

Comment

The story on global health security

At a conference last week on global health security the role of veterinary professionals and the surveillance systems they use were used as examples of how progress could be made in this arena.

The conference, held in London, was hosted by The BMJ, Chatham House and Abt Associates, with delegates coming from human medical, veterinary, public health, military, and disaster recovery and humanitarian backgrounds.

The discussion around making advances in global health security will be familiar to anyone acquainted with similar moves in One Health; and the similarities do not stop there.

As there are many definitions for One Health so, too, is the definition for global health security wide ranging and can mean different things to different people, depending on context and culture. And just like the One Health agenda, it requires people from many different professions and agencies to be involved to make progress, and this progress needs to be successful at an international and national level, but most importantly at a local level.

In some countries understanding is hindered by its name – ‘security’ is misconstrued as meaning military intervention – so another challenge is to build understanding that global health security is non-threatening, both in language and interventions.

At the most basic level global health security is about achieving a world safe and secure from infectious disease threats. The Centers for Disease Control and Prevention (CDC) in the USA describe it as ‘a disease threat anywhere can be a disease threat everywhere’.

Perhaps a more useful definition for those charged with delivering global health security strategies is that provided by the Global Health Security Agenda (GHSa) (www.ghsaagenda.org). Launched in 2014, as a partnership of nations, international organisations, and non-governmental stakeholders, it sees its purpose as using a ‘multilateral and multi-sectoral approach to strengthen both the global capacity and nations’ capacity to prevent, detect, and respond to human and animal infectious diseases threats whether naturally occurring

or accidentally or deliberately spread’.

But as with One Health, does it matter if the definition is so wide ranging? In some ways, probably not. The broadness allows a fluidity and the ability to add in people and skills as situations develop and potentially respond quickly to what is happening on the ground.

So what are the priorities for action?

David Heymann, head of the Centre on Global Health Security at Chatham House, believes it would be much better to prevent these diseases at source, so a paradigm shift is needed to develop preventive systems – and take capabilities from ‘detection and response’ to ‘being prepared’ (see also *VR*, May 31, 2014, vol 174, pp 546-551).

He points to the Human Animal Infections and Risk Surveillance Group (HAIRS) as a multidisciplinary group that is already working well to identify risks. The group is chaired by Public Health England but includes members from Defra, the Animal and Plant Health Agency (APHA), the Department of Health and the Food Standards Agency (FSA), among others. As Professor Heymann said at the meeting, ‘intersectoral collaboration is the most difficult to achieve but the most effective’ in making a difference, so any initiative that is achieving this collaboration should be applauded and promoted.

In giving an overview of the surveillance systems in place for animal and zoonotic diseases, Trevor Drew, head of viral diseases and lead scientist for animal and zoonotic viral diseases at APHA, highlighted surveillance as an area where he thought veterinarians were ahead of their medical colleagues. There are, he said, a variety of resources, such as OIE’s World Animal Health Information Database (WAHIS), FAO’s Emergency Prevention System (EMPRES), ProMed and UC Davis’s PREDICT, and collectively these provide a great resource to vets and public health officials to monitor disease. There are currently limited cross-sectoral resources which operate across the human/animal/environmental interface, but current projects recording antimicrobial resistance, rabies cases and zoonotic tuberculosis cases in India are examples of how global health security sector could work.

The point was made a number of times that to be successful, capacity needs to be built at the regional and local level, so that there will be less need for international responses, as recently seen in the Ebola disease outbreaks in West Africa.

Another area where animal health professionals are possibly ahead of their human health colleagues is in the area of assessing disease risk to build the necessary regional capability to manage it.

The UK is particularly strong here. This strength is due in part to the disastrous outbreak of foot-and-mouth disease in 2001 and the BSE epidemic that arose in the 1980s and 90s. As a result, the UK put systems in place we wouldn’t have without these events, such as the development of risk-based approaches, multi-sectoral collaboration – with HAIRS being a good example – and the development of arms length bodies, such as the FSA. It would be a great opportunity to turn these negative events into something more positive if the experiences that have led to the systems we have in place today could be exported around the world to help reduce the burden of infectious diseases in both people and animals.

The UK should not be shy here in acknowledging that while this approach will bring benefits to the countries that import these disease prevention initiatives, it will also bring benefits to the UK by reducing the risk of diseases arriving from other countries.

The veterinary profession does not have all the answers, but they have a great deal of relevant experience in making a practical difference on the ground, as well as contributing to the political debate.

What came out strongly from the meeting was the need for a compelling narrative to move the global health security agenda on. What was also clear was that the veterinary sector has a lot to contribute here and that their story must be part of this narrative if progress is to be made in global health security.

Suzanne Jarvis

■ The meeting discussed in this article was held under the Chatham House Rule, which aims to encourage candidness and open discussion. Under the rule, participants are free to use the information received, but neither the identity nor the affiliation of the speakers, nor that of any other participant, is revealed. The individuals named in this article agreed to speak on the record.

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