South Africa unveils national HIV/AIDS treatment programme

The South African Cabinet approved a national HIV/AIDS treatment programme on 19 November 2003 representing a major policy change for President Thabo Mbeki’s government which had been criticized for failing to tackle the AIDS pandemic.

The programme plans to distribute free antiretroviral drugs through service points in every health district within one year and in every local municipality within five years. It aims to treat about 1.2 million people by 2008.

It is not yet clear when the drugs will be made available. Dr Manto Tshabalala-Msimang, South Africa’s Minister of Health, said that the government still needed to put out a tender for the drugs, train health care workers and identify and upgrade distribution centres, particularly in rural areas.

“There is still a long way to go,” she said. “I don’t want to raise false hopes, but a decision has been made. There is hope.”

“This is a far-reaching decision which demonstrates that the South African Government is ready to play a stronger role in meeting the challenge of treating millions of people living with AIDS in Africa,” said Dr LEE Jongwook, Director-General of the World Health Organization.

The programme’s treatment goals were brought further within reach following an agreement on 10 December by pharmaceutical companies, GlaxoSmithKline and Boeringer Ingelheim, to permit large-scale manufacture of generic versions of their patented HIV/AIDS drugs for the country, following an out-of-court settlement with South African’s Treatment Action Campaign.

Around 5 million people in South Africa are currently HIV-positive — that’s 11% of the country’s total population of 47 million. WHO estimates that around 15% of the total HIV-positive population are in need of treatment — higher than anywhere else in the world. By 2008, this figure will have increased as more people reach the final stages of the disease. The programme’s 1.2 million target figure includes this projected increase.

“South Africa’s bold move to ensure that millions of HIV-positive people have access to treatment should mobilize other African governments to make treatment a reality for those infected,” said Dr Peter Piot, UNAIDS Executive Director, welcoming the new phase in South Africa’s response to AIDS. The South African Government had previously been criticized by AIDS activists for asserting that HIV did not cause AIDS and for questioning the effectiveness of antiretroviral drugs.

The treatment programme is part of a wider plan known as the “Operational Plan for Comprehensive Treatment and Care for HIV and AIDS” presented to the Cabinet by the Minister of Health on 19 November. The Cabinet had requested the Department of Health to prepare the plan on 8 August 2003. It represents the final part of the National Strategic Plan for HIV and AIDS 2000-2005.

As well as treatment, the plan also includes a prevention campaign, an education and mobilization programme to strengthen partnership within the community, the expansion of programmes aimed at improving HIV patients’ immune systems and slowing
down the effects of HIV infection, the
treatment of opportunistic infections and
intensified support for families affected
by HIV/AIDS.

The South African Government
plans to spend over US$ 1.73 billion over
the next three years to combat HIV/
AIDS, of which US$ 270 million is to be
set aside for antiretrovirals. The cabinet
stated that the funds should be “new
money” — in other words money not
taken from other health care, develop-
ment or social service programmes.

“The decision to provide free anti-
retroviral treatment is a very positive
development,” said Dr Charles Gilks,
Coordinator of WHO’s 3-by-5 initiative
which aims to provide antiretroviral
treatment to 3 million people living with
AIDS by 2005. “But now the difficult
decision of who gets the drugs must be
made. New programmes have to begin
somewhere. Countries starting new HIV/
AIDS treatment initiatives are now facing
this problem — how to decide where to
start. They need to make clear choices.
They need to decide who is mandated to
make these choices.”

The Consultation on Ethics and
Equity in HIV/AIDS Care which will
take place at WHO, Geneva on 26–27
January 2004 aims to identify and
review the issues raised in deciding who
will benefit first from HIV/AIDS
treatment programmes. “It will review
what choices need to be made and what
the potential options are so that
countries can decide who to involve and
what key issues should be included in
making such difficult decisions,” said
Gilks.

Sarah Jane Marshall, Bulletin

Drug research must aim for
health care benefits, not just
commercial returns

Representatives from the UK-based
Wellcome Trust — one of the world’s
largest funders of health research —
and the virtual drug research and
development organization, the Drugs
for Neglected Diseases Initiative
(DNDi), launched in July 2003,
described efforts to encourage a priority
shift in health research agendas from
commercial viability to potential health
health care benefits, during the annual
meeting of the Global Forum for
Health Research on 4 December.

One of the greatest obstacles in
addressing the 10/90 gap — in which
only 10% of the US$ 73.5 billion spent
on health research every year is used for
research into 90% of the world’s health
problems — has been the need for drug
research to be profitable. A study in the
*Lancet* (2002;359:2188-94) showed
that between 1975 and 1999, just 16 of
the 1393 new medicines launched on
the market were for tropical diseases
such as malaria — which kills over 1
million people every year. Diseases like
malaria and tuberculosis have been
dubbed “neglected diseases” because of
the disproportionately low level of
spending allocated for research into
their prevention and treatment by
pharmaceutical companies.

At the close of the seventh Global
Forum for Health Research, Dr Ted
Bianco, Director of the Wellcome Trust’s
Technology Transfer division stated that
the policy of the Trust was to “give
priority to potential health care benefits
over and above considerations of
commercial return.”

In March 2003, the Wellcome
Trust’s Technology and Transfer division
called for proposals for its “translation
awards” programme. The translation
awards — which have an annual
budget of approximately US$ 14
million a year — are based on the
experience that fundamental research is
often “too early” or “too high-risk” to be
pursued by corporate health care or
investment sectors. In other words, new
discoveries and technologies might fail
to realize their potential because they
are not attractive to industry.

“We want to take an invention out
of the lab to a point where it becomes
credible to those who have commercial
drivers,” said Bianco. In an attempt
to move away from the traditional
objective of scientific research which,
according to Bianco, is geared towards
publication rather than products, he
explained that proposals would not be
assessed by conventional peer review
but by commercial due diligence.

“Whereas peer review emphasizes the
qualities of the individual practitioner,
due diligence also considers the
environment this invention is going to be
placed in and asks if it is likely to
attract commercial interest,” he said.

Dr Bernard Pécoul, Director of
DNDi reported that it would first
concentrate on three killer diseases —
leishmaniasis, sleeping sickness and
Chagas disease which together threaten
the lives and health of 350–500
million people every year.

Supported by Médecins Sans
Frontières, among others, DNDi works in
close collaboration with the UN
Development Programme (UNDP), the
World Bank and WHO’s Special Programme
for Research and Training in Tropical Diseases
(TDR). It aims to encourage researchers
in academic institutions and scientists in
pharmaceutical companies to resurrect
work on drugs which could have
potential against neglected diseases but
did not make clinical trials because of
lack of potential profit.

“In 12 years, at an estimated cost
of US$ 255 million, DNDi hopes to
develop six or seven drugs to combat
neglected diseases,” said Pécoul. “At
the end of this same period, DNDi also
hopes to have seven or eight new drugs
in the development pipeline.” To
increase the chances of short- and
mid-term success, the initiative will
develop drugs from existing compounds, as
well as coordinate research to identify new
chemical entities for drug development.

A call for letters of interest was sent
to the scientific community in
February 2003 and again in November
2003. Seven projects are already under
way but Pécoul hopes that this will
increase to 12 next year.

“DNDi’s success will depend not
only on government and private
donations, but also on the contribution
of pharmaceutical companies in the
form of access to compound libraries,
expertise and research and development
facilities,” said Pécoul. The DNDi
intends to publish details of any drugs
it develops so that anybody can make
and distribute them to patients in
developing countries.

Cathy Garner, Chief Executive of
a global initiative called the Management
of Intellectual Property in Health
Research and development (MIHR)
highlighted the importance of intellectual
property management in increasing access
to health technologies for the poor.

“There is a huge demand for
[intellectual property] skills among researchers in
developing countries who feel isolated,”
she said. They don’t know how to connect
the knowledge they have to the product
cycle and the commercial world, she
explained, adding: “We’re offering a
Health research influences political manifestos in Nigeria

The report of a Nigerian health systems scientist on progress in addressing political obstacles to equity in access to health care services in south-western Nigeria, received a warm welcome at the seventh meeting of the Global Forum for Health Research in Geneva, 2–5 December.

“It really is a legitimate area of research in and of itself,” said Dr Tikki Pang, Director of WHO’s Research Policy and Cooperation department. “How do you connect and talk to the politicians and decision-makers?” he asked.

Dr Lola Dare who works for the African Council for Sustainable Health Development — a partnership between African civil society, governments, private sector and development partners — and a team of researchers have begun to provide the answer. Dare and her team have been studying access to health care services in Nigeria’s Ondo State, an oil and mineral producing region with a population of 3–4 million.

They found that the number of general hospitals available to Ondo’s wealthier population was 2–3 times as many as the figure recommended by the national health care plan. For the poor, however, there were only one-tenth of the recommended number of dispensaries, health clinics and health posts.

The Commissioner of Health for Ondo State, Dr Oluremi Akinbobola described the disparity. “We have many private hospitals in Nigeria … but the poor have no access to them,” he said. “We have 203 political [constituencies] in Ondo and 289 basic health centres. Yet there are 54 [constituencies] without a single basic health care centre,” he said.

Dare described how she used her research to work with potential state governors to develop manifestos which respond to the inequities in health care experienced by Ondo’s poor. The conclusions of her research have influenced the manifesto of the current state administration, she said.

Dare’s research led to a move away from free health care in Ondo to selective exemption fees for certain categories of people. Access to the data resulting from her research was essential in order for Ondo’s government to reach this decision. “You can’t over-emphasize the value of evidence-based policy dialogues … even politicians want evidence to show that they can change the way the electorate votes, if they do this or that,” she said.

This kind of research — which translates knowledge into action by decision makers — is the kind that Pang hopes to see more of. He predicted that 2004 would be a “fantastic year” for health research. In 2004, WHO will publish a report on health research — The world report on knowledge for better health — a draft of which will be distributed in January. In November 2004, the World Summit on Health Research is scheduled to take place in Mexico City and will coincide with this year’s annual meeting of the Global Forum for Health Research. The objective of both the WHO report and the forthcoming summit is to find ways to turn research products into actions for health through health systems research that breaks down delivery and access barriers.

Robert Walgate, London

Global Forum highlights deficits in disease and gender research

Public health officials, scientists, nongovernmental organizations (NGOs) and private sector representatives from over 100 countries gathered on 2–5 December 2003 at the annual conference of the Global Forum for Health Research, a Geneva-based NGO which lobbies to raise awareness about the fact that less than 10% of health research funds are spent on 90% of the world’s health problems. The Forum looked at the contribution of health research to economic investment, poverty, gender, globalization, violence and injuries and noncommunicable diseases.

Only a tenth of the US$ 73 billion spent on health research last year went towards developing vaccines, medicines or new treatment for “diseases of the poor” — like malaria and tuberculosis, said conference organizers. Participants in the conference heard that although health research was a major factor in poverty reduction it was often overlooked by governments and other donors.

Nancy Birdsall, President of the Washington-based Center for Global Development, said that most of the 13 million deaths from infectious diseases each year can be prevented with known, relatively inexpensive treatments. “What is striking … is that the full benefits of existing technologies are far from being fully realized,” Birdsall told the conference.

Carlos Morel, Director of the joint WHO Special Programme for Research and Training in Tropical Diseases (TDR), used historical examples to illustrate the importance of continued investment in health research. Polio control was transformed by the discovery of an effective vaccine which relegated the “iron lung” machine to little more than a museum piece, he said. He also stated that the health sector often fails to invest in further research once a promising tool is discovered. Malaria research was neglected once insecticide appeared to be an effective tool for disease control — so when resistant mosquitoes appeared, no one was prepared, he said. Morel pointed out that it was a very different story in the defence sector: even though it possesses highly sophisticated and effective weapons, massive investment in research continues.

Louis Currat, the former World Bank economist and outgoing Executive Secretary of the Global Forum described the imbalance in health research funding as understandable since the private sector — which accounts for 42% of global spending on health research — responds to market forces while public health officials tend to focus on national health.

Currat said, however, that health problems like AIDS, malaria and
tuberculosis contributed towards poverty, instability and violence which in turn triggered migration and a need for humanitarian aid — both of which could be costly for rich, developed countries.

“AIDS in Africa not only means instability, and a tremendous loss of income and people in the labour force but it also means that the economic partners of Africa suffer,” said Currat. “Africa would be a better economic partner if its economy were growing and it were buying more products,” he added.

However, governments are beginning to pay attention to the 10/90 health research gap, stated Currat who said this was indicated by the fact that a tool devised by the Global Forum called the Combined Approach Matrix to help countries calculate their health priorities was catching on.

Lesley Doyal of the University of Bristol in England, one of the world’s leading experts on gender, and Vikram Patel of the London School of Hygiene and Tropical Medicine described how globalization affects the health of men and women differently. Global restructuring is leading to increasing economic difficulties in developing countries and the burden of poverty is disproportionately borne by women, they said. Patel cited several examples from the field of mental health: decreasing fertility in South Asia is making the sex of a new born child a risk factor for post-natal depression; Fiji, whose culture did not traditionally favour a slim figure, has witnessed an increase in eating disorders; several Eastern European cultures have experienced a rapid rise in alcohol use disorders. The Global Forum conference also heard that although women’s health is more vulnerable than that of men, mainly due to their childbearing role, there is a lack of research into maternal mortality, pregnancy-related disorders and other women’s health problems in the developing world.

Dr Stephen Matlin succeeded Louis Currat as Executive Secretary of the Global Forum on 1 January 2004. Louis Currat, who has led the Secretariat from its establishment in 1997, retired at the end of 2003. Matlin said that he plans to engage the media much more in the activities of the Global Forum.

Corrigendum
In the article “Human health benefits from livestock vaccination for brucellosis: case study” on pages 867–76, of Vol. 81, issue number 12, 2003 by Felix Roth et al:

Page 873
Table 2: “Ministry of State” should read “Ministry of Health”;

Table 3: the second column heading should read “Disability class II”, and the third column heading, “Disability class I”. Footnote1 should read “For public health sector, avoided out-of-pocket health costs and change in household income.”;

The left-hand column of the text should begin “… with the Mongolian policy to register brucellosis cases over a period of three years.”;

Page 874
In the last sentence of the article (penultimate line) the word “human” should be omitted.

Fiona Fleck, Geneva