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Since our last newsletter, the HTM cluster has been very busy promoting collaborative action on HIV/AIDS, tuberculosis (TB), and malaria. We continue to work on "3 by 5" scale-up, with the next progress report to be released end of June. With partners, we marked both World Tuberculosis Day (24 March) and Africa Malaria Day (25 April). On both occasions, we published updated information on the status of the two diseases in the world, in the Global Tuberculosis Control Report 2005 and the 2005 Global Malaria Report, the latter being produced jointly with the United Nations Children's Fund (UNICEF).

The findings to date are mixed: the global prevalence of TB has declined by more than 20% since 1990, and incidence rates are falling or remain stable in five of the world's continents. Africa is, however, a glaring exception, with TB incidence rates that have tripled since 1990 in countries with high HIV prevalence and that are still rising across the continent at 3-4% annually.

The conclusions of the 2005 World Malaria Report show scaling-up of antimalarial interventions in many countries. In Africa, which carries 60% of the global malaria burden, several countries will reach at least some of the key malaria control targets set by African Heads of State in Abuja in 2000.

Both reports stress, however, that much more could be achieved with more resources.

These and other health issues were major topics of debate during this year's World Health Assembly which concluded on 25 May. The Assembly, WHO's supreme



decision making body, adopted two resolutions – one each on malaria and tuberculosis. The Malaria Control resolution calls for WHO to intensify its collaboration with Member States to reach internationally agreed malaria control goals, including actions to facilitate scale-up of distribution of insecticide-treated nets and antimalarial medicines.

With passage of the Sustainable Financing for TB Prevention and Control resolution, the Assembly backed action to confront the increasing number of cases of multidrug-resistant tuberculosis and of TB/HIV co-infection, and to strengthen health workforces. Member States are further urged to set up collaboration between TB and HIV programmes and to integrate the prevention and control of TB in the mainstream of their health development plans.

We are heartened by the growing commitment of partners to confront the three pandemics, and WHO is contributing its expertise in multiple areas towards attaining the Millennium Development Goals.

Dr Jack C. Chow, Assistant Director-General, HIV/AIDS, Tuberculosis and Malaria

HIV/AIDS prevention and control: the Cuban response

José Alvarez Martín has a special mission. Five times a week, the 26-year-old Cuban social worker gets into his van and drives around Havana to speak to young people about HIV/AIDS.

The van is a mobile AIDS centre from which José and his small team educate hundreds of teenagers on how to avoid the deadly HIV infection. From Wednesday through Sunday, José's group is on the road in their colourful *carrito por la vida* ('van for life'). They stop at beaches, villages, parks and other places where young people gather and engage them in informal conversation. "We don't want to act like schoolteachers; we just explain what AIDS is and how they can avoid getting it", José says.



The *carrito por la vida* is the mobile part of the Government's AIDS prevention centre, which is located in a large mansion in downtown Havana. The centre was inaugurated in 1998 with support from Doctors without Borders Holland. It is now funded in part by a grant from the Global Fund to Fight AIDS, Tuberculosis and Malaria, awarded to Cuba in 2003.

More than 200 health promoters and a group of psychologists and HIV/AIDS experts work here every day on a voluntary basis to give the population advice and to answer all AIDS-related questions. Anyone can drop in, meet the health promoters, seek psychosocial support or simply borrow a book from the library and have a cup of coffee. The centre also provides counselling pre- and post-HIV testing. People living with HIV can consult the experts on adequate treatment and nutrition.

Cuba started implementing an HIV/AIDS programme right at the beginning of the epidemic and therefore managed to keep the AIDS prevalence rate under effective control: the country's 0.07% infection rate is among the lowest in the world. Certain routes of HIV transmission seen elsewhere in the world are almost inexistent on this Caribbean island. There is almost no transmission of the virus through intravenous drug use or blood transfusion or to newborns at birth. HIV is transmitted mainly among men having unprotected sex with other men. According to the national programme for the control and prevention of sexually transmitted infections and HIV/AIDS, 4724 people in Cuba are currently living with HIV. By the end of 2004, a total of 1222 people had died of AIDS since the beginning of the epidemic in 1986.

The Government's national surveillance system which tracks both known cases and partners provides the basis for an extensive

data-base for analysis and supportive public health response. Thus, prevention and tracking of the disease are well advanced. Furthermore, a successful treatment and care strategy has been put in place. The Government has been providing antiretroviral treatment to people living with HIV/AIDS since 2001, mainly as nationally produced generic drugs. All patients with HIV/AIDS receive medical care and drugs

free of charge.

When AIDS started to spread across the globe in the early 1990s, Cubans infected with HIV were placed in sanatoria. The oldest of Cuba's 14 AIDS sanatoria is located in Santiago de las Vegas, a half-hour drive from Havana. The 380 patients living here receive comprehensive education on all aspects of living with HIV/AIDS; treatment and care are free of charge, and patients can stay as long as they wish. They live together in small pavilions, and some of them work at the sanatorium, produce and sell handicrafts or study. The peaceful, quiet environment appears to correspond to the patients' needs, as most prefer to stay. Raudél, 41 years old, is one of them. He has been living in the sanatorium since 1993. "The nurses here treat me well, and I can be with other people who are HIV positive. There is no stigma: they are all like me," he says.

Since 1993, placement in a sanatorium has no longer been mandatory, and people living with HIV/AIDS can choose whether to use community health services or receive care in a sanatorium. Strengthening of community-based treatment and care services is an important element of a comprehensive HIV/AIDS response, complementing services provided by the sanatoria.

"Other countries can learn a lot from the Cuban system", says Dr Lea Guido López, representative of the Pan American Health Organization in Cuba. "Cuba has sent doctors and other health workers to African countries to assist them in tackling their health and HIV/AIDS management problems and would like to expand this exchange," she suggests.

Indeed, this could set an example for south-south cooperation and help countries in Africa to design a comprehensive strategy to halt the uncontrolled spread of the pandemic.

Melanie Zipperer



World Health
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Keep the promise
Millennium Development Goals



Health and the Millennium Development Goals

Meet with Dr Andrew Cassels

TITLE: Director, Millennium Development Goals, Health and Development Policy, WHO

AGE: 54

BRIEF BIOGRAPHY: Dr Cassels worked in international public health in Nepal and India, before being appointed to the staff of the Liverpool School of Tropical Medicine. He has also worked as a senior adviser on health to governments in developing countries as well as to multilateral and bilateral agencies. Dr Cassels has published widely on issues of health sector reform and new approaches to development assistance.

The Millennium Development Goals (MDGs), set by world leaders in 2000 at the Millennium Summit in New York City, United States, are targets for reducing poverty, hunger, disease, illiteracy, environmental degradation and discrimination against women by 2015. Three of eight goals are directly related to health. The sixth is to have halted and begun to reverse the spread of HIV/AIDS and the incidences of tuberculosis, malaria and other major diseases.

Dr Cassels coordinates WHO's contribution to the health-related MDGs. He considers that the world needs such goals. "They are a means of focusing political attention on crucial development issues, and the overarching goal of development must be to improve people's lives."

WHO's role in the achievement of the MDGs is threefold, he explains. First, WHO provides essential technical assistance to countries and promotes strategies to improve health. "Secondly, WHO has the capacity of tracking progress and measuring achievements in these areas." Thirdly, WHO works closely with national governments. "As more funding is now available, we need to make sure that health is well represented in national poverty reduction strategy papers, expenditure plans and sector programmes."

To date, 5 years later after the launch of the MDGs, Dr Cassels notes that progress on the health MDGs is too slow. "No country in sub-Saharan Africa is on track to reduce child mortality by two-thirds and we have to do much more to tackle communicable diseases—particularly HIV/AIDS and malaria."

How optimistic can we be that we are moving towards the 2015 targets? "Real progress requires change in the way that men relate to women, in the way that the State relates to civil society and that donors relate to governments. AIDS more than anything else has shown how changes in people's health depend on the way the world handles trade, debt, aid and technology. If we, as members of the international community, do not make progress on these issues, our struggle against AIDS, TB, malaria and most other causes of ill health will be very difficult indeed."

Melanie Zipperer

DID YOU KNOW?

4 in 4 goal surpassed

On World Tuberculosis (TB) Day, 24 March 2005, the Global Drug Facility (GDF) celebrated an important landmark: more than 4 million treatments provided in 4 years.



The GDF was established in 2001 to increase access to high-quality anti-TB drugs for implementing direct observation of treatment, short course (DOTS), the internationally recommended strategy for fighting TB.

The GDF is not a traditional procurement mechanism but represents a new perspective on access to TB drugs. It is based on tying demand for the drugs to supply, out-sourcing all services on a competitive basis, using product packaging to simplify drug management, and linking grants of drugs to TB programme performance. The GDF also includes technical assistance in TB drug management and monitoring of use.

In recognition of this achievement, the Canadian International Development Agency announced that it will provide CDN\$ 25 million in additional support to the GDF in 2005.

In just 4 years of operation, the GDF has provided drugs for 4.4 million TB patients in 58 countries around the world, nearly all with average per-capita incomes of less than US\$ 1000. Assuming an 85% cure rate (the global target for TB control) of patients in whom TB is diagnosed and who commence treatment, this means that an additional 3.8 million patients are being cured through GDF support.

Donor support to the GDF will help to control TB and improve the supply, distribution and monitoring of TB drugs. Since its inception, the GDF has helped to drive down prices by an average of 30%, to US\$ 12–14 per patient for a full 6-month course of treatment.

Thaddeus Pennas

Q & A: 2005 World Malaria Report released

The *2005 World Malaria Report* provides an analysis of data on malaria collected throughout 2004. It was released on 3 May 2005 by the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF).

Q. What are the report's main findings?

A. Considerable progress has been made in preventing and treating the disease since 2000. A number of countries are now engaged in intense antimalarial campaigns. In particular, more people are being protected with insecticide-treated nets, a highly effective method of malaria prevention.

Countries in which the previous mainstays of malaria treatment are no longer effective are moving towards new therapies. Since 2001, 42 malaria-endemic countries, 23 of them in Africa, have adopted the artemisinin-based combination therapies recommended by WHO, currently the most effective against falciparum malaria. An additional 14 countries are in the process of changing their malaria treatment policy.

Q: Where do things stand with respect to the burden of malaria worldwide?

A. The report indicates that there are an estimated 350–500 million cases, of which 270–400 million are falciparum malaria. About 70% of the burden of falciparum malaria is estimated to be in Africa and about 20% in South-East Asia.

About 60% of all cases of malaria worldwide and more than 80% of malaria deaths occur in Africa south of the Sahara. *Plasmodium falciparum* causes the vast majority of infections in this region and

about 18% of deaths among children aged under 5. In endemic African countries, malaria accounts for 25–35% of all outpatient visits, 20–45% of hospital admissions and 15–35% of hospital deaths, imposing a great burden on already fragile health-care systems.

Q. It seems most countries are unlikely to meet their Abuja targets. Why is that?

A. An ambitious goal requires ambitious efforts by all – and the commitment of appropriate funding. Malaria still remains seriously under-funded – US\$ 3 billion is required annually – but annual global spending today is around US\$ 400–500 million. For Africa, the region with the highest burden of malaria, this year's attention to the Abuja targets of 60% coverage of high risk populations with malaria prevention and treatment by the end of this year provides an opportunity to galvanize the global community around greater action against malaria. Nonetheless, countries will be reporting on their progress towards the Abuja targets at the end of 2005 and it is expected that many countries will be able to announce notable increases in coverage of one or more interventions. Eritrea has already been successful, and Togo has by one campaign in late 2004 achieved the target of one treated net per household.

Judith Mandelbaum-Schmid

DOTS: Expansion and intensification

How do you convince a traditional village healer to adopt DOTS?

This is one of the challenges facing TB control: DOTS continues to be scaled up but at the same time fails to reach some of the most vulnerable and poorest TB patients. Massive implementation of DOTS is having an impact, but, as the expansion continues, intensification and "fine tuning" are needed to engage new partners.

This was the task facing over 50 delegates at the third meeting of the Public-Private Mix (PPM) subgroup of the DOTS Expansion Working Group, which met in Manila, Philippines, in April 2005.

We live in a world where patients with symptoms of TB seek treatment from all kinds of health-care providers. The roles and qualifications of these frontline "medics" vary from country to country and from community to community. This is where PPM implementation of DOTS plays a role: bridging and improving links between national TB programmes and public, private and voluntary providers that offer services to persons with TB.

A new set of guidelines on PPM was drawn up by delegates at the Manila meeting. These guidelines provide instructions on how to initiate and expand programmes to involve various health providers, advice on developing a national strategy that can be used in local settings, and a step-by-step approach to achieving this aim on the basis of experience with existing initiatives.

"Over the last couple of years, we have gained a tremendous amount of experience of how to engage with all sorts of public and private health care providers in DOTS—everything from traditional healers to university hospitals. We are now confident that the PPM DOTS strategy is effective and helps reach TB control targets. The tools are ready. Now the time has come to more actively promote the PPM DOTS strategy to countries, donors and technical agencies," said Mukund Uplekar, Secretary of the PPM DOTS subgroup.

Glenn Thomas



Photo: Philippine nurses are a valuable link in placing TB patients into PPM DOTS programmes.