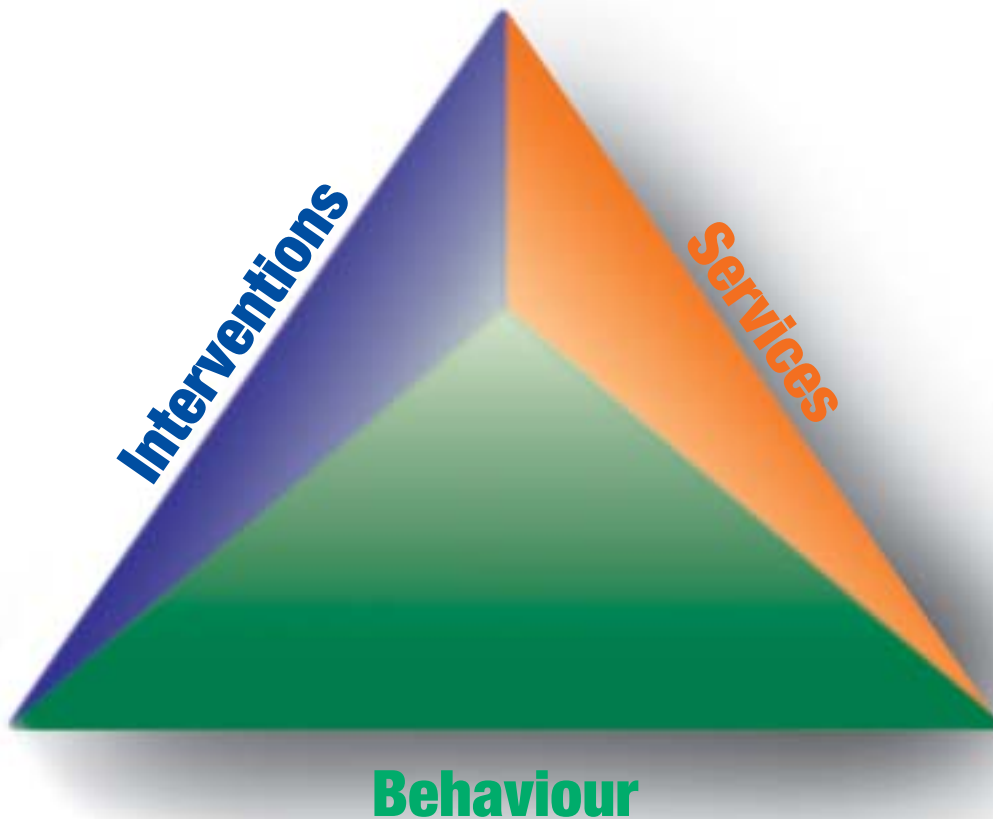


# GOING TO SCALE



***As we stand at the dawn of the 21st century, there is unprecedented political momentum for dramatically scaling up the global response to the main infectious diseases, starting with HIV/AIDS, tuberculosis and malaria.***

## **GLOBAL RESOURCES**

As we stand at the dawn of the 21st century, there is unprecedented political momentum for dramatically scaling up the global response to the main infectious diseases, starting with HIV/AIDS, tuberculosis and malaria. At long last, political will – a key component for social change – has begun to coalesce around the interlinked concerns of poverty alleviation and the control of infectious diseases.

Like all other resources, political will can either be used to advantage or disregarded. While political will is a prerequisite for massive global efforts such as those needed against diseases of poverty, alone it is insufficient to save a single human life if not followed up with specific action. If massive and successful action to expand effective interventions, extend health services and increase healthy behaviour are not forthcoming, political will can vanish as quickly as it appeared.

We live in a world in which personal wealth is greater than ever. Global trade continues to increase and expand. Information technology is bringing us into closer contact with each other than ever before. And yet almost 1.2 billion people, one-fifth of the world's population, subsist on less than US\$ 1 per day, and the poorest 10% of the world's citizens share in less than one-half of 1% of global trade in goods and services.

In the poorest countries of sub-Saharan Africa, per capita government spending on health has fallen from US\$ 11 a year in the 1980s to only US\$ 8 a year in 2001, amounting to only 20% - 40% of the cost of what the World Bank regards as the minimum basic package of health and environmental services.

The developing countries of the world, where the majority of the poor live, are to a large extent excluded from international trade and investment, and foreign aid to these countries continues to fall. Over the past decade, financial

flows to developing countries have fallen by 39% in real terms; official development aid (ODA) has fallen by 45%; foreign direct investment to developing countries is now only 1.4% of the world's total; and the exports from these countries amount to only 0.4% of the total.

Even though developed countries have made commitments to provide 0.7% of their gross national product (GNP) for development assistance, only Denmark, Luxembourg, Netherlands, Norway, and Sweden have honoured their pledges. Current levels of total ODA stand at about US\$ 50 billion per year, of which only about 7% - 8% – US\$ 3.5- 4.0 billion – are devoted to health, nutrition and population. However, the real value of this assistance may be less, since much of it is provided in the form of earmarked aid and loans rather than grants.

Only a tiny fraction of resources for health in low- and middle- income countries is provided by international organizations. In 1994, for example, health spending in low- and mid-

dle- income countries totalled US\$ 250 billion, of which only US\$ 2-3 billion were from development assistance. By the late 1990s this assistance had increased to a maximum of US\$ 4 billion per year, equivalent to about 8% of all ODA.

The magnitude of this calamity in developing countries has triggered unprecedented action by the international community, with pledges for massive financial and technical support. This is vital because only decisive action initiated by national governments and supported by a broad range of partners can begin to reverse this dire situation.

## THE NEW RESOURCE OF POLITICAL COMMITMENT

New resolve to scale up the global response to the three major diseases of poverty (HIV/AIDS, tuberculosis and malaria) has been evident over the past two years. The agendas of a



series of international meetings have reflected a wave of unprecedented political support for health issues at the highest levels. A brief chronology of these meetings follows.

### **Ministerial Conference on Tuberculosis and Sustainable Development**

March 2000, Amsterdam, Netherlands

Ministers of health, planning and finance from 20 of the 22 countries with the highest number of cases of tuberculosis met in Amsterdam to set targets for reducing the epidemic. The resulting Amsterdam Declaration called for scaling up at a quicker pace, more political commitment and additional resources to reach the global targets. The Declaration also requested assistance in developing national TB plans and greater research to develop new drugs. The Ministers pledged to expand DOTS coverage to reach at least 70% of all infectious TB cases by the year 2005. They also agreed to work with WHO to establish a Global TB Drug Facility in order to help make anti-tuberculosis medicines universally accessible and to develop a Global Investment Plan to further coordinate the efforts of governments and NGOs in implementing the DOTS strategy.



### **African Heads of State Summit on Roll Back Malaria**

April 2000, Abuja, Nigeria

The Heads of State of 19 African nations met, along with heads of international development agencies, to declare war on malaria. Their Abuja Declaration called for quick action to ensure that at least 60% of those at risk of malaria are provided protection (such as insecticide-treated nets) and have access to treatment within 24 hours. Commitments were also made to protect pregnant women and children from malaria and to remove taxes and tariffs on nets imported into African countries. A report released at the meeting – prepared by WHO, Harvard University and the

London School of Hygiene and Tropical Medicine – showed that malaria has been hindering economic growth on the continent possibly by 1.3% each year; i.e. the GDP of African countries is currently 32% lower than it might have been had malaria been controlled two decades ago.

### Summit of G8 Leaders

July 2000, Okinawa, Japan

After making HIV/AIDS, TB and malaria one of the top four agenda items of the Summit, the leaders of the G8 countries (Canada, France, Germany, Italy, Japan, Russian Federation, United Kingdom and the United States) pledged to take decisive action against the diseases. Signalling their commitment in their final communiqué, specific targets were endorsed for reducing the number of young people infected by HIV/AIDS by 25%, cutting tuberculosis mortality and prevalence by 50%, and bringing down the burden of disease associated with malaria by 50%, by the year 2010.

### Massive Effort Advocacy Forum

October 2000, Winterthur, Switzerland

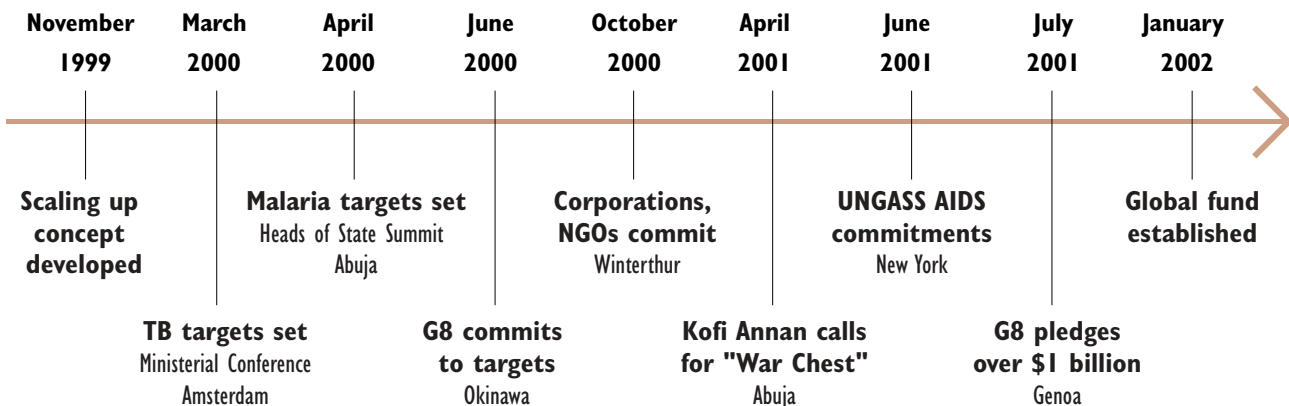
Nearly 200 leading advocacy and communications experts – primarily from NGOs and the private-sector; and from all parts of the world – met for four days in the Swiss city of Winterthur to discuss how to initiate a larger social movement to address diseases of poverty. They agreed to mobilize global, national and community advocacy networks to hold governments accountable to agreed-upon disease control targets and to increase the involvement of civil society in meeting these targets. Subsequently, dozens of these organizations have embarked on new activities to fight AIDS, TB and malaria.

### African Summit on HIV/AIDS, TB and Other Related Infectious Diseases

April 2001, Abuja, Nigeria

Following on from the disease control targets adopted the previous year, impressive pledges were made during the

## Unprecedented political support for HIV/AIDS, TB and malaria



## Benefits from the Global TB Drug Facility

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Preclusion of further TB drug resistance.

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Rationalisation of procurement mechanisms.

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Improved cost-effectiveness of drug purchasing.

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Improved quality of TB drugs worldwide.

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Creation of a successful model of commitment and cooperation to confront global epidemics.

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Treatment of an additional 10 million patients by 2005 and 45 million by 2010.

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Prevention of 25 million TB deaths and 50 million TB cases by 2020.

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Abuja Summit of the Organization of African Unity (OAU) in April 2001. The UN Secretary General called for the creation of a global “war chest” for the control of HIV/AIDS, TB and malaria and requested US\$ 7-10 billion annually in new funding for this purpose. In addition, 47 African Heads of State committed their governments to allocating at least 15% of their annual budgets to improving the health sector, and setting aside a substantial proportion of these funds to fight HIV/AIDS, TB, malaria and other infectious diseases.

## UN General Assembly Special Session on HIV/AIDS

June 2001, New York, United States

The United Nations Secretariat convened a Special Session of the General Assembly on HIV/AIDS to address the pandemic at the highest political level. In focusing the world's attention on the epidemic, international action to fight the spread of HIV/AIDS and mobilize additional resources was intensified.

## Summit of G8 Leaders

July 2001, Genoa, Italy

Responding to recent calls for increased financial support for scaling up efforts to control HIV/AIDS, TB and malaria, the Government of the United States became the first to commit resources – a US\$ 200 million pledge – to the proposed new Global Fund to Fight AIDS, TB and Malaria. Subsequently, the United Kingdom pledged US\$ 200 million, matched by Japan. France promised US\$ 130 million and the International Olympic Committee, US\$ 100 000 in the months leading up to the annual Summit of G8 Leaders. Other donations of US\$ 100 million or more have followed from the European Commission, Germany, Canada and Italy. Nigeria has also pledged US\$ 10 million to the fund, Uganda US\$ 2 million and Zimbabwe US\$ 1 million. In responding to the G8's call for the world's 1 000 leading corporations to each donate US\$ 1 million, Crédit Suisse and its subsidiaries Winterthur

Group and Medvantis became the first private-sector partner to commit to this initiative. Additionally, the Gates Foundation announced a US\$ 100 million commitment to the Fund, which it said should be used for innovative HIV/AIDS prevention efforts.

## PARTNERSHIPS AND NETWORKS TO MULTIPLY SUCCESSES

The deaths, suffering and poverty caused by HIV/AIDS, TB and malaria worldwide call for a massive global response. An enhanced and expanded framework of partnerships and networks – involving governments, UN agencies, financial institutions, NGOs, private-sector partners and civil society – is urgently needed to deal with these three major infectious diseases. For maximum effect, impetus must come from both local and global players.

Such a strategy must be backed up by the necessary political and financial commitment. It is important that this global strategy should complement – not replace or negate – action by developing countries to build and strengthen their own health systems. The following are a few of the global initiatives that can help the world “go to scale” in addressing diseases of poverty.

### Stop TB Initiative

The Stop TB Initiative has been set up to fight the global burden of TB and has developed a political and social movement against the disease by promoting the use of DOTS. The initiative is a partnership between countries with serious TB problems, UN agencies, NGOs, private industry and public health institutions. Stop TB functions through a process of consensus to agree on priorities and follow best practices. Its actions are conducted according to the comparative strengths of individual partners. It aims to increase access to treatment for TB patients, develop effective strategies to meet the challenges of multidrug-resistant TB and

### The targets of Stop TB

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2005: 70% of people with infectious TB will have been diagnosed, and 85% of those detected, cured.

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2010: The global burden of TB disease – deaths and prevalence – will be reduced by 50% of year 2000 levels.

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2050: The global incidence of TB disease will be less than 1 in 1 million people.

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## The targets of Roll Back Malaria

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Halve the malaria mortality for Africa by 2010.

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Initiate actions at country level to provide resources to facilitate realization of RBM objectives.

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At least 60% of those suffering from malaria have prompt access to and are able to use correct, affordable and appropriate treatment within 24 hours of onset of symptoms, by 2005.

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By 2005, at least 60% of those at risk of malaria, particularly pregnant women and children under age five years, benefit from the most suitable combination of personal and community protective measures such as insecticide-treated mosquito nets and other interventions which are accessible and affordable, to prevent infection and suffering.

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the deadly link of TB and HIV, and promote the development of new drugs and vaccines.

One immediate priority is to expand the use of DOTS to all populations at risk, which is at the heart of the Global DOTS Expansion Plan of the Stop TB Initiative. The plan supports a scaled-up response by mobilizing human and financial resources as part of national health systems to achieve the TB targets agreed to by Ministers in March 2000 in Amsterdam.

The two pillars of the plan are the development of national strategies and partnership building to support public health efforts. The first stage is to identify country needs and resource gaps, including shortages of diagnostic supplies, drugs and staff. Next, health plans must be developed which are specifically aimed at increasing case-detection and cure rates to enable additional resources to be allocated efficiently and progress to be made towards reaching national targets. Strong partnerships are crucial for the success of the plan, since a large-scale improvement in TB control can only be achieved through collaboration among partners. As a priority issue, the Global DOTS Expansion Plan has calculated the financial resources needed to expand DOTS. Initial estimates for the 22 high TB countries with the highest burden of TB show that the basic investment required is between US\$ 700 million and US\$ 900 million each year.

To overcome the serious shortage of TB drugs in some developing countries, the Global TB Drug Facility was established during 2001 as a part of the Stop TB Initiative. This facility supports a large-scale response to TB control by increasing the availability of high-quality drugs and diagnostics at a low cost, and facilitating DOTS expansion. The Facility also provides pooled procurement services for countries and buffer stocks, and ensures quality control of drugs. It addresses the need to ensure uninterrupted global supplies of quality drugs, to catalyze rapid treatment expansion, to stimulate political and popular support in countries throughout the world for public funding of appropriate drug supplies, and to secure sus-

tainable disease control or even elimination. Together with the Global DOTS Expansion Plan, this is a major step towards applying the principles of the DOTS strategy on a larger scale.

## Roll Back Malaria

The Roll Back Malaria (RBM) initiative was launched in October 1998. It has four founding partners; WHO, UNICEF, UNDP and the World Bank. This initiative is unique in that, unlike previous global campaigns against malaria, RBM is horizontal in its approach, focusing on building sustainable community capacity. RBM is also unique in its ability to raise the level of political commitment and advocacy at the country level. It draws inspiration and support from the joint efforts of national governments acting as stewards, plus a range of development partners, including the international and local private-sector, NGOs and civil society.

The partnership facilitates scaling up by supporting country strategic plans of action focusing on increased coverage for the prevention and treatment of malaria. RBM is helping health systems to deliver cost-effective interventions including better health care – focusing on pregnant women and advocating for the strengthening of IMCI strategies for the prevention and treatment of childhood illnesses at community level – insecticide-treated nets, and improved environmental management. At the same time RBM is harnessing the support of public- and private-sector researchers in developing new malaria drugs and vaccines. RBM is based on the principle that people at risk of malaria should be at the centre of a movement to reduce the impact of the disease in their communities through more effective action and widespread use of preventive and treatment interventions.

Forging country partnerships and exploring effective ways to work with communities at risk to improve the distribution of goods and delivery of services is vital, as is an increased emphasis on home treatment. Expanding access to affordable drugs, insecticides, nets and supplies at the household level is possible

## Mid-term targets of the International Partnership Against AIDS in Africa (to the year 2005)

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Increased access to HIV prevention interventions.

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Provision of appropriate support and care to persons infected and affected with HIV/AIDS .

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Expanded and decentralized responses to the epidemic.

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Increased financial, technical and political resource investments.

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## Scaling up priority areas for HIV/AIDS control

Baseline (2000) and scaling up HIV interventions (2005) assumptions for prevention programmes in sub-Saharan Africa.

Intervention	Potential target group (age, in years)	Measure of coverage	Baseline (2000)	Target (2005)
<b>Youth-focused interventions</b>	Male and female youth enrolled in school.	Proportion aged 6 – 11 receiving HIV education Proportion aged 12 – 16 receiving HIV education	5 – 20% 20 – 50%	50% 80%
<b>In-school youth</b>	aged 6 – 11 aged 12 – 16			
<b>Youth-focused interventions</b>	Males and females aged 12 – 16	Proportion aged 12 – 16 receiving HIV education	5 – 20%	50%
<b>Out-of-school youth</b>				
<b>Sex-worker interventions</b>	4% urban women aged 15–49. Average 2 sex acts per week	Proportion total reached Proportion using condoms often	20 – 50% 10 – 30%	60% 70%
<b>Strengthening public- sector condom distribution</b>	All sex acts with non-regular partners 20% sex acts in regular partners	Proportion using condoms often in non-regular partnerships Proportion using condoms in regular partnerships	10 – 40% 2%	70% 2%
<b>Condom social marketing</b>	All sex acts with non-regular partners 20% sex acts in regular partners	Proportion using condoms often in non-regular partnerships Proportion using condoms in regular partnerships	10 – 40% 2%	70% 2%
<b>Strengthening STI services</b>	Men and women with curable STIs and access to health services	Among those with access to health services, proportion of curable STIs treated by health service	5 – 20%	30 – 40%
<b>Voluntary counselling and testing (VCT)</b>	Current sexually active population	Proportion receiving VCT urban Proportion receiving VCT rural	1% 5%	0 – 1% 5% (including mother to child transmission testing)
<b>Strengthening blood-transfusion services</b>	Blood for transfusion	Proportion units of blood for transfusions tested Urban Rural	70 – 90% 70 – 90%	100% 100%
<b>Mother-to-child transmission</b>	Pregnant women aged 15 – 49	Proportion pregnant women tested for HIV, All pregnant women	0 – 0.5%	50%
<b>IEC / mass media</b>	National campaigns for entire country	Number campaigns per year	2	6

Source: UNAIDS 2000

through additional development assistance and public debt-relief, as well as new resources from the private-sector. In order to improve global access to essential new interventions such as combination drug therapy and permanently-treated nets, global subsidies will have to be provided by a global commodity fund similar to the one developed for the TB procurement of antituberculosis drugs.

### International Partnership against AIDS in Africa

The International Partnership against AIDS in Africa (IPAA) is a coalition bringing together African governments, the United Nations, donors, the private-sector, NGOs and civil society, working together to achieve institutional change. It is supported by UNAIDS and its pur-

pose is to curtail the spread of HIV and reduce its impact through sustained national responses.

An IPAA innovation is the development of national partnership mechanisms to overcome the fragmentation that has characterized the response to date. Investing in such mechanisms is intensive in terms of time and resources, but it is critical to achieving the institutional change needed. IPAA's goal is to ensure that national strategic plans are reviewed, operationalized and financed in at least 20 countries by 2002.

No other region has developed such a comprehensive framework for action, although there are a number of promising initiatives that, like IPAA, are supported by a partnership of governments, the UN, bilateral agencies and NGOs. Efforts in Latin America, the Caribbean,



## Estimates on cost for care for people with HIV/AIDS in sub-Saharan Africa.

All cost estimates are given in million US\$; 2000 values.

<b>Costs for care (without antiretroviral therapy)</b>	<b>Low</b>	<b>High</b>
Palliative care	30	43
Treatment of opportunistic infections	151	216
HIV testing in treatment sites	4	5
Prophylaxis of opportunistic infections	15	22
Service delivery cost (in- and outpatient visits)	748	1,068
Care for orphans	175	250
<b>Total care (US\$ million)</b>	<b>1 123</b>	<b>1 604</b>

Source: UNAIDS 2000

South Asia, South-East Asia, and eastern Europe that support national responses, and ensure that international partners act more effectively, have played a significant role and have considerable scope for expansion.

## Global Fund to Fight AIDS, TB and Malaria

Ideas and activities for the creation of a Global Fund to Fight AIDS, TB and Malaria have recently been converging. Public attention was drawn by the call of the United Nations Secretary-General for the establishment of a fund that would contribute to the US\$ 7-10 billion increase in spending needed to combat HIV/AIDS, TB and malaria, and to strengthen health services. The purpose of the Fund would be to mobilize, manage and disburse additional resources that will enable countries to progress more rapidly to achieving positive health outcomes.

The Fund would be characterized by highly-visible operating systems, transparent processes, the relentless pursuit of results, speedy disbursement, and support for a range of service providers under common (usually government) stewardship. Investors would be able to predict the likely impact of their investments. The continued availability of financing for any recipient country or community would be linked to performance of relevant social systems (particularly health systems) and the results achieved among vulnerable communities. Outcomes would be monitored independently. The Fund would focus initially on better outcomes in relation to HIV, malaria and tuberculosis. Countries would decide on detailed programming; the Fund's board would review strategy, overall cost, indicators of commitment and feasibility within national development processes. Financing would be made available in ways that take national mechanisms for coordination and strategic planning into account. Care should be taken to reduce burdens on national finance or health-management systems. National and local ownership is a key to successful imple-

mentation of interventions, geared to different national contexts.

## Massive Effort Campaign

A new global advocacy network is catalyzing the emergence of a social movement against diseases of poverty, particularly HIV/AIDS, TB and malaria. The Massive Effort Campaign (MEC) is a network of individuals, NGOs, corporations and civic organizations which promote best practices in advocacy and communications to stimulate social and political change. MEC works in support of the priorities of the United Nations, WHO and national public health institutions, while operating independently to use the most effective advocacy and communications strategies to help achieve these goals.

The Massive Effort Campaign will work by supporting networks of existing organizations with strategic information, best practices, prototype messages, useful opportunities for collaboration and coordination, funds for priority social mobilization projects and evaluation of efforts to affect the knowledge, skills and behaviour of target audiences. The Campaign is empowering a much larger global movement of people who cannot tolerate the injustice of millions of people dying every year for lack of effective medicines and supplies that cost US\$ 10 or less.



## Global Business Council on HIV/AIDS

As the HIV/AIDS epidemic continues to spread, its direct economic impact is becoming more and more evident worldwide. Apart from the human cost, HIV/AIDS is increasingly affecting the people – consumers as well as workers – on which businesses depend. The Global Business Council is an international partnership between the public and private-sector whose underlying objective is to minimize the worldwide human and economic cost of HIV/AIDS. Created in 1997, the

***As increased funding becomes available, it will be important to secure resources for research to develop new tools and to better understand the reasons for the persistence of infectious diseases as well as the determinants for their optimal control.***

Council is supported by Nelson Mandela and some of the world's best-known companies and emerged from efforts by UNAIDS to encourage direct corporate involvement in the fight against HIV/AIDS.

As an independent body working closely with UNAIDS, the Council sets out to develop programmes, share information and research that will help halt the spread of the epidemic and develop a support network for those already living with HIV/AIDS.

### **The Special Programme for Research and Training in Tropical Diseases (TDR)**

TDR is cosponsored by WHO, the UN Development Programme (UNDP) and the World Bank, as well as collaborators in academia, industry, public and private institutions and donors from both developing and developed countries. In scrupulously giving precedence to science over politics, TDR provides a neutral platform where scientists, disease control experts, decision-makers and other partners from all over the world can work together.

TDR has increased its emphasis on public health solutions, including tools and products, for poor and marginalized populations to counteract the growing inequity in access to health care services and products. It recognizes the key role that collaboration and partnership between public and private-sectors at all levels should play in closing the global gaps – in research and product development, as well as between those who are affluent and poor marginalized populations suffering from neglected infectious diseases.

As increased funding becomes available, it will be important to secure resources for research to develop new tools and to better understand the reasons for the persistence of infectious diseases as well as the determinants for their optimal control. TDR has a sound reputation in this area and could be used as a model for other similar partnerships.

## Global public goods

These are defined as “goods whose benefits reach across borders, generations and population groups. All public goods, whether local, national or global, tend to suffer from under-provision. The reason is precisely that they are public. For individual actors, it is often the best and most rational strategy to let others provide the good – and then to enjoy it – free of charge. At the international level, this collective action problem is compounded by the gap between externalities that are becoming more and more international in reach and the fact that the main policy-making unit remains the nation state”.

It is clear that cost-effective interventions work only when they are accessible to, and affordable for, those who need them. This applies to diagnostics, to commodities such as insecticide-treated nets and to treatments such as pharmaceutical drugs. Key strategic elements for addressing barriers to the affordability of existing health products include clarification of the role of intellectual property protection, wider and more effective use of voluntary licensing, and increased support for basic and applied research.

Public-private partnerships can develop mutually beneficial mechanisms to bring down the costs of existing medicines, vaccines and health products that are essential for improving the health of people living in poverty. Although public-private-sector partnerships are a relatively recent phenomenon, the incentive behind them is clear and simple. Socially-responsible businesses operate on the principle of enlightened self-interest. They want to keep productivity – and profits – high; therefore, businesses that operate in disease-prone areas have a vested interest in keeping their employees healthy. It makes sense to support the public health sector in extending public goods to all. In instances where the health sector is ineffective, the private-sector may itself assume a direct, if limited, responsibility.

Six of the world's leading pharmaceutical companies – Abbott Laboratories, Boehringer Ingelheim, Bristol-Myers Squibb, Glaxo-





SmithKline, Hoffmann-La Roche and Merck & Co., Inc. – agreed to work with the UN system to improve access to better health care and HIV-related medicines for people in developing countries as part of a global initiative, including prevention, education and research, to combat AIDS. For example, Pfizer announced that it will expand its free distribution of the AIDS drug Diflucan to patients in 50 of the least developed countries.

Another example of making drugs affordable is the recent agreement between Novartis and the World Health Organization to provide a new drug – Coartem – for drug-resistant malaria in developing countries at cost price, reducing it from US\$ 40 to less than US\$ 2.50 for the full course of treatment for adults, and considerably less for children. Additionally, Aventis and WHO have entered into a partnership over a period of 5 years. Through this collaboration, some of the barriers that make existing medicines and tools unaffordable to developing countries can be tackled. The partnership aims to explore the feasibility of drug donations and to provide more effective support for disease management as well as research and development.

## WHAT WILL IT COST?

Scaling up the response to infectious diseases calls for the mobilization of sufficient financial resources to support necessary interventions, including training, tools, medicines, research, and an adequate supply of health professionals. The Commission on Macroeconomics and Health (CMH) recently published a report, *Macroeconomics and Health: Investing in Health for Economic Development*, which estimated that, by 2010 around 8 million lives per year could be saved – mainly in the low-income countries – through the essential interventions against infectious diseases including, but not limited to – AIDS, TB and malaria – and nutritional deficiencies.

The CMH report sets out the level of resources necessary to have effective interventions to improve the health and

extend the life spans of poor people, which in turn would stimulate economic development and reduce poverty.

To address health challenges in low-income countries, minimum financing needs to be US\$ 30- US\$ 40 per person per year to cover essential interventions, including those needed to fight the HIV/AIDS epidemic. Current actual spending on health in the least-developed countries is around US\$ 13 per person per year.

Donor finance will be needed to close the financing gap, in conjunction with best efforts by the recipient countries themselves. The CMH estimates that a worldwide scaling up of health investments for the low-income countries to provide the essential interventions of US\$ 30 to US\$ 40 per person will require approximately US\$ 27 billion per year in donor grants by 2007, compared with around US\$ 6 billion per year that is currently provided. This funding should be additional to other donor financing, since increased aid is also needed in other related areas such as education, water and sanitation.

Scaling up of domestic budgetary resources for health in the low-income countries is also necessary. The CMH report sets out that, for low-income countries, this entails an additional budgetary outlay of US\$ 23 billion by 2007.

For all low-income countries, approximately US\$ 66 billion per year above current spending levels would be needed by the year 2015, which would result in a total economic gain of at least US\$ 360 billion per year.

The three main diseases of poverty, HIV/AIDS, tuberculosis and malaria, call for an additional scaling up of research, and prevention and treatment interventions. The CMH report calls for two new funding mechanisms: the Global Fund to Fight AIDS, TB and Malaria to fund to make annual outlays of US\$ 8 billion by 2007, and; the Global Health Research Fund to make annual outlays of US\$ 1.5 billion by 2007.

Earlier estimates for the three diseases have shown that for these diseases alone, there is a need for investments of: US\$

### The cost of going global against HIV/AIDS, tuberculosis and malaria

Disease/condition	Annual amount needed (US\$)	Annual funds available (2001) (US\$)
HIV/AIDS	9.2 billion	1.8 billion
Tuberculosis*	1-1.5 billion	600-800 million
Malaria**	1 billion	600 million

\* TB in the 22 high-burden countries only.

\*\* Malaria in sub-Saharan Africa only.

## Overcoming obstacles to global public health by enhancing affordability and incentives

Current obstacle	Response (corrective measures or new initiative)
Lack of effective demand (including the ability to pay)	<ul style="list-style-type: none"> <li>• A global fund for health</li> <li>• Global TB Drug Facility</li> <li>• Tax incentives for product donations</li> <li>• A framework for tiered pricing</li> <li>• More widespread and effective voluntary licensing</li> </ul>
Weak incentives for R&D investment	<ul style="list-style-type: none"> <li>• A global fund for health (advance- purchase commitment)</li> <li>• Clarity on the terms of intellectual property protection</li> <li>• Targeted public support for R&amp;D</li> <li>• Securing of potential markets and co-investments in marketing new products</li> <li>• Tax incentives for R&amp;D</li> <li>• Public-private partnerships for R&amp;D</li> </ul>
Drugs: weak incentives for extra investment in basic research	<ul style="list-style-type: none"> <li>• Support for basic and applied research</li> <li>• TDR</li> </ul>
Drugs -- blockages in progress at the clinical trials stage	<ul style="list-style-type: none"> <li>• Establishing a clinical trials platform</li> </ul>
Drug clearance: regulatory delays	<ul style="list-style-type: none"> <li>• Harmonizing the regulation of new products</li> </ul>

9.2 billion a year for HIV/AIDS, with half of these resources needed in sub-Saharan Africa; US\$ 1 to 1.5 billion a year for tuberculosis in the 22 high-burden countries alone, and; US\$ 1 billion for malaria in sub-Saharan Africa alone.

## GOING TO SCALE

We may be witnessing a truly unique moment – a moment of heightened awareness and action. Something similar happened two decades ago around environmental awareness, which brought not only a spate of new initiatives, but concrete action as well. Today health stands high on the world's political agenda. The time has come to scale up the global response against diseases of poverty, starting with HIV/AIDS, tuberculosis and malaria.

The international community has agreed upon a series of development targets to be met. Three of these are to halve deaths from malaria and tuberculosis by 2010 and to reduce HIV prevalence by 25% in young people by 2010. Achieving these ambitious goals requires a comprehensive global strategy that builds on existing initiatives.

WHO is an active and ardent proponent of the global scaling-up movement. It proposes a framework for action that builds on current activities, gearing up for at least 10 years of intense action aimed at moving the world – especially its most needy countries and people – onto a “superhighway” to health. The framework, which will focus initially on HIV/AIDS, malaria and tuberculosis, has six components:

- **Fresh, additional resources:** Ideally, US\$ 10 billion a year to build national health systems, carry out interventions and upgrade global public goods.
- **Key global functions:** Research to develop essential new drugs and vaccines; partnerships to lower drug prices and improve access for the poor; efficient purchase and equitable distribution of vital commodities, including quality, low-cost medicines against the diseases of poverty .

- **Resource-transfer mechanisms:** The ability to move funds rapidly to where they are needed, while ensuring transparency, decision-making at country level and a results-related feedback link.
- **Enhanced health systems:** Delivery of essential goods and services via private, voluntary and public providers with an emphasis on government stewardship; investments in infrastructure and better logistics to distribute medicines and other vital commodities and services.
- **Impact monitoring:** Independent and reliable monitoring, reported rapidly and openly, to sustain long-term involvement through an ever-present feedback loop.
- **Social mobilization:** Advocacy and communications programmes that work through governments, NGOs and the media to catalyse social mobilization “trickling up” from local to global levels.

The specific elements of scaling up efforts to fight diseases of poverty will vary from country to country according to factors such as prevalence, differences in modes of transmission, the relative maturity of the epidemic, the extent of the dispersal – or concentration – of the epidemic through different sectors of the population and the extent to which the existing health system is able to respond.

All global efforts must eventually be achieved within a framework of strong, cohesive national planning and strengthened by community action. Moreover, scaling up prevention and control activities cannot be addressed by the health sector alone: it must involve other social and economic sectors across all levels of society. Nor will it succeed if only tackled by the public sector alone. Only with massive involvement of civil society and the private-sector can this challenge be met.

