened to me? I have no idea who

they are, but they are there, in a place I don't know, and I imagine they are probably working in public health. And I think, oh my, this is really global. So as I know that these people heard my voice there, I say to myself that I'm going to do this as much as possible.

Season 2 of the podcast launched on 12 April 2022 and you can listen to the monthly podcast directly through the TDR website or subscribe through your preferred podcast platform. ■



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Transforming care focused on the patient – trailblazer in Geneva

Interview with Rodolphe Eurin, CEO of Hôpital de La Tour

GARRY ASLANYAN, WHO

Rodolphe Eurin is the CEO of Hôpital de La Tour. With an engineering background and years of experience in multinational companies within the pharmaceutical and medtech industries, he has a quite atypical profile for the world of hospitals. Discussion with someone who is passionate for patient-oriented care, and driven by a belief that medical outcomes will be a key differentiating factor for healthcare institutions in the future.

Mr Eurin, tell us more about you and your work at the Hôpital de La Tour. How do you serve the international civil servants community in Geneva?

La Tour has a long-standing connection with the international world in Geneva. Both our board of directors and our management team reflect this particularity, with 6 nationalities represented. This is important in an institution where about 25% of our patients

work for, or are retired from the international organizations. I have myself been working in multinational companies before taking the lead of La Tour 4 years ago, and I had the chance to be one of two Swiss citizens among 90 participants from 46 different nationalities during my MBA at IMD in Lausanne a few years ago. Multiculturalism brings strength to a team and ensures that we draw inspiration from best practices beyond regional borders, this is a major asset for La Tour and extremely important in my view.

Tell us more about the hospital and its place in Geneva. How does it fit into the health and hospital system in the canton/Switzerland?

Our 24/7 emergency department, internal medicine unit and intensive care unit make La Tour very special within the landscape of private institutions, and essential to Geneva's healthcare system. During the most critical moments

of the covid crisis, where the university hospital had to focus all its resources on covid patients, the most complex and critical patients from the canton were redirected to La Tour.

Alongside this local mission to care for patients from our region, we take care of patients from all over Switzerland and even coming to La Tour from other countries in orthopedics. We have a team of renowned orthopedic surgeons, sports doctors and physiotherapists, all highly specialized by joint and located in a brand new infrastructure dedicated to movement, where we invested more than 100 million CHF 4 years ago. Cardiology, gynecology and oncology are other important therapeutic areas in La Tour, with a comprehensive heart center and a certified breast cancer center. And every year, around 500 babies are born in La Tour, in an environment optimally combining comfort and safety with a unique team

of experts specialized in high risk pregnancies.

I understand the hospital has embarked on an import refocusing of patient care, what are the main goals of this transformation? How will patients benefit from this approach ?

From my first day in La Tour 4 years ago, I embarked with all La Tour teams on a strategy placing the patient at the very top of our priorities. I always wanted to lead a hospital offering the care that I would be seeking for myself as a patient or for someone from my own family. Therefore I asked myself: what would I expect from a hospital as a patient? Of course, I would like to be treated well during my stay, in a comfortable environment. But much more than this, I want to be sure that I will receive the care that will give me the best chances to recover the best possible quality of life after the end of my treatment. For example, I want to be sure that I



will be able to get back to the sport I like with a fully and long-term recovered mobility and no pain after an orthopedic surgery.

This is the mission of a hospital: restoring people's quality of life. Now, how can any company be among the best at what it does? Not only by having the best team, but also by measuring directly with customers the impact and the quality of the services or products that it provides, and by continuously improving based on customer feedback. This is obvious in other industries, but this is something that the healthcare sector has not been good at until today. This strategy is called Value Based Health Care ("VBHC") and aims at delivering the best possible value for the patient, defined as optimal medical results delivered at reasonable cost for the system. VBHC is

spreading rapidly throughout the world, and we have defined this approach as our top priority for the future in La Tour. We started several initiatives now making La Tour a pioneer at Swiss and European level. For example, we convinced a large health insurance company to partner with us in order to develop innovative reimbursement models based on medical results.

Today, people often consider as comfort the fact of having a hospital or a surgeon within less than 10 or 20km from home. But geographical proximity is not the true source of value for a patient. We just need to reflect on what is most important when we are seeking care for ourselves. The certainty to access the best possible treatment for one's specific medical condition matters in the choice

Hôpital de La Tour

Hôpital de La Tour is a private, independent, human-sized facility offering high-level acute care. Committed to delivering the best quality of life to its patients, La Tour places continuous improvement and medical excellence at the heart of its priorities. The hospital's ambitions are backed by highly skilled doctors and nursing staff, as well as state-of-the-art infrastructure.

In fact, La Tour is the only private institution in French-speaking Switzerland to offer 24/7 emergency care, internal medicine, intensive and continuous care, as well as pneumology services for acute care. It is also equipped with an intermediate neonatal care unit and a sports-medicine facility as part of the Swiss Olympic Medical Center.

In 2022, an independent study conducted by Newsweek magazine ranked Hôpital de La Tour as one of the best hospitals in the world.

Hôpital de La Tour's annual figures include: 7,500 inpatients – 340,000 outpatients including 39,000 emergencies – 6,600 surgeries – 52 doctors trained in 11 medical disciplines – 1,000 employees – 511 active licensed doctors.

of a hospital or a doctor, much more than the fact that it is close to where I live. This will be the trend more and more as transparency on medical outcomes increases with time. We want to be at the forefront of this development in La Tour.

The VBHC strategy catalyzes transformation around core values such as patient involvement, team empowerment and accountability, end result transparency and continuous improvement. It is a major cultural shift that reconnects medical teams with their humanistic aspiration to deliver outcomes that matter to patients, and therefore it has the fantastic power to strengthen employee engagement within a health care organization.

What other plans does the hospital have for the next few

years that would be of interest to our readers?

La Tour has significantly extended capacity within the last few years. However, our growth requires a constant strategic reflection on our infrastructure. We will be opening a new building this summer for mostly our pain clinic, a new center for metabolism and a specialized gastroenterology center for inflammatory bowel diseases. Within the next 5 years, we will be considerably reshaping our campus with another building designed to cover all that patients can expect from a hospital of the future. ■

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Video-recording Thailand WR Jos Vandelaer for his speech about childhood obesity and the need to fight against marketing of unhealthy foods and beverages to children. Credit Gemma Vestal

What's a short-term developmental assignment?

and why it benefits both staff and organization?

Have you ever felt the urge to work in another country or duty station just to have a break from the monotony of daily grind and get to know more about your Organization from a different perspective?

GEMMA P. VESTAL, WHO

Well, I've had many of those feelings but never really had anything materialize in the last 19 years until just a few months ago when a colleague said that she had this offer to serve in WCO Thailand on NCD issues while they were going through a selection for the replacement focal point.

This colleague had three young kids so she couldn't just pick up and head to Bangkok for 90 days. And she thought of me because I have made it known for quite some time in my department, through my year-long involvement with the WHO Internal BOOST Initiative¹ in 2021, that I would be willing, ready, and able to go on short-term assignments for the Organization.

What's a short-term developmental assignment (STDA)?

Promulgated in March 2018, STDAs are encouraged to give staff opportunities to enhance their skills and gain diverse experiences by broadening exposure to different work environments. STDAs are one of the measures which support Pillar II of the HR Strategy, "Retaining talent" and of the Corporate Framework for Learning and Development, particularly Objective², "To support Staff Development: career paths and learning pathways".

Benefits to the Organization

1) Possibility to address temporary needs and support

emergency response, as an alternative to recruiting temporary staff, including to fill-in for positions suddenly left vacant by a staff member; 2) Development of internal talent through job enrichment and enhancement; 3) Improvement of processes, development of networks and enhancement of consistency across WHO through the exchange experiences, knowledge and skills between offices; and 4) Promotion of and support to functional and geographical mobility.

Benefits for staff

1) Job enhancement and enrichment; 2) Facilitation of a change of mindset in viewing geographical and functional mobility as an opportunity for growth and development; 3) Learning and skills enhancement; and 4) Opening of potential future professional and career development opportunities.

Who is eligible to undertake an STDA?

The present policy applies to WHO staff members holding continuing and fixed-term appointments in all staff categories, i.e., international professional category at the P and D level (IPs), National Professional Officers category (NPOs) and General Service category (GS), who are willing to take up a STDA as a developmental and learning opportunity. The voluntary nature and the right to return to the previous job or duty station are key factors of the STDA model.²

Timing is everything.

As in most facets of life, timing is indeed everything. Had this opportunity knocked at my door in the middle of the year, I would have had to decline because I would have been worried about not achieving the planned deliverables in my PMDS mid-stream. But this precious

Bangkok opportunity presented itself in early December 2021, which meant that my workplan for 2022 wasn't etched in stone yet. Therefore, both my first-level supervisor and director found the assignment easier to support.

Touch-down in Bangkok on 7 March 2022.

Although I had started supporting the country office remotely since mid-January, it wasn't until 7 March that I was actually physically in Bangkok because as we all know, travel during the pandemic times was challenging. I had to deal with approvals from the region and HQ, visa procurement, and the various requirements of the Thai Health Pass, which allows one to enter Thailand. By that time though, the quarantine requirement was only one night. And I had only 40 days left of to achieve the agreed deliverables under the STDA terms of reference.

Having facetime in WCO Thailand.

Being physically at the country office and meeting WR³ Jos Vandelaer, Dr. Sushera "Joy" Bunluesin (the Thai NPO⁴ who serves as the backbone of our NCD work in Thailand), and Programme Assistant Ganokrat "Took" Teachanuntra, was a hundred times better than being on weekly Teams call with them. The office has about 20 Thai nationals and five (5) internationally recruited staff. The physical offices are on the 4th floor of one of six beautiful buildings of the Ministry of Public Health located in Nonthaburi province, which is about 1.5 hours by commuter train from Bangkok.⁵ For two years in Geneva during the lockdown, I was happily content working from home and didn't really miss my office. But here in Bangkok, I tried as much as allowable to be at the office even when there were only three or four other



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Thailand WR Jos Vandelaer, Dr Joy Bunluesin (NPO/NCD), and Gemma Vestal as they discussed the NCD investment case for Thailand. Credit Gemma Vestal

colleagues each time I went.⁶ I think it was just this opportunity to have a change of scene. Even the 30-minute commute from the apartment to the office didn't feel like a chore, rather, it felt like an exciting adventure each day.

What's unique about Thailand.

The country is best in class in several aspects of public health. Over the years, with 32 WHO Collaborating Centres and progressive health-related laws, Thailand has become a knowledge exporter. Many countries from the ASEAN region and beyond try to emulate Thailand's examples. For instance, Thai Health Promotion Foundation (ThaiHealth)'s annual revenue of about 120 million USD is derived from surcharged 2 percent of the excise taxes on tobacco and alcohol collected directly from tobacco and alcohol producers and importers. This revenue funds ThaiHealth's health promotion mandate.

Learnings from this STDA opportunity.

From this experience, I have come to profoundly respect the work done by our country offices. In Thailand, for NCDs and all the

risk factors, there is only one NCD focal point, an NPO, and a Programme Assistant. Contrast this to what we have at HQ where we have the NCD and Health Promotion Departments to tackle these issues. And the WR has to be well-versed and conversant in all health topics and proficiently articulate WHO's position. As DG Tedros had repeatedly said, we need to amply support our country offices because that's where our work matters.

Conclusion.

Don't wait for luck to get an opportunity to do a short-term developmental assignment. Be proactive and network across the three levels of the Organization to find something for 3 to 6 months. It's an excellent means to augment ones experiential knowledge of WHO so we can work more meaningfully in our respective jobs, learn some new things in order to skill-up, and flex those muscles in preparation of our global mobility. At least for me, this STDA has been one of the highlights of my long WHO career. See for yourself. Give STDA a try! ■

1 Enseignants-chercheurs à l The Boost Initiative is a three-level aligned approach to augment the capacity of country offices through virtual attachments of staff from HQ with up to 50% of staff working time. Contact Gyanendra Ghale at ghaleg@who.int or Mubashar Sheikh at sheikhm@who.int for more information

2 The previous 4 paragraphs were quoted verbatim from the STDA policy. With special thanks to Sara Canina for providing relevant documents for this article.

3 WHO Country Office Head

4 National Professional Officer

5 Only 30 minutes by car

6 Due to the pandemic, only 25% of the WCO workforce were allowed to be at the office each day

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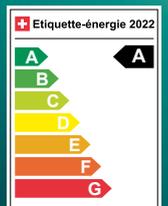
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L'innovation pédagogique pour sauver des vies

KARL BLANCHET, THOMAS FASSIER,
AIMAD OURAHMOUNE, PATRICIA
PICCHIOTTINO¹

La formation des acteurs et actrices de la santé connaît de profondes mutations depuis une dizaine d'années². Ces évolutions de l'offre et des approches pédagogiques répondent aux exigences croissantes en vue de garantir la qualité des soins et la sécurité des patient-es, y compris dans des situations de fragilité, de vulnérabilité ou de conflit. Mais comment l'innovation pédagogique contribue-t-elle à sauver des vies?

Approche par les compétences (*Competency-based education, CBE*), formation interprofessionnelle (*Interprofessional education, IPE*), évaluation au service de l'apprentissage (*Assessment for learning*), etc.: autant de tendances qui transforment les approches pédagogiques traditionnelles. Le domaine de la santé est familier de ces innovations, qui se traduisent de manière croissante dans les formats et outils de formation, de la mise en situation aux études de cas, en passant par l'enseignement en ligne, et de plus en plus, par le recours à la simulation.

A Genève, le Centre interprofessionnel de Simulation (CiS) incarne, entre autres institutions et partenaires, ce souffle novateur. Depuis 2013, ce centre conjoint³ bien connu des professionnel-les de la santé et au-delà, œuvre à développer la simulation comme technique pédagogique au bénéfice du développement des compétences. Grâce à la simulation, les personnels médicaux

et paramédicaux peuvent se préparer à travailler en équipe et à mieux appréhender les situations de crise. Une approche qui se déploie de plus en plus dans les contextes humanitaires, avec grand intérêt des acteurs/trices de l'action humanitaire et des populations locales, à travers le Centre d'Etudes Humanitaires de Genève⁴ et InZone⁵.

La santé, un défi en contextes humanitaires

Systèmes et infrastructures de santé endommagés, pénuries de personnel de santé qualifié, accès limité aux fournitures médicales, isolement des professionnel-les dû à l'insécurité sont certaines des nombreuses contraintes auxquelles sont soumises les organisations œuvrant dans le domaine de la santé dans des situations telles que les crises humanitaires, les situations d'urgence prolongées ou les conflits armés. De fait, celles-ci demeurent rares à avoir adopté une approche globale pour améliorer la sécurité des patient-es et la qualité des soins cliniques. Or, c'est justement dans de telles circonstances, où les besoins sanitaires des populations sont prépondérants, que la qualité et la sécurité des soins sont essentiels, et que la formation est un précieux levier d'action.

Pour ce faire, les spécificités des contextes humanitaires (camp de réfugié, centre sanitaire avancé, ou encore un hôpital) nécessitent de réviser les modalités pédagogiques, voire de créer des curricula sur-mesure, afin de répondre aux besoins du terrain. Bien souvent, une offre d'enseignement à

distance tirant profit des outils numériques (visio-conférences, e-learning, télé-simulation) est développée, mais non sans défis. Les obstacles techniques et logistiques, tels que l'accès à l'électricité et à internet, ou encore le manque d'équipements individuels, demeurent des défis quotidiens. A cet égard, une étroite collaboration est essentielle avec les partenaires locaux, nationaux et étrangers.

Une formation sur la qualité et la sécurité des soins incluant les analyses des risques et incidents est en cours de construction par le Centre d'Etudes Humanitaires en collaboration avec les Hôpitaux Universitaires de Genève (HUG), le Comité International de la Croix-Rouge (CICR) et Médecins Sans Frontières (MSF). Elle sera assurée en ligne pour une plus grande participation des acteurs de l'humanitaire. Une approche similaire est adoptée par InZone qui, avec la Fédération Internationale de la Croix Rouge (FICR), développe un cours en Santé Communautaire pour les personnes réfugiées.

La simulation comme outil de formation

Bien plus qu'un simple outil technologique, la simulation est une technique pédagogique qui est au service du développement de compétences. Des modalités spécifiques de simulation sont choisies pour une formation en fonction du public cible (individus ou équipes) et selon les compétences visées: procédures techniques (ex: simulation avec mannequin haute-fidélité pour un accouchement) ou

compétences inter-personnelles (simulation avec patient-es simulé-es et jeux de rôle scénarisés pour entraîner à la communication). Une multitude de simulations peuvent être transposables aisément, sans devoir nécessairement faire appel à une technologie de pointe. Les scénarios peuvent en effet être le plus souvent adaptés aux ressources locales.

La simulation apparaît ainsi, notamment de par son adaptabilité à de multiples contextes, comme un outil de formation d'avenir dans des situations où les ressources sont limitées, et les infrastructures hospitalières et de formation éloignées. Par exemple, dans un camp de réfugiés au Kenya, la simulation en présentiel a été utilisée comme entraînement à la prise des paramètres vitaux, et un module de télé-simulation a permis de développer des compétences dans l'évaluation initiale d'un blessé.

La simulation est au bénéfice de la sécurité des patient-es, enjeu majeur pour la santé. Il s'avère que, même dans les secteurs à haute fiabilité comme l'aviation, 80% des incidents sont dus aux facteurs humains. Dans une étude⁶, il a été estimé qu'environ 10% des hospitalisations enregistrées dans le monde chaque année donnent lieu à des événements indésirables qui se traduisent en préjudice pour les patient-es, et ce parfois jusqu'au décès. Il s'avère que deux-tiers de tous les événements indésirables recensés se produisent dans des pays à faibles revenus ou à



©Louis Brisser/HUG

revenus intermédiaires. L'enjeu en contexte humanitaire est donc d'autant plus prégnant.

Afin de réduire l'occurrence de ces événements indésirables et d'ainsi assurer une meilleure qualité des soins et sécurité des patient-es, plusieurs actions ont été mises en œuvre, dont notamment l'introduction d'une checklist de bloc opératoire sous l'égide de l'Organisation mondiale de la santé (OMS) en 2008. La formation des personnels de santé aux facteurs humains (*Crew Resources Management - CRM*), soit un ensemble de procédures de formation qui prennent place dans des environnements où l'erreur humaine peut avoir de graves conséquences, a également un rôle majeur à jouer.

A cet égard, le CiS développe des formations sur un référentiel de compétences

interprofessionnelles telles que la communication, le leadership, la clarification des rôles et l'organisation de l'équipe, la résolution de conflits, etc. et s'appuie sur des stratégies et des outils issus de TeamSTEPPS⁷, modèle visant à améliorer la performance des équipes et la sécurité des patient-es. La simulation est une modalité largement utilisée pour ces formations. Elle permet de pratiquer et de développer la conscience de la situation des individus et des équipes. Par exemple, l'outil TeamVision⁸ (primé lors de la journée de l'innovation 2021 des HUG) apporte une approche innovante qui utilise des capteurs mesurant la position dans l'espace, la direction des regards, ou encore la communication verbale pour aider les équipes en simulation à optimiser leur collaboration au service de la sécurité des patient-es.

Vers un cadre international pour valoriser la formation et l'apprentissage

En prévision du Conseil des Délégués du Mouvement international de la Croix-Rouge et du Croissant-Rouge des 22 et 23 juin 2022, le CICR et la FICR ont proposé un document de référence pour expliciter l'approche du Mouvement pour garantir la sécurité des patients et la qualité des soins. L'un des objectifs de cette initiative est d'ouvrir la voie à une politique commune du Mouvement qui permettrait notamment d'harmoniser les approches et les outils, aujourd'hui très différents d'une composante à l'autre du Mouvement, tout en instituant une culture de l'apprentissage et de l'amélioration continue dans le contexte des soins de santé d'urgence. Il répondra ainsi à une volonté de s'aligner sur le Plan d'action mondial 2021-2030 pour la sécurité des patient-es élaboré par l'OMS. Garantir et améliorer la qualité et la sécurité des services de soins cliniques à travers la formation et l'innovation pédagogique (et notamment la simulation), sera essentiel à cet effort. ■

- 1 Prof. Karl Blanchet, Directeur du Centre d'études humanitaires à Genève et InZone. D' Thomas Fassier, Directeur du Centre Interprofessionnel de Simulation. Patricia Picchiottino, Directrice Adjointe Centre Interprofessionnel de Simulation. D' Aimad Ourahmoune, Médecin adjoint du chef de service qualité des soins (HUG).
- 2 Frenk et al. Lancet 2010.
- 3 La Faculté de Médecine de l'Université de Genève, la Haute École de Santé de la HES-SO à Genève, les Hôpitaux universitaires de Genève – HUG, et l'Institution genevoise de Maintien à Domicile – Imad.
- 4 Plus de détails sur <https://humanitarianstudies.ch/>
- 5 Plus de détails sur <https://www.unige.ch/inzone/>
- 6 Jha A.K., Larizgoitia I., Audera-Lopez C., Prasopa-Plaizier N., Waters H. et Bates D.W. «The global burden of unsafe medical care: analytic modelling of observational studies». *BMJ Quality and Safety*, Vol. 12, N°10, octobre 2013, pp. 809-815.
- 7 Plus de détails sur <https://www.cis-ge.ch/teamstepps>
- 8 Plus de détails sur <https://teamvision.ai/>



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Raising awareness on tobacco and plastics pollution

a partnership between the Secretariat of the WHO FCTC and UNEP Clean Seas Campaign

I urge all of you to join this campaign. Let's all do our part to ensure our seas and oceans – together with all their inhabitants – are protected for future generations.

ADRIANA BLANCO MARQUIZO, HEAD OF THE SECRETARIAT OF THE WHO FCTC

The COVID-19 pandemic has made apparent, once again, the fact that we live in an interconnected world.

There are very few issues that can be considered simply “health problems”, as nearly every aspect of life is connected to other societal, economic and environmental issues. That is why the *2030 Agenda for Sustainable Development* is “a plan of action for people, planet and prosperity”, and its 17 goals and 169 associated targets are “integrated and indivisible”. Tobacco control is linked to 67 of the Sustainable Development Goal targets, and it is integrated in Target 3.a on strengthening the implementation of the WHO Framework Convention on Tobacco Control (WHO FCTC).

We all recognize the health impact of tobacco, which kills more than 8 million people around the globe annually. We tend to think less frequently about the economic impact of tobacco use on health expenditures and productivity losses, which are equivalent to 1.8% of the world's annual gross domestic product. What is even less well known is how tremendously destructive tobacco cultivation and use are for the environment – on land,

water and air. The noxious effects of tobacco on the environment begin with the preproduction process, as massive deforestation occurs to create space for tobacco farming. Once tobacco is harvested, huge quantities of timber are required for drying the leaves. Estimates show that tobacco farming causes up to 5% of global deforestation, with 200 000 hectares of natural wood biomass lost each year.

During production, tobacco crops require large amounts of chemical fertilizers, pesticides and growth regulators that pollute the ground, nearby waterways and aquifers. In terms of health, tobacco cultivation also presents serious hazards for farmers and their families because of the intensive use of pesticides and nicotine poisoning due to the handling of the leaves.

When asked, many of us would probably guess that the most common form of plastic pollution would be plastic straws or bottles. While these are good guesses, in reality, cigarette butts, composed of thousands of cellulose acetate fibres, are the most widespread form of plastic waste in the world. An estimated 5.6 trillion cigarettes are smoked each year, out of which two thirds are disposed of improperly. That is an estimated 4.5 trillion cigarette butts being thrown away

every year worldwide, representing 1.69 billion pounds of toxic trash annually. Since the 1980s, cigarette butts have accounted for 30–40% of all litter found in coastal and urban litter clean-ups.

The cellulose acetate fibres in cigarette butts take years to degrade and disappear from the environment. These fibres, like other microplastics, are also a common contaminant found throughout the world's ecosystems, even accumulating at the bottom of the deep sea. Under specific circumstances – such as exposure to sunlight and moisture – cigarette filters break into smaller plastic pieces containing – and eventually leaching out – some of the 7000 chemicals contained in a single cigarette.

Many of these chemicals are themselves environmentally toxic, and at least 50 are known human carcinogens. Studies have also shown that harmful chemicals such as nicotine, arsenic, polycyclic aromatic hydrocarbons, or PAHs, and heavy metals leach from discarded tobacco product waste, and they can be acutely toxic to aquatic organisms. Field researchers often find cigarette butts inside of dead sea birds, sea turtles, fish and dolphins. What's more, a 2011 study found that the chemicals leaching from smoked cigarette



butts and smoked and unsmoked cigarette filters can be lethal to freshwater and marine fish species. When ingested, the hazardous chemicals in microplastics cause long-term mortality in marine life, including birds, fish, mammals, plants and reptiles. These microplastics enter the food chain and are associated with serious human health impacts, which can include changes to genetics, brain development, respiration rates and more.

It thus comes as no surprise that the United Nations Development Programme (UNEP) has described tobacco as “a threat to our oceans”.

Article 18 of the WHO FCTC calls on countries to protect the environment and the health of people.

The UNEP and the Secretariat of the WHO FCTC recently launched a partnership to raise awareness and drive action on the extensive environmental and human

health impacts of microplastics in cigarette filters.

Through an extensive social media campaign, the partnership will aim to engage influencers, UNEP’s Goodwill Ambassadors and Young Champions of the Earth to raise awareness of the issues surrounding microplastics. It will also adopt a political advocacy approach, drawing upon the expertise of the Secretariat of the WHO FCTC. By highlighting a recent European Union directive requiring all tobacco products with plastic filters to be labelled clearly, the initiative will encourage citizens to advocate for similar changes globally. The regulation, which was adopted in December 2020 and took effect in July 2021, establishes harmonized labelling specifications for a wide range of products, including tobacco products with filters and filters marketed for use in combination with tobacco products, which contain plastics. The labelling

cannot obstruct in any way the visibility of the health warnings required by the Tobacco Products Directive on these packages – which, in the case of tobacco products for smoking, cover 65% of the front and back of packages – and, at the same time, cannot be totally or partially covered by other labels or stamps. The information text of the labelling must be in the official language or languages of the Member State(s) where the single-use plastic product is available.

Another exciting development occurred on 2 March 2022 when Heads of State, Ministers of Environment and other representatives from 175 nations endorsed an historic resolution at the Fifth session of the United Nations Environment Assembly (UNEA-5) in Nairobi to End Plastic Pollution and forge an international legally binding agreement by 2024. The resolution addresses the full life cycle of plastic, including its production, design and disposal.

The resolution, based on three initial draft resolutions from various nations, establishes an Intergovernmental Negotiating Committee, which will begin its work this year, with the aim of completing a draft global agreement by the end of 2024. It is expected to present a legally binding instrument, which would reflect diverse alternatives to address the full life cycle of plastics, the design of reusable and recyclable products and materials, and the need for enhanced international collaboration to

facilitate access to technology, capacity-building, and scientific and technical cooperation.

This partnership between UNEP and the Secretariat of the WHO FCTC is facilitated through the former’s Clean Seas campaign – a global coalition comprising 63 countries devoted to ending marine plastic pollution. It weds the Secretariat of the WHO FCTC’s experience on the health and public policy dimensions of tobacco products with UNEP’s research and advocacy on plastic pollution.

UNEP Clean Seas and the Secretariat of the WHO FCTC are committed to enabling meaningful change on microplastics by raising awareness on the fact that our health is intrinsically linked to that of our planet and to help drive policy in the right direction. This partnership signals an important first step towards resolving the critical health and environmental impacts of microplastics in cigarette filters. ■



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Bridging the age gap in the digital era

In this new world that has emerged from COVID-19, it's hard to imagine life without access to the online world.

CAROLYN DOSS, WHO

For many of us, it has become a basic necessity, a lifeline, to shop, pay bills, telework, to visit family and friends, or even binge-watch television shows simply to distract oneself from all things COVID.

The list of on-line benefits goes on, but have we thought about the many older adults in our society who do not have access to the internet, who have never used tablets or smartphones and who are marooned at home because of their fear of infection? How many are forgotten because they live alone, perhaps without children or family nearby to guide them? This in no way implies that learning to use technology is not possible as we get older or that one must depend entirely on others to learn; nevertheless, we should recognize that a lot of older people are marginalized by the digital technology that we now take for granted.

I recently had the experience of helping my eighty-three-year-old

aunt get set up with internet access for the first time in her life. While it was something we had touched upon in pre-COVID times, she never deemed it a necessity. My aunt who lives alone, has always been very independent (despite having lived through a serious illness), paid her bills, and did her shopping unassisted, and regularly used public transportation, never having had a driver's license. This all changed when COVID became a part of our daily lives. Suddenly, it seemed more important than ever for her to be online, to be able to connect and keep in touch, even if only virtually.

Coming from the information technology world, where I cut my teeth in user support, I was convinced it could all be done relatively easily.

Well yes and no.

Yes, I remembered how to be patient and yes, I could slip right back into my 'user support voice' but no, I had not banked on what

it would be like to provide support to someone who not only was having trouble hearing me but who had perhaps never really used a computer or a mobile device. In my enthusiasm, I had not taken into consideration, that in my technical support days, the people I encountered were generally younger, and already familiar with technology. None of them had been retired for decades with no one keeping them in the technology loop.

Having decided that a tablet would be the easiest option and living in a different country from my aunt, I knew I would need to set it up for her before shipping it out. I created her very first email address, installed a few basics, filled the address book, and removed the unnecessary applications to keep things as simple as possible.

Next came getting her subscribed to broadband. I didn't find any obvious discounts for pensioners, even though the price for a broadband connection can

be considerable and what I did find, meant concessions on data allowance. When there are discounts for everything else as you get older, I wonder why not for broadband services?

After sorting out the basics, I then realized that it's not just about the device you choose, or about the hours you spend on technical support; it's also about the technical environment that we now take for granted as we zip around seamlessly from device to device, without a second's thought.

While a lot of us have progressively been exposed to modern technology perhaps by way of the personal computer and then on to mobile devices, etc., we forget that there is a whole generation out there who have not been afforded the same opportunities. Just being able to swipe and scroll is instinctive for most of us but when you have to explain this to someone long distance who has

never had the benefit of a 'technical evolution', it quickly becomes a humbling experience.

Utility and other service companies are now imposing fees for paper bills. I understand the environmental reasons for them doing so, but they ignore the people who struggle with online access. Consideration must be given to those who do not have the means or know-how, which begs the question of why this practice is not regulated for the public good. Forcing anyone who is not tech-savvy to shell out more for paper bills and then making them travel farther to pay them as more and more services go online is not the answer, especially when the support is not available to ensure that people do not find themselves digitally excluded.

Society must consider older adults and not assume that almost everyone has access to technology nowadays. Certainly,

not everyone can afford it and even if they can, we do not have inexpensive tech support services readily available that specialize in helping people with no experience but who need it the most. Yes, you can always contact service providers but often they are not trained in helping people with little or no technological experience.

Perhaps we could make a start at reducing this digital exclusion by getting local governments and organizations to sponsor programs aimed at bringing older people into the digital age. As the former UN Secretary-General Kofi Annan once remarked, "You are never too young to lead, and we are never too old to learn" (addressing Global Citizen Live - Twitter: online). ■

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A child holding one of the newly formulated, properly-dosed pediatric TB drugs approved by the World Health Organization. The new regimen is sweet and water-dispersible, making it specially adapted to children.

Unitaid turns 15

Saving lives through health innovation

The disastrous health, economic, and social consequences of the COVID-19 pandemic have put equitable access to health tools at the top of the international political agenda.

THALIA BAYLE

When Unitaid was founded fifteen years ago, efforts to curb some of the greatest threats to health were stymied by similar access barriers that meant vital products were not available everywhere they were needed. It was in response to this challenge, which resonates with recent events, that Brazil, Chile, France, Norway, the Republic of Korea, Spain, the United Kingdom, and the Bill & Melinda Gates Foundation came together

to form Unitaid as a global health partnership hosted by the World Health Organization (WHO).

In the wake of the adoption of the Millennium Development Goals by the United Nations in 2000, which led to the setting of elimination targets for the “three great pandemics” – HIV/AIDS, tuberculosis, and malaria – Unitaid was given a primary mission: to make innovative health solutions, drugs, screenings, and new approaches affordable and

available in low- and middle-income countries.

To achieve this objective, Unitaid developed an agile and unique operational model based on a network of partnerships with a multitude of actors: countries, the WHO, pharmaceutical industries including manufacturers, NGOs, and communities. Its innovative financing model, initially based on the solidarity tax on airline tickets, has evolved with contributions from the founding



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countries and other donors, including Canada, Germany, Italy, Japan, Portugal, Spain, and the Wellcome Foundation in the context of the COVID-19 pandemic response.

Over time, Unitaïd has been able to transform this unique model into a true public health revolution, saving lives, time, and money. Since its inception, Unitaïd has supported countries in their response to major epidemics such as HIV/AIDS, tuberculosis, and malaria, as well as HIV-related co-infections and co-morbidities, such as cervical cancer and hepatitis C. The organization also supports projects targeting cross-cutting areas such as fever management.

Today, the results are in. Each year, Unitaïd provides 100 million people in low- and middle-income countries with access to life-saving health products.

Many health products, such as life-saving medicines that have become mainstays of the global health response, would not exist without Unitaïd's support. These include: antiretroviral medicines currently used to treat people living with HIV in low- and middle-income countries; tests used to detect tuberculosis and medicines currently used to treat drug-resistant tuberculosis; malaria prevention tools, including specialized treatments for children and pregnant

women; and new insecticides and long-lasting insecticide-treated mosquito nets.

By facilitating the availability of such quality innovations at affordable prices in countries where they are otherwise slow to reach, Unitaïd has been a driving force in advancing access to care and improving the lives of patients.

An innovative mechanism created by Unitaïd ten years ago stands out. The Medicines Patent Pool (MPP), founded and funded by Unitaïd, allows pharmaceutical companies to license their rights on a voluntary basis. These agreements allow Unitaïd and its partners to obtain lower prices for vital drugs. The MPP has made it possible to manufacture generic medicines that are used to treat tens of millions of people around the world. As a result of this mechanism, for example, the annual cost of HIV/AIDS treatment is less than \$70 in Africa, compared to \$10,000 in Europe.

Unitaid is also particularly active in women's and children's health, seeking to facilitate access to health innovations for these populations and adapting them to their specific needs.

In this regard, Unitaïd has contributed to the development and introduction of all drug formulations adapted to children affected by tuberculosis, HIV, and malaria

in low- and middle-income countries. These efforts have also resulted in improved access to drugs to treat or prevent malaria in children and pregnant women. Finally, initiatives are currently underway to develop a cervical cancer screening and treatment solution for less than 3 euros per woman, in support of the World Health Organization's (WHO) global strategy to eliminate cervical cancer.

Since 2020, Unitaïd has lent its expertise to the fight against COVID-19 as a lead agency of the Access to COVID-19 Tools Accelerator, also known as the ACT Accelerator.

Within this framework, the organization is contributing to the development and availability of new diagnostics and treatments in response to the pandemic. In particular, Unitaïd has invested in supporting research into new drugs for COVID-19 through support for research platforms and clinical trials.

Unitaid is also working to improve access to medical oxygen to alleviate severe shortages in countries affected by the pandemic. In this capacity, Unitaïd leads the ACT Accelerator's Oxygen Emergency Taskforce, which has provided technical support and emergency medical oxygen supplies to nearly 100 countries. The Taskforce has also made it possible to broker an unprecedented

agreement with global oxygen suppliers to reduce the price of bulk liquid oxygen by 15 percent from current prices and oxygen cylinders by 10 to 50 percent.

Finally, Unitaïd's work early in the pandemic helped reduce the price of rapid antigen tests to \$2.50 and increase production to make 250 million tests available in low- and middle-income countries.

Scaling up these innovative initiatives, which Unitaïd pilots and perfects, depends on the interplay with other partners, notably the Global Fund to Fight AIDS, Tuberculosis, and Malaria, whose efforts are complementary to those of Unitaïd.

According to an analysis by the Global Fund, without Unitaïd's investments, it would take an additional three to five years to reach the targets set in the Global Fund's investment plan. By reducing the cost of health care and critical tools in low- and middle-income countries, Unitaïd's activities are also expected to generate more than \$5 billion in savings for resource-poor settings by 2030. ■

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Unitaid Celebrating 15 years of innovation



Fifteen years ago, Unitaid was founded with the primary mission to make innovative health solutions and tools affordable and available in low- and middle-income countries (LMICs). At the initiative of Brazil, Chile, France, Norway, the Republic of Korea, Spain, the United Kingdom, and the Bill & Melinda Gates Foundation, and originally funded through a solidarity tax on airline tickets, Unitaid was created as a hosted partnership of the World Health Organization (WHO) to support the achievement of the Millennium Development Goals, which established the first globally agreed targets to combat HIV/AIDS, tuberculosis, and malaria.

To achieve these objectives, Unitaid has developed a unique operational model based on inclusive partnerships with countries, the WHO, pharmaceutical industries including generic manufacturers, NGOs, and communities.

Its financing model has evolved with contributions from the founding countries and other donors, including Canada, Germany, Italy, Japan, Portugal, Spain, and the Wellcome Foundation in the context of the COVID-19 pandemic.

Over time, Unitaid has transformed this unique model into a public health revolution. Each year, the organization provides 100 million people in LMICs with access to life-saving products at affordable prices.

Since 2020, Unitaid has leveraged its expertise to advance new, life-saving solutions to the COVID-19 pandemic as a lead agency of the Access to COVID-19 Tools Accelerator (ACT-A). The organization is contributing to the development and availability of new diagnostics and treatments. It is also working to improve access to medical oxygen to alleviate severe shortages in countries affected by the pandemic.

By facilitating the availability of quality innovations at affordable prices in countries where they are otherwise slow to reach, Unitaid has been a driving force in advancing access to care and improving the lives of patients.

Many health products, such as life-saving medicines that have become mainstays of the global health response, would not exist without Unitaid's support. These include: improved antiretroviral medicines; better tests to detect tuberculosis and medicines currently used to treat drug-resistant tuberculosis; and malaria prevention tools including specialized treatments for children and pregnant women, new insecticides and long-lasting insecticide-treated mosquito nets.

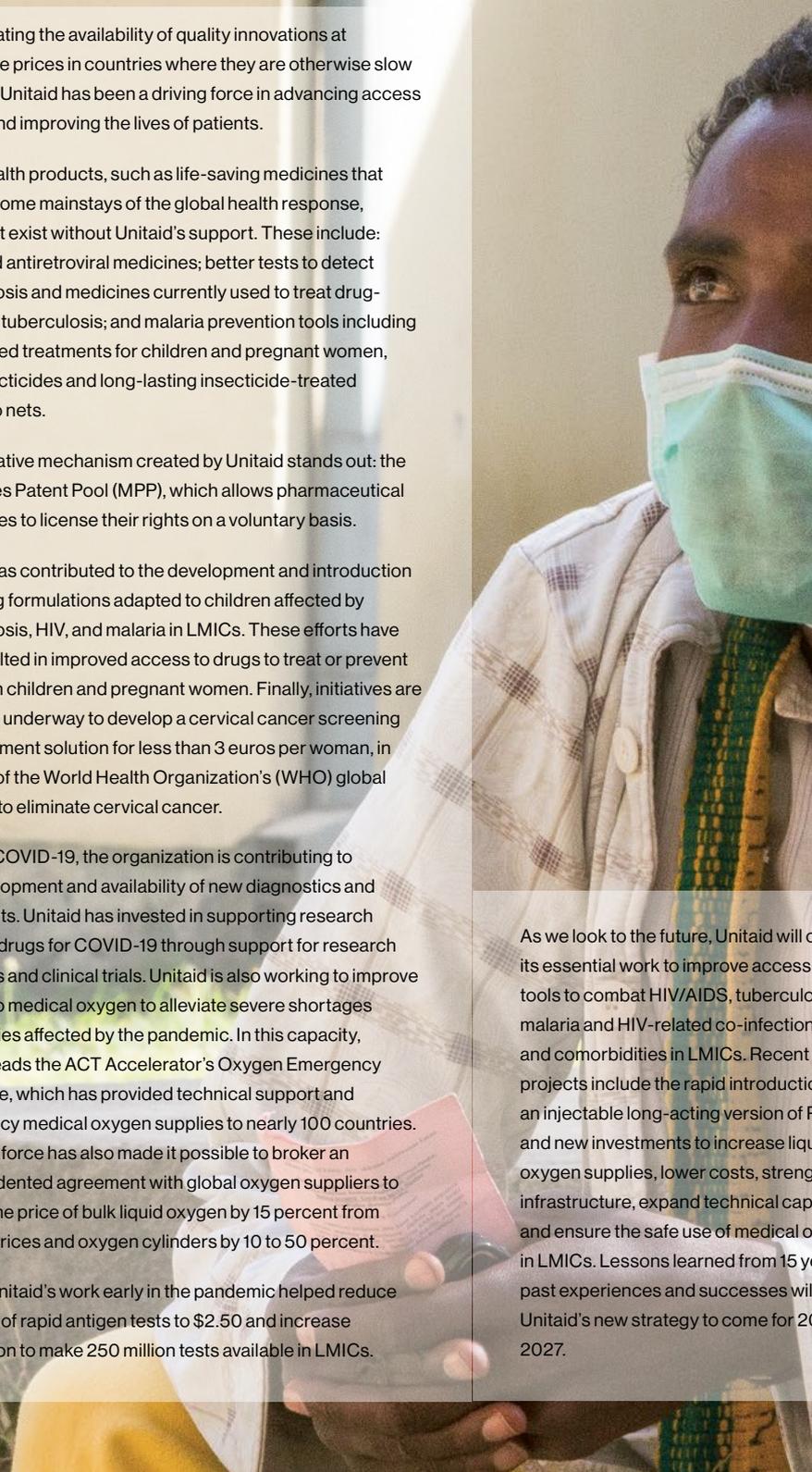
An innovative mechanism created by Unitaid stands out: the Medicines Patent Pool (MPP), which allows pharmaceutical companies to license their rights on a voluntary basis.

Unitaid has contributed to the development and introduction of all drug formulations adapted to children affected by tuberculosis, HIV, and malaria in LMICs. These efforts have also resulted in improved access to drugs to treat or prevent malaria in children and pregnant women. Finally, initiatives are currently underway to develop a cervical cancer screening and treatment solution for less than 3 euros per woman, in support of the World Health Organization's (WHO) global strategy to eliminate cervical cancer.

Against COVID-19, the organization is contributing to the development and availability of new diagnostics and treatments. Unitaid has invested in supporting research into new drugs for COVID-19 through support for research platforms and clinical trials. Unitaid is also working to improve access to medical oxygen to alleviate severe shortages in countries affected by the pandemic. In this capacity, Unitaid leads the ACT Accelerator's Oxygen Emergency Taskforce, which has provided technical support and emergency medical oxygen supplies to nearly 100 countries. The Taskforce has also made it possible to broker an unprecedented agreement with global oxygen suppliers to reduce the price of bulk liquid oxygen by 15 percent from current prices and oxygen cylinders by 10 to 50 percent.

Finally, Unitaid's work early in the pandemic helped reduce the price of rapid antigen tests to \$2.50 and increase production to make 250 million tests available in LMICs.

As we look to the future, Unitaid will continue its essential work to improve access to tools to combat HIV/AIDS, tuberculosis, malaria and HIV-related co-infections and comorbidities in LMICs. Recent projects include the rapid introduction of an injectable long-acting version of PrEP and new investments to increase liquid oxygen supplies, lower costs, strengthen infrastructure, expand technical capacity and ensure the safe use of medical oxygen in LMICs. Lessons learned from 15 years of past experiences and successes will inform Unitaid's new strategy to come for 2027.



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Weston Kandawasvika, sitting next to with his wife, Patience Mbeve, takes an HIV self-test. Through Population Services International, Unitaaid is funding the largest effort ever to kickstart wider use of HIV self-testing.

© Eric Gnaess/Unitaid



Trezahellen Akinyi is a primary school pupil in Kisumu town who has had malaria and used medication provided under the Affordable Medicines Facility – malaria (AMFm) project, funded by Unitaaid.

© Thomas Omoyi/ The Global Fund



A tuberculosis patient at Alert Hospital in Addis Ababa, Ethiopia. Alert Hospital provides free treatment for multi-drug resistant tuberculosis (MDR-TB) patients, funded by the Ethiopian government and international donors. Patients stay at the hospital for up to four months to start their treatment.

© Michael Towade/Unitaid

Bringing Leadership Training Online during the COVID-19 Pandemic

The response to the global pandemic resulted in adaptations to the ways we live, work and learn. In early 2020, while countries restricted travel and training venues shut their doors, the great shift to online learning began.

ANDREW BLACK, HEINI UTUNEN AND RYAN CROWDER, WHO

Building on the experience of running a successful online learning platform¹ and face-to-face training, the Learning and Capacity Development Unit (LCD) in the WHO Health Emergencies Programme took the decision to move classroom-based leadership learning online. This meant that important training could continue for WHO staff and colleagues in Ministries of Health during the pandemic.

This article explores how LCD combined online tools with adult learning techniques to develop an innovative approach to leadership training that could be delivered remotely. Using this approach, 108 participants were trained in 2021 and a further 200 will attend in 2022.

Novel Coronavirus, Novel Approach

The Leadership in Emergencies (Leadership) Programme was launched in 2019 to provide professionals with the necessary personal skills to lead a response in emergencies. It is one part of a blended curriculum that combines self-paced online learning and will be expanded to include an operational training package. Face-to-face contact has traditionally been seen as essential for leadership training,

with training 'on-site' viewed as particularly impactful.² However, with in-person learning disrupted by the pandemic, a custom blend of online learning was needed.

The pandemic also saw development of online tools for hosting video calls for discussion, collaborative group work, networking and realistic training exercises. These tools coupled with people's increasing experience and comfort with working online made moving a classroom-based training course to an online format a viable proposition.

The LCD approach was to replace a five-day workshop with 16 hours of online classes conducted over eight weeks. Participants meet for an hour twice a week using Zoom. Each week, the participants tackle a different topic and great emphasis is placed on 'peer learning'. Every session is broken down into three parts, each lasting about 20 minutes: a presentation of the topic, group work and a plenary discussion. After each 60-minute session there is a 30-minute 'virtual coffee' so that interested participants can stay behind to speak with each other and the facilitators.

This core curriculum focuses on developing self-awareness and the impact that leaders have on teams. Over the eight weeks,

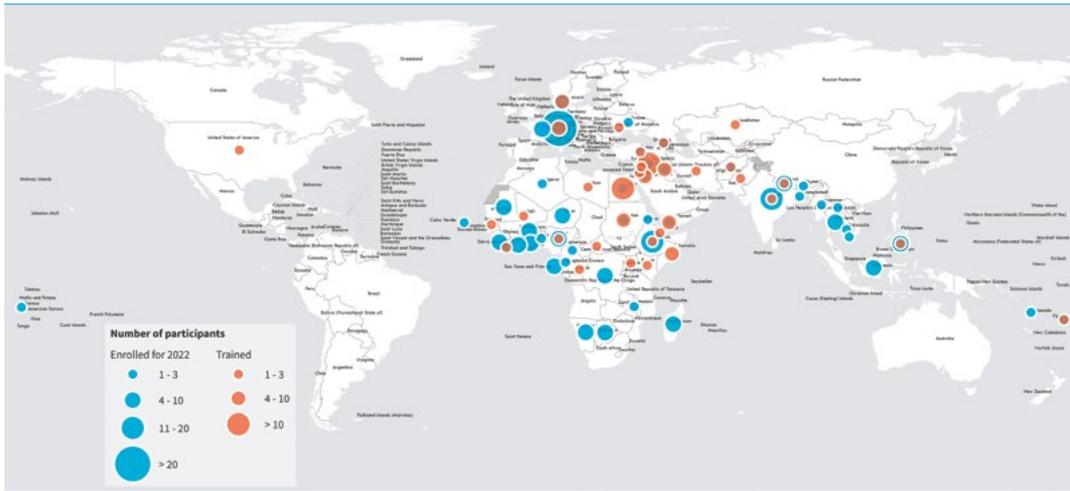
participants focus on: defining leadership; emotional intelligence; leadership styles; diversity; communication; decision-making; and giving and receiving feedback. On completion of the course, participants enter a 'community of learning' which helps them network and learn from each other. This 'community' also provides a platform to deliver learning on cross-cutting issues such as mental health and prevention of sexual exploitation and abuse which we look to integrate into the programme.

More equitable, diverse learning

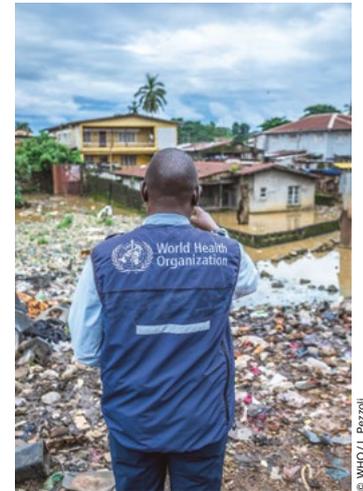
Although moving the training online was initially taken as a measure to counter the impact of travel restrictions, it has demonstrated several advantages.

Increased access. Online learning allows learners to access training anywhere,³ removing the need for transportation and accommodation, countering the environmental impacts of travel and removing the administration burden on trainers. Moving the course online also minimised disruption to day-to-day work: participants can access the learning even when on deployment.

Greater reach. Participation has expanded to include future leaders and previously marginalised populations, especially women,



Leadership in emergencies programme trainees by country



who often face numerous barriers to learning.⁴ In fact, representation of women is set to grow from 31% in 2019 when the course was run in-person to 48% in 2022.

Shared experience. The quality and diversity of trainers, facilitators and participants has also increased, with easier integration of participants from different regions. Larger cohorts with up to 40 participants allow for a greater mix of more experienced and less experienced participants with a range of skills and response roles. Participants have reported the value of engaging and learning with colleagues with this broad range of experience. They also report that they have developed their networks through contacts made on the course.

Applying learning. As in-person training sessions are often condensed into consecutive days to reduce costs, learners can be overwhelmed with too much information which can be detrimental to learning. Online learning has enabled short face-to-face sessions to be spread over many weeks, allowing learners to integrate new knowledge and skills into daily work,⁵ promoting the habit of lifelong learning.

Making the Leap
The move to online training was not without risk. It was originally thought that an online class

could not replace the in-person experience and that training outcomes would suffer – that people would not learn as well and would become disengaged. However, 91% of programme graduates confirm they ‘feel more confident about applying leadership abilities’. The majority have also reported that the increased access to training by conducting it online and the ability to directly apply learning are benefits. In addition, LCD has seen high levels of attendance for ‘voluntary’ training sessions organised through the ‘community of learning’.

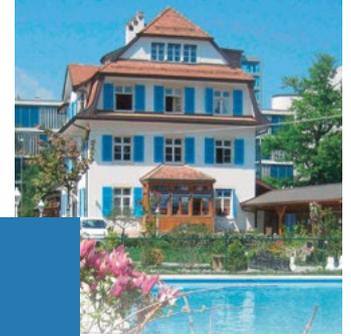
Online learning of this type is not a panacea. The decision should not be between online learning or in-person learning: instead, the focus should be on what is best for the learner, not what methods are easiest or readily available. Online learning technologies and in-person learning each have drawbacks, and in-person learning for some skills is, of course, critical. However, the Leadership programme has shown that advances in online learning technology, and our increasing ability to work online, mean that blended online training can deliver benefits and advantages far beyond what we could imagine just a few years ago. ■

- 1 OpenWHO.org
- 2 Lacerenza, C.N., Reyes, D.L., Marlow, S.L., Joseph, D.L. and Salas, E., 2017. Leadership training design, delivery, and implementation: A meta-analysis. *Journal of Applied Psychology*, 102(12), p.1686.
- 3 Basic information and communications technology infrastructure should be in place and appropriate devices available for use.
- 4 Women have traditionally been excluded from initial selection for training programmes in favour of men or left out due to limited training budgets. Source: <https://www.personneltoday.com/hr/female-employees-miss-work-based-training/>

- 5 As encouraged during weekly sessions, learners can direct the social learning aspects of the course (e.g., group work, discussions, Q&As) to problems and situations in which they have previously or currently find themselves.



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GISRS: adapting to a changing world

SEBASTIAN ZIELINSKI & ASPEN
HAMMOND, WHO

Influenza remains a serious public health threat with up to 1 billion people each year affected by seasonal “flu” and its associated risk of severe illness and death. In addition, previous influenza pandemics have caused millions of deaths. This article provides a historical perspective on the WHO Global Influenza Surveillance and Response System (GISRS) and highlights how its activities remain as vital today as they have ever been – if not more so.

The beginning

In 1947, one year before the World Health Organization’s constitution entered into force,¹ a proposal was made to the United Nations Interim Commission to set up a special committee to review the magnitude of the public health threat posed by influenza and how best to address it. It had become apparent that influenza viruses were constantly evolving and had the potential to cause further pandemics, widespread societal disruption and millions of deaths. Although vaccines against influenza had been in use in the 1940s, it had also become clear that such vaccines would need to be updated in response to the emergence of new influenza viruses.

Given the threat of another potentially catastrophic influenza pandemic, and ongoing seasonal epidemics, the newly inaugurated WHO decided in 1948 to establish and finance a World Influenza Centre under the auspices of the Medical Research Council in the United Kingdom – an event now seen as the start of the WHO Global Influenza Programme (Fig. 1). The activities of the Centre remain just as necessary and relevant today, and include the sharing of information on influenza between countries (Fig. 2), the collection and detailed characterization of influenza viruses, and the provision of technical training.

In 1952, a WHO Expert Committee for influenza convened for the first time in Geneva to present plans for a WHO influenza surveillance network to monitor and strengthen influenza surveillance and response efforts. Thus, the entity that would eventually become GISRS was born. At that time, 25 countries had some degree of influenza surveillance in place and were able to report data to WHO. By 1957, there were 60 WHO-designated national influenza centres in 40 countries.² In 2022, as we celebrate the 70th anniversary of

GISRS is a proven global network that has provided a first line of defence against influenza for almost 70 years.⁴

Dr. Tedros Adhanom Ghebreyesus,
WHO Director-General

GISRS,³ the system now encompasses 148 national influenza centres in 127 countries, seven WHO collaborating centres, four essential regulatory laboratories and 13H5 reference laboratories.

The multiple roles of GISRS However, GISRS has grown to become more than just a network of laboratories. It now proactively develops vital national infrastructures, resources and capacities, both physical and human, serves as a platform through which information and virus specimens can be exchanged around the world, promotes research and acts as a communications hub. GISRS also serves as a crucial global alert system, warning the world of respiratory viruses with pandemic potential.

Warning signals

Advances in research during and after the influenza pandemics of 1957⁵ and 1968⁶ led to the development of more-sophisticated laboratory methods. As a result, it was discovered that the causative

pandemic viruses had acquired 2–3 gene segments from an avian influenza virus, with the remaining 5–6 segments coming from previously circulating human influenza A viruses. This alerted the world to the vital importance of monitoring influenza viruses circulating in animals, particularly aquatic fowl and pigs – a surveillance and research function which remains a critical part of GISRS activities today.⁷ Since 1959,² WHO has worked closely with other agencies working on viruses that cross the animal–human interface, including the Food and Agriculture Organization of the United Nations (FAO) and the World Organisation for Animal Health (OIE). Newer laboratory methods developed in the 1980s and 1990s, such as polymerase chain reaction (PCR) testing and other molecular technologies, revolutionized the analysis of influenza viruses from different hosts and are now routinely performed by GISRS laboratories.

GISRS really encapsulates so many aspects of what we've been doing right, and maybe what we should have been doing more of, which is linking that laboratory-based surveillance of the organism with the surveillance of its impact.¹⁰

Dr. Michael Ryan,
Executive Director, WHO Health Emergencies Programme

«In view of the possibility that certain domestic animals, particularly swine, may play a role in the epidemiology of human influenza, arrangements were made by WHO to collect sera from swine and other domestic animals in different parts of the world before the epidemic reached them. Later, after the epidemic has passed, further sera will be collected from the same animals and the two compared for antibodies against the Asian strain.⁸»

The First ten years of the World Health Organization (1958)

Responding to non-seasonal influenza and other virus outbreaks and emergencies

GISRS serves as a vital resource for countries facing outbreaks and emergencies caused by non-seasonal influenza and other respiratory viruses. GISRS demonstrated its capability in this respect through its rapid detection of, and response to, avian influenza A(H5N1) in 1997 (Fig. 3) and its re-emergence in 2003; SARS-CoV-1 in 2002⁹; pandemic A(H1N1) in 2009; MERS-CoV in 2012; and the emergence of avian influenza A(H7N9) in 2013.

GISRS is also providing vital support to the global response

to the COVID-19 pandemic. In many countries, national influenza centres rapidly became the primary hubs for COVID-19 testing and response activities. GISRS continues to conduct integrated sentinel surveillance for both influenza viruses and SARS-CoV-2 to guide public health response to these twin threats and during 2020–2021 conducted 44.2 million SARS-CoV-2 tests. As of February 2022, 107 countries had integrated COVID-19 surveillance into their existing influenza sentinel systems. Approximately 80 such countries provide the resulting data on a weekly basis to regional and global reporting platforms. The Global Initiative on Sharing All Influenza Data (GISAID) – a long-term partner of GISRS – published the first SARS-CoV-2 sequence data hours after it became available.

Another key GISRS activity is the monitoring and control of respiratory syncytial virus (RSV) – a leading cause of hospitalization in young children. With several candidate vaccines likely to be available soon, RSV surveillance has become increasingly important. With the support of the Bill & Melinda Gates Foundation, GISRS has helped to strengthen RSV surveillance in 25 countries

to provide the evidence needed to inform RSV vaccination policy.

Keeping the world informed

Between 2014 and 2019, GISRS tested an average of 3.4 million virus specimens each year – surging to 6.7 million tests in 2020 and 2021. In addition, every year around 20,000 influenza virus specimens are shared with WHO collaborating centres.

The resulting laboratory and epidemiological data reported to the FluNet and FluID platforms allows for GISRS and associated systems to conduct real-time monitoring and risk assessment. GISRS then publishes biweekly summary reports on the influenza situation thus providing timely risk assessments and alerts to countries.

Updating vaccines against seasonal influenza

Every year an estimated 1 billion influenza cases, 3–5 million severe cases and 650 000 influenza-related respiratory deaths occur.¹¹ Vaccination remains the most effective way to prevent influenza, and to reduce disease severity and deaths. In the early 1940s, vaccination against seasonal influenza was practised in some countries, with the need for

continuous monitoring of the vaccine's effectiveness against newly circulating influenza viruses becoming apparent in 1947. Now – twice a year – WHO publishes its recommendations on the composition of vaccines for both the southern and northern hemispheres based on a comprehensive analysis by GISRS experts of the viruses circulating worldwide. Over the decades, this core GISRS activity has been key in significantly increasing both the quality and take-up of influenza vaccines.

From the present to the future

As has clearly been the case for the past 70 years, the vital work of GISRS in strengthening and coordinating influenza and other respiratory virus surveillance and response activities will be an ongoing global public health need – seasonal influenza continues to cause its heavy burden, and the question is not if there will another influenza pandemic but when – and we need to prepare.

Since its inception, GISRS has demonstrated itself to be an efficient, cost-effective and sustainable platform for country collaboration and cooperation – including during the world's response to the COVID-19



Fig. 3 WHO Weekly Epidemiological Record announcement of human cases of influenza A(H5N1) in China, Hong Kong SAR

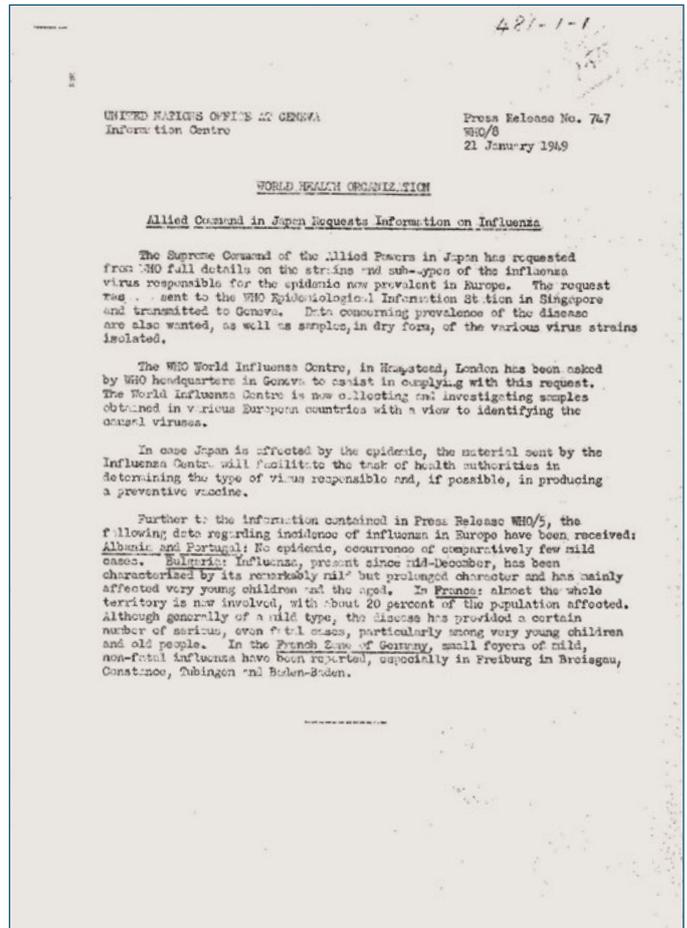
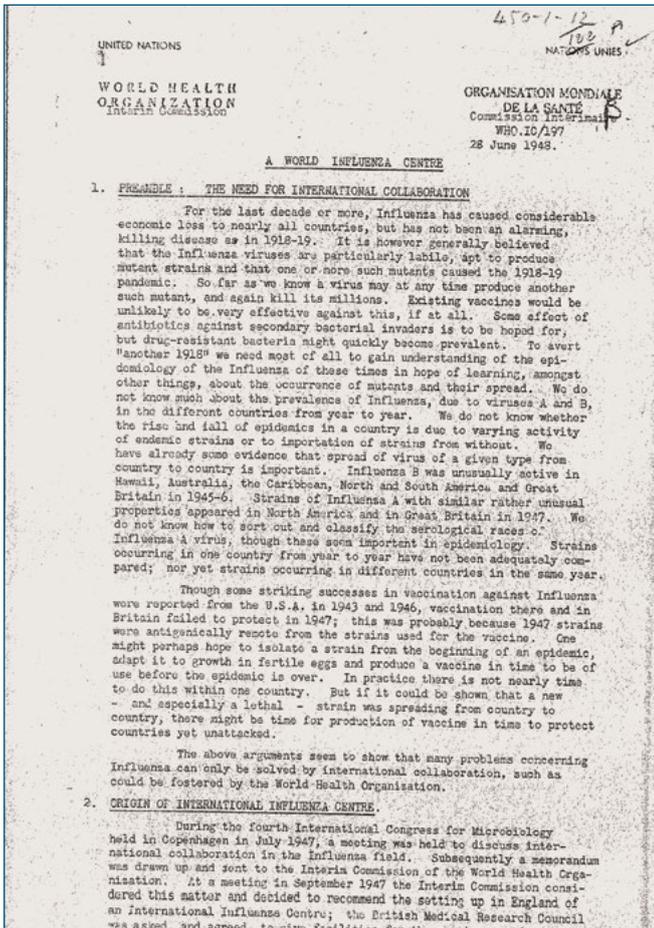


Fig. 1 The start of the WHO Global Influenza Programme

Fig. 2 Beginning of information sharing at the WHO World Influenza Centre

pandemic. Since 1959, expert voices have called for the expansion of the system both geographically and technically. Today, WHO is developing a roadmap to further expand GISRS into GISRS+: an enhanced, sustainable network built upon the existing influenza infrastructure but capable of bringing about integrated surveillance and response capabilities not only for influenza but for a range of other respiratory viruses with epidemic or pandemic potential.

GISRS today stands as a testament to the efforts of generations of scientists and others who have dedicated – and continue to dedicate – themselves to achieving its core purpose of protecting lives. It is also a tribute to the many governments that have committed political, financial and logistical support over the years. GISRS will now look to further develop and

expand to become a truly integrated and cross-cutting system for respiratory disease surveillance and response worldwide. ■

- 1 History of WHO [website]. Geneva: World Health Organization (<https://www.who.int/about/who-we-are/history>).
- 2 The First ten years of the World Health Organization. Geneva: World Health Organization; 1958 (<https://apps.who.int/iris/handle/10.665/37.089>).
- 3 GISRS 70th anniversary [website]. Geneva: World Health Organization (<https://www.who.int/initiatives/global-influenza-surveillance-and-response-system/gisrs-70th-anniversary>).
- 4 <https://www.morfa.ca/GISRS2022revised3.mp4>
- 5 The First ten years of the World Health Organization. Geneva: World Health Organization; 1958 (<https://apps.who.int/iris/handle/10.665/37.089>).
- 6 Webster RG, Laver WG. The origin of pandemic influenza. Bull World Health Organ. 1972;47(4):449–52 (<https://apps.who.int/iris/handle/10.665/263.530>).
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- 8 The First ten years of the World Health Organization. Geneva: World Health Organization; 1958 (<https://apps.who.int/iris/handle/10.665/37.089>).

- 9 Stöhr K. A multicentre collaboration to investigate the cause of severe acute respiratory syndrome. Lancet. 2003;361(9370):1730–33 ([https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(03\)13376-4/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(03)13376-4/fulltext)).
- 10 <https://www.morfa.ca/GISRS2022revised3.mp4>
- 11 Global Influenza Programme. Burden of disease [website]. Geneva: World Health Organization (<https://www.who.int/teams/global-influenza-programme/surveillance-and-monitoring/burden-of-disease>).
- 12 Salk JE, Suriano PC. Importance of antigenic composition of influenza virus vaccine in protecting against the natural disease. Am J Public Health. 1949;39(3):345–55 (<https://ajph.aphapublications.org/doi/10.2105/AJPH.39.3.345>).
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Le Geneva Cities Hub (GCH)

Villes et acteurs locaux dans le concert international

Le rapport annuel 2021 du GCH, disponible en ligne sur son site¹, laisse apparaître une progression de son but initial visant à favoriser les interactions entre les villes, gouvernements locaux et régionaux (GLRs) et la Genève Internationale.

CHRISTIAN DAVID, ONUG

En dépit d'une période difficile liée à la crise sanitaire, la plateforme du GCH a permis d'améliorer les synergies entre acteurs locaux et institutions internationales, favorisant l'abord des thématiques qui peuvent échapper aux radars d'une approche conventionnelle. Dans ce contexte, l'écosystème genevois apparaît comme novateur.

Une certaine agilité a, de fait, été mise en place grâce à une consolidation de l'équipe et de la structure, capable de proposer des événements qui rassemblent toujours plus d'intérêt auprès de ses partenaires.

Pas moins de Quatre GUD (Geneva Urban Debates) ont été organisés en 2021 en présentant les thématiques des ODD, l'eau, la relance économique, ou encore les droits de l'homme.

La diplomatie des villes a également été présentée sous forme d'événements permettant de s'inspirer de l'expertise locale pour solutionner les problèmes rencontrés notamment en termes de changement climatique. Ces «city diplomacy events» associés au GUD mettent en exergue et partagent des solutions pour le futur.

Durant sa deuxième année de vie, le GCH a renforcé sa collaboration avec ONU Habitat et la

Commission économique des Nations Unies pour l'Europe (CEE-ONU)

Un répertoire des réseaux internationaux permet désormais de visualiser les contacts et réseaux des villes. Trois discussions informelles et confidentielles, favorisant cette mise en réseau, ont été organisées dans le cadre de la Task Force de l'ONU sur le futur des villes. Cette dernière, établie en novembre 2020 par le Secrétaire général de l'ONU sous l'égide d'ONU Habitat, a pour mission de renforcer les interactions entre GLRs et l'ONU, pour les ODD, les droits de l'homme et notamment l'Examen Périodique Universel.

Par ailleurs, plusieurs événements ont été organisés:

- Les villes de Santiago, Barcelone, Munich se sont réunies pour discuter des moyens visant à développer des «villes intelligentes» grâce aux technologies et innovations répondant aux besoins de leurs résidents, tout en préservant le droit à la vie privée et la protection des données personnelles.
- Des représentants des villes de Genève, Tunis, Kigali et Lyon ont exposé leurs politiques de digitalisation en incluant les populations marginalisées et en tenant compte des enjeux environnementaux.
- Le CICR a co-organisé un événement sur la violence urbaine

et la protection du personnel de santé dans les villes.

- La Mission suisse auprès de l'ONU à Genève, le Fonds des Nations Unies pour la sécurité routière, Pro Vélo, et Urbz ont co-organisé une réception à l'occasion de la journée internationale du vélo
- La Commission mondiale a abordé la thématique des «Villes et politiques de drogues»
- L'Union internationale des télécommunications a organisé, lors de la journée mondiale des villes, une conférence intitulée «Construire des villes résilientes face au climat grâce à la transformation numérique»
- Enfin, le CGLU et la Ville de Genève ont réuni des acteurs humanitaires internationaux et des représentants de GLRs du Liban, du Ghana et du Mali et ont pu échanger sur la gestion des risques et crises humanitaires et les moyens de renforcer le rôle des GLRs à cet égard.

Après deux années d'existence, le GCH semble avoir trouvé un rythme pour organiser ces événements liés à la diplomatie informelle. Il semble maintenant évident à chaque partenaire que les villes et GLRs constituent des acteurs incontournables dans la résolution efficace des défis globaux. ■

¹ <https://www.genevacitieshub.org/fr/>



Cities better prepared for health emergencies

The Sustainable Development Goals – among them Goal 3 to ensure healthy lives and promote well-being for all at all ages – were adopted by the United Nations General Assembly in 2015.

ANDRAS SZORENYI, SENIOR POLICY ADVISOR AT GENEVA CITIES HUB

The very same year the United Nations Security Council, for the first time in its history, called for an emergency session to address a public health issue, the Ebola pandemic.

Recent news about yet again a lockdown – this time in Shanghai – show that coronaviruses are emerging as a major threat to people in the 21st century and they are here to stay. In the last two decades, three human coronaviruses have been reported: in 2003 SARS-CoV, in 2012 MERS-CoV and in 2019 SARS-CoV-2 (COVID-19). Due to the spread of infections in a globalized world with high morbidity and mortality rates, public and high-level political attention focus more on health questions than before.

A special focus is now on cities: on the one hand international cities have become hotspots of pandemics due to globalized travel and trade, on the other hand urban health conditions might be pre determinant regarding the capacity to handle the consequences of a pandemic. The WHO in its 13th General Programme of Work for 2019-23 – as part of the “triple billion targets” – identified better protection from health emergencies as well as enjoying better health and well-being. The High-level Conference on Preparedness for Public Health Emergencies Challenges and Opportunities in Urban Areas in 2018 emphasized that urban health challenges require multi-level and cross-sectoral cooperation with a specific role given to local leaders. Though, COVID-19 demonstrated that

shortcomings still exist in urban preparedness, local response and regional coordination.

While COVID-19 is most often compared to the so-called “Spanish Flu” (1918-19), a more telling parallel in my opinion would be between the influenza pandemics in 1918-19 and in 2009-2010. Both were caused by an influenza A(H1N1) virus. The first was estimated to have caused 20-50 million deaths, the second an estimated 151-575 thousand deaths worldwide. In 90 years, we achieved progress that enabled us to reduce the number of fatalities tenfold. “In 2009 for the first time, a pandemic vaccine was developed, produced and deployed in multiple countries during the first year of the pandemic. With each pandemic, researchers, public health experts

and international organizations have gained a better understanding of the complexity and dynamics of influenza pandemics.” One similarity with COVID-19 is worth highlighting here. Thanks to an extraordinary international cooperation, scientific and financial public-private partnerships, the first vaccines were also developed, approved and produced in less than one year.

Governments made an important step in the direction of more effective coordination between global, national and local levels. The WHO resolution WHA73.8(2020) on ‘Strengthening preparedness for health emergencies: implementation of the International Health Regulations (2005)’ calls upon member states, regional economic integration organizations, international, regional and national partners, donors and partners “to assess the vulnerabilities of cities and human settlements to health emergencies, paying particular attention to communicable disease outbreaks, and to enhance preparedness by integrating policies, plans and exercises across health, urban planning, water and sanitation, environmental

Make the voice
of all relevant
stakeholders heard
at the discussion
table

protection and other relevant sectors, to ensure local leadership and community involvement”.

Increased investment to strengthen capacities and capabilities in urban health services, including health emergency preparedness and response is essential. Following a multi-sectoral, multi-stakeholder approach that involves national and local levels in decision-making could be beneficial. As WEF reports show, a holistic urban health policy is desirable, because social determinants of health have a great influence over health and quality of life. Reducing the risks and negative consequences of global diseases together with creating healthier, more productive societies could add \$12 trillion to global GDP by 2040.

Recent massive urbanization has led cities to become epicenters of disease transmission. Infectious diseases like COVID-19,

tuberculosis, dengue and diarrhea thrive in poor and overcrowded environments and are closely related to unhealthy housing, poor sanitation and waste management. Given the fact that cities deal with many dimensions of health, they need to be involved not only in the response to pandemics but in the international debate on strengthening preparedness. Mayors from different cities, countries and continents expressed very clearly: due to the proximity to their population, their knowledge and understanding of the local actors and context, they have a crucial role to prevent, prepare for, and recover from health emergencies.

The WHO states that “During the pandemic, many cities have strengthened existing networks and partnerships with communities to best respond to people’s needs, while strengthening multisectoral collaboration and strong leadership from the health sector. WHO has been supporting cities in building and shaping these policies and actions.”[5] To ensure that cities are better prepared to face future health challenges, including emergencies, it is a prerequisite to put more

emphasis on their needs in WHO debates.

WHO and its member states should consider preparing a more efficient and credible crisis communication strategy to avoid the dissemination of false and potentially harmful information. As for local authorities, it is important that they become the major source of information for citizens on the local health situation. This role requires strategic preparation by breaking the cycle of “panic and neglect”. There is a need to better communicate among nearby cities to harmonize local policies to avoid confusion of the population by different measures in place, because nobody is safe until everybody is safe. They should involve all stakeholders responsible for health protection, social assistance and economic recovery from the beginning.

All these are only possible if we strengthen coordination among international, national and local actors, and we make the voice of all relevant stakeholders heard at the discussion table. ■

GLOBAL HEALTH MATTERS
THE PODCAST FROM TDR

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CHAMPIONING HEALTH EQUITY IN SOUTH AFRICA
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- PETRO TERBLANCHE**
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Eradicating Wild Polio

Engagement of community informants from insecure areas (CIAs) of Borno State is a “golden bullet” in the latter stage of the road to Wild Polio Eradication in Borno State, Nigeria.

**ABEDE MOMOH MOHAMMED, WHO
STATE FIELD OFFICE, BORNO STATE**

The story of engagement of surveillance community informants from insecure areas (CIAs) of Borno state is one of sheer courage, sacrifice, bravery, determination, commitment and risk taking just to cross the finish line of Polio eradication in the African region. These informants virtually “collapsed” the line of conflict and extended the program reach into the inaccessible areas. As rightly captured by Dr. Arlene King, Member ARCC in September 2020: “We recognize the incredible role they played, and are playing, in the polio program in Borno, Nigeria and globally. So pleased to see the continued penetration in the security-compromised areas in Borno, and absence of poliovirus isolates, very reassuring”

The global drive to eradicate polio has seen the virus cornered in fewer places than ever before, yet polio’s final stronghold are some of the most difficult and complicated places to deliver primary health care services including strategies for polio eradication (1). As the world gets ever closer to achieving global wild poliovirus (WPV) eradication, armed conflict and insecurity limiting access to populations has emerged as a significant threat to polio eradication (2,3). Armed conflicts can have adverse effects on population health and healthcare systems (4). Borno state in north-eastern

Nigeria is the epicentre of the > 12 years’ insurgency activities that have affected the region since 2009, resulting in the destruction of health facilities, abduction and killing of health workers, massive population displacement and lack of access to populations.

In 2016, after 23 months without any case of wild poliovirus type 1 (WPV1), Nigeria witnessed a significant setback in its bid to eradicate polio with confirmation of four cases of WPV1 from three LGAs in Borno state. All the WPV1 cases were from security compromised areas of the state where acute flaccid paralysis (AFP) surveillance was suboptimal, also genetic evidence showed that the viruses had been circulating for at least 5 years without being detected (5,6). This event triggered a host of responses and innovation to ensure the WPV1 outbreak was controlled, transmission interrupted and eradicated from the African region. One of such Innovations was the engagement of CIAs.

January 2018 will forever remain turning point in history of the drive to reach every last child with Polio Surveillance intervention in Borno state and a defining moment of the latter stage of the road to certification in Africa. At a stage when access to some security compromised settlement in the state seemed totally impossible, WHO with the support of the Government of Borno state

and implementing partners introduced the strategy of engaging CIAs to actively search for AFP cases in these insecure settlements. As of January 2018, of the 311 wards in the state: 99 (32%) were accessible, 85 (27%) were partially accessible and 127 (41%) were inaccessible. Two Local Government Areas (LGAs): Abadam and Marte were inaccessible, and all Borno state island settlements along the Nigeria-Lake Chad border were also inaccessible. These CIAs revolutionized the conduct of Surveillance with geo evidence in insecure areas and in the process demystified the apparent impossibility to reach this security compromised settlements.

These informants were any person who resided primarily in a security compromised area, had regular contact with secure areas and had volunteered to support the program in AFP surveillance. They were typically male with Koranic education or primary education and included traders (i.e., firewood, cattle, or fish traders), traditional leaders, traditional barber, hunters, fisher men, nomads, informal health care providers [Traditional Birth Attendants (TBAs), traditional healers] and community members. The LGA DSNOs with the support of these resource contact persons engaged these informants after establishing that they resided in insecure areas and were willing to conduct polio surveillance in insecure areas.

Each informant once selected was tasked to use his/her circle of influence to engage additional volunteer informants from neighbouring settlements and link them with the LGA surveillance officers.

After a series of meeting and consultation between stakeholders of the State Ministry of Health (SMOH), Disease Surveillance and Notification Officers (DSNOs) with their assistants and partners from the United States Centers for Disease Control and Prevention (CDC), Bill and Melinda Gates Foundation (BMGF), and United Nations Children's Fund (UNICEF) in January 2018, We eventually piloted the strategy in Kukawa LGA of Borno state in February 2018 with 17 informants engaged from 17 inaccessible settlements of four security compromised wards namely, Bundur, Kauwa, Alagarno and Kekeno Ward. Informants were trained to search for AFP cases by visiting all households and any informal health care provider in their area of responsibility every week, reminding them on signs of AFP and to report any child who develops such symptoms or signs immediately to the informant. They were provided Android phones enabled with Vaccination Tracking System (VTS) technology and Open Data Kit (ODK) mobile applications and trained on capturing of geo-coordinates as proxy evidence of polio surveillance activity conducted.

As of December 2021, a total of 1,318 CIAs have been engaged to conduct polio surveillance in 19 security compromised LGAs of Borno state. From 2018-2021, these informants had reached 6,756 Security compromised locations with valid geo evidence as proxy indicator for active surveillance activities conducted. 1,406 of these security compromised locations were previously unreachable by any other intervention. With the successes recorded in surveillance activities vaccination intervention with oral polio vaccines was integrated into the CIIA program and a total of 1,164 previously unreachable security compromised location were also reached with polio vaccines in addition to polio surveillance by CIIA (Figure 1). Within this period these CIAs also reported and supported the evacuation of 584 cases AFP cases from insecure areas of the state to safe areas for investigation. Of these 584 AFP cases outbreak of circulating mutant Polio virus two (cMPV2) was detected from samples of 11 cases and no wild polio virus detected.

The documentation of activities routine structure of disease surveillance in safe areas of Borno state, Nigeria which was complemented by the effort by CIAs in insecure areas provided objective evidence that wild polio virus transmission had being interrupted in the state and eventually culminated in the African

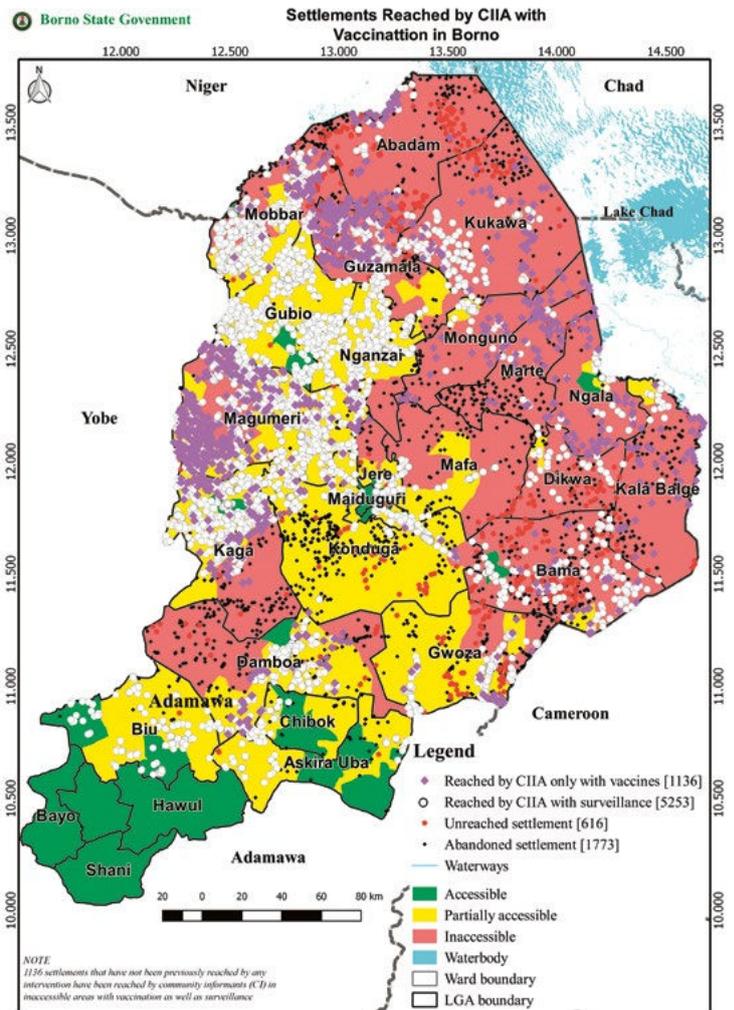


Figure 1 Map of Borno state Nigeria showing surveillance reach (left) and contribution of informants to state surveillance reach (right), 2018-2021.

Abbreviation: CIIA, community informants from inaccessible areas

region being certified as Polio free on August 25th 2020. Dr. Fiona Braka the then team leader of WHO programme on Polio Eradication aptly described the CIIA strategy in September 2020 as "A remarkable story of innovation, dedication and bravery. We owe a lot to the community informants whose work has not only supported the polio programme but gone beyond for malaria, COVID19 and other life-saving interventions. We remember the lives lost and are grateful that their sacrifices were not in vain". ■

From Virus to Vaccine

Vaccination remains the most effective way of controlling influenza (“flu”) and preventing its potentially serious health consequences.

XIYAN XU & THEODORE ZIEGLER, WHO

The life-cycle of seasonal influenza vaccines.

Current seasonal influenza vaccines protect against four different influenza viruses – namely the H1N1 and H3N2 subtypes of influenza A viruses, and the Victoria and Yamagata lineages of influenza B viruses. Because these viruses are continuously evolving, the composition of influenza vaccines is reviewed each year and updated as needed.¹ In order to predict exactly which variants are likely to spread and cause illness during the upcoming influenza season, year-round global influenza surveillance must be conducted.

The most commonly administered influenza vaccines are still made using an egg-based manufacturing process invented more than 70 years ago. Influenza viruses grown in hens’ eggs are used to prepare both inactivated (killed) vaccines for injection (often called the “flu shot” or “flu jab”) and live attenuated influenza vaccines (LAIVs) which are weakened live vaccines that are given as a nasal spray.² In recent years, influenza viruses have also been grown in qualified cell cultures thus removing the need for hens’ eggs. A third type of influenza vaccine – so called “recombinant” vaccine – does not even require a virus grown in eggs or cell culture but is instead directly produced using the virus’ genetic sequence data.

It is probably not widely known that the viruses and sequence data used each year for seasonal influenza vaccine production are identified, characterized and provided by the WHO Global Influenza Surveillance and Response System (GISRS).³ Fig. 1 shows the entire life-cycle of conventional seasonal influenza vaccine production – all the way from detecting the virus in clinical specimens to commercial-scale vaccine manufacture.

From virus to vaccine – the seasonal influenza vaccine life-cycle

The journey from virus to vaccine starts with the surveillance carried out by the 148 national influenza centres (NICs) in 127 countries which form the backbone of GISRS.⁴ Each NIC receives and tests samples taken from patients presenting with influenza-like illness at a network of sentinel sites. Together, these NICs test millions of such samples and regularly submit influenza-positive specimens or the isolated viruses themselves to WHO collaborating centres (WHOCCs). Following detailed characterization, the WHOCCs in collaboration with the essential reference laboratories (ERLs) prepare the candidate vaccine viruses (CVVs) needed to manufacture traditional inactivated vaccines or LAIVs. NICs also collect vital clinical and epidemiological information to identify

any changes in disease patterns or severity, the speed of virus spread and those most affected. This information is submitted to the WHO FluNet database to monitor disease trends.

Influenza surveillance and response is a truly global endeavour. The seven WHOCCs within GISRS are located in Atlanta, USA; Beijing, China; Koltsovo, Russian Federation; London, United Kingdom; Melbourne, Australia; Memphis, USA; and Tokyo, Japan.³ These WHOCCs characterize in great detail the virus specimens received from NICs to ensure the early detection and identification of any new “antigenically drifted” seasonal influenza viruses, as well as any novel influenza A viruses that may have pandemic potential. Virus characterization also involves sequencing either the entire virus genome or just those genes coding for the two major virus proteins – haemagglutinin and neuraminidase. WHOCCs also assess the susceptibility of circulating viruses to currently licensed antiviral drugs. All of the resulting data are then shared within GISRS and promptly submitted to publicly accessible databases such as the Global Initiative on Sharing All Influenza Data, the Epiflu™ database, the European Molecular Biology Laboratory Nucleotide Sequence Database or GenBank.

The comprehensively analyzed and suitably qualified CVVs prepared by the WHOCCs, ERLs and other specialized laboratories are then used to manufacture traditional inactivated vaccines or LAIVs. In addition to supporting the production of CVVs, WHO ERLs located in Canberra, Australia; London, United Kingdom; Tokyo, Japan; and Washington DC, USA also produce and calibrate the vital reference reagents, including vaccine potency reagents, needed by vaccine manufacturers to monitor vaccine production, and vaccine quality and potency.

Twice each year (in February and September), WHO convenes its vaccine composition meetings to make recommendations on the vaccine viruses to be included during the upcoming northern and southern hemisphere influenza seasons. Experts drawn from the seven WHOCCs and four ERLs meet, along with observers from representative NICs and other specialized groups, and carefully review the complex epidemiological, genetic and antigenic data collected. In addition, the results of serological testing are also reviewed to evaluate how well the previous season’s influenza vaccine is likely to protect against any newly emerged viruses. Finally the availability of any required new CVVs are discussed.⁵ Following the

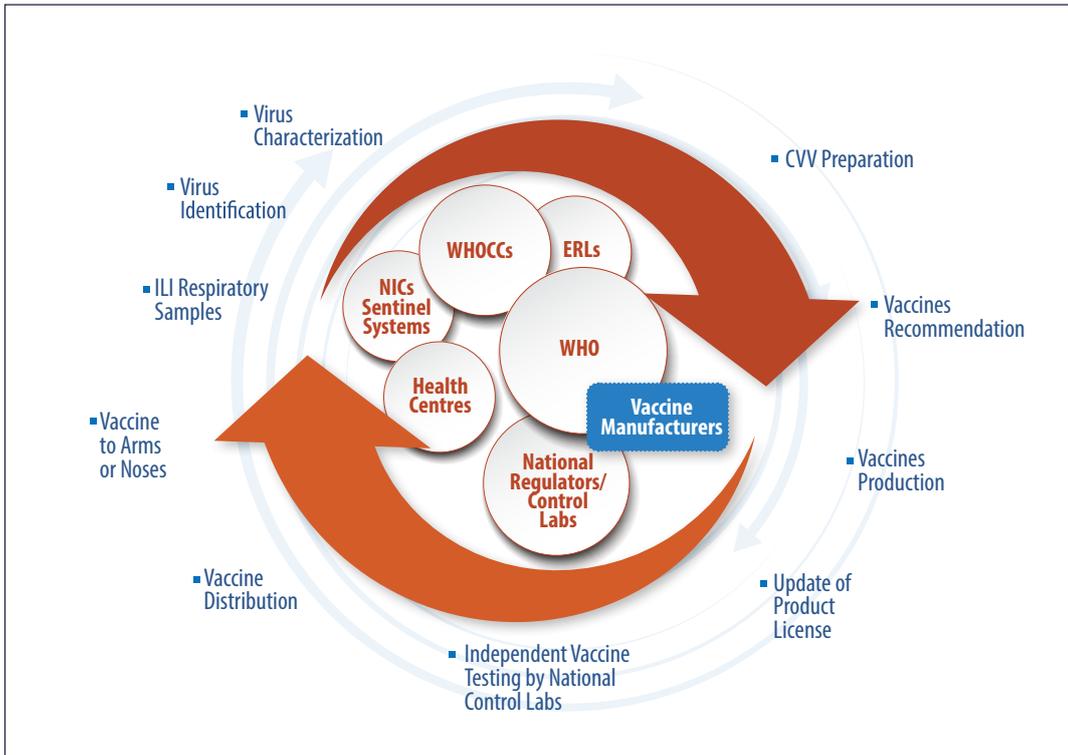


FIG. 1:
From virus to vaccine – the seasonal influenza vaccine life-cycle

ILI = influenza-like illness;
NIC = national influenza centre;
WHOCC = WHO collaborating centre;
CVV = candidate vaccine virus;
ERL = essential regulatory laboratory

analysis and discussions of the expert group and guided by its conclusions, WHO makes its official recommendations to countries on the optimum vaccine composition for the upcoming influenza season. Each country will then make its own decision as to which viruses should be included in influenza vaccines licensed for national use. In almost all cases, countries follow the WHO recommendations.

Following the WHO vaccine recommendations, the CVVs generated and qualified by GISRS are shipped to seasonal influenza vaccine manufacturers worldwide to allow production to begin.⁶ Several months are typically needed to produce the hundreds of millions of vaccine doses required each year. National regulators and control laboratories, in line with national policies and regulations, then conduct independent vaccine testing and license approved vaccines for distribution and use. Before the start of an influenza season, influenza vaccines become available at various health facilities, including

public and private health centres, clinics, general practitioner's surgeries and pharmacies to be injected into millions of arms or sprayed into noses.

The 70-years-young global network that is WHO GISRS will continue to play its crucial role in protecting the world from influenza. The life-cycle of seasonal influenza vaccine production will be repeated every year for as long as is needed to prevent and control this global threat. Furthermore, in addition to its wide range of influenza-related activities, WHO GISRS has taken on a key role during the ongoing COVID-19 pandemic, as well as during previous emergencies such as avian influenza, SARS-CoV-1 and MERS, by conducting the vital virological, epidemiological and clinical surveillance of the causative viruses.⁷ In these and countless other ways, GISRS will continue to play its full role in the global control and prevention of influenza and other deadly respiratory diseases.⁸ ■

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Entretiens et visions croisés pour les Objectifs de Développement Durable

En rencontrant Pascale Fressoaz et René Longet, au delà de la présentation de leurs deux livres respectifs, j'ai voulu savoir comment deux personnalités engagées et reconnues dans le paysage international pour leur expertise et leur énergie communicative, parviennent à mobiliser les énergies et interpeller les décideurs de tous bords.

DOSSIER PRÉPARÉ PAR CHRISTIAN DAVID, ONUG

Entretien avec Pascale Fressoaz

Quelles sont les circonstances, vos histoires personnelles qui vous ont rendue sensible à ces causes?

P.F. J'ai toujours été sensible au problème de pauvreté et refuse de voir tant d'enfants vivre dans la misère la plus totale. Trop de gens doivent inventer des stratégies de survie et vivre avec nos miettes. 783 millions de personnes vivent encore dans l'extrême pauvreté et cela a été renforcé par le COVID, pour environ 130 millions personnes.

Je pense que j'ai l'immense privilège de vivre dans une société libre et prospère, ce qui me confère une responsabilité supplémentaire, celle de m'engager pour les autres. En 2002, je me suis impliquée pour la libération d'Ingrid Betancourt et de 3 000 otages en Colombie. J'ai pris conscience du lien intime entre extrême pauvreté et violation des droits humains. Je suis aussi très concernée par les questions environnementales. J'interviens dans de nombreuses écoles de management sur les ODD, notamment à Sciences Po, Polytech, GEM... pour les responsabiliser face à l'urgence climatique, aux défis sociaux et aux nouvelles formes d'économies (économie circulaire, ESS, économie symbiotique...). Les

enjeux restent majeurs. Nous devons à présent briser le cercle de la déresponsabilisation. Nous devons aussi conduire le changement de manière structurée et planifiée, avec créativité car les métamorphoses doivent être réalisées avec envie et optimisme, et pas uniquement sous l'effet de la peur ou de la contrainte.

L'Agenda 2030 et les 17 ODD, sont-ils intelligibles pour le grand public?

Les avis sont très partagés, beaucoup vont dire en effet que les ODD c'est trop compliqué. D'autres, comme Vaia Tuuhia, Association 4D, diront qu'un enfant de 4 ans peut les comprendre. Selon Gilles Vermot-Desroches, Vice-Président de Schneider Electric, en tête du classement des entreprises les plus durables au monde (Corporate Knights), les ODD parlent à tous, contrairement aux normes! Tout le monde comprend lorsque l'on parle de nourriture, de santé, d'éducation, de paix, etc. ce sont des éléments de la vie quotidienne. Les ODD, c'est un outil qui permet de fédérer, de donner la chance de construire des projets qui associent tous les acteurs pour entrer dans des logiques de co-construction. L'écologie doit s'initier et accompagner de nouvelles formes d'économies. Malheureusement, les ODD sont encore trop peu présents dans les débats. Le multilatéralisme doit marcher sur deux pieds, en intégrant les ODD

et l'Accord de Paris, en articulant mieux la gouvernance internationale et locale... Par ailleurs, les décisions prises au niveau des Nations Unies ne sont pas suffisamment déclinées au niveau des Etats.

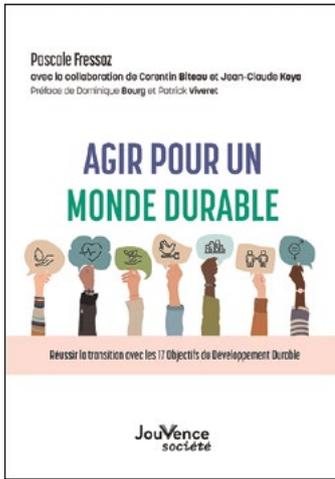
Nous avons signé avec la Députée Florence Provendier, et une centaine d'acteurs, en France, une tribune intitulée «ODD, tout est lié» pour une meilleure intégration du Climat et des ODD dans les politiques nationales. Des radars des ODD évaluent le programme de chaque candidat à la présidentielle sous le prisme des ODD.

Focus sur votre livre

Nombreux sont les ouvrages sur les difficultés que rencontre le monde actuellement mais ils ne donnent pas forcément des pistes d'action. Lorsque des actions sont mentionnées, elles concernent surtout les Etats et peuvent paraître parfois trop globales, inadaptées ou axées sur un thème uniquement (ex. l'énergie).

Mon livre «Agir pour un monde durable et réussir la transition à l'aide des 17 ODD», éditions Jouvence, est un appel à l'action et un guide de la durabilité. Nous montrons que tout est lié et interconnecté et le potentiel pour tendre vers une spirale vertueuse. À partir de cette «boussole de la durabilité», nous présentons les actions qui peuvent être mises en place en tant que citoyen,





Mon livre est un appel à l'action et un guide de la durabilité

collectivité ou entreprise, avec une approche globale. Vous pourrez ainsi découvrir la méthodologie des «9 étapes pour Réussir», dont l'objectif est de structurer et conduire le changement dans les organisations.

Cet ouvrage «Agir pour un monde durable» a été réalisé avec une dizaine d'experts reconnus notamment Dominique Bourg, Patrick Viveret, Maria-Luisa Silva, René Longet, mes co-auteurs Corentin Biteau, Jean-Claude Koya et de nombreuses personnalités. Je les remercie infiniment.

Au-delà de votre livre, quelles sont les actions que vous entreprenez?

J'ai fondé, en 2006, l'ONG Alliance Internationale pour les Objectifs de Développement Durable (AI-ODD), basée dans 24 pays, dont le siège est à présent en France (CSI, Annemasse). Entre 2006 et 2022, nous avons organisé environ 1 350 actions dont 6 conférences à l'ONU. Un colloque récent a été organisé à l'Assemblée Nationale française, avec le président de l'Assemblée Nationale, Richard Ferrand, deux ministres et plusieurs maires visant à renforcer l'implication du gouvernement et celle des collectivités locales. Par ailleurs, nous avons travaillé avec les populations en Côte d'Ivoire, au Niger et en Inde, pour la création de 6 Villages du Millénaire. Les habitants définissent le projet avec une approche globale et

intégrée. Nous venons de développer 3 outils pour accompagner les acteurs dans la mise en œuvre des ODD, disponibles dans le livre (QR codes).

Dans le cadre de mon cabinet de Conseil (Millenium) spécialisé en planification stratégique et démocratie participative, nous avons défini des politiques publiques co-construites avec des élus, ce qui a valu le Prix de la Participation Citoyenne aux villes d'Aix-les-Bains, Albertville et à mon cabinet.

D'autre part, j'ai cofondé avec Awa N'Diaye la Coalition des ONG pour les OMD puis les ODD à Genève (2010-2016). J'ai eu la chance de travailler avec de belles personnalités, notamment le professeur Tévoédjéré, ancien conseiller spécial de Kofi Annan, qui m'a nommée Ambassadeur de la Paix en 2015, Stéphane Hessel ou l'Ambassadeur François Rivasseau, qui nous a toujours soutenus, pour la cause des otages en Colombie, pour les OMD puis les ODD. Par ailleurs, j'ai été élue locale en Haute-Savoie, à Thônes, sur deux mandats.

La publication du dernier rapport du GIEC vous inspire quelles réflexions?

Le travail du GIEC est reconnu, il évolue et prend en compte la psychologie des citoyens et décideurs en insistant sur les solutions, le renforcement des capacités, en créant l'urgence.

La phrase « nous avons 3 ans pour agir » a été reprise dans tous les médias... mais la pression retombe vite.

La situation internationale que nous vivons complique-t-elle la résolution pour lever les obstacles?

Cette situation dramatique nous rappelle l'importance de la solidarité, du multilatéralisme, d'une gouvernance partagée et du respect des engagements internationaux. Les 17 ODD ont été signés par tous les Etats! La situation montre à quel point l'ODD 16, «Paix, justice et institutions efficaces», est totalement méprisé alors qu'il a un impact sur tous les autres objectifs. Les logiques de guerre montrent les équilibres fragiles de nos modes de société vacillant entre «liberté pour tous» dans certains pays et «contrôle de tous» dans d'autres.

Cette volonté de maintenir des empires et des rapports de force sans compromis, ni respect aucun pour les vies humaines, devrait être condamné avec mise en place de mécanismes d'urgence, un tribunal spécial d'agression ou autres dispositifs, et de voir pourquoi l'action de la CPI n'a pas fonctionné. La communauté internationale, et les Etats européens en particulier, ont su s'unir, sans logique de guerre. Mobilisons-nous pour la Paix, en agissant chaque jour pour préserver celle des autres.

Je considère, comme René Longet, que le développement durable ne doit plus être considéré comme la cerise sur le gâteau mais l'ingrédient de base, le socle fondamental.

Certes, le Covid puis la guerre en Ukraine compromettent fortement la réussite des ODD mais l'engagement n'était pas assez fort avant 2020. Et pourtant, les acteurs engagés pour les ODD ont développé de belles approches innovantes et fédératrices.

Ayons chacun notre Agenda 2030, global et intégré mais surtout ambitieux, car nos potentialités pour nous améliorer sont infinies. Il s'agit de faire face aux exigences climatiques, de contribuer au bien-être et de tendre vers un futur souhaitable.

A nous de trouver les nouveaux équilibres du monde que nous devons reconstruire ensemble. ■

<https://www.aiodd.org/>

Entretiens et visions croisés pour les Objectifs de Développement Durable



Pascale Fressoz et René Longet

Entretien avec
René Longet
**Quelles sont les circonstances,
vos histoires personnelles qui
vous ont rendu sensible à ces
causes?**

Je suis sensible depuis ma jeunesse aux destructions que l'être humain inflige sans aucune nécessité à la nature, au manque de respect pour les besoins d'autrui et à l'absence de considération pour le plus long terme. C'est pourquoi dès la parution du rapport *Notre avenir à tous* j'ai adhéré à la notion de durabilité, qui exprime pour moi parfaitement la nécessaire synthèse entre l'urgence environnementale et l'urgence sociale.

Une telle option appelle, à travers une réorientation économique et technique et une hiérarchie des besoins revisitée, à combler le fossé entre moyens et besoins, et à utiliser les fonctionnalités de

la nature de manière prudente et équitable.

Aujourd'hui, alors que de nombreux Etats se sont donné les moyens de réagir face à une pandémie, puis à une agression inacceptable contre un pays voisin, nous restons comme tétanisés face aux risques majeurs représentés par le changement climatique ou l'effondrement de la biodiversité. Nous savons pourtant tout ce qu'il faut faire – et que les remèdes à ces dangers sont, de plus, propices aux entreprises et à l'emploi.

**L'Agenda 2030 et les 17 ODD,
sont-ils intelligibles pour le
grand public?**

L'Agenda 2030 reste, comme son frère quasi-jumeau l'Accord de Paris, un miracle de la diplomatie. Il se situe dans le sillage du Plan d'action du Sommet mondial du développement durable de septembre 2002, selon lequel *«des changements fondamentaux dans la façon dont les sociétés produisent et consomment sont indispensables»*.

Il constitue un résumé fidèle, pratique et complet de 30 ans de décisions internationales sur la durabilité. Des centaines de documents – par nature souvent fort indigestes – sont ici résumés en 38 pages, dont la moitié est occupée par le libellé de 169 cibles regroupées en 17 Objectifs de développement durable (ODD).

Ces objectifs forment un ensemble concret et donnent un contenu normatif à la notion de durabilité; ils s'adressent aux Etats mais aussi aux acteurs que l'ONU a retenus dans sa liste des 9 «groupes majeurs». Par rapport au modèle méthodologique des 8 Objectifs du millénaire pour le développement (ODM), il s'agit ici d'un ensemble bien plus complexe et dense en termes de contenus.

Ils permettent aussi de ne rien oublier d'important et d'identifier les interrelations. Par exemple, le changement climatique nécessite de mettre en question des enjeux liés aux inégalités, la gouvernance, les modèles industriels et économiques, la biodiversité, l'emploi... et il ne suffit pas d'être «fossile free» pour être durable. Mais il faut pour leur mise en œuvre bien les vulgariser.

Focus sur votre livre

Mon livre s'inscrit dans cette vulgarisation pour le grand public et aussi les diverses catégories d'acteurs. Il se décline en 4 chapitres.

Le premier rappelle les origines, la raison d'être et le contenu de la riche notion de développement durable, qui est avant tout une reconversion de l'économie:

- de la sous-enchère globale au commerce équitable et fondé sur la prise de responsabilité locale,
- du fossile et du fissile aux



Mon livre présente
l'Agenda 2030, un état
des lieux et la manière de
lever les obstacles pour
atteindre ces objectifs
communs.

énergies renouvelables et à la sobriété énergétique,
• de l'obsolescence et du gaspillage à la limitation de la consommation d'objets et de matériaux neufs, à une utilisation partagée des objets et à leur conception réparable et réutilisable.

De l'agriculture industrielle à l'agro écologie, seule façon de sauvegarder la paysannerie et les sols tout en nourrissant une population croissante.

Pour les substances chimiques et plastiques, l'on devra aller vers des molécules à l'innocuité établie et les matériaux sans impact négatif; quant à l'aviation, elle devra, pour les courtes et moyennes distances, céder le pas au ferroviaire. Enfin, la finance durable devra se substituer aux pratiques spéculatives et hors sol, ponctionnant les entreprises par des attentes abusives de rentabilité.

Un 2^e chapitre explicite les contenus de l'Agenda 2030, soulignant le caractère systémique des ODD et de leurs cibles, qui doivent être comprises comme autant d'éléments d'un tout.

Le 3^e donne un état des lieux dans 8 domaines-clé de la durabilité et le 4^e est consacré aux obstacles et comment les lever. A ce sujet il est essentiel de ne plus opposer écologie et économie: la transition vers la durabilité passe par

davantage de justice globale et sociale, par des emplois pérennes, décents et non délocalisables. Il faudra que le citoyen-consommateur le comprenne et donne sa chance aux biens et services produits selon les règles de la durabilité.

Au-delà de votre livre, quelles sont les actions que vous entreprenez?

Je suis personnellement engagé, après avoir été longtemps un élu politique au niveau national, régional et local (exécutif d'une municipalité de près de 20 000 habitant.e.s), dans des organisations publiques et associatives actives sur l'énergie et l'optimisation du cycle de la matière, l'agro-alimentaire durable, la biodiversité, la coopération au développement et l'économie sociale et solidaire ou encore le soutien aux peuples autochtones.

La publication du dernier rapport du GIEC vous inspire quelles réflexions?

Ce rapport sorti fin février 2022 confirme ce que nous savons depuis plus de 40 ans. Il laisse percer la lassitude et le pessimisme des scientifiques devant notre incapacité à changer nos modèles de production et de consommation.

Alors que les forêts brûlent et que les inondations se multiplient, nous continuons à ne pas ressentir d'urgence climatique.

Ce comportement est proprement suicidaire et met en évidence que notre programmation émotionnelle et mentale qui nous a permis d'arriver jusqu'au 21^e siècle nous conduit désormais à notre perte. Nous sommes en train de gagner la bataille contre la nature, sans comprendre que la gagner signifie tout perdre.

La situation internationale que nous vivons complique-t-elle la résolution pour lever les obstacles

Elle souligne le caractère indispensable de valeurs communes à toute l'humanité, comme la Déclaration des droits humains, le Pacte sur les droits économiques, sociaux et culturels des individus et des peuples, et la notion de durabilité. Elle souligne aussi que des outils de gouvernance et de concertation multilatéraux sont indispensables si nous voulons maintenir une planète vivable et viable.

Mais force est de constater que cette ambition d'instaurer la règle du droit et de la négociation est contrecarrée par le retour de la politique de l'affrontement des nationalismes. Désormais une moitié de la population mondiale vit sous des régimes autoritaires voire dictatoriaux, qui nous racontent la fable que les Droits humains ne vaudraient pas pour leurs pays, voire qu'ils seraient une imposture néocolonialiste de l'Occident.

De plus, alors qu'il s'agit aujourd'hui de passer d'une économie de la prédation à une économie de la valeur écologique et sociale et de replacer l'économie dans le cadre du bien commun, l'attractivité du modèle consumériste et gaspilleur reste entière pour une majorité de décideurs qui ne pensent qu'à la corriger à la marge et qui ne veulent pas changer de modèle économique. Modèle désormais à la fois grippé et pathogène, à remplacer sans délai par un nouveau cycle où les bénéficiaires financiers (plafonnés) seront le fruit d'activités écologiquement et socialement vertueuses – car ces activités auront trouvé leur public et donc leur rentabilité (raisonnable). Il nous faut une mutation qui est du même ordre que l'était le passage, à travers le New Deal, le fordisme et les Trente Glorieuses, d'une économie de la pénurie à celle de l'abondance, devenue aujourd'hui l'obsolescence des objets et des personnes.

Trop souvent la durabilité est comprise comme une sorte de cerise sur le gâteau, comme un luxe pour les nantis. Elle n'est rien de tout cela, elle est le fondement de tout vivre ensemble, toute équité et dignité sur cette planète, elle est la mère de toutes les batailles, perdre la bataille pour la durabilité c'est les perdre toutes. ■



The Swiss National COVID-19 Science Task Force

Legacy and lessons learned

On 16 February 2022 the Swiss Federal Department of Home Affairs (FDHA) announced the early dissolution of the Swiss National COVID-19 Science Task Force (SN-STF), effective as per 31 March.

CHRISTIAN PAULETTO¹

The SN-STF was established shortly after the Swiss Federal Council (government) declared that Switzerland was in a state of emergency (“situation extraordinaire”). This was the first time that such a scientific body was set up in Switzerland. Normally, the Federal Council gathers scientific expertise via extra-parliamentary commissions, which would include scientists among other representatives. One factor that prompted this shift may be that another special body had just been instituted, the “Coronavirus Crisis Unit” (EMCC). The mandate of the Science Task Force was given by this Crisis Unit together with the Federal Office of Public Health (FOPH) and the State Secretariat for Education, Research and Innovation (SERI). The Task Force’s mandate consisted in providing independent advice to the whole Federal Council, the Head of the FDHA (Mr. Alain Berset), and other federal and cantonal competent authorities. Also in that respect, the SN-STF deviated from Switzerland’s administrative practice. However, similar

to normal extra-parliamentary commissions, its members were not remunerated and acted as independent experts. It is noteworthy that the Federal Commission for preparedness and management in case of pandemics did not hold any meetings during the COVID-19 crisis.

The members of the SN-STF were drawn from Swiss public higher education institutions, and its first chairman was Prof. Matthias Egger, president of the National Research Council of the Swiss National Science Foundation. The SN-STF worked from 1 May to the end of July 2020, i.e. the duration of the state of emergency. As stated in the government’s press release, “with the end of the extraordinary situation and the dissolution of the Crisis Unit, the SN-STF no longer had the original official foundation for its continued existence”.

After this period, Switzerland was in a state of “particular situation” pursuant to the Federal Epidemics Act. Related activities such as inter-ministerial coordination

and drawing on scientific expertise were implemented at the level of the DFAH and its FOPH. Under their competence, they also adapted the mandate of the SN-STF so that its experts could continue to provide their advice to them. The new mandate took effect on 1 August 2020.

The SN-STF was composed of experts from various scientific disciplines, including economics, ethics, and psychology. Its mandate encompassed three missions:

- to provide advice to authorities and political decision-makers;
- to identify possible fields of research that can contribute to a better understanding of the pandemic;
- to assess opportunities of innovation in the supply of services and products related to COVID-19.

With approximately 60-70 experts, the SN-STF Task Force published over 40 “policy briefs” under the first mandate (three months). Under the adapted mandate, the Task Force was



significantly reduced to 25 experts, and regularly produced “Overviews and evaluations of the situation” and “Scientific updates”. On the eve of the announcement of its dissolution, it published a long-term oriented action and research agenda, entitled “Scientific update with aspects on the management of SARS-CoV-2 in the coming 12 months”. On the eve of its actual dissolution it published its final report.

During the first mandate, i.e. during the extremely difficult circumstances of the “extraordinary situation”, there was an overwhelming satisfaction with the Task Force. To some extent, the successful management of the pandemic in Switzerland during that period could be attributed to the SN-STF. And in any case, it was recognised that the scientific advice it gave to policy-makers could not have been found elsewhere in the Swiss administration or in extra-parliamentary commissions. Broadly speaking, it is fair to say that for the remaining of 2020, the Task Force was

well perceived in public opinion, though some criticism started to surface.

In 2021 however, and especially from mid-2021 on, critical views became increasingly vocal. The crux of the criticism revolved around the Task Force’s democratic legitimacy or lack thereof. With its unique system of direct democracy, Switzerland is considered as the world’s highest standard of democracy, and issues regarding “democratic legitimacy” can quickly become viral in this country. Lately, during the past six months or so, the Task Force happened to make blatant errors in judgement and forecasts, coupled with proactive public statements, which obviously did not help. If any lessons should be drawn from this experience for possible future task forces, it is thus that, within each political system and culture, the careful balance between powers, public communication and democratic legitimacy should be found. As a “scientific” body, the Task Force’s mandate was limited to science, leaving it up to the

authorities to make the arbitrage between scientific evidence and other national interests. Traditional extra-parliamentary commissions do communicate on their proposals and reports, but such commissions have a broad mix of representatives, which are appointed through an open procedure. The latter aspect strengthens their legitimacy and acceptance in public opinion, even more so because the broader composition results in more balanced conclusions.

The initial concept was simple and clear: “science should advise, policy should decide”. With time however, the lines became blurred. When individual SN-STF representatives entered into the public debate with alarming statements towards the end of 2021, it was an easy game for their opponents to question their legitimacy and to stress that they were sort of bypassing the Federal Council. One argument was that they were pre-empting the political arbitrage of interests, and thus they were biased. Unlike traditional commissions, the SN-STF

did not have among its members some personalities experienced in politics. That was normal given their strictly scientific mandate. But as a result, when the SN-STF attempted to enter into the political public debate this lack of political skills became obvious, especially when some STF members publicly criticised government measures.

Their way to manoeuvre in a political surrounding, and to undertake what was perceived as political communication, made them an easy target for their opponents. When it turned out that the SN-STF never took written records of its meetings, had unclear or at least untransparent internal procedures, and failed to publish some of its “Briefs” in any one of the national languages, criticism spread. However, if it strictly behaved as just an advisory body, such flaws would have gone unnoticed.

To conclude, it may be said that the establishment of a special scientific body, such as a task force, is probably a necessity during a pandemic of the magnitude of COVID-19. The right balance should be found though, especially in a country such as Switzerland, which is used to the highest standards of democratic procedures. If the body is of a strictly scientific nature, it should be cautious and risk-averse in terms of political exposure and public communication. Conversely, if the body is meant to also contribute to the public political debate, its composition should be more representative and, crucially, it should include political expertise and communication skills, and it should also have a sort of assurance that it can count on political backing in case it becomes necessary. ■

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Philippe Geluck, dessinateur, peintre, sculpteur, humoriste, comédien, homme de radio et de télévision.

Le Chat déambule à Genève

Vingt statues monumentales qui mettent en scène le célèbre héros de BD «Le Chat» du dessinateur belge Philippe Geluck ont pris la pose avec humour et philosophie sur le Quai Wilson à Genève du 19 février au 24 avril 2022.



'Le Chat déambule' en tournée mondiale a fait étape à Genève

CLAUDE MAILLARD

Après avoir rencontré un franc succès à Paris, Bordeaux et Caen, l'exposition «Le Chat déambule» avait donc pris ses quartiers en terre genevoise en ce début d'année, pour le plus grand bonheur des promeneurs à qui il a apporté une bouffée de fantaisie, de la joie, du rire et une certaine poésie surréaliste. «Le Chat» a toujours beaucoup de légèreté dans ses propos. Là, c'est du lourd; chaque sculpture en bronze pèse en effet 2,5 tonnes.

Selon Philippe Geluck, à travers les sculptures de son célèbre félin on découvre des messages écologiques ou militants. Celle du Chat qui écrase de tout son poids une voiture est dédiée à la mémoire des animaux victimes des violences routières, bêtement écrasés par un chauffard. Dans

la sculpture «On en a plein le dos», «Le Chat» est représenté en Atlas agenouillé portant une immense sphère pleine de bouteilles en plastique sur les épaules. Comme ce géant de la mythologie condamné par Zeus à porter la voûte céleste, «Le Chat» semble ici endosser le poids de la folie des hommes. Quant au «Martyre du Chat», inspiré du Martyre de Saint-Sébastien, il rend hommage aux confrères de Philippe Geluck de Charlie Hebdo victimes du terrorisme. D'autres statues intrigant, font sourire ou font référence à des artistes.

Philippe Geluck, véritable homme-orchestre
Dessinateur, peintre, sculpteur, humoriste, comédien, homme de radio et de télévision, Philippe Geluck est né à Bruxelles en 1954



'Chantons sous la pluie'



'Flûte à bec'



'Pipi et Grobidet'



'On en a plein le dos' – «Le Chat» semble endosser le poids de la folie des hommes

dans une famille amoureuse des arts. Rapidement, il apprend à dessiner grâce à son père, illustrateur pour la presse écrite belge, et confectionne un petit journal à la maison.

L'un des employés de la famille découvre ses dessins et décide alors de les présenter au rédacteur en chef du journal «L'œuf», Bob De Groot. Ce dernier, épaté par le talent du jeune garçon, décide de publier l'un de ses dessins. Mais, malgré son don, c'est vers une autre carrière que Philippe se tourne car il se voit bien devenir acteur. Il prend des cours au Théâtre national de Belgique où il a l'occasion de monter sur scène pour jouer des classiques comme Faust et Roméo et Juliette. En 1976, il fonde le Théâtre Hypocrite et mène une

carrière de comédien dans les principaux théâtres belges pendant une dizaine d'années. Tout en s'adonnant à sa passion sur scène, il continue de dessiner et invente le personnage du «Chat» en 1983. Séduit par ce personnage excentrique, le journal «Le Soir» décide de publier les dessins de Philippe. «Le Chat» devient rapidement célèbre et a même droit à ses propres bandes dessinées. Grâce au Chat, Philippe se fait connaître du grand public et se lance dans une carrière à la radio et à la télévision. Il crée, anime ou participe à des milliers d'émissions à la RTBF, sur France 2, France Inter, Europe 1 ou RTL. Il est chroniqueur régulier chez Michel Drucker (Vivement dimanche) et chez Laurent Ruquier (Les Grosses Têtes). Parallèlement, il dessine

et expose ses dessins et aquarelles loufoques en galerie à Bruxelles, Paris, Londres, Milan, Copenhague, Neuchâtel et Dallas.

En 2003, la grande expo «Le Chat s'expose», qui célèbre les 20 ans du héros, attire plus de 350 000 visiteurs à Paris, Bruxelles, Bordeaux et Rennes. En 2016, «L'art et Le Chat» initie petits et grands aux œuvres emblématiques de l'histoire de l'art avec cette drôlerie si caractéristique. Depuis lors, les dessins, toiles et sculptures de Philippe Geluck sont exposés dans de nombreuses galeries et salons d'art contemporain.

Aujourd'hui, Philippe Geluck prépare activement l'ouverture du «Musée du Chat et du dessin d'humour» qui ouvrira ses portes à Bruxelles en 2024.

Retour sur les origines du Chat

Philippe Geluck a dessiné pour la première fois «Le Chat» en 1980. Enfin, quand il dit «Le Chat», c'était plutôt un chat. Sur la carte de remerciements qu'il avait réalisée à l'attention de ceux qui avaient offert un cadeau à l'occasion de son mariage avec Dany, il avait dessiné une jolie Madame Chat avec les yeux papillonnants et un grand sourire. Et quand on ouvrait la carte, on voyait qu'il y avait un chat derrière qui lui «offrait ses hommages». Cela a fait rire tout le monde. Trois ans plus tard, à la naissance de son fils Antoine, il dessine le couple de chats amoureuxment enlacés avec un bébé chat devant eux. En 1983, le journal «Le Soir» fait appel à trois dessinateurs pour inventer un personnage. Philippe



©Claude Maillard

'Le martyre du Chat' – En hommage aux confrères de Philippe Geluck de Charlie Hebdo victimes du terrorisme

Geluck propose un chat inspiré de celui du carton de mariage. Il lui a mis un veston, plutôt même un manteau et une cravate et lui a fait dire des bêtises. Ça a plu et c'est ainsi qu'est né «Le Chat» tel qu'on le connaît aujourd'hui.

Depuis, 23 albums du Chat sont parus chez Casterman, ainsi que six best-of, de nombreux livres de textes et trois catalogues d'exposition: «Le Chat s'expose», «L'art et le Chat» et désormais «Le Chat déambule».

La sculpture est un art que Philippe Geluck pratique depuis longtemps. Le premier bronze qui a été réalisé d'après l'une de ses sculptures a été présenté en 2008 dans une galerie de Saint-Germain-des-Prés, et le succès a été immédiat. Evidemment, cela l'a encouragé à faire une série par la suite. Mais le processus est beaucoup plus long que le dessin, qui lui se fait en quelques minutes. La sculpture, ça prend des semaines. Pas dans la conception de la maquette en fil de fer ni dans le modelage avec de la terre glaise qui demandent quelques jours, travail accompli

à 4 mains en compagnie de son ami François Deboucq. Mais ensuite pour les opérations de moulage en silicone, en cire liquide puis en bronze, confiées à des fondeurs professionnels et qui vont prendre de nombreux jours. S'ensuivent les opérations de finition: assemblage, soudage, ciselage et polissage. Enfin, pour donner cette patine couleur verte bien particulière, le bronze subit une opération d'oxydation avec du nitrate de cuivre.

Là, c'est un vrai travail d'équipe avec des artisans d'art tous choisis autour de chez lui en Belgique. Conseillé par Delphine Boël, une amie artiste devenue Princesse de Belgique en 2020, Philippe Geluck a fait confiance à la Fonderie van Geert située à une trentaine de kilomètres de Bruxelles pour s'occuper de l'intégralité de la partie technique de la création de ses statues. Un mois est nécessaire pour arriver à la statue finale haute de 2 m, et toute l'équipe, composée de 60 collaborateurs, a travaillé d'arrache-pied pour réaliser les vingt en un temps record afin que tout soit prêt pour l'exposition sur les Champs-Élysées.



©Claude Maillard

'Tutu et Grominet'



©Claude Maillard

'Pour une fois, c'est une voiture qui s'est fait écraser par un chat' – A la mémoire des animaux bêtement écrasés par un chauffard

L'idée des statues monumentales est venue à Philippe Geluck en 2018 suite à la défection de sponsors qui devaient contribuer au projet de Musée du Chat. La vente des statues, que l'on peut admirer dans l'exposition itinérante, est une opération qui vient compenser cette perte de sponsoring.

A 68 ans, le regard toujours aussi facétieux derrière ses inséparables lunettes rondes, Philippe Geluck, le plus populaire des amuseurs belges, fourmille encore de projets. Et, après nous avoir offert une balade dans les plus belles villes du monde en compagnie du Chat le plus déconcertant de la planète, que nous réserve-t-il? Affaire à suivre... ■

Si vous désirez en savoir plus sur l'histoire des sculptures de Philippe Geluck, l'album-catalogue de l'exposition dévoile les secrets de l'aventure, illustrés par 120 photos et 180 dessins: renseignements@geluck.com

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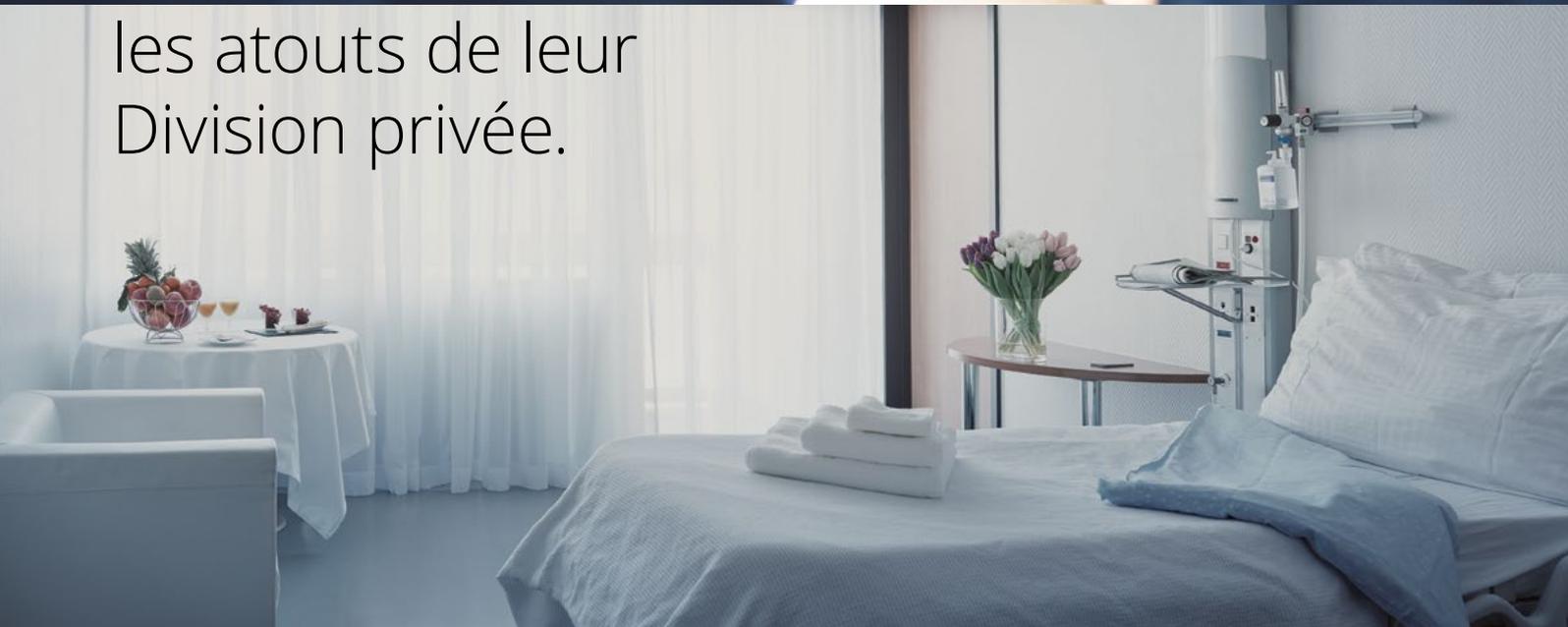
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