NEWS

WORLD BANK REDUCING FUNDS TO FIGHT MALARIA

The Massive Effort Campaign, aimed at mobilising society against AIDS, tuberculosis and malaria, reports that the World Bank is decreasing funds to fight malaria.

The World Bank's spending on malaria will decrease to around $11 million within the next 2 years from its current level of around $43 million per year.

The fact that malaria may be responsible for as many deaths every year as HIV/AIDS, has been largely ignored. The result has been that, despite commitments by African governments and the major international development organisations at the Abuja Summit to Roll Back Malaria in 2000, global malaria mortality has increased.

The August 2004 Malaria Supplement of *The American Journal of Tropical Medicine and Hygiene*, attributes 3 million deaths per year to malaria. Africa bears the overwhelming burden of the disease (90%), and most of its victims are children under 5 years old.

In addition to the profound human suffering, malaria is crushing Africa's economy. Development economists Jeffrey Sachs and John Luke Gallup have estimated that malaria costs African countries $12 billion annually. Considering that the price tag the WHO places on fighting malaria is only $3 billion per year, there is no reason why the world should not be meeting the challenge head-on, especially considering that effective tools for preventing and curing the disease already exist and are inexpensive.

Louis Da Gama of the Massive Effort Campaign says that if the world was truly concerned about Africa, malaria would be our first priority.

In Mali, where the annual number of reported deaths due to malaria has increased from 102 000 to 121 000 since 1999, and where the mortality rate of malaria is over 10 times that of HIV/AIDS, 'the World Bank has a $25.5 million project for HIV/AIDS, and two other projects worth $100 million where HIV/AIDS is a significant component, but there is not one single project that deals with malaria,' said Alexander Soucy of RESULTS Canada.

The World Bank is, however, presently undergoing a review of their malaria strategy, indicating a will from within to improve their response to the disease. 'The best possible outcome from this review would be for the World Bank to do for malaria what they have done for HIV/AIDS,' said Soucy.

Information: The Massive Effort Campaign, tel +44 208 357 7413, or **www.MassiveEffort.org**, or Louis da Gama, **ldagama@aol.com**.

AVIAN INFLUENZA

The following is an update on avian influenza from the World Health Organisation (WHO), September 2004 by Dr Klaus Stöhr, Coordinator of the Global Influenza Programme:

There have been findings in Thailand recently which would indicate that we have a cluster of cases in a single village. In the past, the H5N1 virus has always been transmitted from poultry to humans. What is less well known is that also in the past there has been some inefficient, non-efficient 'dead-end street' transmission between humans, where a person would be moderately ill but would not transmit the virus.

We are concerned, however, because the occurrence of such a cluster could also indicate the beginning of more widespread transmission, which could lead to the global spread of this virus – that's what we would fear, namely human to human transmissibility.

The Thai authorities have undertaken a very thorough epidemiological investigation, and the health care workers who cared for these patients are under very close observation. There is no evidence that the virus has spread beyond this group or beyond the village, but we cannot rule out the possibility that this has taken place, or that the virus has mutated.

What if tests show that this is a mutated virus, human to human transmission: where do we go from there?

A pandemic can occur either very slowly, by gradual mutation from an avian influenza virus, or very rapidly, practically within days, by reassortment of the human and avian influenza virus. If that happens, we would have to work through all the measures which are outlined in the WHO Pandemic Preparedness Plan. Currently, however, only 50 countries worldwide have pandemic preparedness plans.

WHO would discuss with national and international authorities how we could possibly slow down the spread of this virus by using, for instance, large amounts of antivirals at the core of the outbreak to try to slow down the spread.

We would also have to expedite the matter of vaccine development, and we would have to organise global surveillance – there is a long catalogue of measures that would come into place.

Even though we are currently dealing with a small cluster, it reminds us of the need for countries to do pandemic preparedness.

The big problem for us would be if there's widespread human-to-human transmission, if the virus is sustained in people so that the animal reservoir is no longer necessary.

The summer period is normally the period when there is very little avian influenza in poultry. Now that the northern summer is over, there has been an upsurge in Thailand and Vietnam. So we should expect more cases.

We feel there's too little being done on vaccines, which are considered to be the most efficient way to reduce morbidity and mortality from a pandemic. We have a window of opportunity now to work on it.

HIV PREVALENCE CONTINUES TO RISE

The Treatment Action Campaign's (TAC's) newsletter of 24 September states that approximately 5.6 million South Africans lived with HIV in 2003, according to the Department of Health's latest National HIV and Syphilis Antenatal Sero-Prevalence Survey in South Africa. This, the 14th antenatal survey since 1990, demonstrates yet again the need for all sectors of South African society, including government, business, labour, faith organisations and civil society, to improve HIV prevention and treatment efforts. The growth in the number of HIV cases continues and there is no evidence that the number of infections has stabilised, or that the level of new HIV infections is dropping among youth. HIV/AIDS is a national disaster and emergency measures for alleviating the epidemic are needed urgently.

The report can be downloaded from the Department of Health's website: **http://www.doh.gov.za/docs/2003hiv-f.html**.

Key findings of the study are the following:

- The number of women surveyed was 16 643.
- The survey found that 27.9% of pregnant women attending public antenatal clinic surveys in South Africa were HIV-positive in 2003. This is up from 26.5% in 2002. The first antenatal survey conducted in 1990 found a prevalence of 0.7%.
- Among pregnant women younger than 20, the prevalence was 15.8%, up from 14.8% in 2002, but almost the same as in the 2001 survey. KwaZulu-Natal continues to have the highest prevalence rate at 37.5%. Mpumalanga has become the province with the second-highest number of antenatal infections at 32.6%.
- The majority of HIV-positive people, between 2.8 and 3.4 million, are women. Between 90 000 and 103 000 infants are also infected, emphasising the need for a more effective mother-to-child transmission prevention rollout.

The projections made by the Department of Health are similar to those of the Actuarial Society of South Africa's ASSA2002 model and the findings of the Human Science Research Council in a 2002 community survey. Our knowledge of the HIV epidemic in South Africa is growing owing to increased collection of primary data, such as the antenatal surveys, and there has been convergence of a number of different population prevalence estimates.

The TAC, however, expresses their reservation about the tone of this year's report which states: 'When compared to the estimate of the previous year (2002) there is an apparent increase, however it is not statistically significant. Similarly the provincial estimates suggest that although there appears to be some slight increases in the prevalence between 2002 and 2003 in provinces, these increases are not statistically significant. The findings in general seem to suggest that the epidemic is slowly stabilising. This stabilisation is also evident from comparisons made between estimates of national prevalence in 2000 and 2003 which show marginal increases which are statistically significant.' (Department of Health, 2004.)

These comments suggest complacency. While the rate of infection might be slowing, which is to be expected when the prevalence is as high as it is in South Africa, this is not evidence that the epidemic will stabilise any time soon. The survey shows unequivocally that prevention interventions between 2001 and 2003 have been insufficient and need improvement.

The TAC suggests a major move by faith-based and other organisations, including the media, to make condoms easily available, to develop life-skills training at schools and to improve prevention of mother-to-child transmission. This cannot be done without the assistance of the government.

HEALTH CHARTER: KEY ROLE PLAYERS WELCOME THE CONCEPT

Key players in the industry welcomed the launch of the Health Charter process at the recent Quarterly Health Review, a function sponsored by Mx Health and aiming to allow the industry to debate major issues while interfacing with the media. On this occasion, the tone was consensual and positive as panellists and guests mulled over the concept of a charter for the health care industry.

Colin Reddy, research director for black economic empowerment at Business Map Foundation, said that the Health Charter should give weight to the quest to provide access to health care to those currently without it.

Andile Sangqu, group executive, Kagiso Trust Investments, stressed the need for co-operation and buy-in from all parties. 'We need to find a solution that brings together inputs from the whole sector', he said, adding that 'the future of health care cannot be negotiated through the courts'. He sees the Charter as giving the health sector a second chance, but warned that 'if other steps fail, government tends to resort to legislation'.

Sangqu pointed out that there are a number of 'legacy' issues in health – disparities that emanate from the past which must be corrected – and a history of poor relations between the private sector and government that must be overcome. He sees the Health Charter as providing a golden opportunity to achieve this and to set about negotiating the future on the basis of partnership rather than as adversaries.

This is a great chance for the private and public sectors to

collaborate, said Penny Tlhabi, CEO of the Board of Healthcare Funders, but it is essential to do a situational analysis at the outset. 'There are a lot of ideas bandied about, but what is the truth behind them? For example, I am sure it's true that about 20% of our population make use of private health care, but when we talk of 80% making use of the State service, how true is that? How many of the 80% actually have access to State services?' She believes that a situational analysis will facilitate setting more realistic targets.

Tlhabi made the point that health care has to be paid for, one way or another, and extending access will exact a price – but who will pay it? 'This is a wonderful opportunity to articulate the role and responsibility of the private sector, which has never been formulated before.'

Dr Mark Ferreira, medical director of Mx Health, focused on health's social imperative. 'I don't like the term charter, which begs comparison with the Financial Services Charter. I would prefer to talk about a contract with South Africa. And we need to figure out how we, as an industry, can collectively contract with the country.'

Ferreira's major concern is with the human resources element of the industry. We cannot just transform financially and in terms of shareholding – who should we be producing as health care workers to provide access to the people who need it? This theme resurfaced during question time, when Sister Burgie Ireland, now editor of *Health & Hygiene*, made an impassioned plea for better remuneration and conditions for nurses, who are leaving the country in droves.

Dr Fazel Randera, chairman of the Private Healthcare Forum, asked the private and public sectors to identify their common values and start from that basis. Only through co-operation and consultation can we arrive at a final product that has buy-in from all parties. He stressed that inclusivity is vital, and questioned the absence of labour and consumer organisations from the framework meeting held recently.

Randera pointed out that South Africa's health services still fail its people, and like everyone else on the panel saw the Charter as a fantastic opportunity. 'There is an opportunity to define the role of the private sector within what will become a National Health Service.'

The overall consensus was that the Health Charter steps into the territory of constitutional rights, since a right to health is enshrined in our constitution, and this gives it a dimension of complexity beyond that of charters which have gone before. However, industry role players have come to the fore with commitment and even enthusiasm, so it is hoped that the process will be fruitful and effective in solving at least some of the bigger issues facing South Africa.