

Editorial: **Global Health Fund or Global Fund to fight AIDS, tuberculosis, and malaria?**

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The Global Fund to fight AIDS, Tuberculosis, and Malaria (GFTAM) has generated passionate debates since the UN Secretary General called for its creation in April 2001 [The Global Fund to fight AIDS, Tuberculosis, and Malaria (GFTAM) 2002]. The debates concentrated on issues such as the gap between required funds and funds pledged (US\$ 2 billion so far – some of it one-off contributions – where US\$ 22 billion would be needed from donors *annually* to ensure universal coverage of essential interventions, WHO 2002b), the Fund's administrative structure and countries' processes for disbursement of money, but also – not least – on its scope and the types of activities eligible for funding through it.

Not all strategies to fight the three targeted diseases rely primarily on the health services for their implementation – promoting the use of condoms or impregnated bednets, for instance – but most of them do, case management in particular. The Fund claims it will 'address the three diseases in ways that will contribute to strengthening health systems' (GFTAM 2002). This is a virtuous goal, because disease-specific control programmes do indeed have the potential to weaken fragile health systems, by diverting resources and staff from other activities. But how will this strengthening be paid for? Decades of underfunding have taken their toll in terms of derelict infrastructures, poorly motivated staff, chronic shortages of drugs, etc. In the poorest countries of sub-Saharan Africa, per capita government spending on health has fallen to US\$ 8 a year in 2001. This amounts only to 20% – 40% of the cost of what the World Bank describes as the minimum package of health and environmental services (WHO *et al.* 2002).

Accessible and effective health services are a necessary (but, admittedly, not sufficient) requirement to fight the three diseases. One-third of the world's population lacks regular access to essential drugs, and in some parts of

Africa and Asia, this figure exceeds 50% (WHO 2000). What could any strategy of case-detection/treatment be expected to achieve in such a situation? Despite a tenfold increase in external financing for tuberculosis (TB) control in the less-developed countries during the last decade (Raviglione & Pio 2002), only 27% of the world's smear-positive cases of pulmonary TB have access to the DOTS strategy package (WHO 2002a). WHO estimated the costs of expanding DOTS coverage to control TB in the 22 countries that account for 80% of the TB incidence worldwide. For the period 2001–2005, funds required for health care services (US\$ 2.9 billion) amount to more than twice those required for specific TB programme costs (US\$ 1.28 billion) (STOP TB 2001). How much 'strengthening of health services' can be achieved simply as the welcome consequence of GFTAM increased funding for specific disease control activities? More ample resources and improved drug supply systems can have ripple benefits for controlling other health problems, and hopefully 'when more doctors, nurses, and other health providers are trained and posted to rural areas, they will not confine their work to AIDS, TB, and malaria (WHO *et al.* 2002).' But will the Fund finance the new health centres to be built in these rural areas? Or their rehabilitation? The other drugs? Recurrent costs? Salaries? Basic, multipurpose training? If not, who will?

Beyond the ideological debate between advocates of comprehensive health services and advocates of specific programmes, when it comes to achieving targets set for disease control, there are also technical arguments to question the efficacy of health services reduced to the sum of a few priority programmes. Take TB control. *Early* diagnosis and treatment of smear-positive pulmonary TB cases are the key to interrupting the chain of transmission. If the TB programme is good but the overall quality of services is poor, patients are likely to consult late in the

course of their disease, when symptoms have worsened. After all, why should the population targeted for microscopy screening (those coughing for more than 3 weeks) attend a health service that has little to offer to the 90% of them that will turn out negative on microscopy examination, and for whom not much will be done? In a large, externally supported TB programme in Bangladesh, 15% of patients still needed to be hospitalized, and 6% died during treatment, despite impressive results in terms of case detection and cure rate (Damien Foundation Bangladesh 2000). Such figures (in the absence of HIV-infection, as is the case in Bangladesh) indicate advanced disease at the time of diagnosis; that is, *late* case-detection. This is not to downplay the achievements of such a programme in relieving suffering for individual patients, but it puts in perspective its role in 'controlling' TB. Late case detection is related to poorer outcomes not only for TB, but also for severe malaria, or HIV-related morbidity. Health services must be comprehensive to be able to attract patients at a stage where the symptoms of their disease are still unspecific, or felt by themselves to be amenable to self-treatment.

Health care for All is both a basic human right and a necessity for improving global health, fighting diseases, and reducing poverty (Conference on 'Health Care for All' 2001). The GFTAM should be seen as an opportunity for investing in both the short-term needs and in the network of general health services that are necessary to make specific disease control a sustainable and effective activity. A recent evaluation of the Global Vaccine Initiative in four African countries (Brugha *et al.* 2002) found that poor infrastructure and low staffing levels were severely limiting the impact of the extra resources made available to the Expanded Programmes of Immunization in these countries. The GFTAM seems to take a broader development perspective, but 'addressing the three diseases in ways that will contribute to strengthening health systems' is bound to be of limited efficacy without strengthening health systems to address the diseases. Funds have to be earmarked for supporting the operations of national institutions responsible for planning and implementing control of AIDS, TB

and malaria, but a significant proportion of available resources need also be allocated to the general functioning of health services and systems. If the TB costing exercise is anything to go by, this would mean more than 50%. This is not an ideological, but a technical issue – to be put in the context of the highly significant renaming of the 'Global Health Fund' into GFTAM. The first batch of proposals submitted to the GFTAM are presently being evaluated. The processes by which this is done, and the resulting selection of proposals eligible for funding should be subject to intense scrutiny.

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