

Allocazione delle risorse: equa distribuzione?

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Declaration of Alma-Ata

International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978

- I. La conferenza riafferma con forza che la salute è un diritto fondamentale dell'uomo e che il raggiungimento del più alto livello possibile di salute è uno degli obiettivi sociali universali più importanti la cui realizzazione richiede l'azione di molti altri settori sociali ed economici oltre al settore sanitario.
- II. La macroscopica difformità esistente nello stato di salute dei popoli specialmente tra paesi sviluppati e in via di sviluppo , ma anche all'interno di singoli paesi, è inaccettabile sotto il profilo politico, sociale ed economico ed è quindi preoccupazione comune per tutti i paesi.
- III. Uno sviluppo economico e sociale basato su un Nuovo Ordine Economico Internazionale è di importanza capitale per la completa realizzazione della salute per tutti e per ridurre il gap tra paesi sviluppati e in via di sviluppo.
La promozione e la protezione della salute della popolazione sono fattori essenziali per sostenere l'economia e lo sviluppo sociale e contribuiscono a produrre una migliore qualità di vita e alla pace nel mondo.

Closing the gap in a generation

Health equity through action on the social determinants of health



Ridurre le iniquità in campo sanitario è un imperativo etico.

L'ingiustizia sociale sta uccidendo persone su vasta scala.

Increasing income inequality among countries

Gross national income per capita in nominal US\$			
Year	Richest countries*	Poorest countries*	Ratio
1980	US\$ 11 840	US\$ 196	60
2000	US\$ 31 522	US\$ 274	115
2005	US\$ 40 730	US\$ 334	122

*Containing 10% of the world's population. Data derived from Table 1 in the World Bank's World Development Reports for 1982, 2002, and 2007, respectively, and market exchange rates in the relevant years. The ratios among these nominal US\$ figures are comparable across years.

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WORLD HEALTH STATISTICS
2008

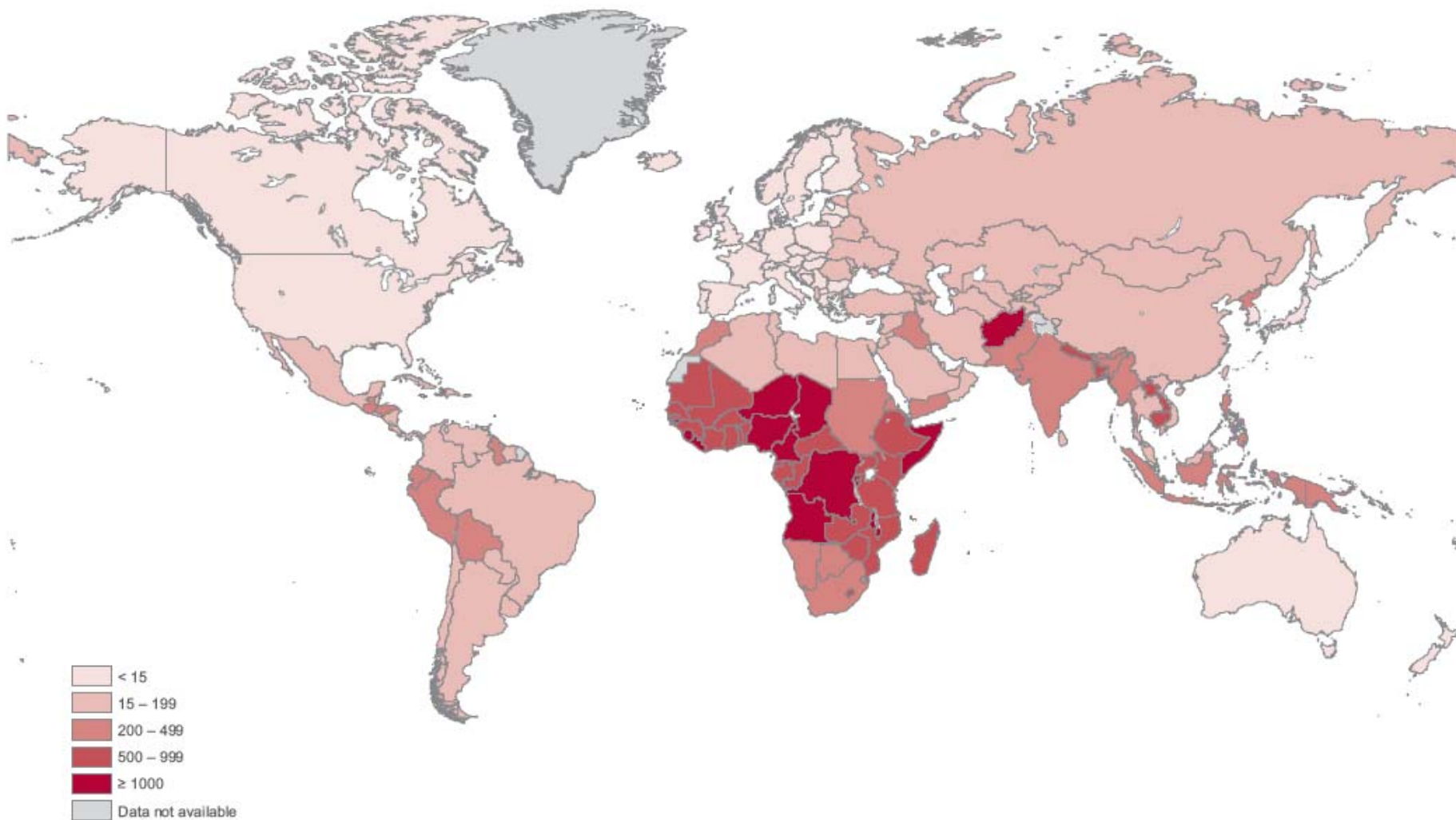


Part 1
**Ten highlights in
health statistics**

Progress towards MDG 5: *maternal mortality*

- The target for monitoring progress towards Millennium Development Goal 5 (MDG 5) (improve maternal health) is to reduce the maternal mortality ratio in all countries so that by 2015 it is one quarter of its 1990 level.
- The most recent interagency estimates developed by technical experts from academic institutions and international agencies (WHO, UNICEF, UNFPA and the World Bank) provide updated data on maternal mortality, while acknowledging the large uncertainty in these estimates because there are few or no data available for most high-mortality countries.
- **Pregnancy and childbirth are still dangerous for most women**
- **Maternal mortality is declining too slowly**

MATERNAL MORTALITY RATIO PER 100.000 LIVE BIRTHS 2005



MATERNAL MORTALITY RATIO BY REGION 1990 and 2005

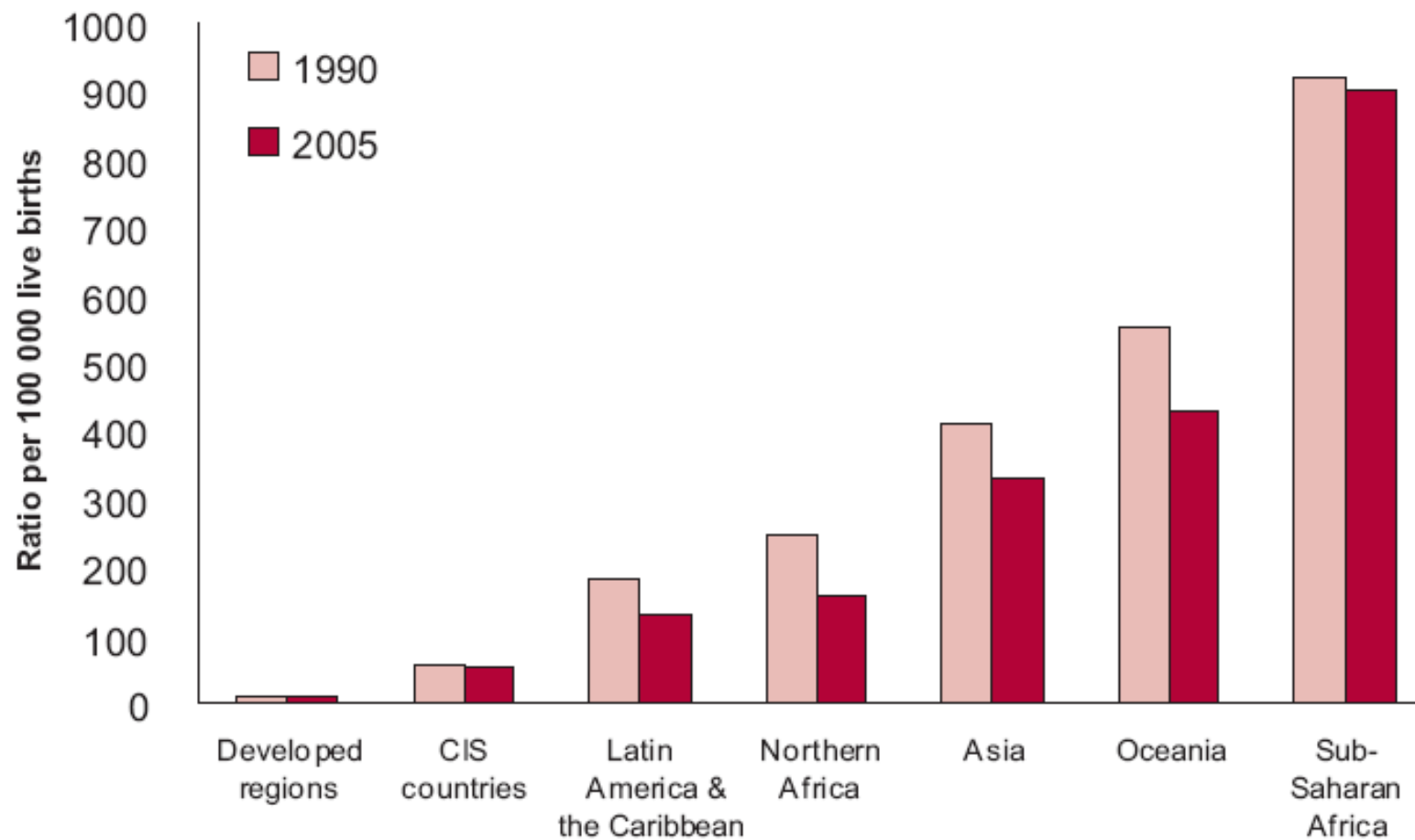
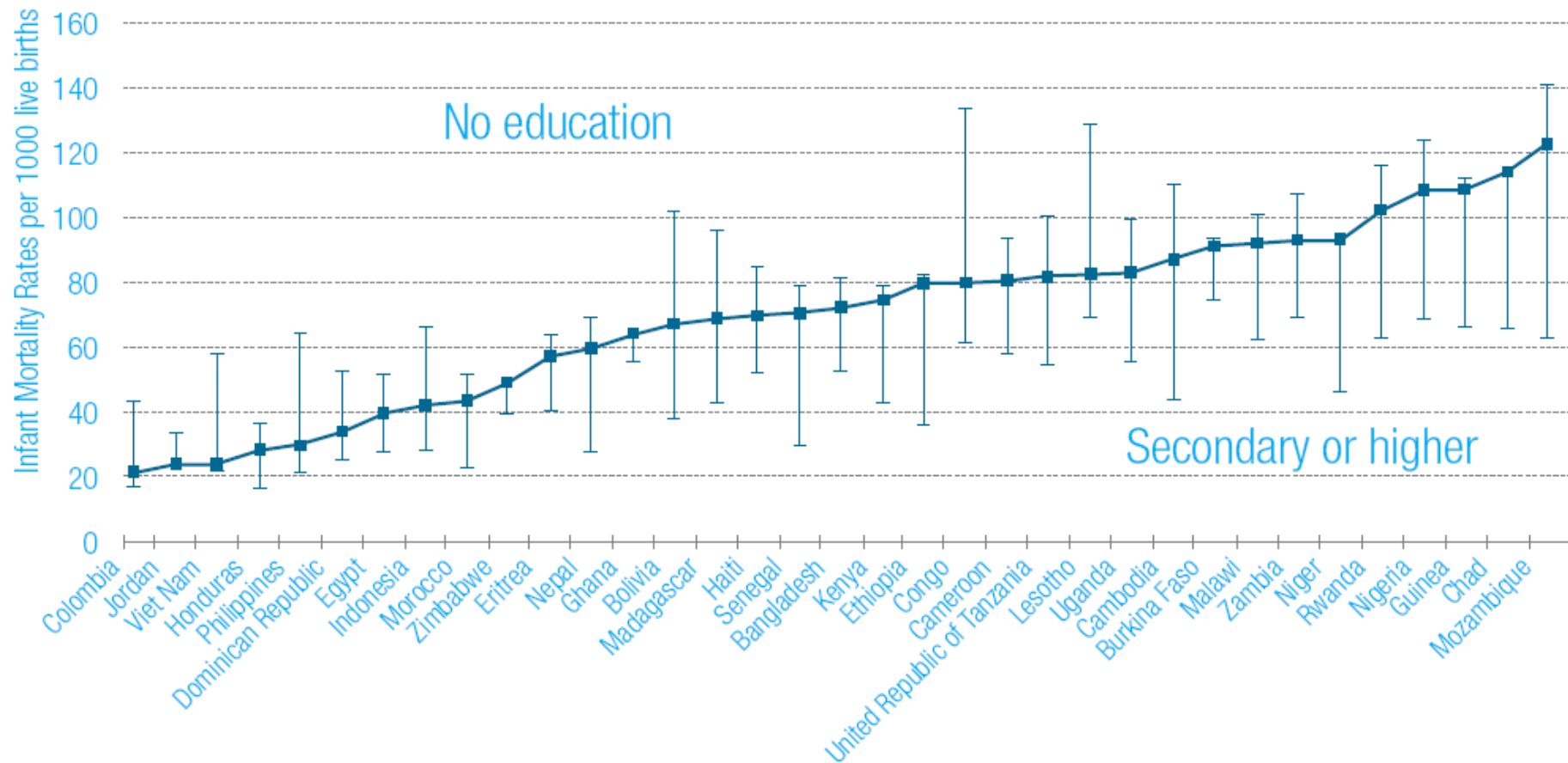
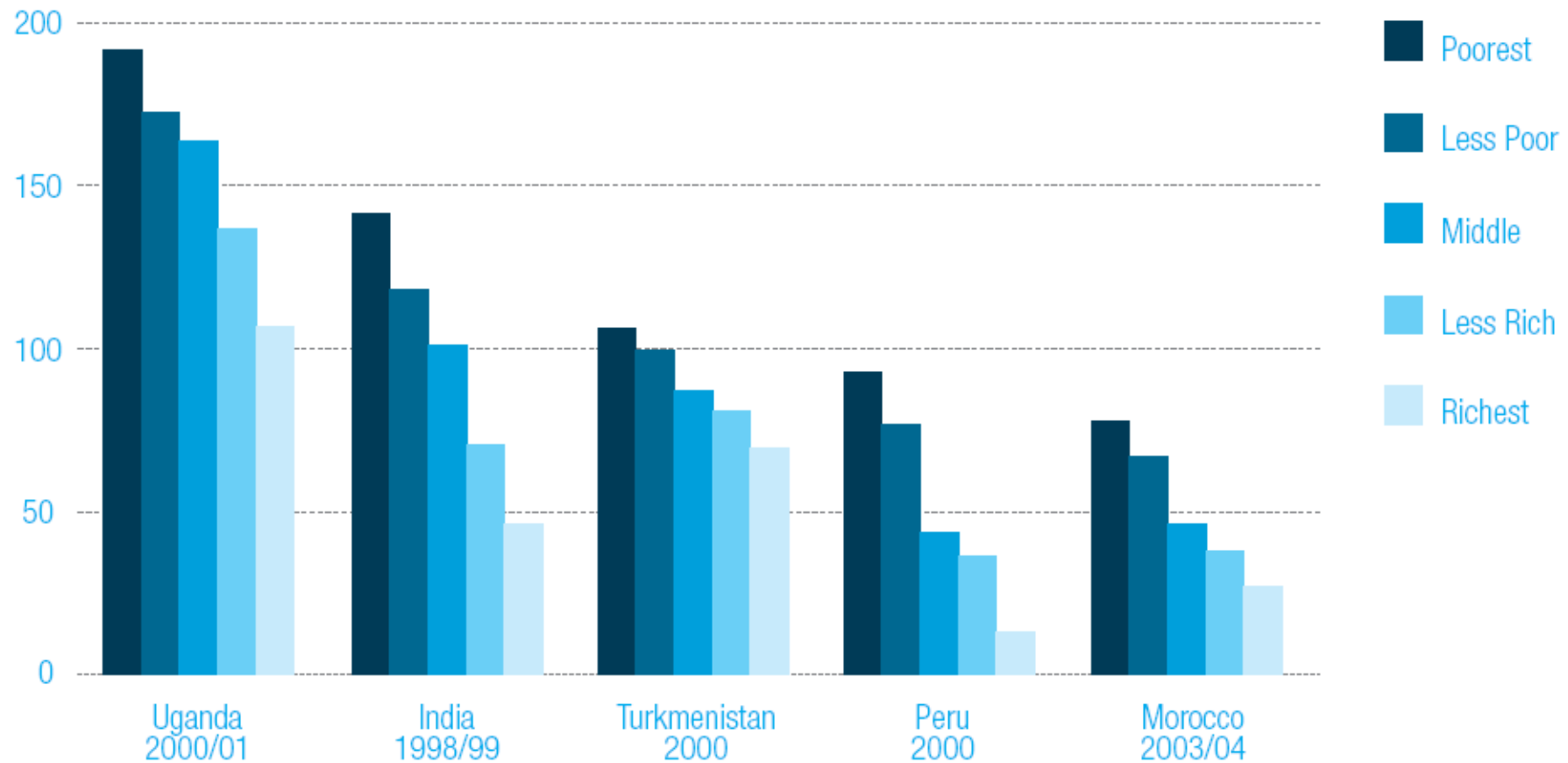


Figure 2.1: Inequity in infant mortality rates between countries and within countries by mother's education.



Data from the Demographic and Health Surveys (DHS, nd) derived from STATcompiler. The continuous dark line represents average infant mortality rates for countries; the end-points of the bars indicate the infant mortality rates for mothers with no education and for mothers with secondary or higher education.

Figure 2.2: Under-5 mortality rate per 1000 live births by level of household wealth.



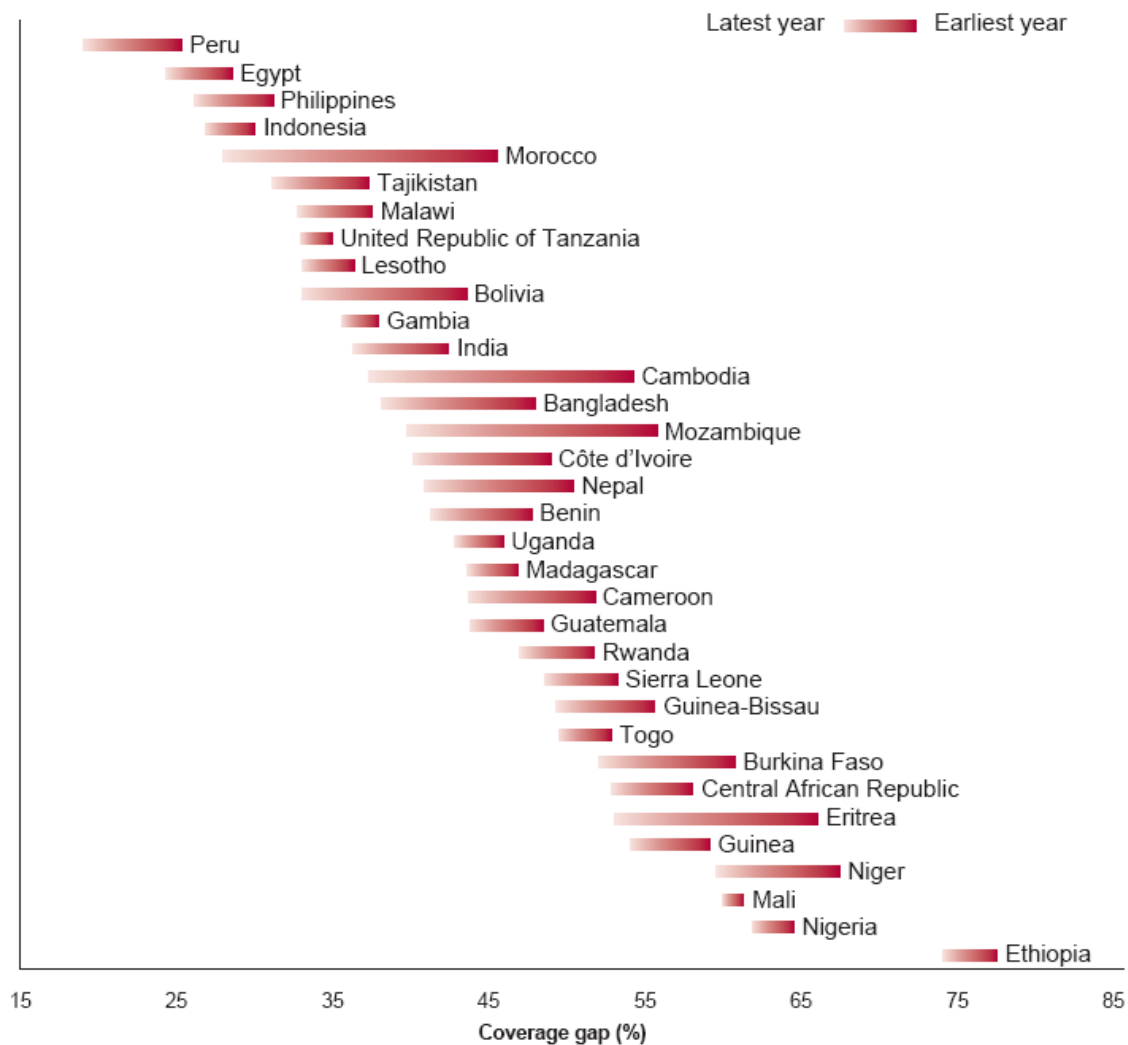
Source: Gwatkin et al. (2007), using DHS data.

The social gradient is not confined to poorer countries. Fig. 2.3 shows national data for some areas of the United Kingdom (England and Wales) for people classified according to levels of neighbourhood deprivation. As can be seen, the mortality rate varies in a continuous way with degrees of deprivation (Romeri, Baker & Griffiths, 2006). The range is large: the difference in mortality between the most and least deprived is more than 2.5-fold.

Coverage gap and inequity in maternal, neonatal and child health interventions

- Coverage, defined as the percentage of people receiving a specific intervention among those who need it, is a key health system output and an essential indicator for monitoring health service performance.
- Using data available from Demographic and Health Surveys (DHS) and UNICEF's Multiple Indicator Cluster Surveys (MICS), a new study conducted in the context of the Maternal, Newborn and Child Survival Countdown examines gaps in coverage in maternal, neonatal and child health interventions (services that are essential to reach Millennium Development Goals (MDG) 4 and 5) and patterns of inequality in 54 countries that represent more than 90% of maternal and child deaths worldwide each year.
- **Gaps in coverage range from 20% to over 70%**
- **Gradual but slow progress in most countries**
- **Up to three times larger gaps among the poor**

Coverage gap in maternal, neonatal and child health interventions, observed in latest (around 2005) and earliest (prior to 2000) periods



Coverage gap in maternal, neonatal and child health interventions, for the poorest and best-off quintiles, by intervention area

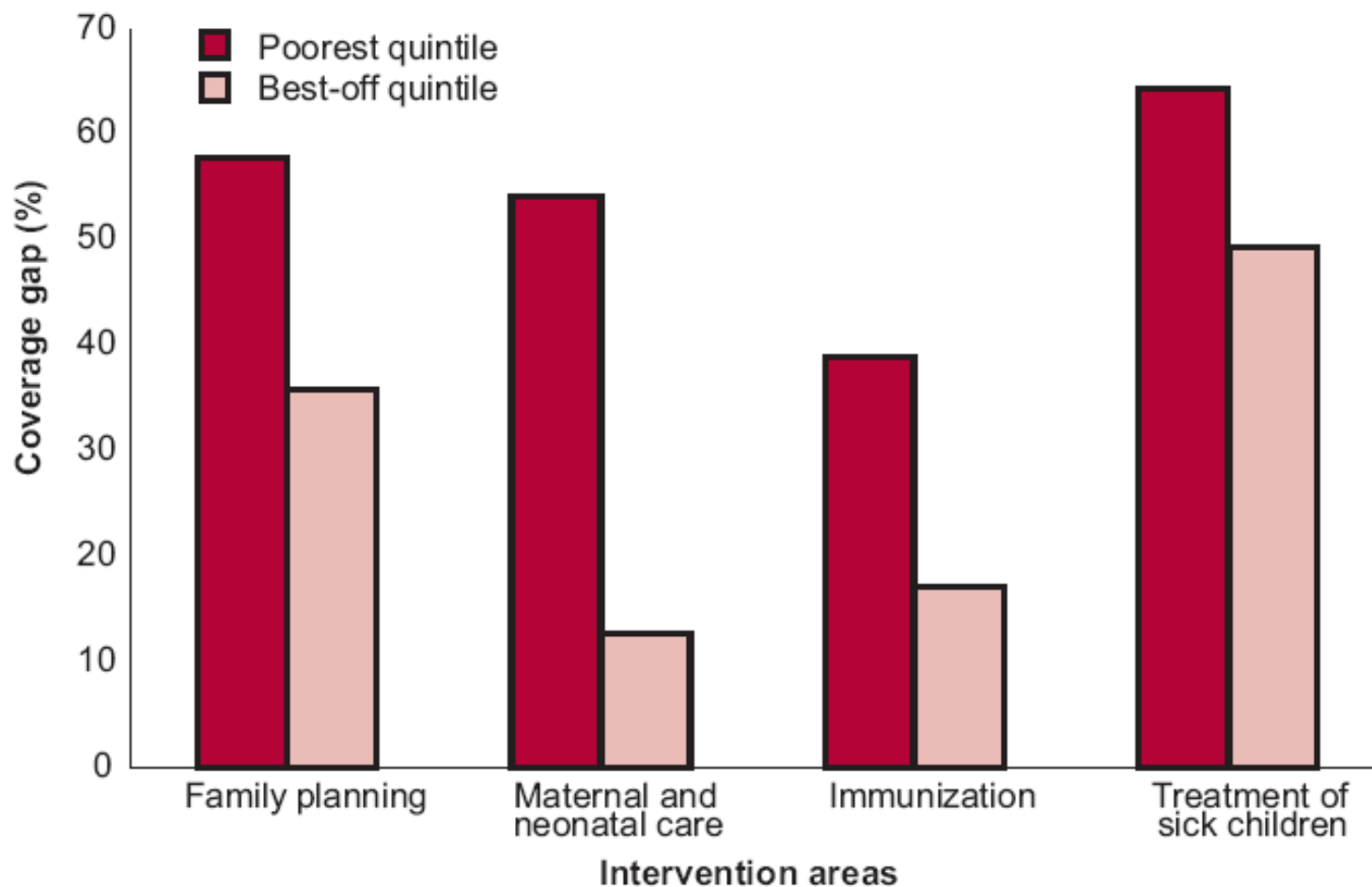
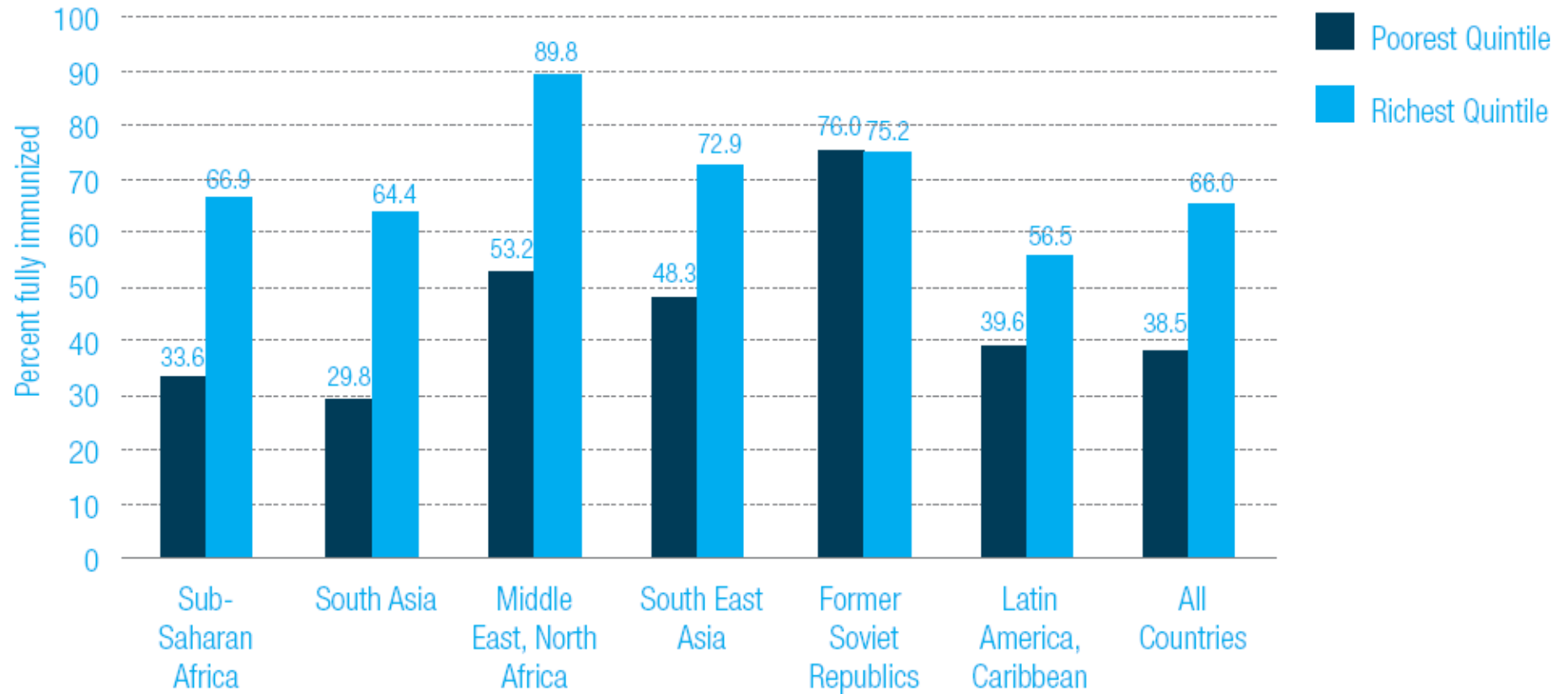


Figure 14.3 Full immunization rates among the poorest and richest population quintiles (regional averages).



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Life expectancy at birth in Europe 1950–2005

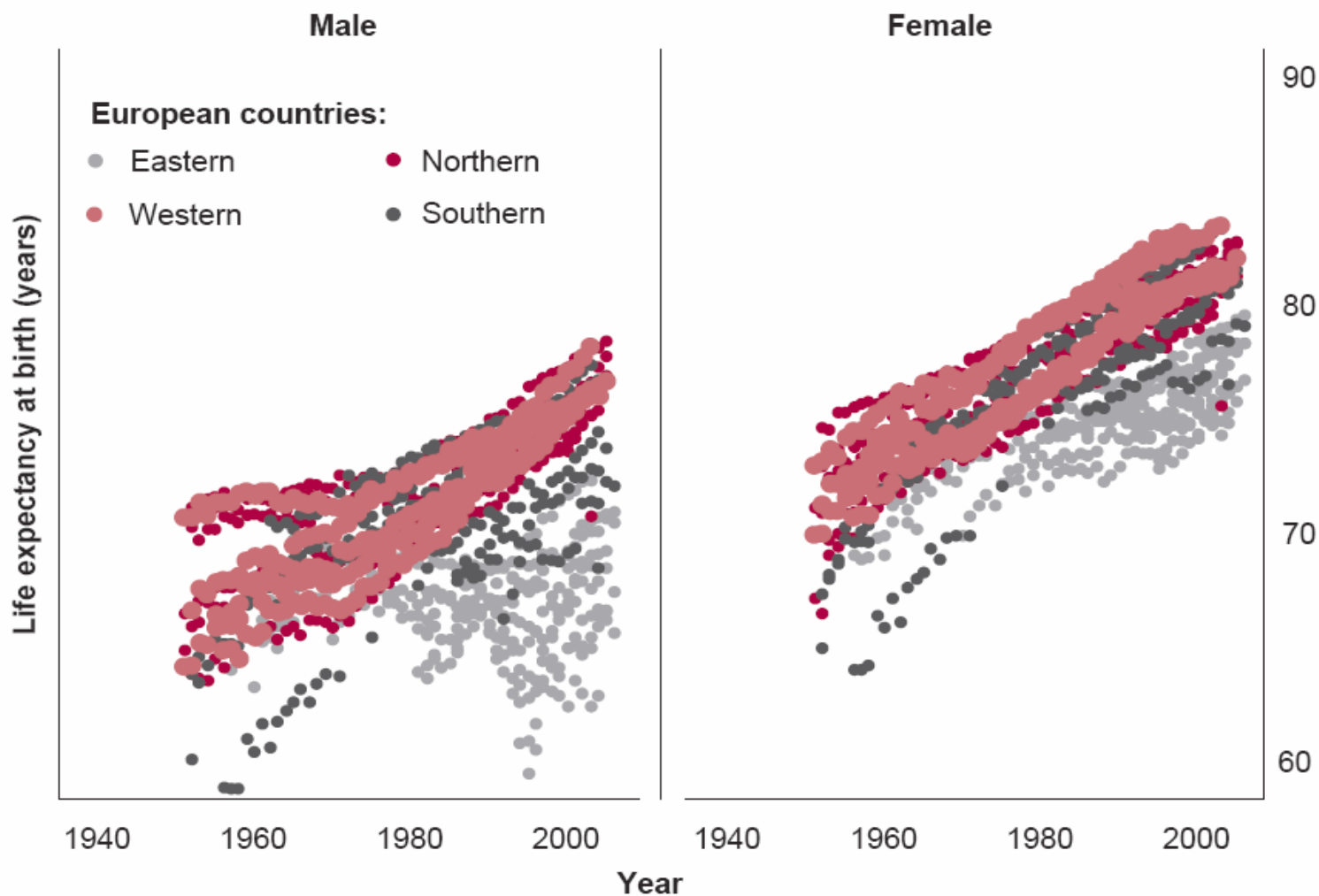
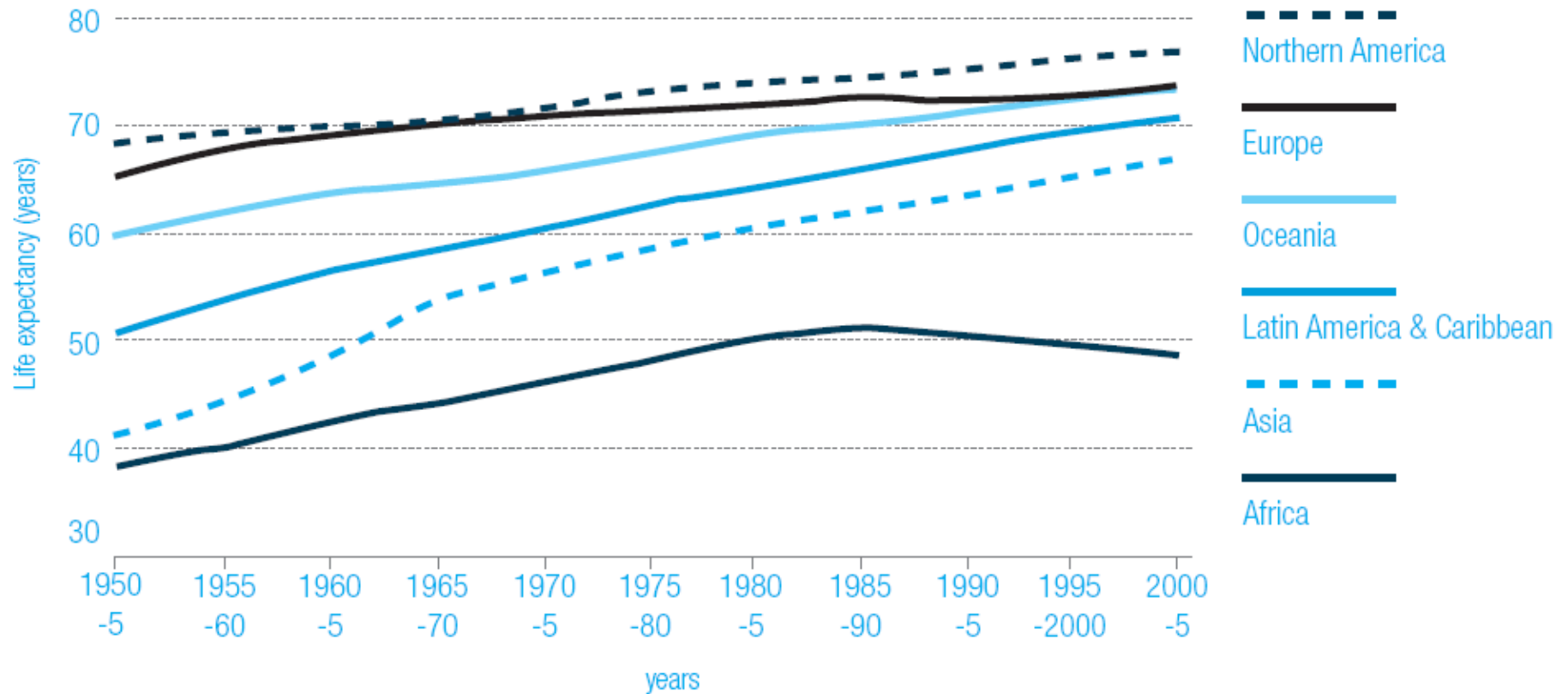


Figure 15.1 Life expectancy at birth (in years) by region, 1950–2005.

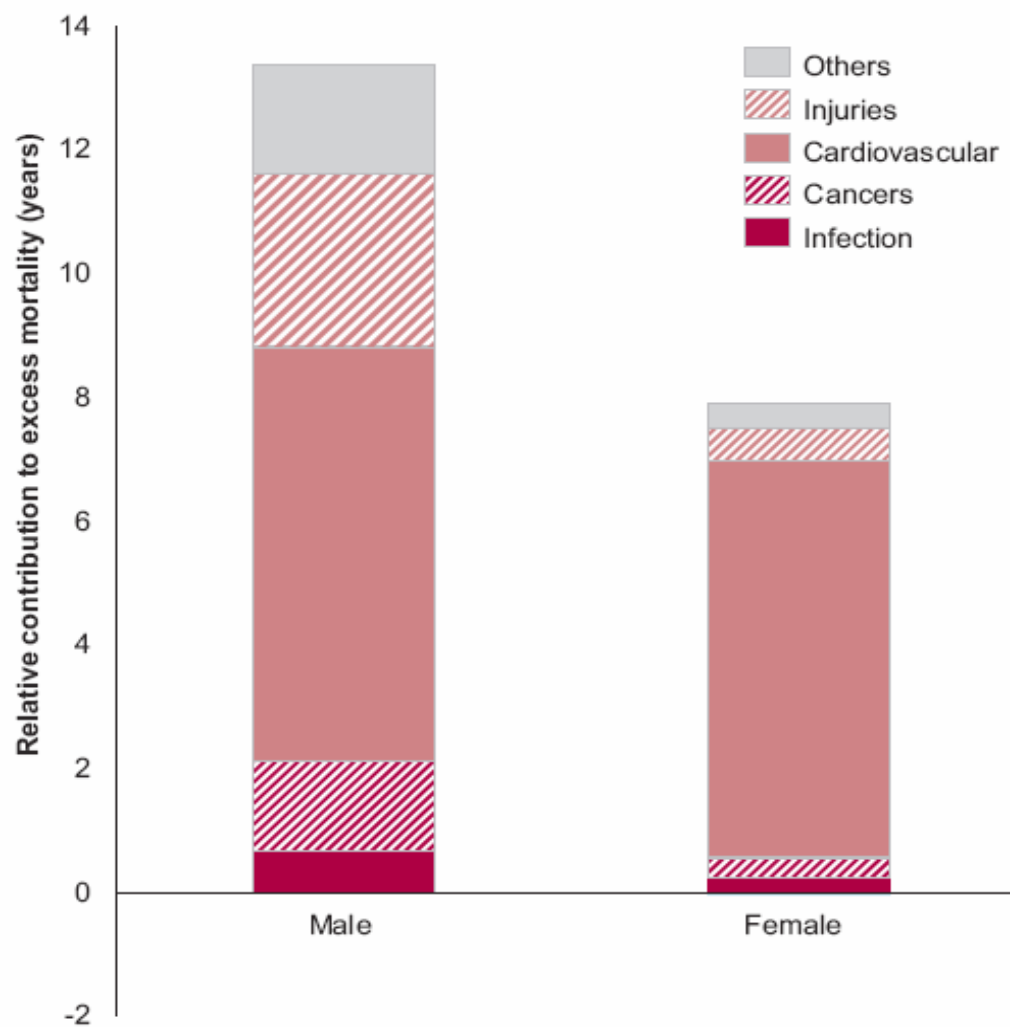


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Divergent trends in mortality: slow down improvements in life expectancy in Europe

	Life expectancy at birth, half a century ago (1950)	Increase in life expectancy over 50 years (2000)
Europe	66	8
Sub-Saharan Africa	38	11
Asia	41	27
Middle East	45	23
Latin America & Carib.	51	21
Oceania	60	14

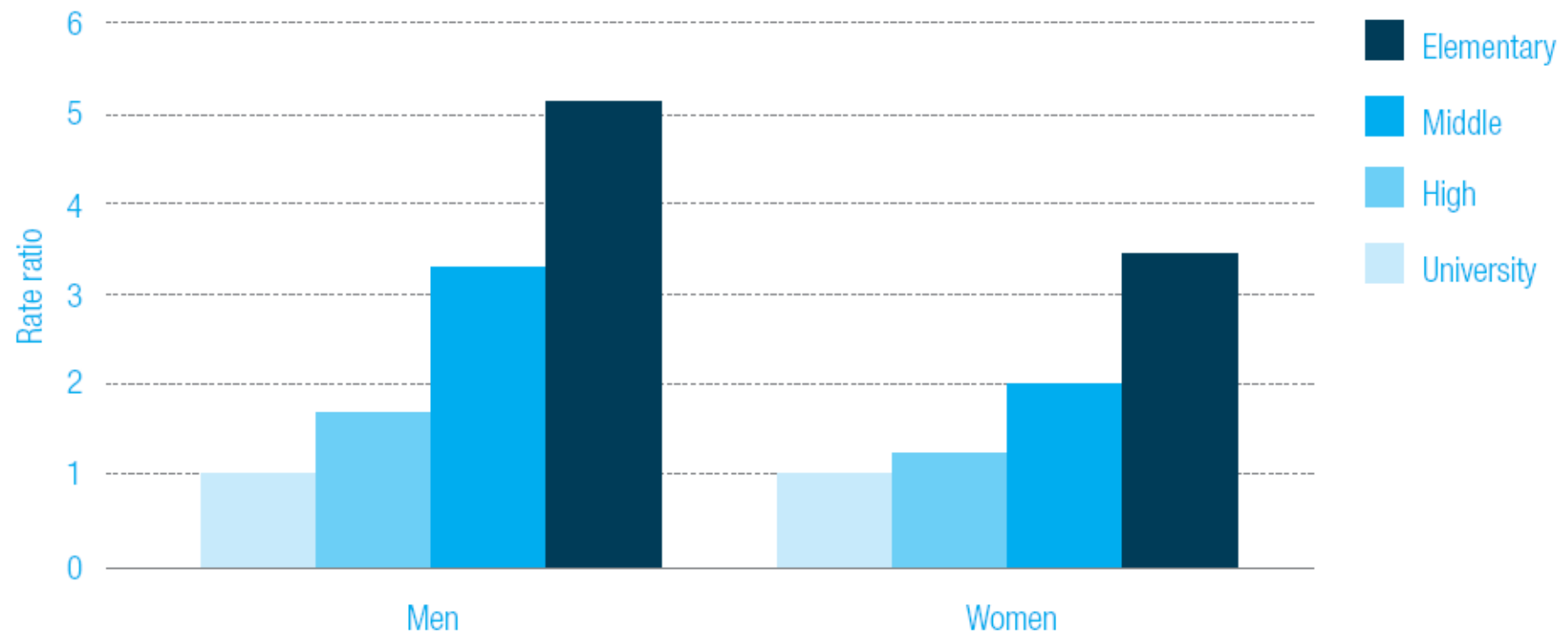
Causes to the deficit in life expectancy in eastern Europe compared to the rest of the continent of Europe



Divergent trends in mortality: slow down improvements in life expectancy in Europe

- Analysis of death registration data suggests that the reason for the relative stagnation in life expectancy in Europe as a whole lies in the very slow pace of change in some parts of the continent of Europe.
- **Eastern Europe has seen only modest increases in life expectancy**
- **Excess mortality in eastern Europe occurs mainly in adult men**
- **Excess mortality is due to noncommunicable diseases and injuries**

Figure 14.2 Age-adjusted mortality among men and women of the Republic of Korea by educational attainment, 1993–1997.

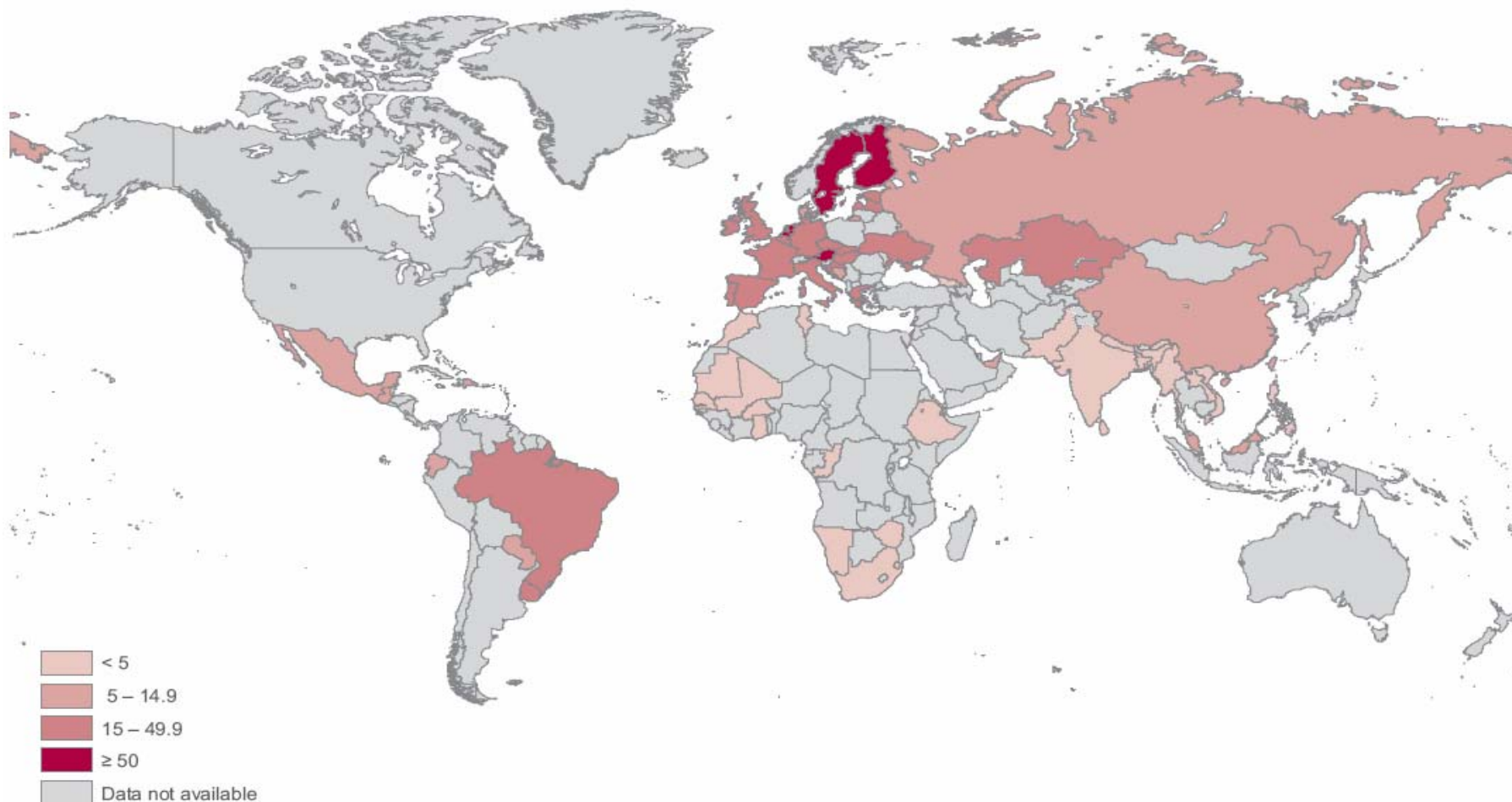


Source: Son et al., 2002

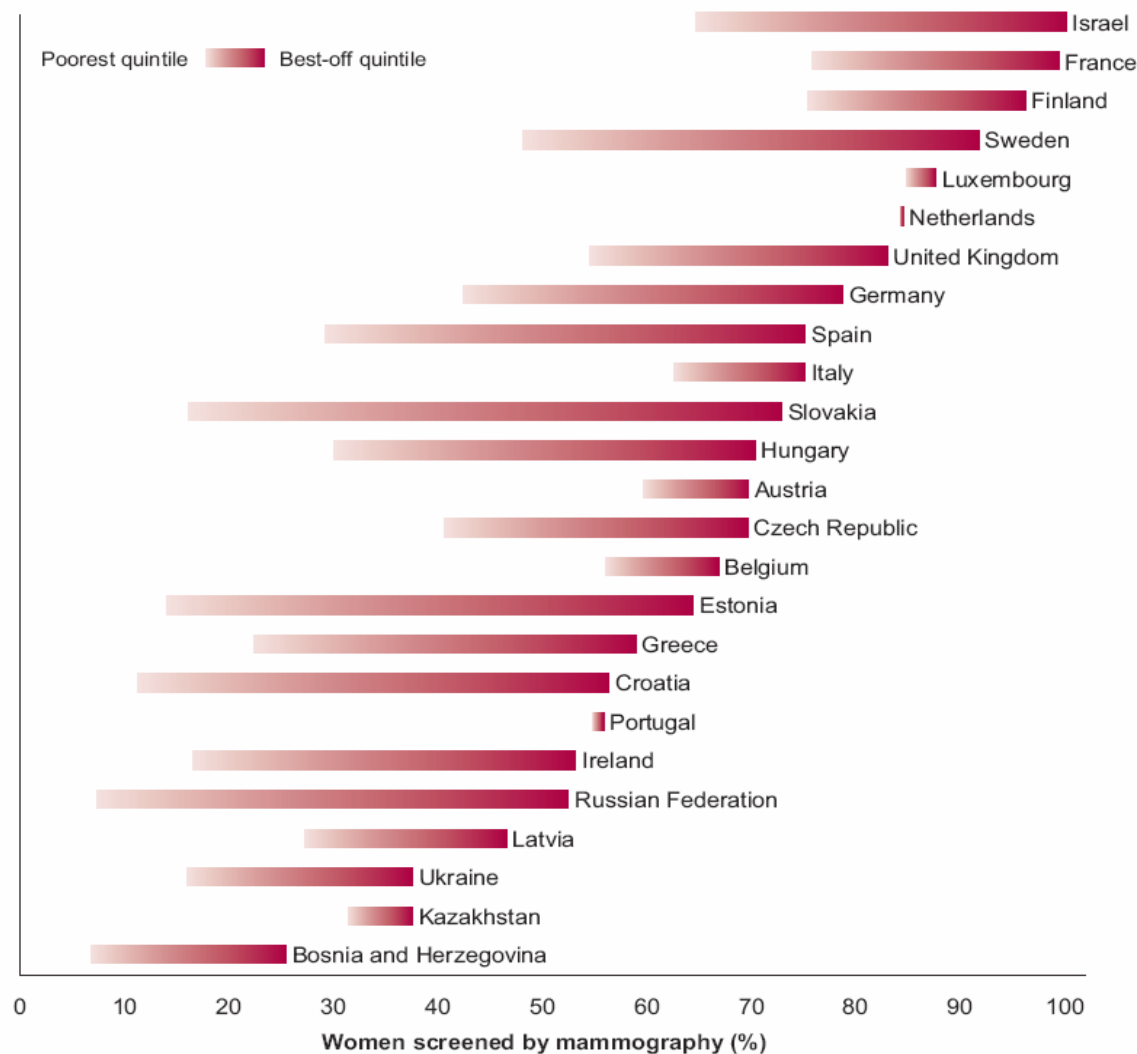
Breast cancer: *mortality and screening*

- Globally, cancer is one of the top ten leading causes of death.
- It is estimated that 7.4 million people died of cancer in 2004 and, if current trends continue, 83.2 million more will have died by 2015.
- Among women, breast cancer is the most common cause of cancer mortality, accounting for 16% of cancer deaths in adult women.
- There is evidence that early detection through mammography screening and adequate follow-up of women with a positive result could significantly reduce mortality from breast cancer.
- The World Health Survey provides the first and a unique opportunity to examine the prevalence of screening in a broad range of countries comprising two thirds of the world's population.
- **Less than a quarter of women had breast cancer screening**
- **Even in countries where screening is common, there are huge differences according to wealth status**
- **Lifetime risk of dying from breast cancer: 1 in 30 in high-income countries**

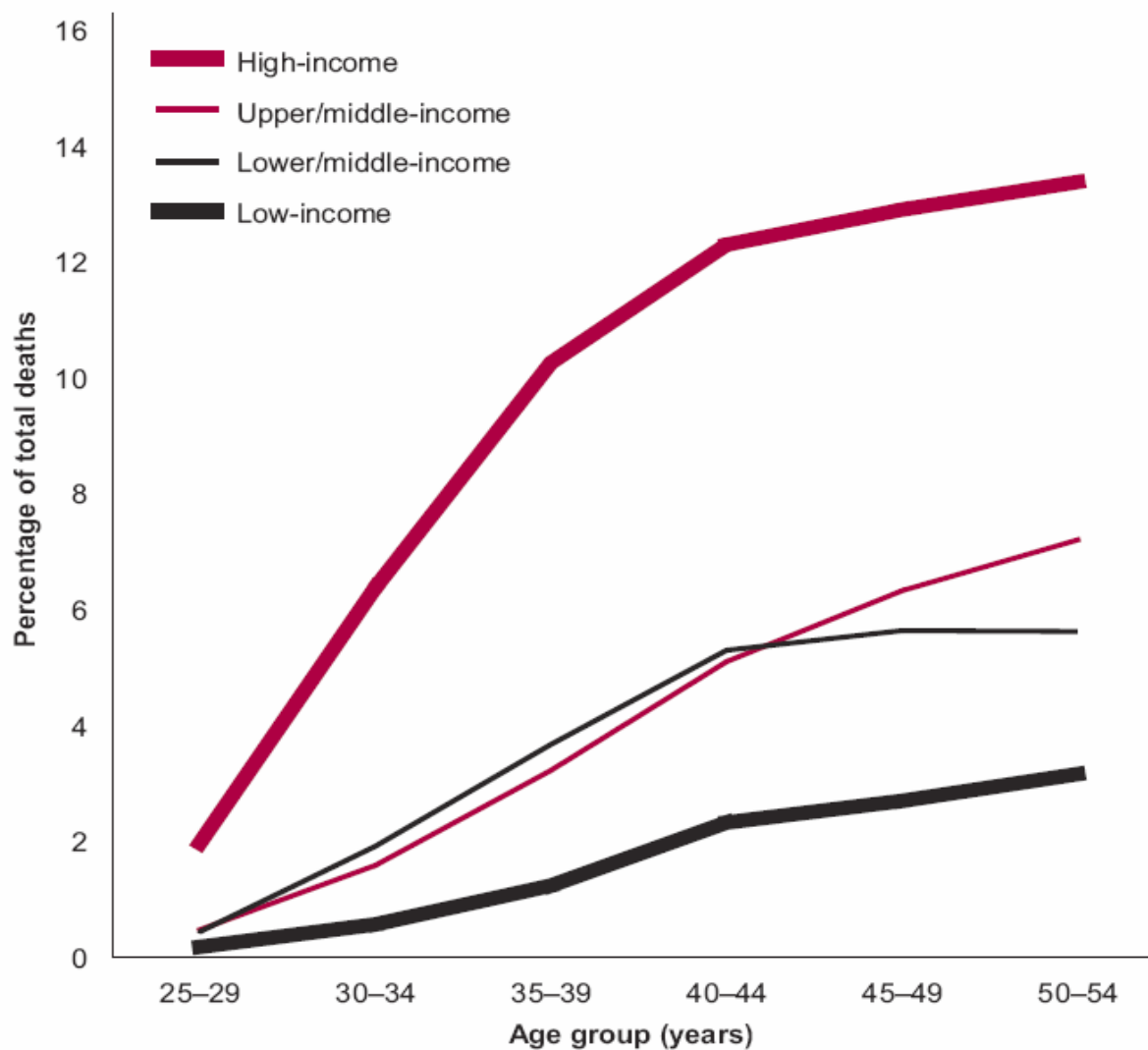
Percentage of women aged 50–69 yrs screened by mamography in the three years preceding the WHS (2000–2003)



BREAST SCREENING IN SELECTED MEMBER STATES OF THE WHO EUROPEAN REGION, BY WEALTH STATUS



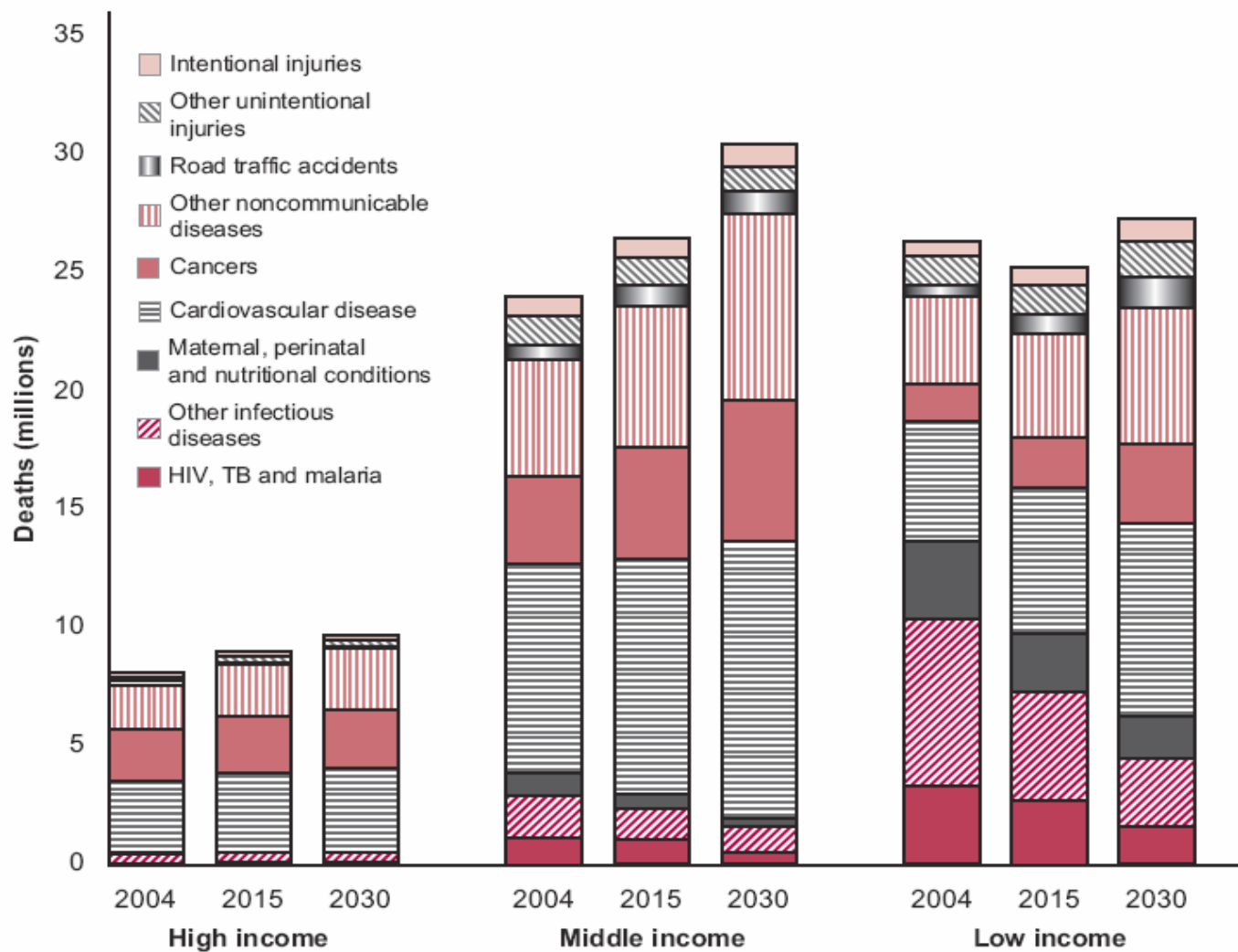
DEATHS FROM BREAST CANCER AS A PERCENTAGE OF TOTAL DEATHS, BY INCOME GROUP



Future trends in global mortality: *major shifts in cause of death patterns*

- The original Global Burden of Disease (GBD) Study was published in 1991 to provide a comprehensive assessment of disease burden for 107 diseases and injuries and 10 selected risk factors for the world and 8 major regions.
- Since then, WHO has regularly published updates of the GBD in its World Health Reports.
- The most recent update goes further and takes into account the latest projections by UNAIDS and WHO for HIV prevalence and mortality, as well as updated World Bank forecasts for economic growth.
- The resulting estimates suggest a massive shift in the distribution of deaths over the coming 25 years.
- **Noncommunicable conditions will cause over three quarters of all deaths in 2030**

Projected deaths by cause for high-, middle- and low-income countries



Leading causes of death 2004 and 2030 compared

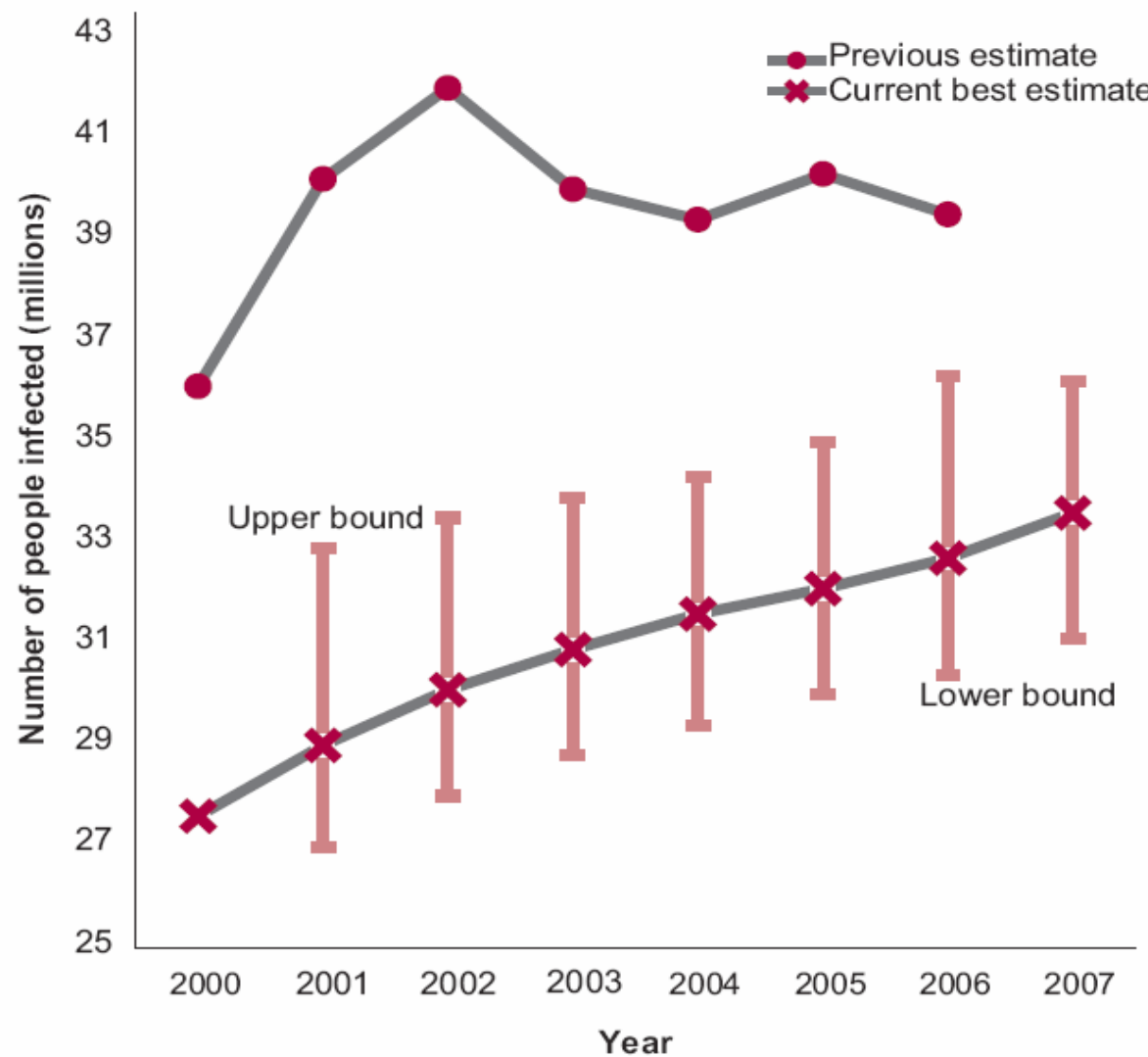
2004			2030		
Disease or injury	Deaths (%)	Rank	Rank	Deaths (%)	Disease or injury
Ischaemic heart disease	12.2	1	1	14.2	Ischaemic heart disease
Cerebrovascular disease	9.7	2	2	12.1	Cerebrovascular disease
Lower respiratory infections	7.0	3	3	8.6	Chronic obstructive pulmonary disease
Chronic obstructive pulmonary disease	5.1	4	4	3.8	Lower respiratory infections
Diarrhoeal diseases	3.6	5	5	3.6	Road traffic accidents
HIV/AIDS	3.5	6	6	3.4	Trachea, bronchus, lung cancers
Tuberculosis	2.5	7	7	3.3	Diabetes mellitus
Trachea, bronchus, lung cancers	2.3	8	8	2.1	Hypertensive heart disease
Road traffic accidents	2.2	9	9	1.9	Stomach cancer
Prematurity and low birth weight	2.0	10	10	1.8	HIV/AIDS
Neonatal infections and other*	1.9	11	11	1.6	Nephritis and nephrosis
Diabetes mellitus	1.9	12	12	1.5	Self-inflicted injuries
Malaria	1.7	13	13	1.4	Liver cancer
Hypertensive heart disease	1.7	14	14	1.4	Colon and rectum cancers
Birth asphyxia and birth trauma	1.5	15	15	1.3	Oesophagus cancer
Self-inflicted injuries	1.4	16	16	1.2	Violence
Stomach cancer	1.4	17	17	1.2	Alzheimer and other dementias
Cirrhosis of the liver	1.3	18	18	1.2	Cirrhosis of the liver
Nephritis and nephrosis	1.3	19	19	1.1	Breast cancer
Colon and rectum cancers	1.1	20	20	1.0	Tuberculosis
Violence	1.0	22	21	1.0	Neonatal infections and other*
Breast cancer	0.9	23	22	0.9	Prematurity and low birth weight
Oesophagus cancer	0.9	24	23	0.9	Diarrhoeal diseases
Alzheimer and other dementias	0.8	25	29	0.7	Birth asphyxia and birth trauma
			41	0.4	Malaria

* Comprises severe neonatal infections and other, noninfectious causes arising in the perinatal period.

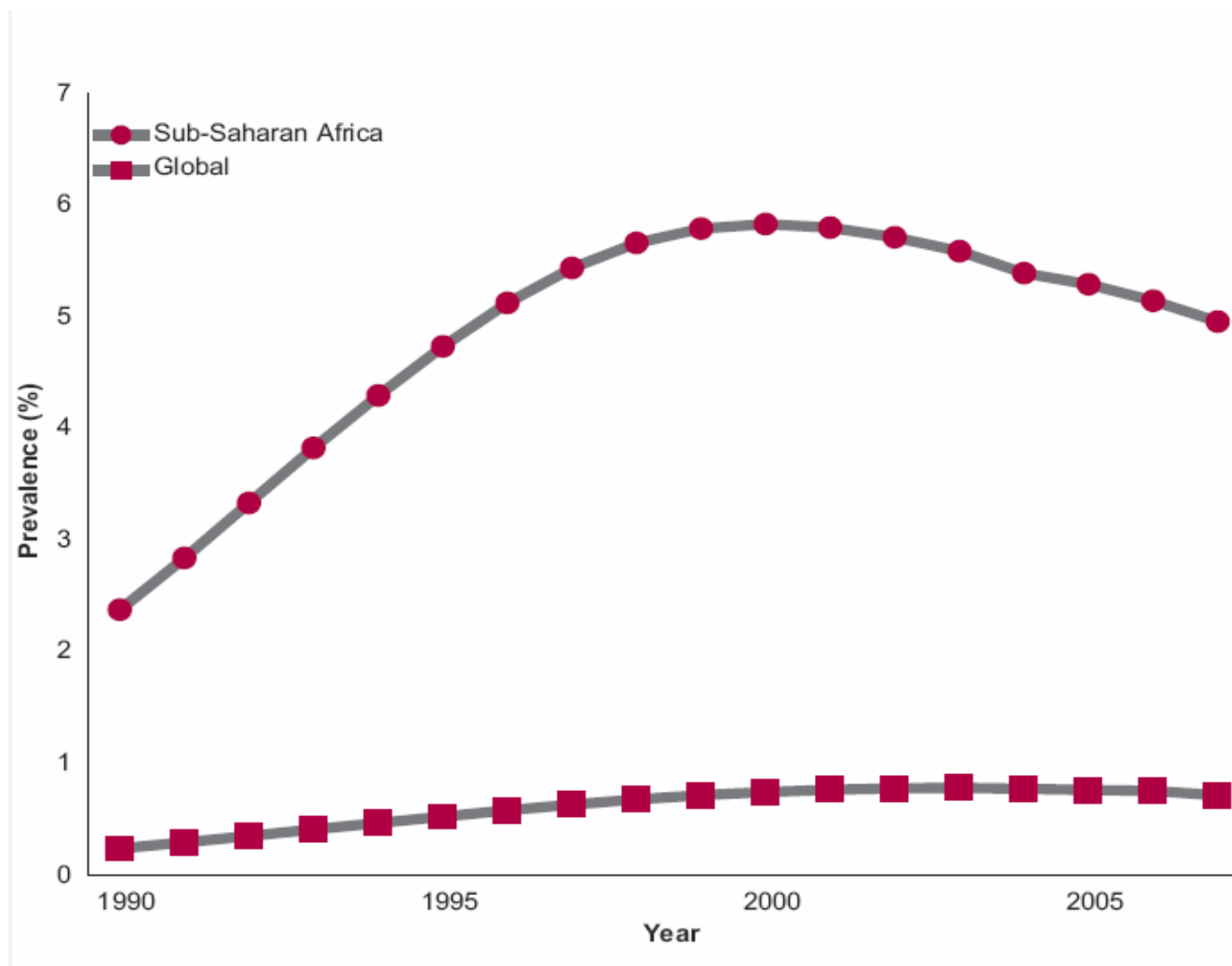
HIV /AIDS estimates are revised downwards

- HIV/AIDS is one of the most urgent threats to global public health.
- Most of the infections with HIV and deaths due to the disease could be prevented if people everywhere had access to good services for preventing and treating HIV infection.
- Estimates of the size and course of the HIV epidemic are updated every year by UNAIDS and WHO.
- In 2007, improved survey data and advances in estimation methodologies led to substantially revised estimates of numbers of people living with HIV, of HIV-related deaths and of new infections worldwide.
- **The number of people living with HIV continues to rise but is lower than previously estimated**
- **While total numbers of people living with HIV have risen, overall prevalence has not changed**

NUMBER OF PEOPLE LIVING WITH HIV: PREVIOUS AND CURRENT ESTIMATES, 2000–2007



PREVALENCE OF HIV INFECTION AMONG ADULTS, 1990–2007: COMPARING SUB-SAHARAN AFRICA AND THE GLOBAL AVERAGE



Global summary of the AIDS epidemic, December 2007

Number of people living with HIV in 2007

Total	33 million [30 – 36 million]
Adults	30.8 million [28.2 – 34.0 million]
Women	15.5 million [14.2 – 16.9 million]
Children under 15 years	2.0 million [1.9 – 2.3 million]

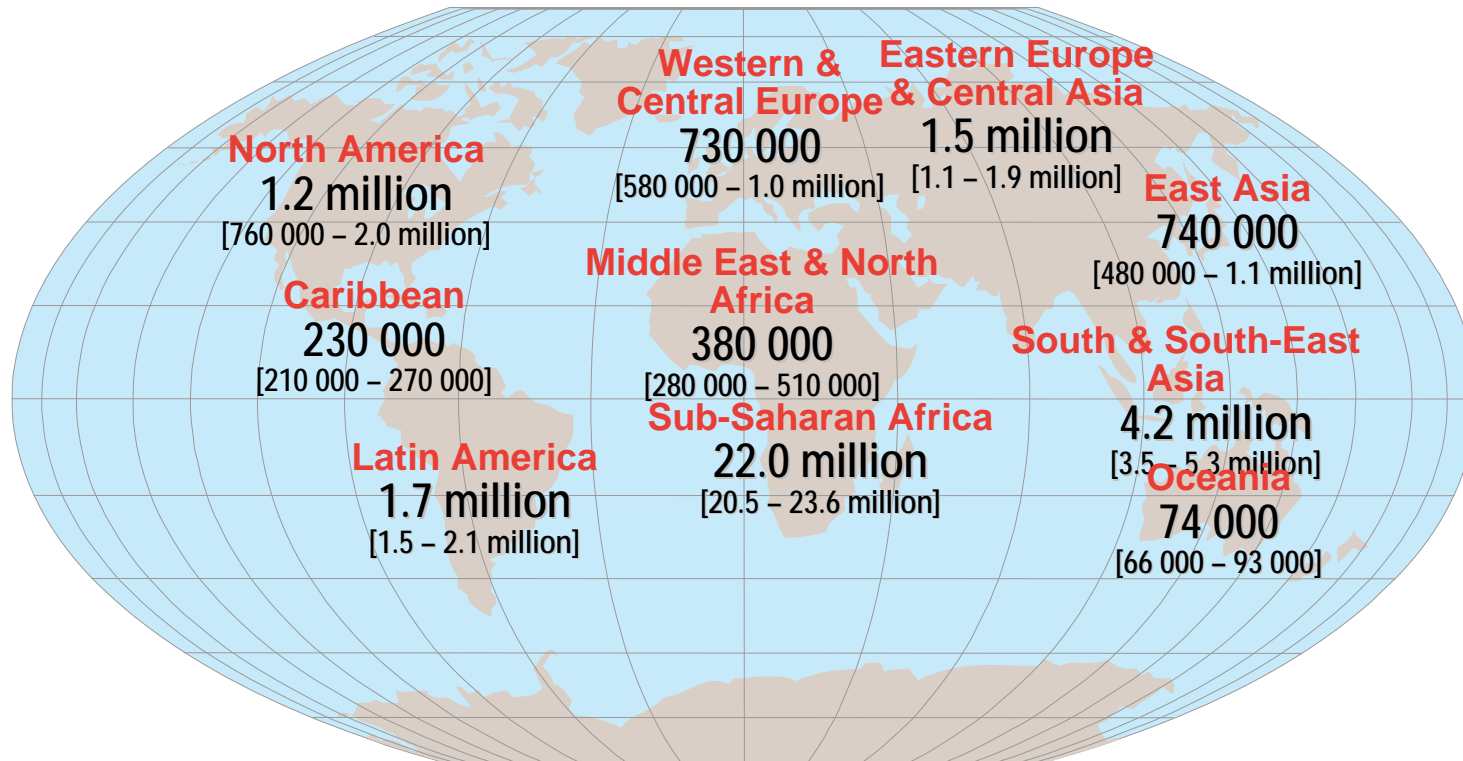
People newly infected with HIV in 2007

Total	2.7 million [2.2 – 3.2 million]
Adults	2.3 million [1.9 – 2.8 million]
Children under 15 years	370 000 [330 000 – 410 000]

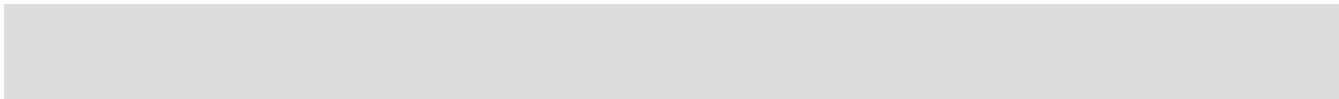
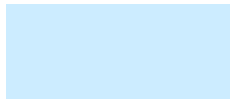
AIDS deaths in 2007

Total	2.0 million [1.8 – 2.3 million]
Adults	1.8 million [1.6 – 2.1 million]
Children under 15 years	270 000 [250 000 – 290 000]

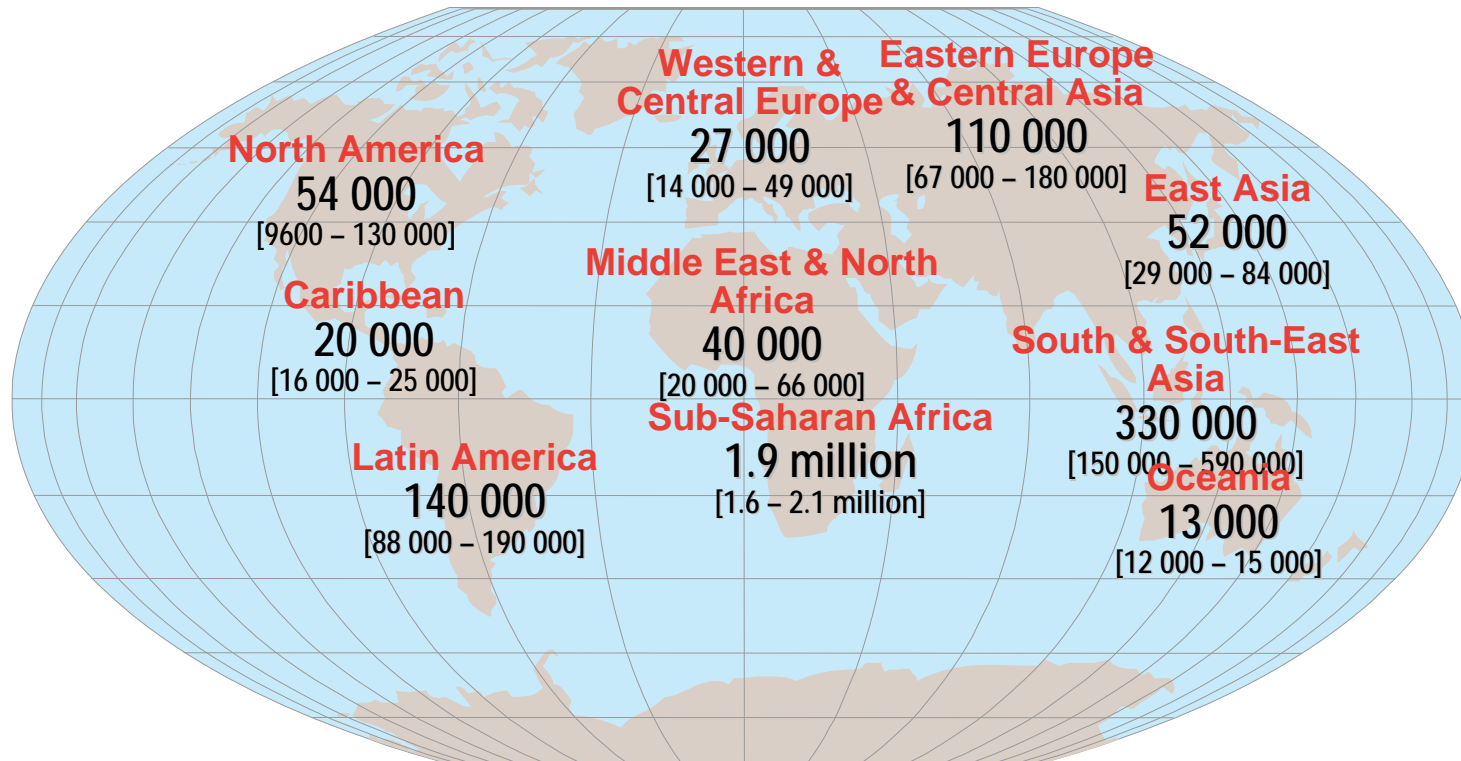
Adults and children estimated to be living with HIV, 2007



Total: 33 million (30 – 36 million)

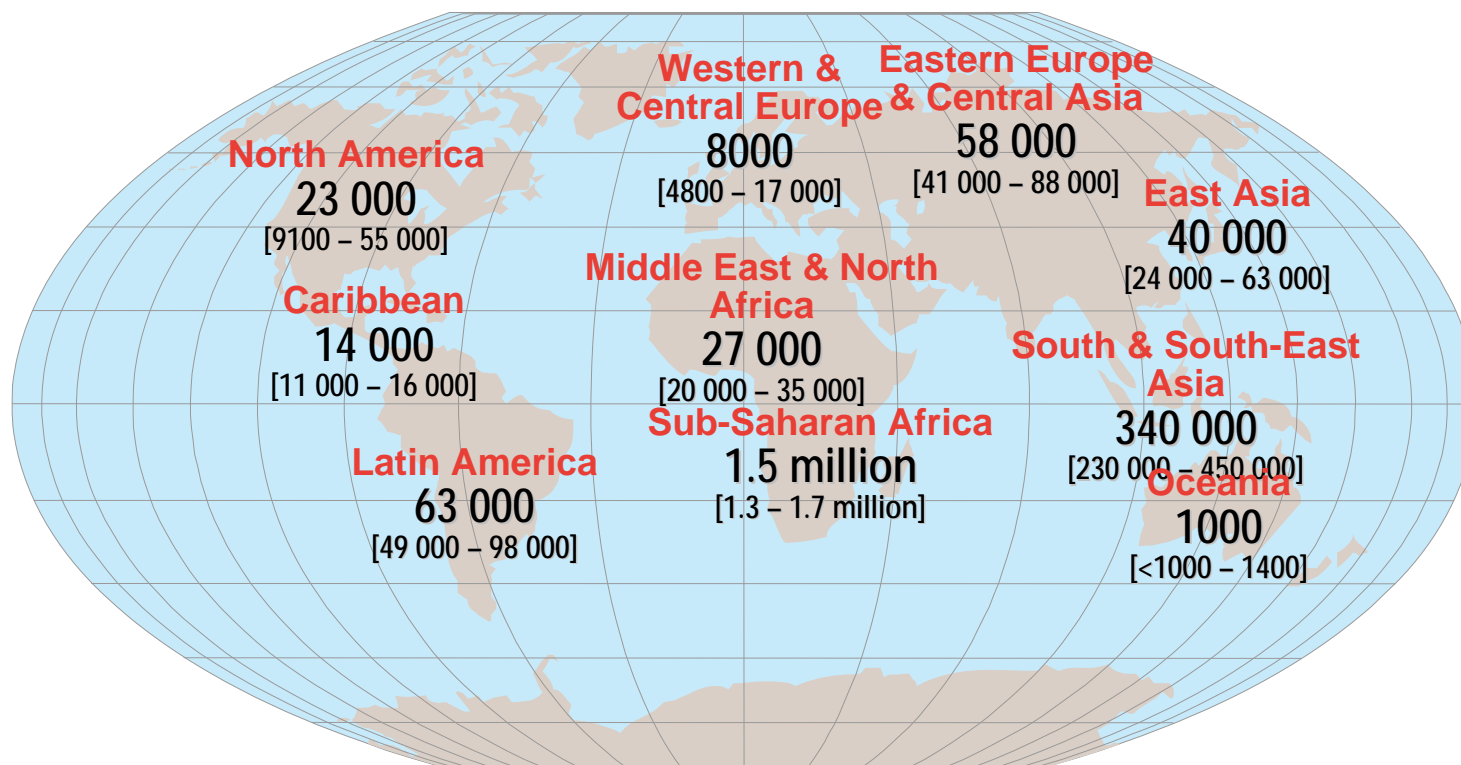


Estimated number of adults and children newly infected with HIV, 2007



Total: 2.7 million (2.2 – 3.2 million)

Estimated adult and child deaths from AIDS, 2007

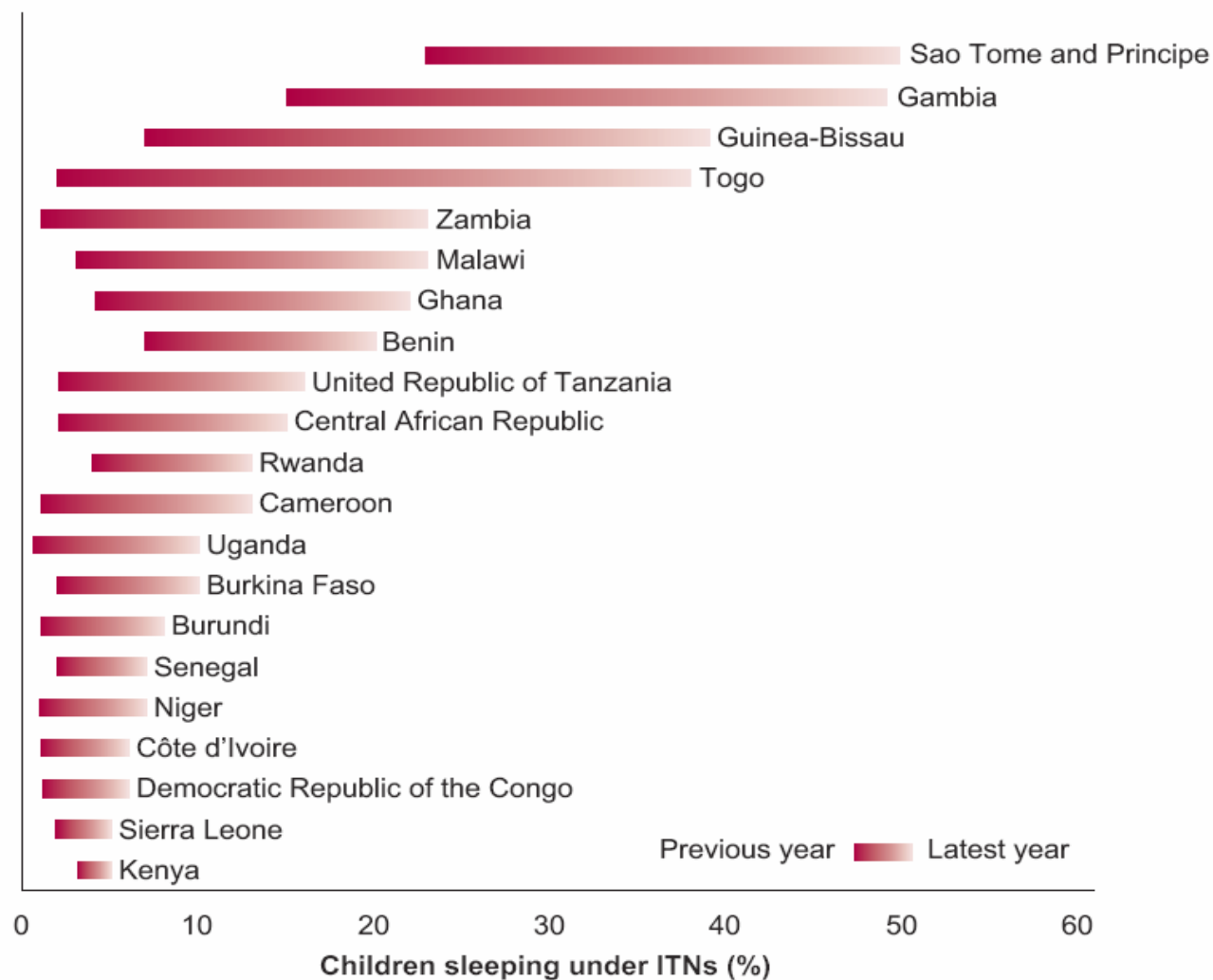


Total: 2.0 million (1.8 – 2.3 million)

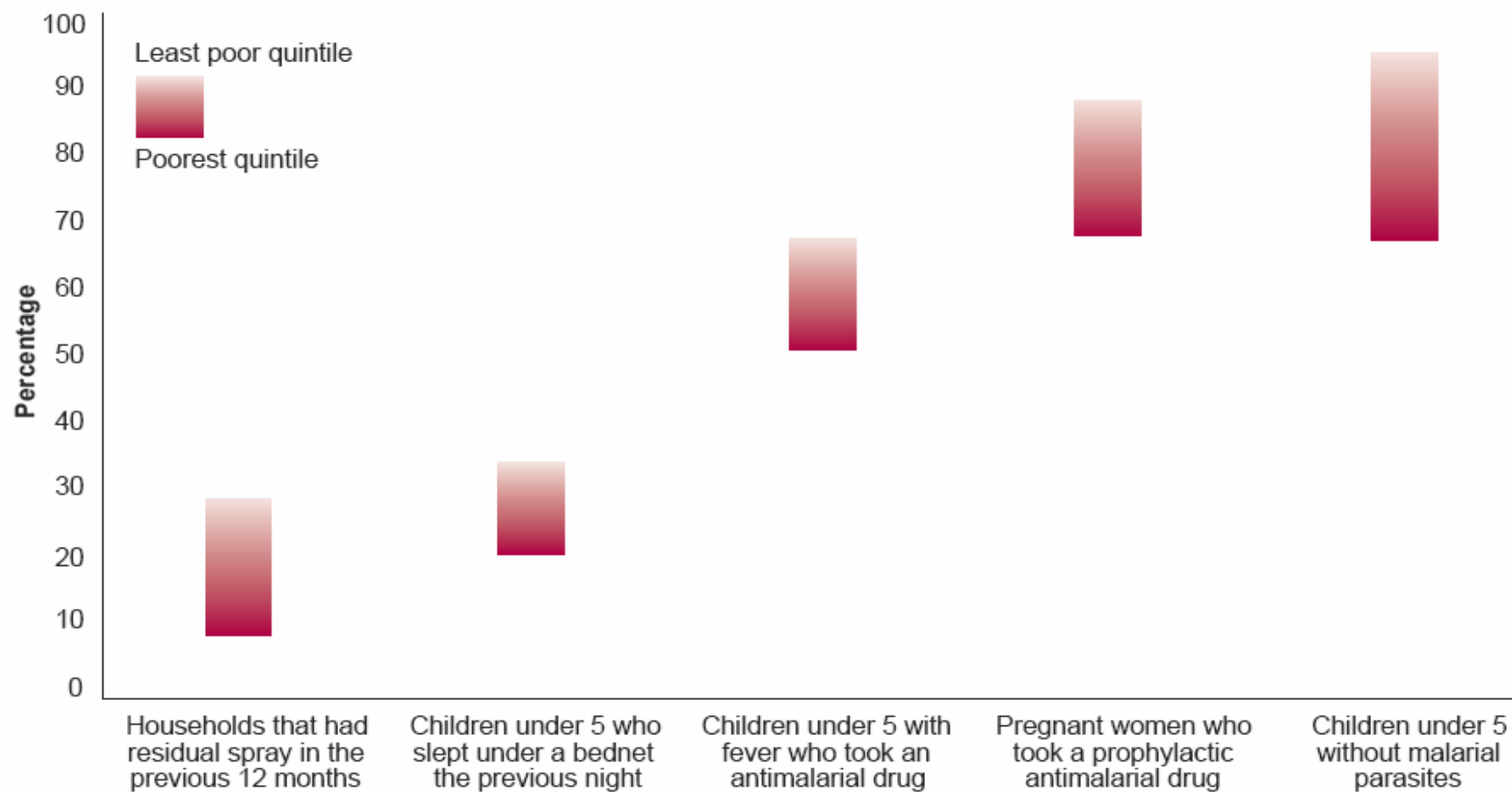
Progress in the fight against malaria

- Malaria is endemic in many of the world's poorest countries.
- The MDG target aims to have halted and begun to reverse the incidence of the disease by 2015.
- Indicators for monitoring progress include the proportion of the population in risk areas using effective prevention and treatment measures, and the incidence and death rates associated with malaria.
- In Africa, where 80% of the global burden of malaria occurs, new data from household surveys and research analysis based on surveillance data allow one to assess changes in intervention coverage in the fight against malaria in the region.
- Nevertheless, further efforts are needed to accurately monitor progress towards the MDG target and evaluate the intensified efforts against malaria.
- Most countries in the region still lack good standard measurement tools.
- **Use of insecticide-treated nets has increased substantially**
- **The poor do not benefit as much from malaria intervention coverage**
- **Studies are increasingly showing the impact of control measures**

Percentage of children sleeping under ITNs in selected African countries: previous year (around 2000) and latest year (around 2005)



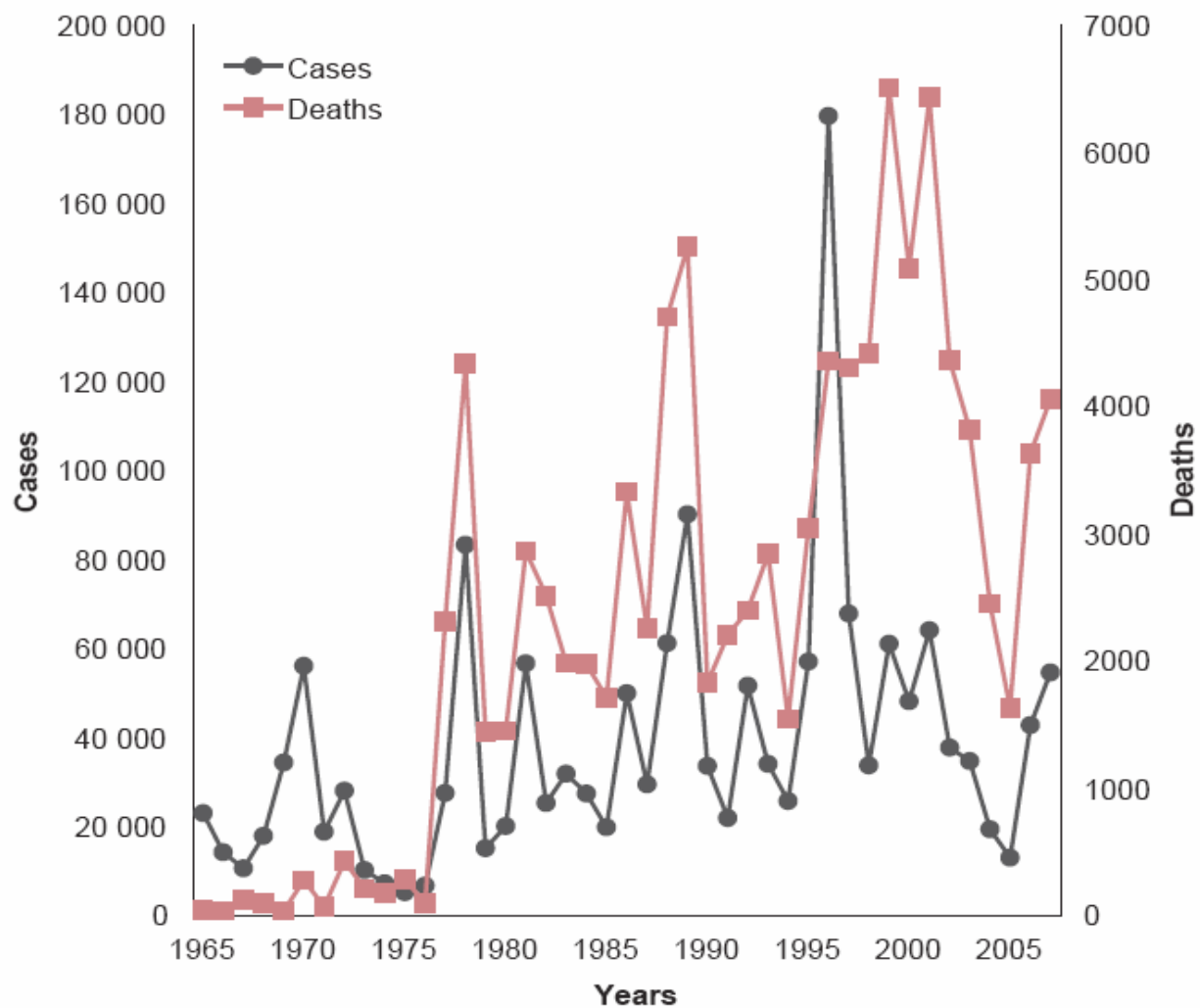
Coverage of malaria interventions by wealth status: Zambia MIS 2006



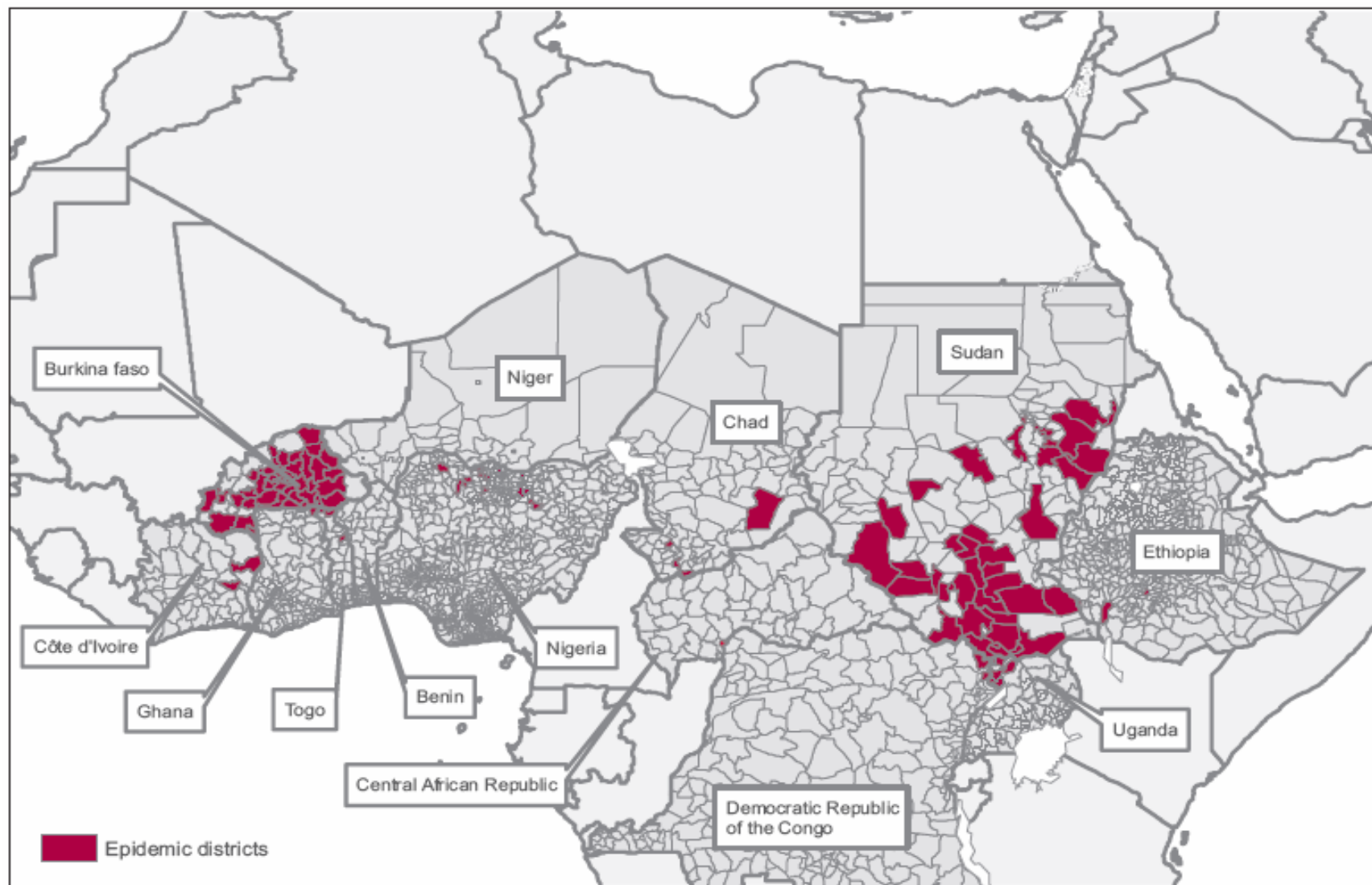
Monitoring disease outbreaks: *meningococcal meningitis in Africa*

- Meningococcal meningitis occurs sporadically and in small outbreaks worldwide, but the highest activity is concentrated in sub-Saharan Africa, in an area determined by its environmental conditions, called the “meningitis belt”.
- In this belt, which covers 21 countries and where about 350 million people live, the highest disease morbidity is recorded during the dry season.
- To avert the burden of the disease and the deaths resulting from it, timely and reliable epidemiological surveillance is very important; only then can an immediate response with reactive vaccination be mounted.
- **Almost 55 000 cases and 4000 deaths reported in 2007**
- **Districts are the primary unit for surveillance and response**

Suspected meningitis cases and meningitis deaths in the meningitis belt 1965–2007



DISTRICTS IN THE AFRICAN EPIDEMIC BELT IN WHICH THE EPIDEMIC THRESHOLD WAS CROSSED, 2006–2007



THE WORLD HEALTH REPORT 2007

A SAFER FUTURE

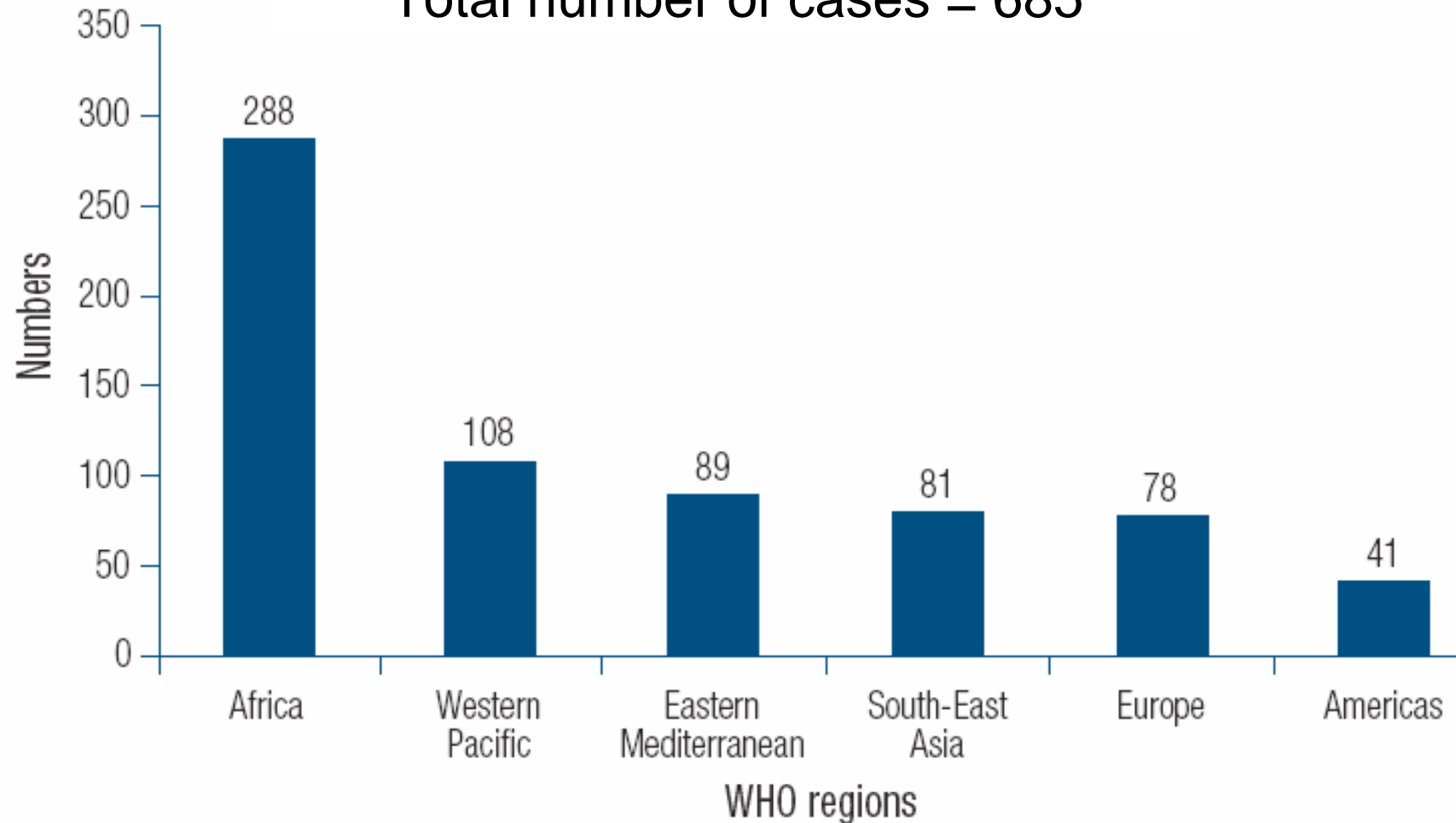
GLOBAL PUBLIC HEALTH SECURITY IN THE 21ST CENTURY



World Health
Organization

Verified events of potential international public health concern, by WHO region (09/2003 – 09/2006)

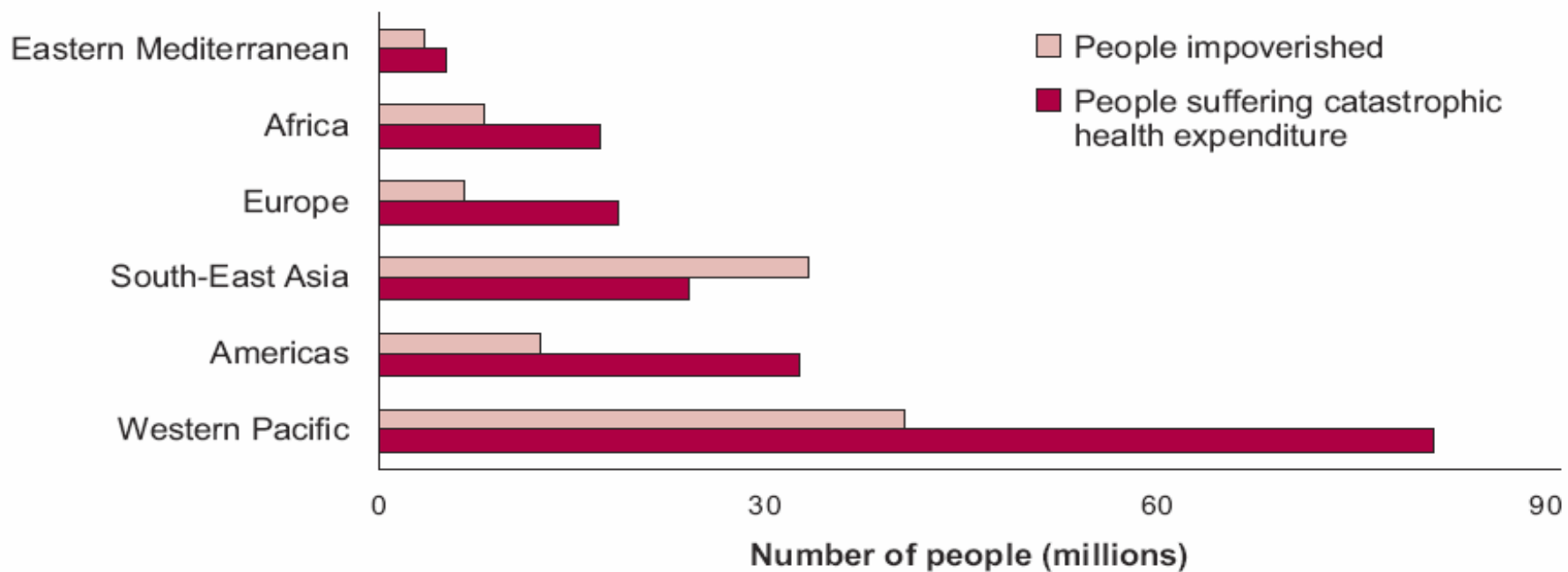
Total number of cases = 685



Reducing impoverishment and catastrophic health care spending

- Many countries rely heavily on out-of-pocket payments (OOPs) by patients to finance their health care systems.
- OOPs include fees for services levied by public and/or private providers (officially or unofficially) and co-payments where insurance does not cover the full cost of care.
- This arrangement prevents some people, especially poorer families, from receiving the care they need.
- In some cases, OOPs can be high enough to cause financial catastrophe and impoverishment, especially when there is severe illness or major injury.
- In 2005, the Member States of WHO endorsed a resolution on “Sustainable health financing, universal coverage and social health insurance”, calling on countries to develop health financing systems that ensure that people have access to health care without risking financial catastrophe or impoverishment.
- A new study, based on surveys conducted in 89 countries covering nearly 90% of the world’s population, provides for the first time a global estimate of the scale and distribution of catastrophic health care spending and indicates how the problem can be reduced.
- **150 million people suffer catastrophic health care costs each year**
- **Out-of-pocket payments are the main cause of catastrophic spending**

CATASTROPHIC HEALTH EXPENDITURE AND IMPOVERISHMENT DUE TO OUT-OF-POCKET HEALTH EXPENDITURE



Millennium Development Goal 8

Delivering on the Global Partnership for Achieving the Millennium Development Goals



UNITED NATIONS

MDG Gap Task Force
Report 2008



Millennium Development Goals

Access to affordable essential medicines

Target 8e

In cooperation with pharmaceutical companies, provide access to affordable essential drugs in developing countries.

Indicator 8.13

Proportion of population with access to affordable, essential drugs on a sustainable basis.



FACT FILE

10 FACTS ON ESSENTIAL MEDICINES

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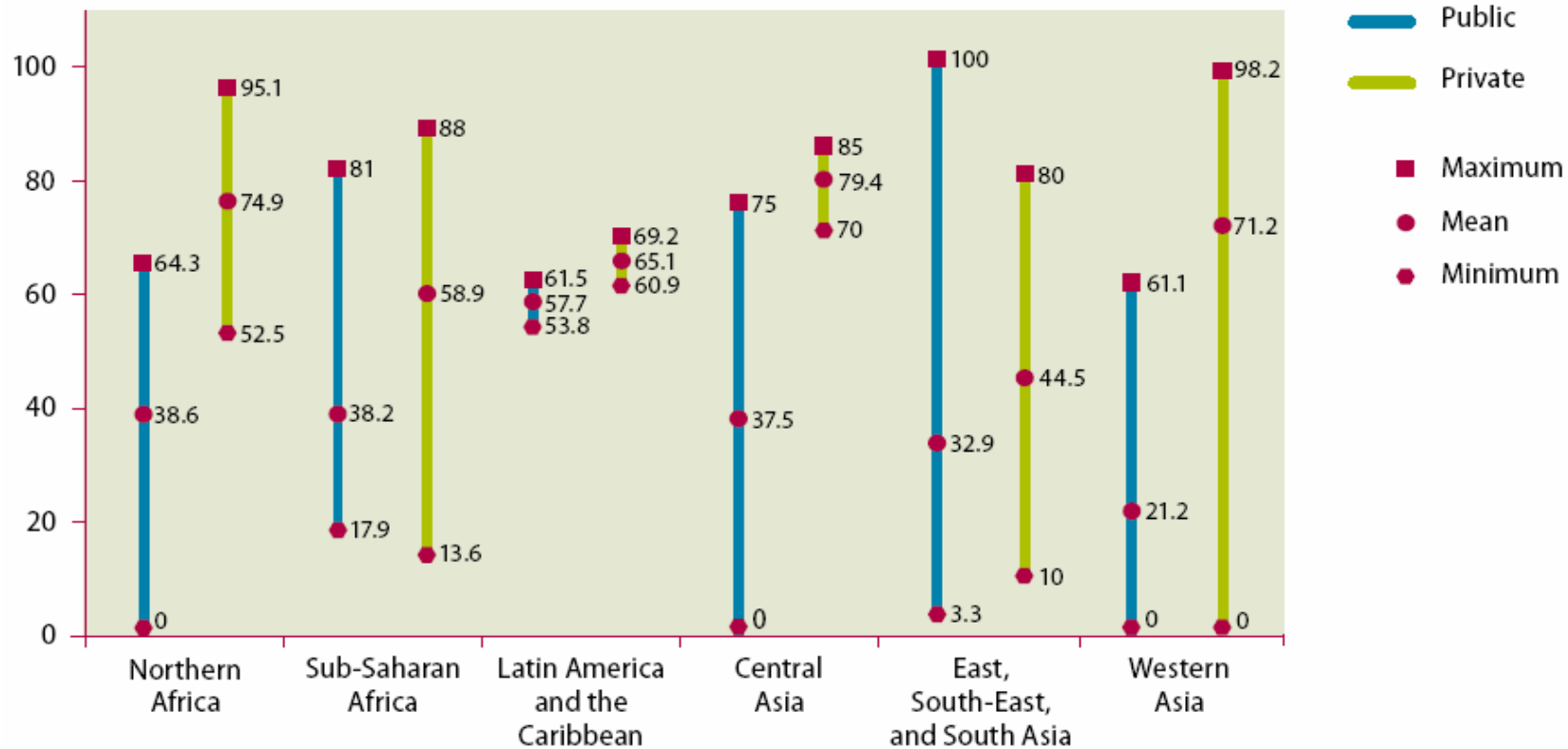
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Fact 1

The availability of medicines in developing countries is undermined by several factors: poor medicine supply and distribution systems; insufficient health facilities and staff; and low investment in health and the high cost of medicines.

The Essential Medicines List can help countries rationalize the purchasing and distribution of medicines, thereby reducing costs to the health system.

Availability (%) of selected medicines in public and private health facilities between 2001 and 2007



Source: Surveys of medicine prices and availability using WHO/HAI standard methodology (available from <http://www.haiweb.org/medicineprices/>).



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10 FACTS ON ESSENTIAL MEDICINES

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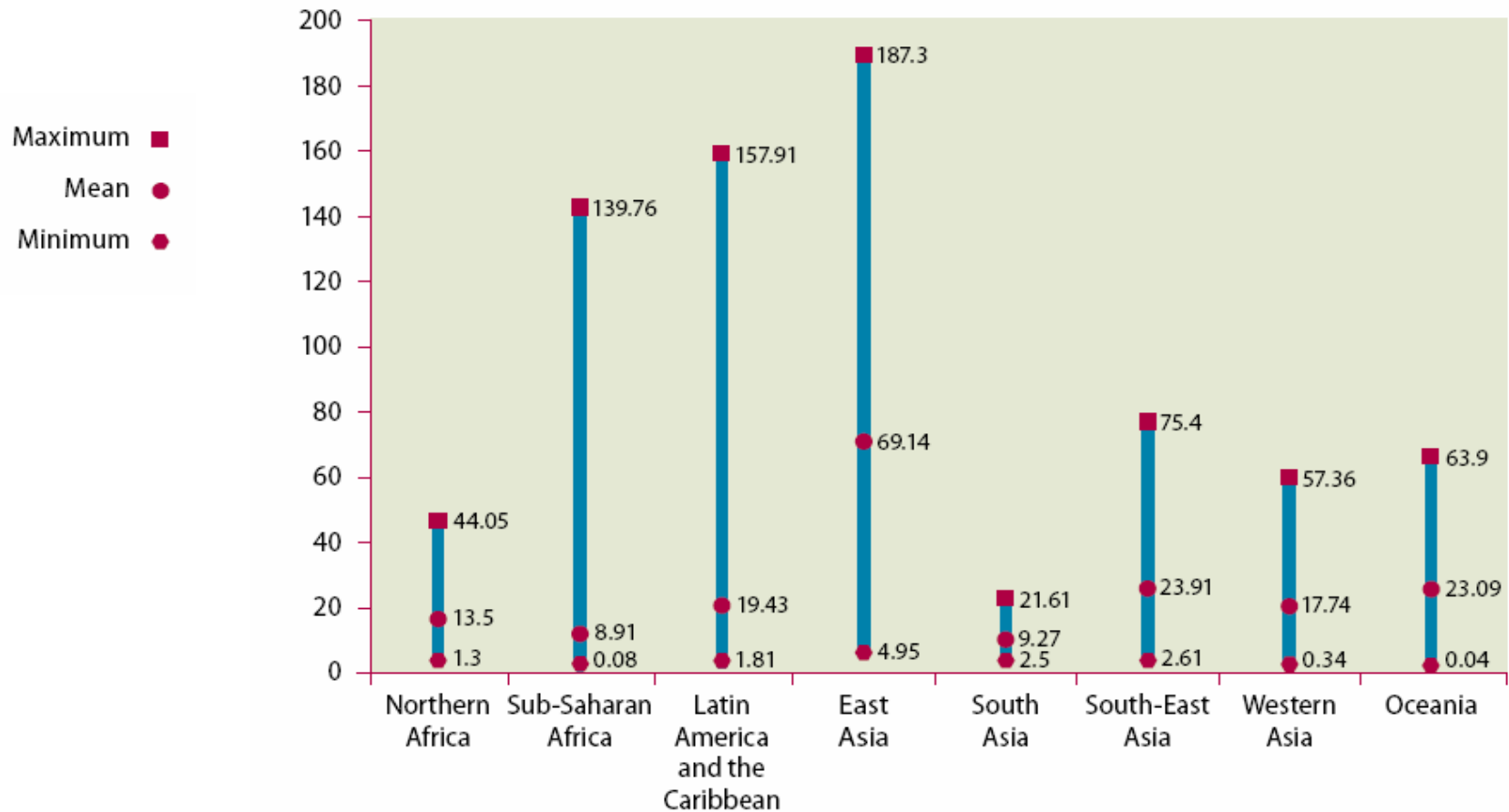
WHO/P. Virost

Fact 2

Pharmaceuticals account for 15% to 30% of health spending in transitional economies and 25% to 66% in developing countries. In some developing countries, medicines are the largest health expense for poor households.

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Public per capita expenditure (\$) on medicines, 2007



Source: WHO, Questionnaire on structures and processes of country pharmaceutical situations, 2007.

Public sector expenditure on pharmaceuticals

- wide variation in national per capita spending on medicines by the public sector across:
- developing countries: \$0.04 - \$187.30
- least developed: \$0.04 - \$16.30
- developed countries: \$26.67 - \$505.46



FACT FILE

10 FACTS ON ESSENTIAL MEDICINES

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WHO/W. Lindwer

Fact 3

A 2006 WHO study in China of 41 surveyed medicines - 19 of which were essential - showed only 10% were available in private pharmacies as branded products and 15% as generics.

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10 FACTS ON ESSENTIAL MEDICINES

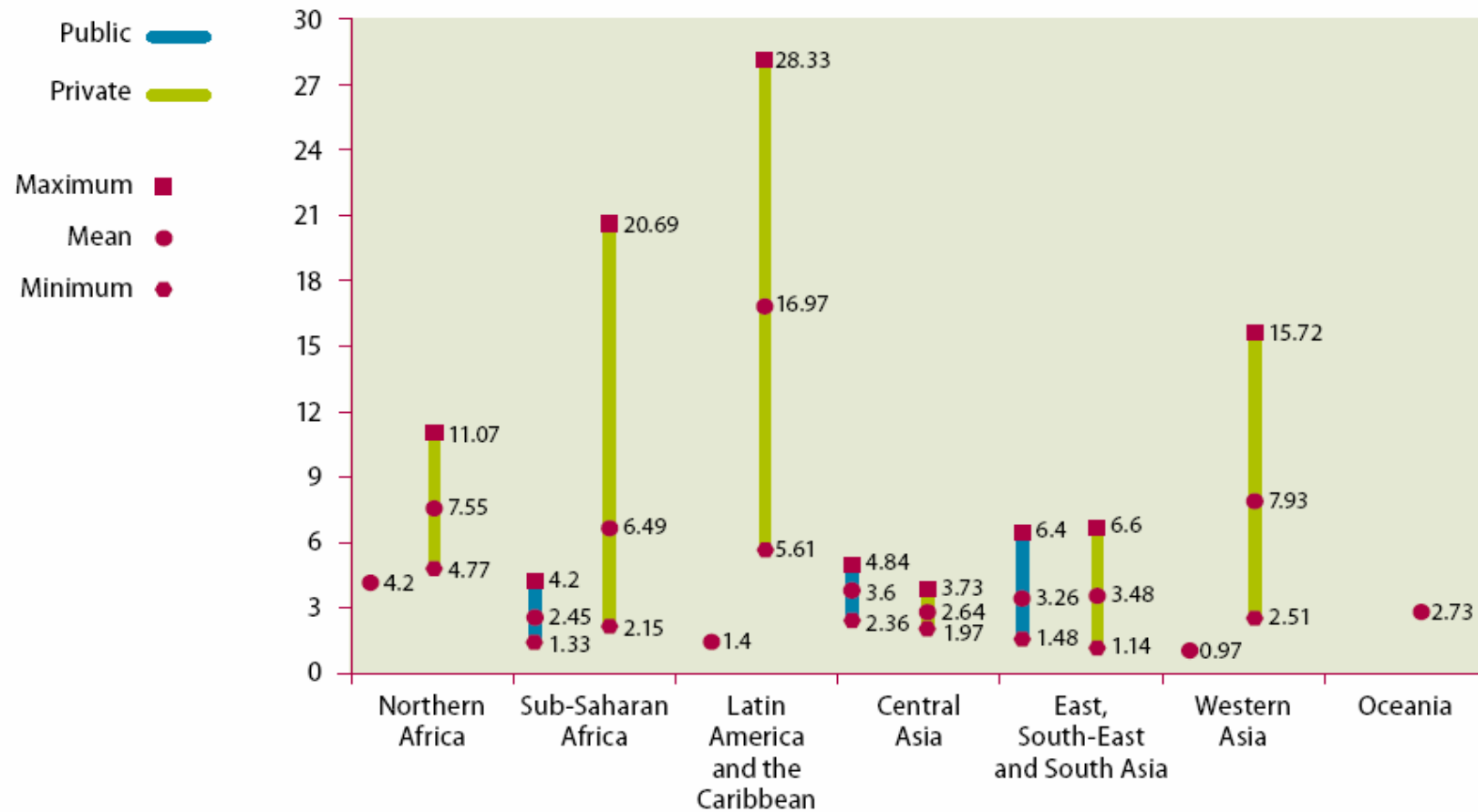
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WHO/M. Sentis

Fact 4

A 2004 survey in Uganda showed that among 28 nationally listed essential medicines, only 55% could be found in free health facilities. "Out-of-pocket" prices were 13.6 times higher for branded products and 2.6 higher for generics than the international pricing reference.

Ratio of consumer prices to international reference prices for selected generic medicines in public and private health facilities



Source: Surveys of medicine prices and availability using WHO/HAI standard methodology (available from <http://www.haiweb.org/medicineprices/>).

Margins (%) between producer and consumer prices in the public and private sectors

Country	Public sector markup	Private sector markup
China	24-35	11-33
El Salvador		165-6 894
Ethiopia	79-83	76-148
India		29-694
Malaysia	19-46	65-149
Mali	77-84	87-118
Mongolia	32	68-98
Morocco		53-93
Pakistan		28-35
Uganda	30-66	100-358
United Republic of Tanzania	17	56

Source: Surveys of medicine prices and availability using WHO/HAI standard methodology (available from <http://www.haiweb.org/medicineprices/>).



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WHO/C. Gaggero

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Fact 5

Only about a dozen countries had an essential medicines list or programme in 1977. Today, four out of five countries have adopted national lists. To be selected, medicines must be available through health systems, in suitable amounts and dosage forms. The list is a cornerstone of national medicine policies and the entire pharmaceutical system.



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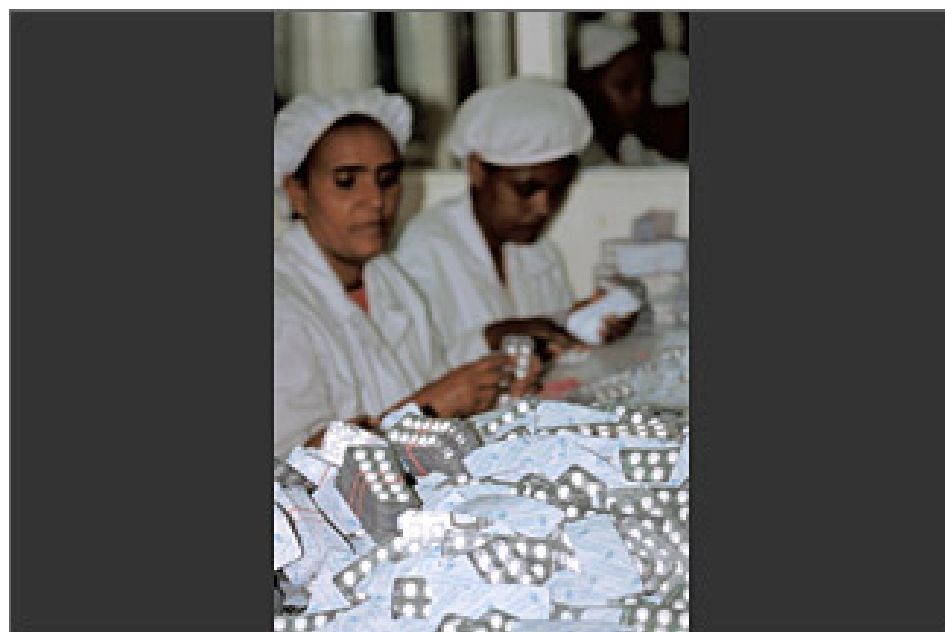
Fact 6

By 2015, over 10 million deaths per year could be avoided by scaling up certain health interventions, the majority of which depend on essential medicines. The Declaration of Alma-Ata in 1978 - a milestone in international public health - was the first official document to underline the importance of primary care and the role of essential medicines at a global level.



FACT FILE

10 FACTS ON ESSENTIAL MEDICINES

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WHO/P. Virost

Fact 7

Thirty years ago, the concept of a national medicine policy was unknown in most countries. Today, over 100 countries have policies in place or under development. They can act as frameworks to advance pharmaceutical sector reform. Early pioneers in essential medicines include Mozambique, Peru and Sri Lanka.



FACT FILE

10 FACTS ON ESSENTIAL MEDICINES

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WHO/C. Gaggero

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Fact 8

Objective information on rational use of medicines was extremely limited, especially in developing countries. Today at least 135 countries have their own therapeutic manuals and formularies with current, accurate and unbiased information.



FACT FILE

10 FACTS ON ESSENTIAL MEDICINES

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1 2 3 4 5 6 7 8 **9** 10



WHO/P. Merchez

Fact 9

Growing from an international effort started in 1977, a global network of 83 countries now monitors for adverse medicine reactions and potential safety problems.



FACT FILE

10 FACTS ON ESSENTIAL MEDICINES

[Previous](#)1 2 3 4 5 6 7 8 9 **10**

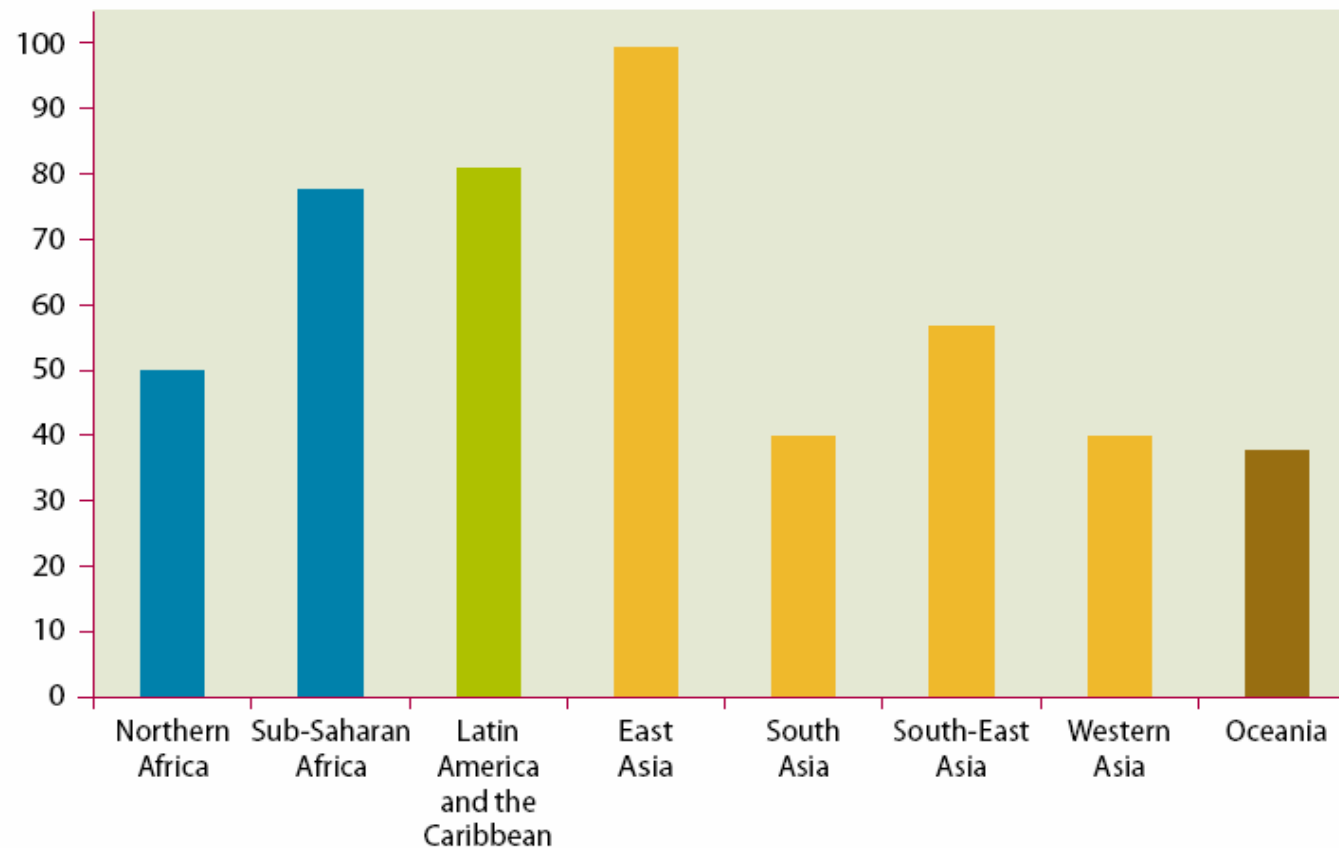
J. Holmes

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Fact 10

Thirty years ago, there was virtually no publicly available price information for medicines and few countries actively encouraged generic substitution. Today, 33 countries collect and make pricing information public. The use of generic medicines has brought down prices through increased demand and competition.

Percentage of countries with legal provisions to allow/encourage generic substitution in the private sector, 2007



Source: WHO, Questionnaire on structures and processes of country pharmaceutical situations, 2007.

Millennium Development Goals

Access to affordable essential medicines

- Accelerated progress requires explicit national and global targets in a number of areas.
- At the national level:
 - Eliminate taxes and duties on essential medicines;
 - Update national policy on medicines;
 - Update the national list of essential medicines;
 - Adopt generic substitution policies for essential medicines;
 - Seek ways to reduce trade and distribution markups on prices of essential medicines;
 - Ensure adequate availability of essential medicines in public health care facilities;
 - Regularly monitor medicine prices and availability.

Millennium Development Goals

Access to affordable essential medicines

- At the global level:
 - Encourage pharmaceutical companies to apply differential pricing practices to reduce prices of essential medicines in developing countries where generic equivalents are not available;
 - Enhance the promotion of the production of generic medicines and remove barriers to uptake;
 - Increase funding for research and development in areas of medicines relevant to developing countries, including children's dosage forms and most neglected diseases.



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HIV/AIDS

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Universal Access by 2010

By the end of 2007 an estimated 33 million people worldwide were living with HIV. That same year, some 2 million died of AIDS. UNAIDS reports that, globally, less than one person in five at risk of HIV has access to basic HIV prevention services. Only 31% of people who needed HIV treatment had access to it by end-2007.



Following the commitment by G8 members and, subsequently, heads of states and governments at the 2005 UN World Summit, the UNAIDS Secretariat along with their partners, have been engaging in consultations to define the concept and a framework for universal access to HIV/AIDS prevention, treatment and care by 2010.



Latest update

2 June 2008 -- *Towards Universal Access: Scaling up Priority HIV/AIDS Interventions in the Health Sector*, a collaboration between WHO, UNAIDS and UNICEF, is the definitive yearly chronicle of the health sector response to HIV prevention, treatment and care. This is the second annual progress report

to examine HIV within the context of the health sector. The 2008 edition features a special focus on women and children.

[More information](#)

GENERAL INFORMATION

[Towards Universal Access: Scaling up priority HIV/AIDS interventions in the health sector, April 2007 \[pdf 4.45Mb\]](#)

[Video: Towards Universal Access by 2010](#)

TECHNICAL DOCUMENTS

[Towards Universal Access by 2010: framework for monitoring and reporting \[pdf 342kb\]](#)

Monitoring and reporting on the health sector's response towards universal access to HIV/AIDS

EVENTS

The Social and Economic Dimensions of HIV/AIDS in Africa

The third symposium of the UNU-Cornell Africa Series

9 September 2008

[More information](#)

KEY PUBLICATIONS

Priority interventions

HIV/AIDS prevention, treatment and care in the health sector

[More information](#)

[English \[pdf 1.87Mb\]](#)



Towards universal access

Scaling up priority HIV/AIDS interventions in the health sector

Progress Report, June 2008

[More information](#)

[English \[pdf 6.69Mb\]](#)

[French \[pdf 7.25Mb\]](#)

Tuberculosis Care with TB-HIV

Co-Management

Tuberculosis Care with

TB-HIV Co-Management

[\[pdf 2.70Mb\]](#)

African centre for infectious diseases opens



The largest infectious disease treatment centre in the east Africa Region, the Infectious Diseases Institute (IDI), has been opened by Ugandan President, Yoweri Museveni, on October 20, 2004.

IDI becomes the largest centre for training medical professionals in Africa in advanced HIV/AIDS treatment techniques.

IDI is expected to establish the medical infrastructure necessary to combat the HIV/AIDS pandemic that has infected more than 30 million people in the continent.

The project is a partnership between Pfizer Inc, Makerere University, Academic Alliance Foundation, Pangaea Global AIDS Foundation and IDSA.

Destined for the wrong recipients?



Africa-bound AIDS drugs resold illegally

CMAJ • NOV. 26, 2002

- Reduced-price antiretroviral drugs intended for Africans are turning up in European pharmacies and in private clinics in Africa, undermining a 2-year-old UN program to provide medicine to people with AIDS/HIV living in the world's poorest nations.
- In October, Dutch officials announced that 36 000 boxes of lamivudine–zidovudine (Combivir) and lamivudine (Epivir), with a market value of around US\$15 million, had been reshipped from Africa and resold to unsuspecting customers in the Netherlands and Germany.
- The antiretroviral drugs were marketed at more than 4 times the price intended by the manufacturer, GlaxoSmithKline.
- A box of lamivudine–zidovudine priced at US\$88 in Africa was being sold for \$390 in Europe.

Human cost of AIDS drugs scam

THE LANCET Infectious Diseases Vol 5 - June 2005

- The AIDS drugs re-sale scandal is spreading.
- GlaxoSmithKline is currently engaged in legal action with a British wholesaler, Dowelhurst, which obtained drugs intended for west Africa and diverted them back to the UK for re-sale to various National Health Service hospitals.
- This action follows a fine of £50 000 imposed in January on AA Worldwide Trading for trading in medicines without a licence after a case was brought against the company by the UK Medicines and Healthcare Regulatory Products Agency (MHRA).
- In late April, reports emerged that AIDS drugs intended for the Ukraine may have been diverted from their intended destination by UKAID.
- This UK-based organisation has bought AIDS drugs for shipping to the area but the MHRA and Médecins sans Frontières have no knowledge of UKAID supplying medicines there.

AIDS warrior: Krisana Kraisintu is determined to bring anti-HIV drugs to everyone who needs them



Kraisintu's goal is to help the DRC, Eritrea and Tanzania to produce generic copies of branded antiretroviral drugs.

Potential Anti-HIV Targets for Plant-Derived Substances

Compound	Entry	Reverse transcriptase	Integrase	Transcription
betulinic acid derivatives	X			
calanolides/inophyllums		X		
DCQA/DCTA (chicoric acid)	X		X	
flavonoids	X	X	X	X
mannose-specific plant lectins	X			
sulfated polysaccharides	X			X
trichosanthin, MAP30, GAP31			X	

DCQA/DCTA) dicaffeoylquinic acid/dicaffeoyltartaric acid.

(Paul Cos, et al. *J Nat Prod* 67: 284-293, 2004)

DNDi drugs for neglected diseases initiative

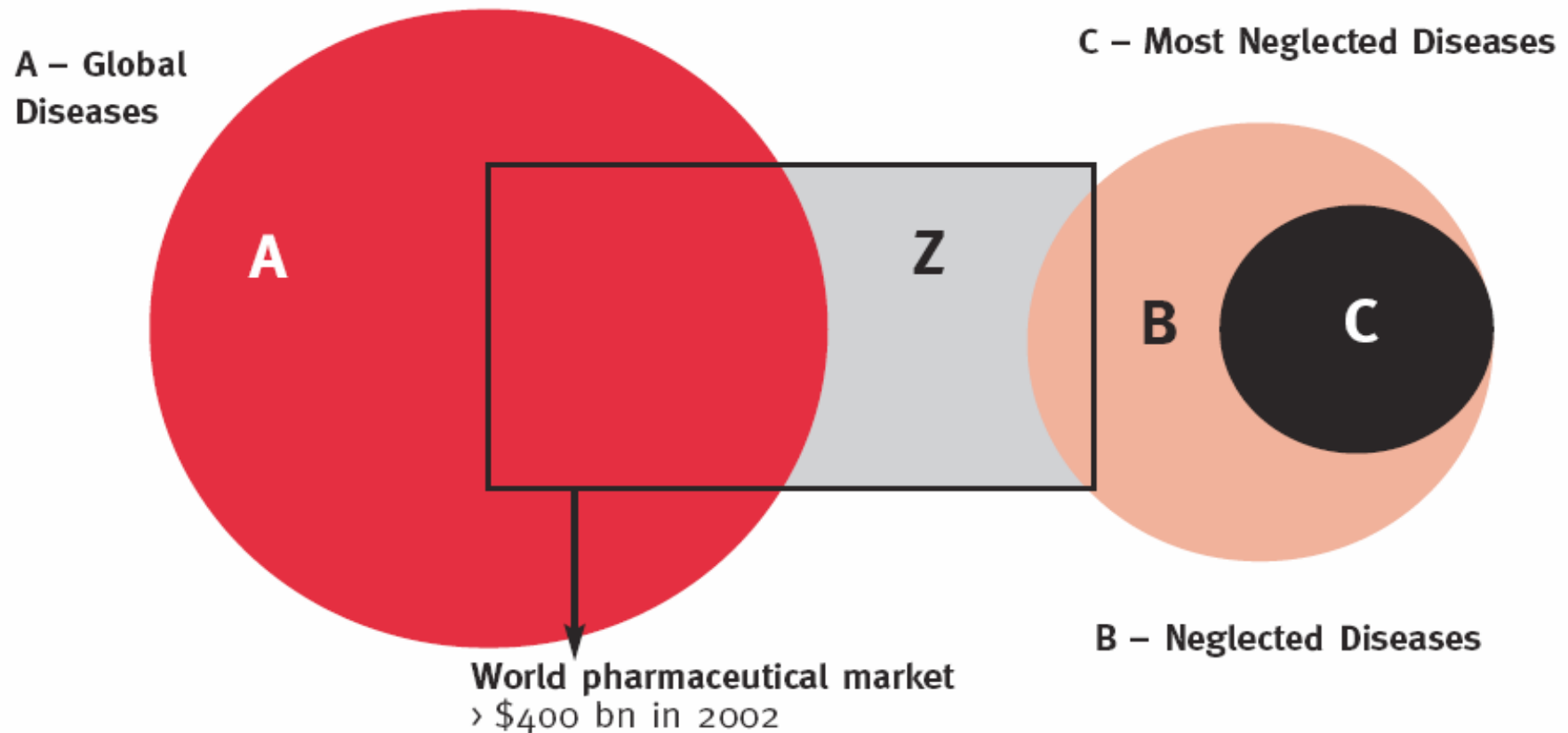
Working Draft

For mailing purposes
DNDi is temporarily housed at:
Campaign for Access to
Essential Medicines
Médecins Sans Frontières
Rue du Lac 12, CP 6090
1207 Geneva, Switzerland

Tel: +41 22 849 8405
Fax: +41 22 849 8404

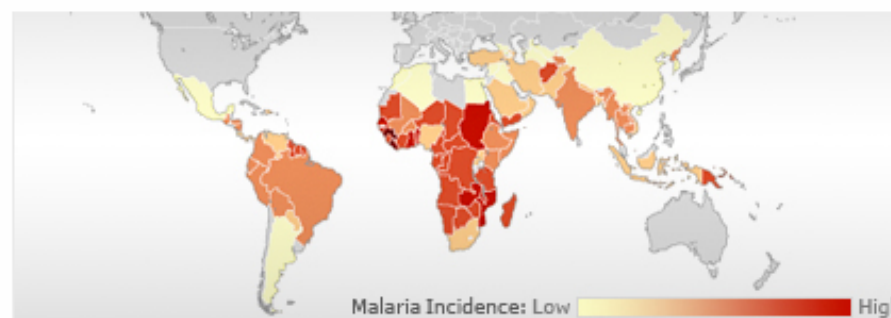
email: access@geneva.msf.org
<http://www.accessmed-msf.org>

Global pharmaceutical market and disease R&D targets



[The RBM Partnership](#)[Global advocacy](#)[Country action](#)[Commodity Services](#)[Publications & multimedia](#)[The RBM Partnership Home](#)[The Partnership](#)[Calendar of events](#)[About us](#)[What is RBM?](#)[Change initiative](#)[Global Malaria Business Plan](#)**New**[Governance](#)[Constituencies](#)[Partnership Board](#)[Board meeting](#)[Partnership forum](#)[Partnership secretariat](#)[Consensus documents](#)[Working groups](#)**New**[Task forces](#)[Affordable Medicines Facility for Malaria](#)**New**

About the Roll Back Malaria Partnership



Welcome to the Roll Back Malaria Partnership

The Roll Back Malaria Partnership (RBM) was launched in 1998 by the World Health Organization (WHO), the United Nation's Children's Fund (UNICEF), the United Nations Development Programme (UNDP), and the World Bank to intensify and coordinate global efforts to control malaria. Today, the Roll Back Malaria Partnership has expanded to become the leading global public-private venture for mobilizing action, raising resources, forging consensus and coordinating actors in the worldwide fight against malaria.

RBM partners work together to meet one of the [Millennium Development Goals](#): that malaria will not be a major cause of death or an impediment to social and economic development by the year 2015.

[Make a difference in the fight against malaria](#)

RBM Partnership news and activities



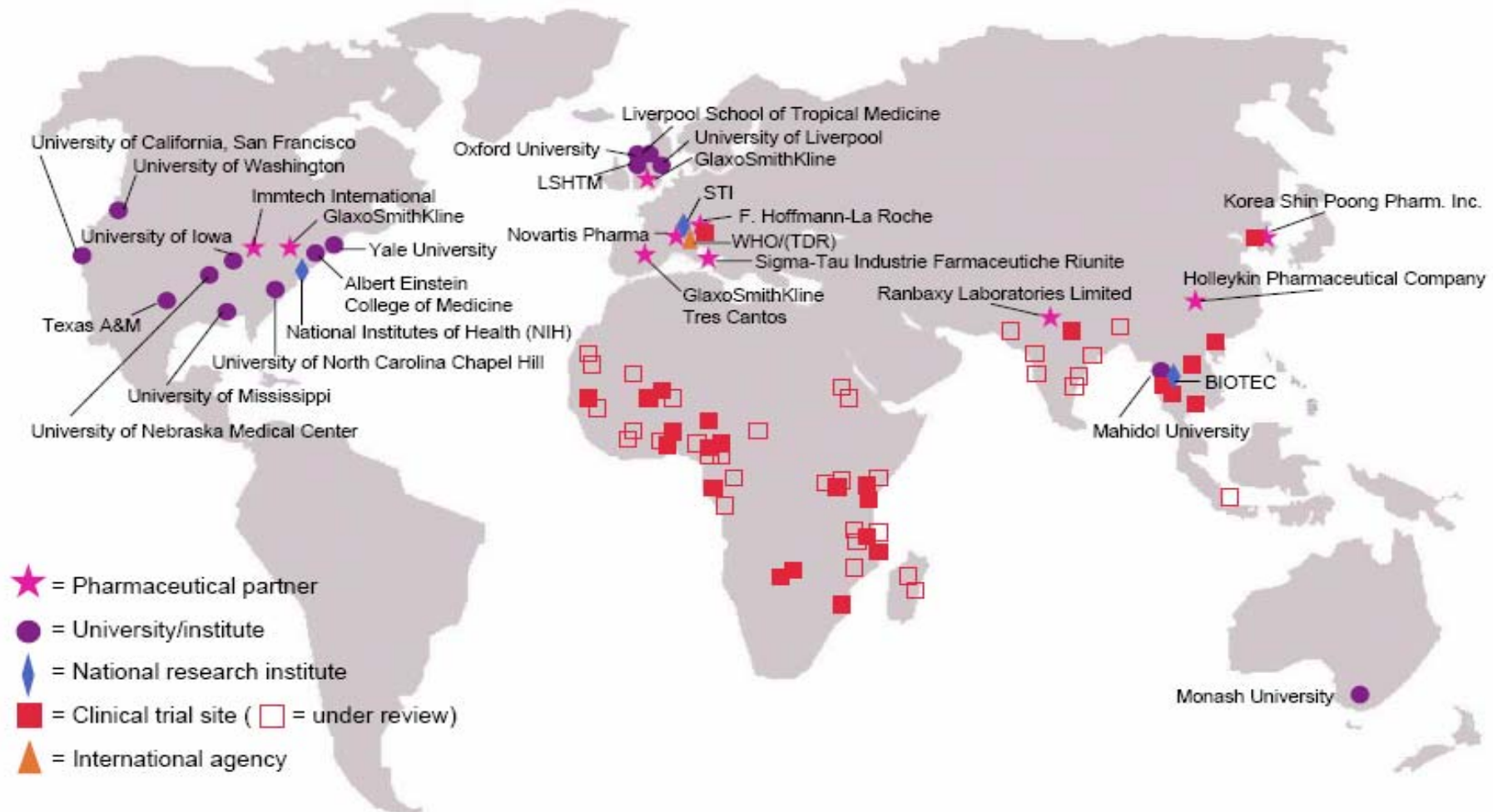
Global Effort on Malaria Kicks Off in France

September 9, Paris 2008: - France hosts a week of keynote events to reinforce global commitment to ending malaria deaths. The French initiative launched with a photo exhibition, attended by over 500 ministers, parliamentarians from Europe and Africa, NGOs and private sector representatives. Friends of the Global Fund Europe, under the leadership of President Michèle Barzach, spearheaded organization of the events. Worldwide advocacy efforts over the next month will launch the World Malaria Report

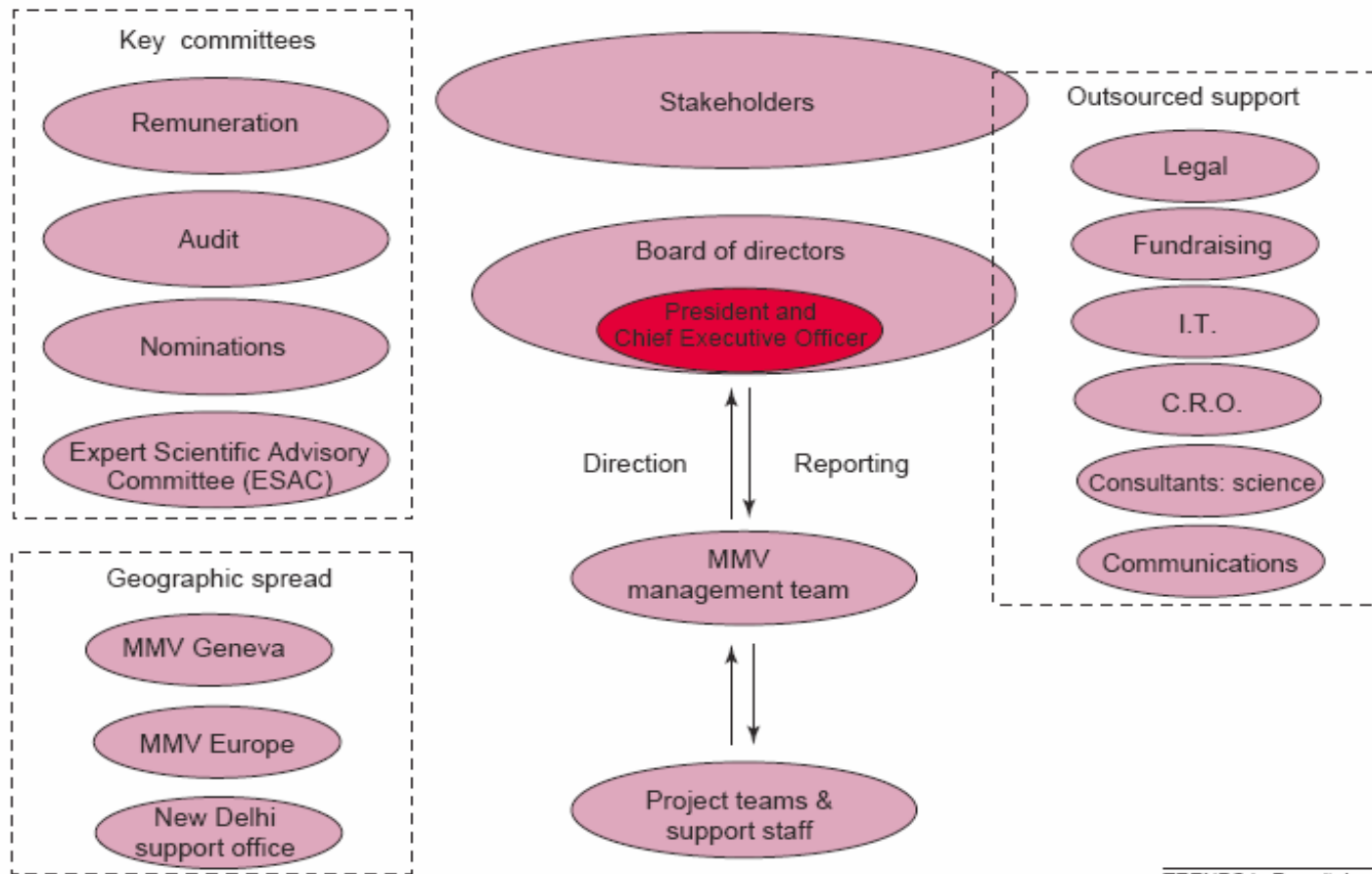
Medicines for Malaria Venture: sustaining antimalarial drug development

- The Medicines for Malaria Venture (MMV) is committed to discovering, developing and delivering new drugs for malaria.
- Founded in 1999 as a nonprofit organization bringing private sector management methods to bear on a global public health problem, MMV is today recognized as a leader among the public–private partnerships working on diseases for the developing world.
- Together with its many partners, MMV manages the world’s largest malaria research and development portfolio, covering the innovation spectrum from basic drug discovery to late-stage development.

The collaborations of MMV, MMV stakeholders, pharmaceutical partners, university and institutional partners, and existing and proposed clinical sites.

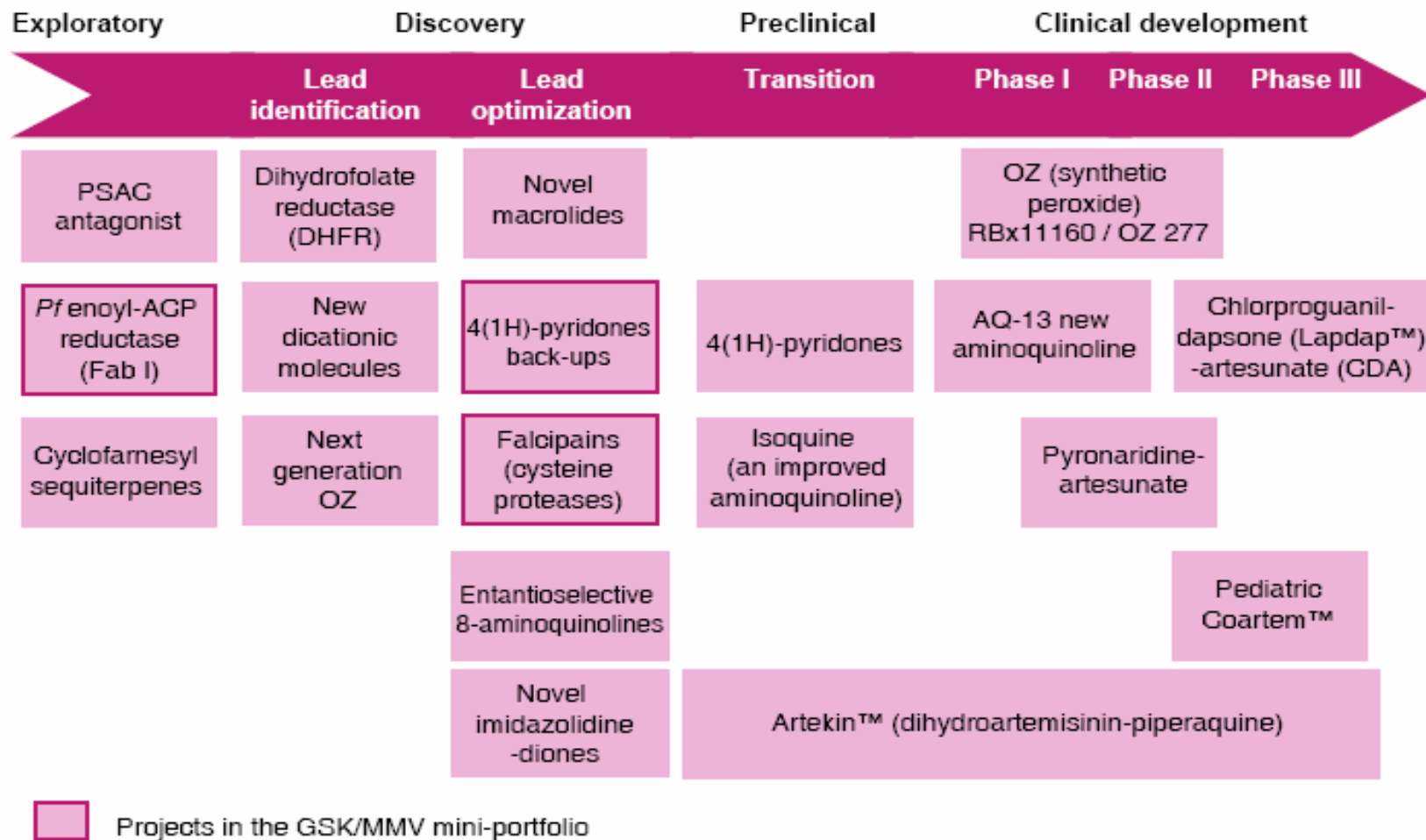


Medicines for Malaria Venture (MMV) Organizational Structure

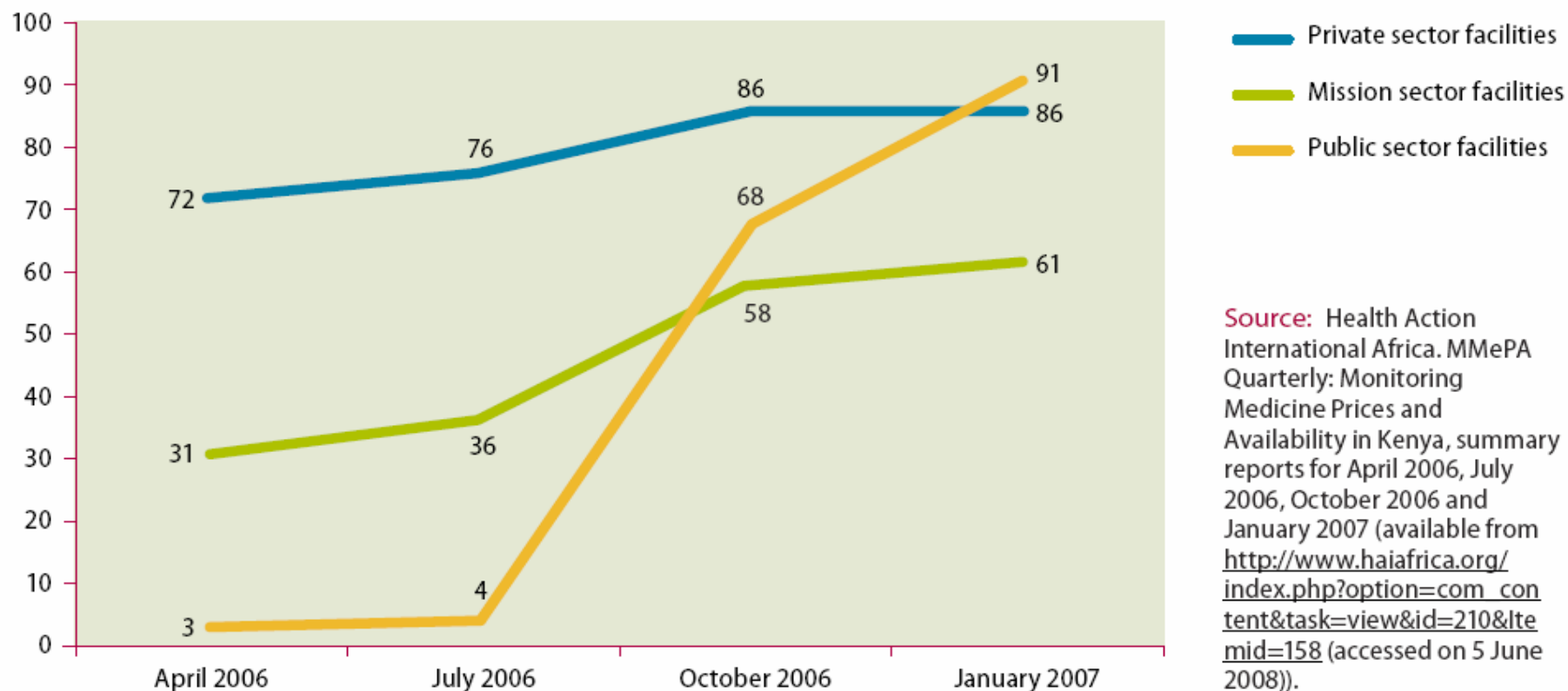


TRENDS in Parasitology

Medicines for Malaria Venture (MMV) Project Portfolio



Availability (%) of artemether/lumefantrine 20/120 mg in Kenya, April 2006–January 2007





About Us	Business Model	Global Health	Diseases & Programs	How to Get Involved	Media Center	
Mission	Our Story	Our Team	Directors	Financials	Advisors	Contributors



OneWorld Health's Role in World Health

- ▣ Identify potential new medicines for disease disproportionately affecting developing countries
- ▣ Assess the safety and effectiveness of investigational medicines
- ▣ Honor international ethical standards for research
- ▣ Establish collaborations with partners to manufacture and distribute new medicines
- ▣ Ensure that medicines will be affordable and available for distribution

Our Vision

The Institute for OneWorld Health will serve as a positive agent for change by saving lives, improving health, and fulfilling the promise of medicine for those most in need.



"I never doubt that a small group of thoughtful committed citizens can change the world. Indeed, it is the only thing that ever has."

Margaret Mead
Anthropologist, Intellectual and Scientist

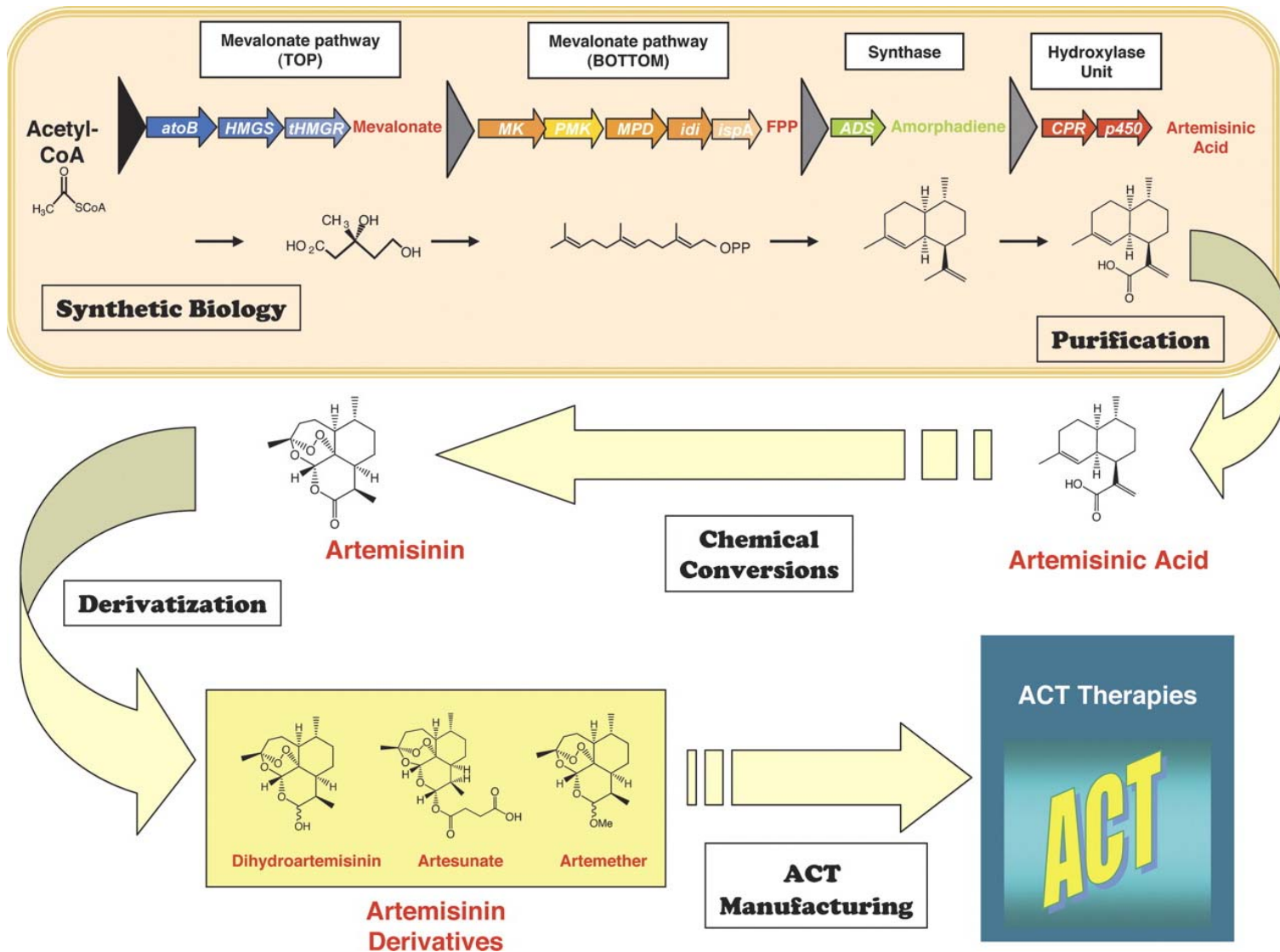
Our Values

Integrity, Courage, Collaboration

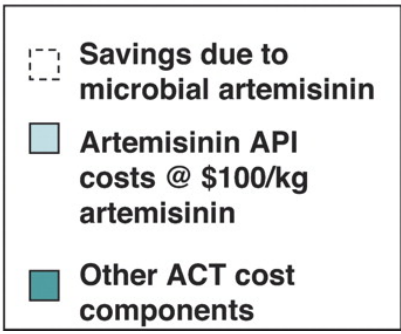
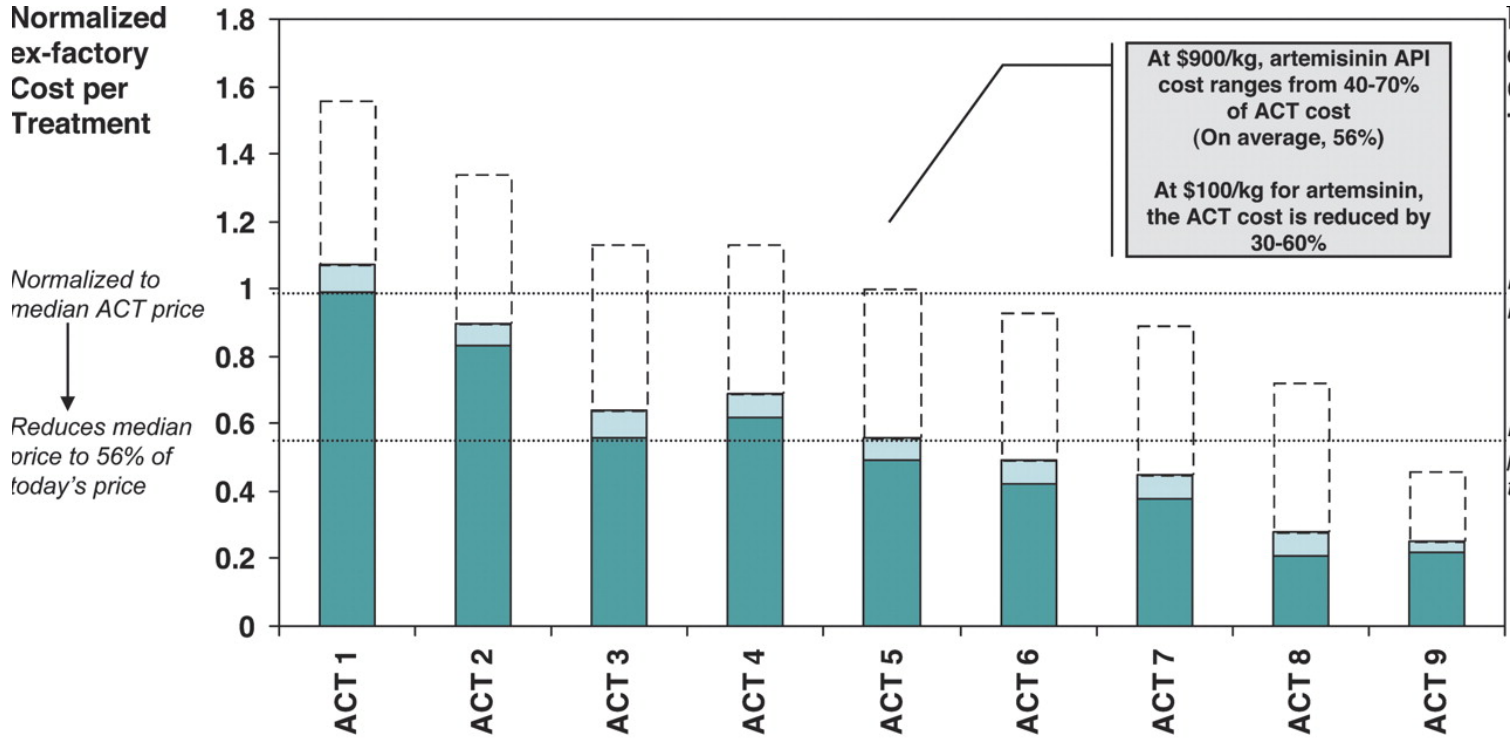
OneWorld Health Quick Facts

- \$90 million**
Dollars currently at work fighting infectious disease
- 2000**
Year OneWorld Health was founded in San Francisco, CA
- 50**
Number of OneWorld Health staff
- 400**
Years accumulated experience in pharmaceutical development

The process for the microbial production of artemisinin



Estimated ex-factory cost per treatment of ACTs



Artemisinin Combination Therapy (ACT)

Source: The Boston Consulting Group.

Medicine per la malaria

- Specialità farmaceutiche
 - Artemisinin-based combination therapy (ACT)
- Strategia ANAMED: tè di *Artemisia annua*
- Famiglia Vincenziana Internazionale: Progetto Malaria

Africa chiama Italia

- Ruolo dell'industria
- Ruolo della ricerca accademica
- Ruolo dei governi nazionali e sovranazionali
- Ruolo degli organi regolatori (EMA, AIFA)
- Ruolo della cooperazione
- Ruolo di una Ethic Pharma Company

Ethic Pharma Company

- Obiettivi di un'industria farmaceutica non-profit:
 - Ricerca e sviluppo preclinico e clinico di farmaci innovativi per le malattie dimenticate;
 - Ricerca e sviluppo di tecnologie farmaceutiche per adattare e migliorare l'uso di farmaci consolidati in funzione delle specifiche esigenze locali (es. formulazioni resistenti alle temperature elevate; formulazioni a rilascio prolungato; package per facilitare la compliance. ecc.);
 - Implementazione di unità di ricerca e sviluppo e di stabilimenti di produzione direttamente nei paesi in via di sviluppo, target di mercato.

Ethic Pharma Company

- **Criteri operativi**

- Opera nel rispetto delle norme nazionali ed internazionali che regolano la ricerca, lo sviluppo, la produzione e la commercializzazione dei prodotti farmaceutici.
- Pertanto si struttura come ogni altra azienda farmaceutica tradizionale.
- Riconosce e rispetta la proprietà intellettuale (brevetti) vigenti nei paesi in cui opera.
- Rifiuta, di norma, di utilizzare il sistema brevettuale per difendere eventuali interessi derivanti da proprie scoperte o innovazioni.
- Eventuali utili di impresa vengono reinvestiti in ricerca e sviluppo o in piani di distribuzione umanitaria dei medicinali.

Ethic Pharma Company

- **Mercato**

- Mercato diretto alle grandi organizzazioni umanitarie (cattoliche) che operano nel mondo (S. Vincenzo, Cottolengo, Salesiani, Missioni Consolata, ecc.) con un bacino di utenti molto ampio che da solo giustifica l'implementazione di strutture produttive locali.
- Mercato della normale distribuzione farmaceutica: l'industria non-profit potrebbe operare come qualsiasi altra industria profit, senza necessariamente mettersi in concorrenza sui prezzi, ma piuttosto sulla qualità ed efficienza dei prodotti

Declaration of Alma-Ata

International Conference on Primary Health Care,
Alma-Ata, USSR, 6-12 September 1978

X. Un livello di salute accettabile per tutte le popolazioni del mondo entro il 2000 può essere raggiunto mediante un utilizzo migliore e più completo delle risorse del mondo, una parte considerevole delle quali è oggi speso in armamenti e conflitti militari.

Una genuina politica di indipendenza, pace, distensione e disarmo potrebbe e dovrebbe liberare risorse ulteriori destinabili a scopi pacifici ed in particolare ad accelerare lo sviluppo sociale ed economico, compresa l'assistenza sanitaria di primo livello, come parte essenziale.