News

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 Jong-wook, Director-General of the World Health Organization.

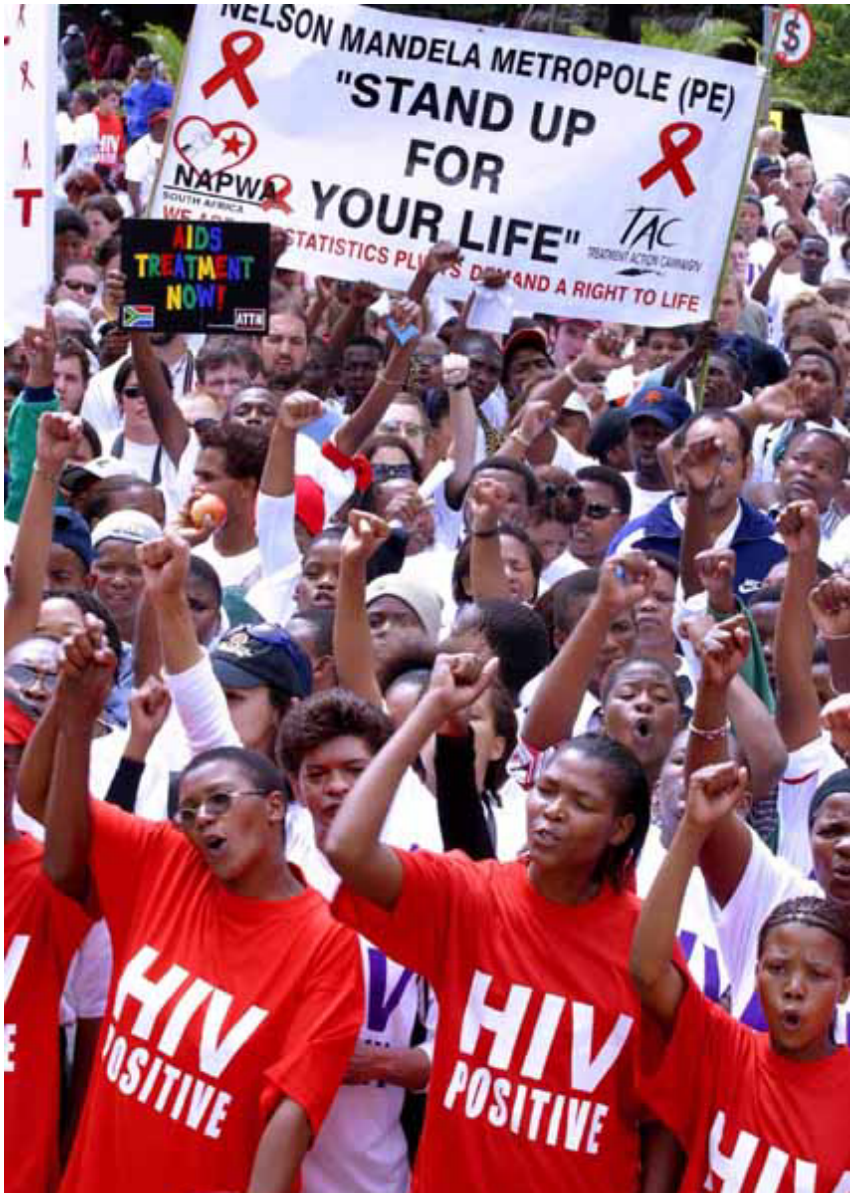
The programme's treatment goals were brought further within reach following an agreement on 10 December by pharmaceutical companies, GlaxoSmithKline and Boeringer Ingelheim, to permit large-scale manufacture of generic versions of their patented HIV/AIDS drugs for the country, following an out-of-court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



KEYSTONE

AIDS/HIV activists protest outside Parliament in Cape Town, South Africa, in February 2003. On 19 November 2003 the South African Cabinet approved a plan to distribute free AIDS medication to all who need it.

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, development or social service programmes.

"The decision to provide free antiretroviral 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 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 out 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

new resource to bring people the lessons we've learned and help them avoid past mistakes."

MIHR aims to support and complement the work of organizations promoting health research in order to address the diseases of the poor. "We need [research] institutions to understand the pros and cons of different licensing strategies," said Bianco.

For more information on the Wellcome initiative, visit their web page: http://www.wellcome.ac.uk/techtransfer and for more information on the Drugs for Neglected Diseases Initiative (DNDi) visit their web site at http://www.dndi.org. For information on MIHR, visit www.mihr.org ■

Robert Walgate, *London*

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. ■

Fiona Fleck, *Geneva*

UN to vote on cloning in one year, not two

The United Nations General Assembly this month agreed to a one-year delay on the debate over a treaty to ban human cloning. The move overturns a November decision by the UN's legal committee that would have postponed the discussion for two years.

The legal committee's vote was largely seen as a defeat for the countries who had pushed for a total ban on all forms of human cloning (see news item in the *Bulletin of the World Health Organization* (2003;81:850). The US and Costa Rica had sought to overturn the committee's decision by forcing a General Assembly vote on the treaty, but instead they proposed a one year deferment, apparently after deciding they did not have sufficient votes to pass their version.

The legal committee had come to their decision by a one-vote margin, reflecting a deep and seemingly irreconcilable division among member states over how far the ban should reach. All Member States agree that cloning should never be used to make babies, but a group of about 60 want a treaty banning any cloning that uses a human embryo.

However, other nations, including China, Japan and most of Europe prefer to allow individual Member States the right to decide whether to permit cloning for research purposes. "Therapeutic cloning is a vital research tool, there's agreement on that," says Richard Gardner, Chairman of the UK's Royal Society working group on cloning and stem cells. Scientific groups and patient advocacy organizations have spent recent weeks lobbying for a ban that would allow Member States to individually regulate therapeutic cloning.

Those supporting a total ban, however, show no intention of changing course. "A total ban on human cloning should be the international standard," said James Cunningham, Deputy United States Representative to the United Nations during a press conference in November. Therapeutic cloning amounts to unethical experimentation on a child-to-be, US delegate Ann Corkery says. "It risks making women's bodies a commodity, with women being paid to undergo risky drug treatment so they will produce the many eggs that are needed for cloning." Costa Rica's ambassador, Bruno Stagno raised concerns that women in the developing world could be exploited for their eggs.

But supporters of a less restrictive ban remain unswayed. Adam Thomson, Representative to the United Kingdom Mission to the United Nations stressed that the UK will sign no ban that prohibits therapeutic cloning. "It is clear that there is no consensus in respect to therapeutic cloning research. But by ignoring this fact and pressing for action to ban all cloning, supporters of the Costa Rican resolution have effectively destroyed the possibility of action on the important area on which we are all agreed — a ban on reproductive cloning," he says. ■

Christie Aschwanden, *St.Moritz*

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". Footnote[d] 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.