Governance of health emergencies

There have been many analyses of the COVID-19 pandemic but little discussion of the governance failures, especially the need for cross-government, multisectoral engagement, and leadership by heads of state and governments at both national and global levels.

Governance is already being discussed within the health context. WHO member states are engaged in two historic negotiations of international treaties: a new pandemic convention, agreement, or other instrument (WHO CA+)[1] and the revision of the International Health Regulations.[2] The WHO CA+ would establish a Conference of the Parties (CoP) comprising heads of government to oversee the treaty's implementation. As the treaty is likely to be adopted under Article 19 of the WHO constitution, only states that have ratified the treaty would be members of the CoP. The International Health Regulations revision under Article 21 is expected to have near universal membership.

Although all countries must be included in governance to ensure worldwide coordination, only countries that have ratified a convention can be members of the CoP and oversee the treaty itself. We propose two separate committees: one committee comprising only the CoP with other countries acting as observers, and a second committee with representatives of all countries supported by a common secretariat for both committees and a common chair. Furthermore, there has to be coherence and complementarity between the new convention and the revised International Health Regulations, with compliance measures that cover both.

Solutions have been proposed for multisectoral global governance. The Independent Panel on Pandemic Preparedness and Response proposed a Global Health Threats Council established by the UN General Assembly as a standing body including heads of state and other global leaders.[3] Heads of state already dealing with enormously complex responsibilities are not likely to fully engage outside times of emergency, and the council might also overlap with the work of a heads of government CoP of the new treaty.

The UN's Secretary-General has proposed an emergency platform, which would not be a standing body but a set of protocols triggered automatically by a crisis of sufficient scale and magnitude—for example a pandemic.[4] The UN's Secretary-General would convene leaders from countries, the UN system, international financial institutions, and subject experts including civil society, industry, and research bodies. We strongly support this approach as the best means to bring the world together to act at the time when a global coordinated response to a pandemic is needed the most.

We declare no competing interests. We write as the Panel for a Global Public Health Convention.

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Non-communicable diseases in Afghanistan: a silent tsunami

Afghanistan is experiencing an untypical humanitarian crisis resulting from a chronic 40-year conflict and political upheavals. This crisis has led to a rapid economic collapse, inflation, drastic rises in poverty, hunger, and risk of malnutrition.[1] Afghanistan is suffering from the double burden of communicable and non-communicable diseases. Outbreaks of many communicable diseases such as acute watery diarrhoea, measles, dengue fever, pertussis, and Crimean–Congo haemorrhagic fever in addition to COVID-19 have worsened the situation. Non-communicable diseases (NCDs) account for almost 50% of mortality in the country with a transition towards a heavier burden by 2030. If these diseases are not addressed by context-based interventions, they will cause more than 70% of years lived with disability in a country with a population of 48 million by 2030 and more than 60% of mortality mainly among women by 2030.[2]

NCDs are a neglected issue in the Afghanistan humanitarian context. NCD services are mostly only available at the tertiary-care level and through the private sector, which makes accessing the services challenging for patients. Given that services for NCDs are expensive, these services, including medicines, might not be available in those facilities that should provide them at the public primary health-care level. A national assessment on the provision and use of essential health services in 2022 showed that NCDs were the most disrupted services and an unmet need of the Afghan population during the COVID-19 pandemic. This study showed that people need diagnostic tests and medication for the treatment of chronic diseases.[3]

Afghanistan's health system is highly dependent on financial donors. To provide NCD management as

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routine health care to the Afghan population, the Ministry of Public Health has designed the Integrated Package of Essential Health Services, which is an integration of two existing packages, the Basic Package of Health Services and the Essential Package of Hospital Services.[4] However, the new package has never been implemented due to high costs and because NCDs have not been the priority for donors and many humanitarian actors in the country.

To control this silent tsunami in Afghanistan, humanitarian actors should integrate NCD care into their activities and allocate specific budgets for harmonising and enhancing NCD management in humanitarian crises. The key points to be considered are training of health workers on the identification of NCDs, access to treatment, continuity of care through the referral pathways, patient self-management and education, health promotion, and community engagement. This approach has been developed by WHO in the Package of Essential Non-Communicable Diseases that can be piloted and implemented in Afghanistan. Only a collaborative approach by all actors will address the needs of people affected by NCDs during this humanitarian crisis.[5]

We declare no competing interests.

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Climate change justice goes beyond authorship equity

Mehr Muhammad Adeel Riaz and colleagues commented on the poor global authorship equity in the 2022 report of *The Lancet* Countdown on health and climate change.[1] This letter not only describes the inequity in reporting but also enlightens the need to dissect climate change in detail to truly understand cause and effect.

The countries responsible for the highest carbon emissions are China, the USA, India, Russia, Japan, Germany, Iran, South Korea, Saudi Arabia, and Indonesia.[2] The first five countries in the list, along with the EU, account for 70% of total global carbon emissions.[3] The countries that published the most scientific articles on climate change are the USA, the UK, China, Australia, Germany, Canada, France, Netherlands, Spain, and India.[4] One cannot help but notice the overlap between the two lists. None of the top ten countries most affected by climate change are on the list. These countries include Afghanistan, Bangladesh, Chad, Haiti, Kenya, Malawi, Niger, Pakistan, Somalia, and Sudan;[5] their contribution to the global emissions is miniscule yet they face the harshest consequences.

Hence, there is more literature on cause and little on effects of climate change, with a sharp demographic contrast. It is the obligation of high-income countries to take the lead in building capacity and developing collaborations with low-income and low-middle income countries to produce a well-distributed cohort of literature. Similarly, countries responsible for high emissions need to be made accountable to support nations affected by the consequences of their emissions. Otherwise, climate change will remain a predator–prey relationship with some countries benefiting at the cost of others.

We declare no competing interests.

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Essential role of staff development in addressing structural racism

After the recent Comment[1] by Saleem Razack and Thirusha Naidu, we thought it essential to emphasise the importance of faculty development. As medical educators, we must role-model the behaviours and attitudes we expect of our students, including the critical consciousness mentioned, but also an awareness of structural racism and its effects on students, patients, and staff. We are concerned that too much of the focus in recent years has been on the