News

Global Fund for AIDS, TB and malaria opens shop

We have the money, we have the commitment — now what do we do? This is the unusual question that will be facing AIDS, TB and malaria programme managers over the next few months.

The reason? The Global Fund to Fight AIDS, Tuberculosis and Malaria is ready to spend its first moneys. The fund is a new international financing mechanism championed by Kofi Annan, Secretary-General of the UN, to tackle these diseases in low- and middle-income countries.

In February of this year the interim secretariat, now based in Geneva, issued a worldwide appeal for proposals for interventions against the three diseases. Formal proposals, agreed by all partners in the countries concerned, must be in by 10 March 2002. On 23 and 24 April the Board of the fund will meet to make the first allocations from the US$ 800 million to be spent in the first year of operation. Donors have so far pledged US$ 2000 million over the next five years.

Although this spending will be nothing like the US$ 13 000 million a year WHO estimates is needed in total — from all sources combined — to deal with the three diseases, it represents a large and sudden injection of funds into the control, treatment and prevention of HIV/AIDS, TB and malaria.

If the whole US$ 800 million now made available by the fund can be allocated to effective programmes (probably in two or three separate rounds during 2002), it will increase the scale of existing spending on the three diseases by roughly half, according to Anders Nordstrom, the acting director of the fund. As he put it: "WHO and UNAIDS projections we got just before the fund's first board meeting [28–29 January] were that without the fund, US$ 200 million would be spent in 2002 on malaria, US$ 200 million on TB, and US$ 1200 million on AIDS. That makes US$ 1600 million. Now, in addition, the fund has the possibility of disbursing between US$ 700 million and US$ 1000 million for the same year. So if we can disburse US$ 800 million, for example, that's a 50% increase — quite substantial."

Nordstrom, who has been seconded until May from his post as director of the health department of the Swedish International Development Agency, told the *Bulletin* "The increased political, economic, and financial interest in investing in health has been dramatic in the last two or three years. I think that's partly related to the work of the Director-General of WHO, Gro Harlem Brundtland, and the way she's been able to put health on the agenda."

WHO/TDR/Mark Edwards

A young mother and her baby son who is receiving treatment for malaria at the Laquintinie hospital in Douala

"But now the critical question is what to do with this money and political momentum," said Nordstrom.

He believes the fund could be a very important financial mechanism for the next 10–30 years, but that the key to that will be results. Donors are waiting to see how the fund performs before they top it up, even for one more year.

"That's why we are moving as quickly as we can," said Nordstrom. "We will be judged on whether we are able to disburse money, get it out to effective programmes, and report back clearly — both on how the money was spent and on the results. This might mean, for example, going from a 10% to a 20% geographical coverage with a particular programme, or ensuring that medicines now reaching 50% of patients start reaching 80%."

Given the speed with which they have become available, it seems likely that, to begin with, the new funds will primarily generate an expansion of existing programmes. "But at the same time I hope the new resources will stimulate new thinking, new partnerships at country level; we're definitely not just looking at gap filling or continuing business as usual; there's a strong emphasis on results but also on new partners" said Nordstrom.

The fund's call for proposals and guidelines was sent to ministers of foreign affairs and ministers of health, "but with a very clear message that they should reach out to NGOs, the private sector, and all partners in the country" said Nordstrom. The letters went to every country in the world, to ensure transparency, but the priority will be to given to countries most in need.

But with the very short time available will the countries most in need have the capacity to come up with competitive projects?

"Yes, the structures are weak, there is lack of capacity" said Nordstrom, "but still, in all African countries there are national AIDS programmes, in all countries affected by malaria there are malaria programmes, and the same for TB. I think the fund comes in at just the right moment for the work that's been done by Roll Back Malaria and StopTB in making situation analyses and preparing national strategies and programmes. There's been a big discussion about how quickly to move, but in the countries they say, 'Don't wait. People are dying! People are waiting for the fund to be operationalized, to be disbursing money!' So we've decided it's very important to move quickly, at least for the first round." Part of the challenge for the fund is to start by striking the right balance between prevention, treatment and care.

Until May at least, Anders Nordstrom will be having an exciting time. ■

Robert Walgate, *Bulletin*

Nurse and mother faces her own TB and HIV

The global statistics of HIV/AIDS and TB are so high that it is sometimes hard to remember that each case represents a human being with his or her unique experience. Thulisiwe Luhabe, who is a nurse in South Africa and has both AIDS and TB, described what this entails for her, her family and her work.

"Knowing that I had HIV motivated me to change my lifestyle. Now I live for my children. Whatever I do, I put them first and I try to motivate them to change their lifestyles." Luhabe leans back in her chair, and gestures around her lounge. "I bought this flat after I knew that I was HIV positive. I have made my will. I sold my car to get an education policy so my daughters can study after school."

Luhabe, a nursing sister at Port Shepstone Hospital in South Africa's KwaZulu-Natal province, first suspected she had HIV in early 1999 after a series of illnesses. So, without going for any counselling, she asked a colleague to take her blood and sent it off anonymously to the hospital laboratory to be tested for HIV.

"The test came back to me and it was positive. So there I was sitting with it, and not knowing much about the disease and not having had any counselling."

For three months, Luhabe told no one of her HIV status. But by June of that year — after working in the highly infectious environment of the hospital's outpatients department — she developed the unmistakable symptoms of TB. "I had night sweats and persistent coughing," says Luhabe. "I would arrive at work on a Monday, feeling tired. My face looked puffy, my limbs were swollen and I looked anaemic.

"Eventually, I went to the sister in charge and told her that I was HIV positive. She called the matron and I told her too. Matron was so taken aback she immediately gave me sick leave. I was the first nurse to come out and say I have HIV, and I am still the only one."

But after sitting at home for a week, Luhabe went back to the hospital and decided to take a sputum test and have chest X-rays. "The tests confirmed that I had TB. I spoke to one of the doctors who was working with TB patients and she explained the treatment to me. I started on it immediately. I had to take eight tablets a day, first thing in the morning — INH [Isoniazid], Ethambutal and Pufaniprain.

"Luckily, they did not make me feel sick. I took these for two months. Then I went on to one capsule a day of combined INH and Pufaniprain. I took these for four months. The TB made me lose appetite. It was also a problem for my children, as I had to say they must be careful of coming near me because I did not want to infect them. But the treatment was very successful. By February 2000, I was cured. I now have my appetite back and I am all right. I was so lucky to have a supportive management, who explained that I could be cured of the TB."

Shortly after being cured of TB, Luhabe started antiretroviral (ARV) treatment, which is being paid for by her medical aid, a private health insurance policy she took out after discovering she was HIV positive. Now her viral load has been reduced to an undetectable level (less than 400 copies/ml of blood).

Luhabe is one of the lucky ones, however. Less than 20% of all South Africans are on medical aid. Those with medical aid who are HIV positive generally pay higher premiums to get access to antiretroviral drugs. No ARV drugs are being offered in public health facilities. However, the South African government has set up two 'pilot sites' in each of its nine provinces, offering the ARV drug, nevirapine, to pregnant HIV-positive mothers in a bid to prevent mother-to-child HIV transmission.

Today, one of Luhabe's ambitions is to be involved with the hospital's voluntary HIV counselling and testing programme.

"All the TB patients should take the test. I want to show them I am here, I am HIV positive. I had TB but I was cured. Some of the people with HIV develop TB and other AIDS-related illnesses but they don't come to the clinic. They stay at home and hide from us because they are ashamed and they lack information."

For now, Luhabe has to stay on night shift as the hospital can't spare her. But she is not discouraged, and talks to her patients about the importance of taking the HIV test. ■

Kerry Cullinan, *Health-e News Service,* Johannesburg

Thulisiwe Luhabe