clear focus on the health needs of vulnerable migrant populations is needed to prevent inequalities in health outcomes for tuberculosis due to limited access to health care, which prevents migrant populations from accessing information that would enable them to avoid tuberculosis or to obtain early diagnosis and treatment. Ensuring access to and proper diagnosis and treatment is not only important from a public health standpoint but also to prevent and combat racism and xenophobia.

Second, surveillance must be strengthened but with due consideration of the special confidentiality issues related to legal status. In low-incidence high-income countries, entry screening of immigrants for tuberculosis while costly, has had little overall effect and has not proven to be cost effective. Thus, third, a much more cost-effective and sanguine approach is increased investment in global tuberculosis control. One analysis concluded that US-funded investments to expand tuberculosis control in Mexico, Haiti, and the Dominican Republic could reduce tuberculosis-related morbidity and mortality in migrants to the USA, and would result in substantial cost savings to the USA.13,14 Additionally, we must invest in national tuberculosis programmes, in line with the Global Plan to Stop TB (which is based on the WHO national tuberculosis programmes, in line with the WHO Stop TB Strategy).13,14 Moreover, the intra-European Union Health Policy further enhanced the visibility of HIA, but achieved little to put its high ideals into operation. By contrast, the private sector HIA has had a more focused history, with an emphasis on large industrial projects in the developing world with rigorous adherence to assessment protocols. Has the post-Gothenburg HIA movement expanded beyond being Eurocentric and moved towards a global perspective? These considerations are relevant.

Barbarians at the gate: storming the Gothenburg consensus

The concept, techniques, and applications of health impact assessment (HIA) hold promise to raise the profile of health within the overall project, policy and programme planning, and assessment cycle.1 HIA in the public sector has progressed over the past two decades with a strong Eurocentric focus on transportation and social programmes and policies. In 1999, the publication of the Gothenburg consensus1 from WHO’s European Centre for

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for the alignment and implementation of HIA protocols between the private and public sectors, which have seemingly developed in different universes (figure).

In 1999, the Gothenburg HIA framework stated that, in addition to promoting the maximum health of the population, four values would be emphasised: democracy, equity, sustainable development, and ethical use of evidence.2 Equity considerations would be ultimately incorporated into the Gothenburg-driven HIA model by a wholesale embrace of the work of WHO’s Commission on Social Determinants of Health (CSDH).3 Hence the Gothenburg consensus fused with CSDH and produced an HIA methodology that was mainly based on the social determinants of health model, which was initially developed in the early 1990s.4 This HIA movement further accelerated a growing number of scholarly articles on HIA.5–7 The geographical concentration of the published work, however, was mainly centred on the industrialised world.8 Quietly and in parallel, a more focused and limited set of HIA processes and procedures was being developed by both the private sector and the International Finance Corporation (IFC). IFC’s health methodology is based on results that show that almost half of measurable health improvement in sub-Saharan Africa was unrelated to the health system itself, but rather caused by improvements in the housing, water, sanitation, transportation, and communication sectors.9 This type of strategy that links environment and health is appealing to private industrial corporations and major financial institutions, because it capitalises on engineering and logistical skills inherent to industrial projects while avoiding the placement of private companies in the de-facto role of ministry of health. In the industrial context, IFC’s performance standard framework has been made operational and has been adopted by a large consortium of multilateral lending institutions known as the Equator Principles Financial Institutions (EPFIs). The EPFIs incorporate IFC’s performance standards as part of loan covenants, thereby creating a clear mechanism of enforcement.10

The WHO CSDH framework emphasises policies at national level with correspondingly broad-based impact assessment and mitigation. By contrast, the private sector highlights impacts and mitigation only for communities in which causal links between community and project impact are anticipated. The implementation of CSDH aspirations lies in the future, whereas, at present, the private sector projects are creating tangible results on the ground. As the scramble for access to natural resources in the developing world accelerates,11 the tension between the two approaches increases, particularly for host communities in developing countries.

Meanwhile, the growing effect of Chinese direct investment in extractive industry projects in developing countries is becoming an important but largely unspoken
driver of the overall developmental model debate. Chinese investments, at present, do not come with sufficient requirements on environmental, health, and social impact assessment. The competition for financing infrastructure and extractive industry projects is intense, and places adherents to IFC’s performance standards at a potential competitive disadvantage. However, at real issue is the focus of the health assessment and the subsequent ability of the government or corporation to avoid, eliminate, or mitigate negative effects, and enhance positive project benefits and opportunities, without simultaneously marginalising the project economically.

The methodological battle for the hearts and minds of individuals, private companies, and ministries of health is ongoing. The aspirational HIA discourse, stemming from the 1999 Gothenburg consensus and WHO’s CSDH, directs attention away from solvable issues in which the private sector can make a difference. The overall HIA initiative is at a tipping point. The wholesale adoption of CSDH definitions and methodologies for HIA in industrial projects of the developing world is neither desirable nor ultimately beneficial for host communities.

The large multilateral lending institutions have taken a step in moving health to centre stage. There is still an available window to establish a workable framework that major multilateral financial institutions, countries hungry for resources, and international health agencies can and should seize. To be accepted as a fully functional tool and method that can be embraced by all of the key stakeholders.

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The Wakley Prize 2010

“The future of humanity resides in the lost laughter of the child in the yellow sari—listen”. Last year James Levine1 won the Wakley Prize for his moving and imaginative essay about the sexual exploitation of children in India. Each year the Wakley Prize is awarded for the best essay on a clinical topic of international health importance. We invite submissions for this year’s Wakley Prize from anyone working or training in a health-related field, and encourage entrants to write about their country of origin. The winning essay will be a carefully crafted piece of prose that is a pleasure to read and prompts readers to wider reflection. The winner, as judged by Lancet editors (with authors’ identities masked), will receive £2000, with publication in the final issue of the year. Essays of no longer than 2000 words should be submitted through the journal’s electronic submission system; specifying Wakley Prize as the article type. The deadline is Oct 4, 2010.

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