WHO reinvigorates role to fight 'big three' diseases

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Dr Jack C. Chow

Dr Jack C. Chow, 44, obtained his medical degree from the University of California in 1987 and trained at Stanford University Hospital. He has since held a number of senior public health posts in the US Government and worked as a management consultant with McKinsey & Company. Prior to joining WHO, Dr Chow was the Special Representative of the US Secretary of State for Global HIV/AIDS and became the first US diplomat of ambassador rank to be appointed to a public health mission. He led US diplomatic efforts to help establish the Global Fund To Fight AIDS, Tuberculosis, and Malaria in 2002 and in combating global infectious diseases, including SARS (severe acute respiratory syndrome).

Never has the combined toll of the 'big three' diseases been so high and the risk to global health so great. In 2004, an estimated three million people died of HIV/AIDS, two million of tuberculosis (TB) and one million of malaria, and the number of deaths is increasing in the poorest regions as each disease feeds off the other. In this ***Bulletin*** interview, Jack C. Chow, WHO's Assistant Director-General for HIV/AIDS, Tuberculosis and Malaria, talks about the challenges in fighting the three diseases.

Q: HIV/AIDS and TB have drawn huge attention. Is malaria being neglected?

A: One of the themes of my stewardship has been to advance the concept of the compounding effect of the three diseases. I am particularly concerned about the confluence of these in resource-limited settings, their depletion of the health workforce and the economic cost to societies alike. More attention is being focused on malaria, on the practical low-cost and no-cost solutions that can reduce morbidity and mortality in malaria. The Roll Back Malaria Partnership and WHO's Roll Back Malaria Department have been very proactive in promoting a number of critically needed interventions, like the long-lasting insecticide-treated bednets and the new generation of ACTs (artemisinin combination therapies) medicines which are transforming malaria treatment, and we are very encouraged by the response that we have seen. For example, the UK recently dedicated US$ 74 million (£40 million) for malaria bednet distribution, and at the World Economic Forum meeting in Davos in January a call for personal donations for malaria garnered about a million dollars.

Q: Donors are pledging a lot of funds for HIV/AIDS, but less for TB and malaria, how do you ensure each disease gets adequate resources?

A. We make clear that WHO's role is in articulating public health strategies on how to support countries and implement programmes. We are very heartened that the Dutch Government has allocated a very significant extra-budgetary contribution to malaria and we also welcomed donations for HIV/AIDS and TB, particularly the Canadian '3 by 5' contribution and their ongoing contribution to TB control. My mission is to make clear the benefit of investment in WHO. If we do our job right at country level for our Member States the resources will follow. Again, like all challenges, it's an ongoing need because each of the three diseases is unfortunately rampaging.

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Q: What are the challenges in the fight against TB?

A: Regrettably, TB infects nearly one-third of the world's population generating nine million active cases per year and killing two million people every year. WHO's technical support and operation of the Global Drug Facility has expanded the worldwide implementation of DOTS and contributed to solid progress in detection and treatment success goals. We are invigorating our TB work in collaboration with the Global Fund and by confronting the challenges of TB/HIV co-infection (see feature on pp.165–166) and multi-drug resistance. Of the six WHO regions, five have TB incidence that is falling or stable, but Africa has an incidence that keeps increasing at almost 10% per year, offsetting the gains in the rest of the world. There needs to be special focus on Africa, while maintaining TB control programmes in the rest of the world.

Q: Other organizations have taken up the cause of the 'big three': UNAIDS and the Global Fund To Fight AIDS, Tuberculosis and Malaria, to name two. Has WHO's central role been undermined?

A: We have reinvigorated our mission to provide timely, accurate and robust advice for governments and civil society to implement the strategies of prevention, treatment and care. We welcome the advent of the Global Fund and the vigorous efforts of UNAIDS. I view the work in confronting the three diseases as a chain of concerted action with three links: finance, expertise and implementation.

WHO and UNAIDS are in the middle link of providing the expertise, blueprints and strategies that can be financed by The World Bank, Global Fund and bilateral donors, and implemented at country and community levels through governments, NGOs, the private sector and individual citizens. We have always had this role.

Q: How have you reinvigorated WHO's mission?

A: The '3 by 5' is a fresh campaign. We have stronger partnerships, like the Stop TB Partnership and the Roll Back Malaria Partnership, we are finding ways to strengthen those and sharpen the vision and the mission. For TB, for example, there has been significant progress on the goal to detect 70% of existing cases and successfully treat 85% of those that get treatment. So far countries have reached a detection rate of about 43% and treatment success rate of 83%. We are also spotlighting new interventions: the long-lasting insecticide-treated nets and ACT medicines for malaria.

Q: What are the major challenges facing the '3 by 5' campaign, to get ARVs to three million people in developing countries by the end of 2005?

A: The treatment numbers went from about 300 000 to 700 000 in a year. We are very encouraged by this progress but much more needs to be done. The stories of several countries show that when a confluence of factors come together this goal can be attained. For instance, in Uganda political leadership, investment of the country's own resources and investment by external donors working with societal partners helped to deliver health care and HIV/AIDS care and de-stigmatize the illness. The top-line story is that when you make treatment available and abundant at low cost people are much more willing to seek testing, counselling and treatment for HIV/AIDS. When access to treatment is scarce and the price is high people are discouraged. We are seeing that in Uganda. We are encouraged also by what we see in Zambia. Botswana is one country that has already attained the 50% goal to deliver treatment, and there are several countries in South and Latin America that have made ARVs universally available. The challenge is making treatment more available in big countries, such as South Africa, India and Nigeria because of their size and the number of people with the virus.

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Q: Even if WHO and its partners achieve the '3 by 5' goal, how sustainable is this treatment and what happens after December 2005?

A: '3 by 5' has a time-limited goal, but the mission is much longer term. Building health systems, training and educating the health workforce, and promoting community action are among the key things that need to happen.

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Q: How do you persuade donors to make that long-term commitment?

A: It's been made very clear that the present therapy is lifelong. That implies a logic of having ample supplies of medicine and a long-term financial commitment by the global community, as well as having a sufficient numbers of doctors nurses, community workers and counsellors who can confer clinical judgement, manage care, and treat other primary and secondary illnesses. WHO and others are striving to say that with the benefit of ARVs people can live longer and be productive members of the workforce. AIDS care has economic value and is socially indispensable.

Q: How is the global community helping governments to fill the huge shortage of health workers needed to scale up ARV treatment in sub-Saharan Africa?

A: That's the emerging story. In public health as well as in development human resources are the critical pillar. We need to make a robust investment not only in the health workforce but in getting communities involved in health care. WHO is rolling out a number of products and projects to help train and educate the health workforce. One is the IMAI, the Integrated Management of Adult and Adolescent Illness package, which is a module which can be rolled out at country and community level to train health workers in HIV/AIDS care. It's the challenge of promoting what I call 'skill' and 'will': 'skill' is the tasks that can be done through education and learning by doing, but even more important is 'will'. How do you motivate people to provide health services or to educate patients amid very difficult circumstances? We are thinking about economic incentives as well as morale boosting actions through role models and group discussions so that people feel connected to a greater cause and that they are contributing to their neighbourhoods and countries.

Q: Can this approach to health-care delivery be applied to other diseases?

A: The story is emerging, and we absolutely hope the lessons of '3 by 5' will be studied and applied to treating other infectious diseases or other primary health-care needs.

Q: Why are generic medicines important to your work with the 'big three' diseases?

A: We value both generic and research-based medicines because HIV is a very powerful mutator and we need fresh, innovative generations of ARVs that can stay ahead of drug resistance, have fewer side-effects and could eventually contribute towards a curative treatment. At the same time, HIV is penalizing the poor disproportionately and generics are valuable because they are effective and low cost. I don't see it as an 'either' 'or', it's about promoting a strong armamentarium to offer people with HIV in developing and developed countries.

Q: Was the switch in WHO's drug recommendation to ACTs last year a setback for the malaria cause?

A: WHO has articulated the value of ACTs and worked assiduously with countries to change their policies in favour of these drugs, which are highly curative when applied properly. The old line of medicines, chloroquine etc., have encountered parasite resistance. They were inexpensive but didn't work so any expense on them is too high. We are heartened that at least 20 countries in Africa have adopted ACTs as part of their first-line regimen and we are working with the private sector, and countries such as China to grow more of the plant that provides the raw ingredient for ACTs. ■

Recent news from WHO

- African health leaders gathered in Geneva pledged on **13 January** to step up vaccination programmes in their countries to meet the goal of eradicating polio by the end of 2005. The Bill & Melinda Gates Foundation said on **27 January** it was providing US$ 10 million in grants to finance the development of a new polio vaccine against the predominant type-1 strain. The vaccine is due to be introduced in Egypt in May. The Foundation said it was contributing a total of US$ 750 million over 10 years to the Vaccine Fund, the financing arm of the Global Alliance for Vaccines and Immunization which promotes the development of vaccines for the world's poorest countries.
- The Millennium Project, an independent advisory body to the United Nations, proposed a series of specific cost-effective measures on **17 January** that could halve extreme poverty and radically improve the lives of one billion people in poor countries by 2015. Dr LEE Jong-wook, WHO Director-General, called on wealthy nations to summon up the political will and resources to help to achieve the Millennium Development Goals.
- This year's Executive Board meeting in Geneva from **17 to 25 January** reviewed WHO's response to the tsunami crisis in south-east Asia and the health agency's role in emergencies in general. The 32-member Board proposed a resolution on being prepared for emergencies and minimizing the destructive effect of conflict or natural disasters on health systems.
- The Board also discussed whether WHO's 192 Member States were adequately prepared for an influenza epidemic. Member States will consider draft resolutions on influenza preparedness, alcohol, blood safety and WHO's e-health project at the World Health Assembly **16–25 May**.
- The Board confirmed the appointment of a new Regional Director for Africa, Dr Luis Gomes Sambo, and a second term for Dr Marc Danzon, WHO's Regional Director for Europe. The Board also discussed WHO's cooperation with nongovernmental organizations. For more information, please see: http://www.who.int/gb/e/e_eb115.html
- In a major drive to reach millions more readers, WHO expanded its web site on **17 January** to provide navigation and the top-level content pages in Arabic, Chinese and Russian in addition to the other three official UN languages: English, French and Spanish (see illustration).

- WHO said on **26 January** that the target for 2004 had been met in the '3 by 5' campaign to get three million people with HIV/AIDS in developing and transition countries on antiretroviral treatment (ARV) by the end of 2005. The number of patients receiving this life-saving treatment in those countries rose to about 700 000 from 440 000 in July 2004, boosted by progress in sub-Saharan Africa, WHO and UNAIDS said. WHO warned that obstacles remained to getting treatment to the remaining 2.3 million people, including the high cost of ARV medicines and an acute shortage of doctors and nurses in countries with the highest HIV/AIDS burden.
- WHO launched a project on **26 January** that aims to produce one or more works on the role of WHO in the history of global health, including a complete history of the Organization itself. WHO's Global Health Histories initiative plans to publish the first of these works to coincide with WHO's 60th anniversary in 2008.
- Authorities in Zimbabwe have opened an investigation into the death of WHO staffer Lisa Véron, 30, in a roadside attack on **10 January** in the capital Harare. Véron, who held dual Swiss and British nationality, had been posted to the WHO African Regional Office in Harare in August 2004 to help to get more patients in poor countries on the DOTS anti-tuberculosis strategy. She joined WHO in 2000 and had been a technical officer for the Tuberculosis Strategy and Operations team of the Stop TB Department since 2002. Department Director Dr Mario Raviglione said: "The loss of such a remarkable and wonderful person has deeply shocked all her colleagues".
- At a meeting from **31 January to 4 February** Member States proposed setting up a secretariat, an independent body based at WHO that will help them implement tough anti-tobacco control measures under the WHO Framework Convention on Tobacco Control. They also discussed screening activists to prevent tobacco companies infiltrating meetings of the future secretariat.
- About 50 experts from developing and industrialized countries presented and discussed their HIV vaccine research and development efforts at the first WHO-UNAIDS Meeting of Global Partners Promoting HIV Vaccine Research and Development in Montreux, Switzerland **2–3 February**.
- Afghanistan, India, and Pakistan — the three Asian countries where polio is still endemic — halved the number of their polio cases last year. The countries are on target to meet global polio eradication goals by halting transmission by the end of this year, WHO said on **4 February**.
- WHO made its annual recommendations on the formulation of the influenza vaccine for the Northern Hemisphere 2005–06 season on **11 February**. These are used by pharmaceutical manufacturers to update the composition of the influenza vaccines they produce. WHO will make its recommendations for the Southern Hemisphere in September.
- WHO sets up a Commission on Social Determinants for Health on **18 March**, in a new initiative to tackle factors affecting health, such as wealth, education, ethnicity, gender and job. For more details, see: http://www.who.int/social_determinants/en/

For more about these and other WHO news items please see: http://www.who.int/mediacentre/en/