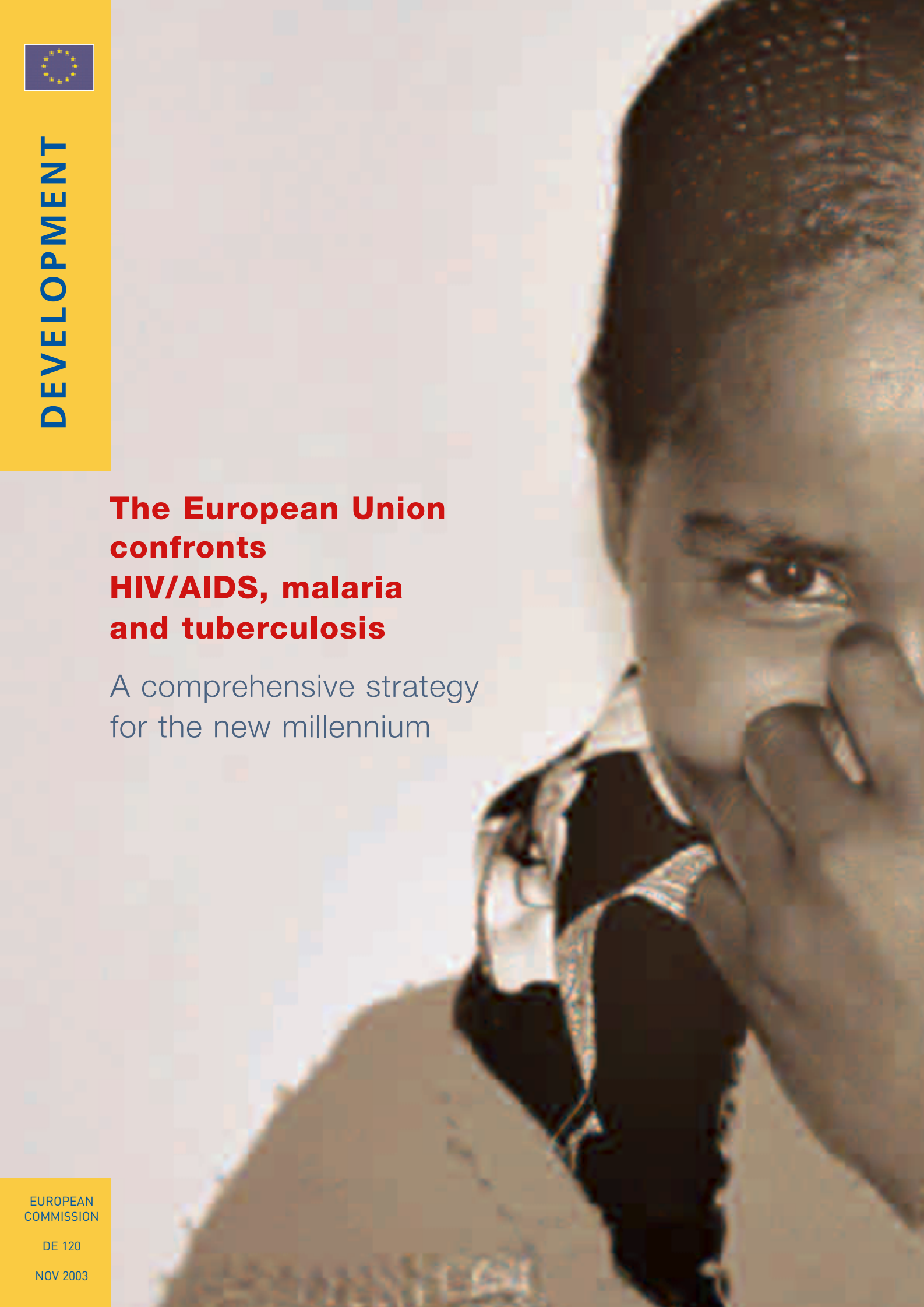
DEVELOPMENT

The European Union confronts HIV/AIDS, malaria and tuberculosis

A comprehensive strategy for the new millennium



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The spread of HIV/AIDS, malaria and tuberculosis (TB) continues. These three diseases pose a threat to societies around the globe, especially in the developing world. While they also affect the wider global community, it is the poorest people in the world who are worst hit. The link between these diseases and poverty is well established. There is no space for under-estimating the challenge that faces us all.

The health crisis besetting the developing world is not just a social and personal tragedy for the men, women and children suffering from these diseases. It is also an economic and developmental catastrophe because it attacks children and the active members of the population: young working adults, those who run businesses, have children and raise them. The situation is particularly devastating in Africa. For these reasons, HIV/AIDS, malaria and tuberculosis pose the gravest threat to Africa's survival and as a result, a challenge to all mankind.

Equal opportunity for a healthy life is a cornerstone of all human societies. It is a test of our will to build a world that is more in harmony with our fundamental values.

In order to confront these three major communicable diseases, action needs to be carried out on many fronts at the same time. This approach is outlined in the aims of the European Union's Action Programme launched in February 2001. We must work towards economic and social development and continue the struggle against poverty. We must make pharmaceuticals affordable, and develop effective new vaccines. We also need to create peace and security, for without them nothing is possible.

We are ready to do more and to act quickly to contribute to the global efforts to control these diseases. As the world's largest donor of development aid, the European Commission and the European Union are fully aware of this responsibility.

We have tripled our support to confront the three diseases in our regular assistance programmes for developing countries. With the full support of the Member States and the European Parliament, the European Commission has allocated in total more than an additional ¤1 billion to the Action Programme to date and this is in addition to what we do through our regular channels already. More than €450 million will be allocated over the next four years to research and development covering new pharmaceuticals and vaccines for poverty-related diseases.

The European Commission has strongly advocated 'tiered pricing' of medicines since September 2000 and this has just received a boost through the adoption of unprecedented legislation in the European Union: this legislation seeks to prevent the re-importing of reduced-price medicines into Europe and therefore encourages the pharmaceutical industry to make products available at near to cost of production price. Some laboratories have already done so. I call on others to show the same willingness to make more progress on this critical issue.

And access to affordable treatments has to go hand in hand with prevention as the core element to control these diseases: information, education, communication and access to bed nets and condoms is often a matter of life or death. We cannot afford any complacency until those vulnerable; particularly women and children looked after by them, and have access to an informed choice of tools to protect themselves and their families from these diseases.

This brochure explains our strategy and gives an overview of our actions so far. We must continue to rally everyone – researchers, the medical profession, industry, associations, civil society and politicians. History will judge us harshly if we do not use our power to control HIV/AIDS, malaria and tuberculosis. We have the knowledge, the technology, and the resources to address the enormous challenges posed by these diseases.

Commissioner Poul Nielson

Summary and key messages

1. HIV/AIDS, malaria and tuberculosis (TB) are major global health problems. On the one hand they predominantly affect poor people in developing countries, and on the other their occurrence increases poverty. The three diseases pose a major threat to development and to the global community.

2. The response to date has been characterised by inadequate efforts which have prevented scaling up of successful interventions, by collapsing health and education systems, and by failure to develop new but affordable products for treatment and care.

3. The international community has now made a fresh commitment to tackle these three diseases within the framework of the Millennium Declaration, agreeing to reverse the spread of HIV and the incidence of malaria by 2015. To achieve this target donor countries have pledged to massively increase overseas development assistance over the next few years.

4. In the context of this renewed international commitment, the European Community has adopted a comprehensive strategy for confronting the three diseases. Building on the European Commission's areas of comparative advantage, the strategy entails a series of actions to: (a) increase the impact of existing interventions, (b) increase the affordability of key pharmaceuticals, (c) encourage research in and development of specific global public goods targeting HIV/AIDS, malaria and tuberculosis and (d) improve the effectiveness of global partnerships and regional co-operation.

5. The EU is playing a key role in the international response by developing and strengthening partnerships with key stakeholders at global level, working for increased harmonisation of donor support, and by providing substantial support to the Global Fund to Fight AIDS, Tuberculosis and Malaria.

6. At country level, the European Commission's strategy is aimed at creating a favourable environment for an effective national response to the three diseases through such measures as providing support to social institutions and services, by increased funding and lowering the prices of pharmaceuticals and other essential commodities.

The State of the epidemics

HIV/AIDS, malaria and tuberculosis are communicable diseases that affect the poorest countries disproportionately and cause enormous suffering among households and communities. They feed into the cycle of poverty and insecurity, creating an obstacle to development. These diseases cross borders and also affect the global community.

Progress has been made in the control of many of the other communicable diseases over the last few decades, however, HIV/AIDS, malaria and tuberculosis are still far from showing signs of regressing in most of the regions of the world. There are only a few exceptions where recent successes provides hope and direction.

Knowledge and tools to confront these diseases exist and could significantly ease the burden and decrease the spread of HIV/AIDS, malaria and tuberculosis: education and health services for those in greatest need, condoms, bed nets and adequate care and treatment could prevent millions of needless premature deaths.

HIV/AIDS

Today approximately 40 million people are infected with HIV. More than 24 million people – including almost five million children – have already died since the beginning of the epidemic; 90% are from developing countries, leaving behind a legacy of more than 15 million orphans. More than three million people died and another five million were newly infected during 2002(1).

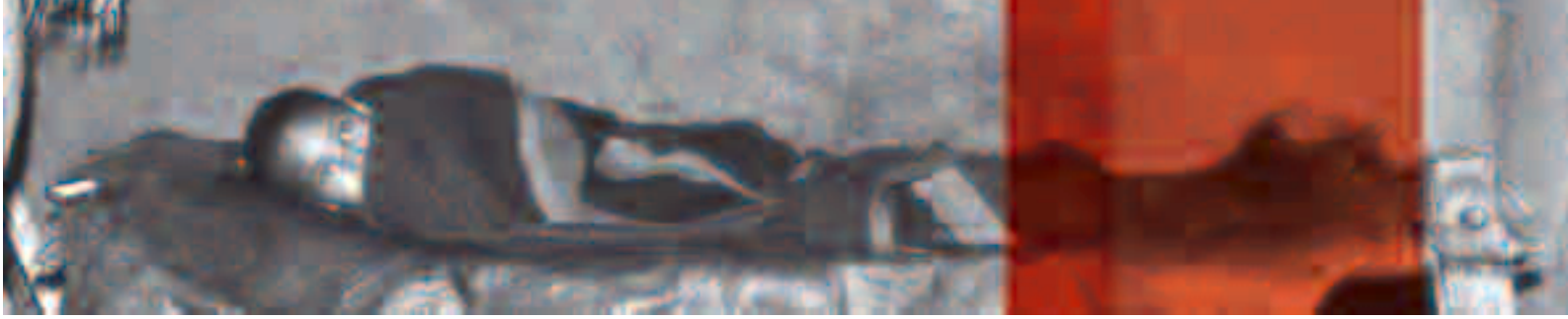
Africa, especially sub-Saharan Africa, is the region most affected. HIV/AIDS, is responsible for 30% of ill health and almost 40% of all deaths on the continent. Sixty million Africans are either living with HIV, have died of HIV/AIDS or they have lost their parents to the disease. Inequality, poverty, limited education and knowledge and lack of access to prevention care and treatment fuel transmission. The projected toll is likely to reach 55 million additional deaths by 2020 in sub-Saharan Africa alone.

Sixty per cent of adults infected in Africa are women and they are often infected at a much younger age. The spread of HIV/AIDS is rapidly increasing among young girls and women. In addition to biological reasons, this is caused by inequalities in information, education, and empowerment. Economically, many women are dependent on men, and often they cannot control when and with whom and in what circumstances they have sex. Response must be gender sensitive. Specific strategies and interventions must address women's and girls' vulnerability and also mitigate the socio-economic

(1) UNAIDS Epidemic update 2002.

▼ **Adults and children estimated to be living with HIV/AIDS, end 2002**

Source:
UNAIDS, 2002



impact on women. A recent study by the World Bank(2) has found that the long-term effects of HIV/AIDS could result in economic collapse of the worst affected countries. The study estimates that in South Africa by 2050 the per capita income per family will be half the amount it was in 1990.

Malaria

Malaria causes at least 3,000 deaths a day, more than 90% of which are in Africa south of the Sahara. Most of the victims are young children(3). It is a contributing factor to low birth weight, chronic anaemia and weakened immunity for another some two million premature deaths among the most vulnerable.

Besides premature deaths, malaria causes 500 million cases of acute illness and is one of the leading causes of school and work absences, undermining education and economic development. The disease has hindered economic growth in Africa by as much as 1.3% of the Gross Domestic Product (GDP) each year. This means the GDP of African countries is currently 32% lower than it might have been had malaria been controlled two decades ago(4).

Overall, the burden of malaria is increasing, mainly in sub-Saharan Africa. Rural communities, especially children under five years old and pregnant women, are worst affected because they have less access to effective treatment and prevention services and commodities. The poorest in society are more exposed to transmission due to poor sanitation, nutrition and lack of access to prevention means such as Insecticide Treated Nets (ITNs).

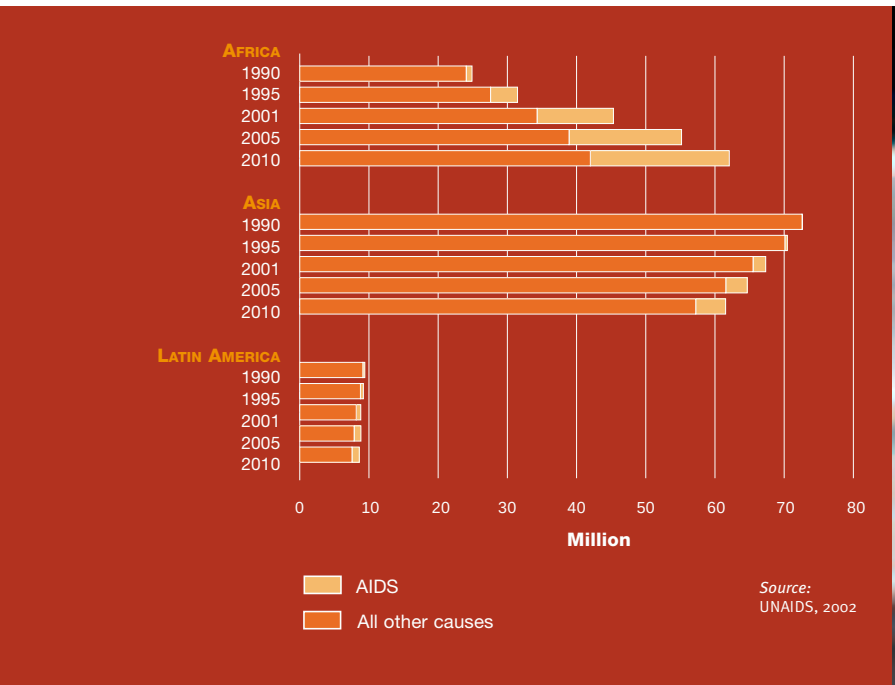
Lack of education and knowledge about the disease and limited access to effective prevention and treatments leads to recurrent disease and premature deaths, mainly in children and often taking place at home, untreated, and often unrecorded. Global climate changes, the discontinuation of many vector control programmes, deforestation and the increase of displaced persons have led to increased morbidity. Morbidity translates into premature deaths due to poor access to effective health services and effective pharmaceuticals for prevention and treatment, which are a cause and consequence of the spread of resistant strains.

(2) 'The Long-Run Economic Costs of AIDS: Theory and an Application to South Africa', World Bank 2003.

(3) Roll Back Malaria update March 2003.

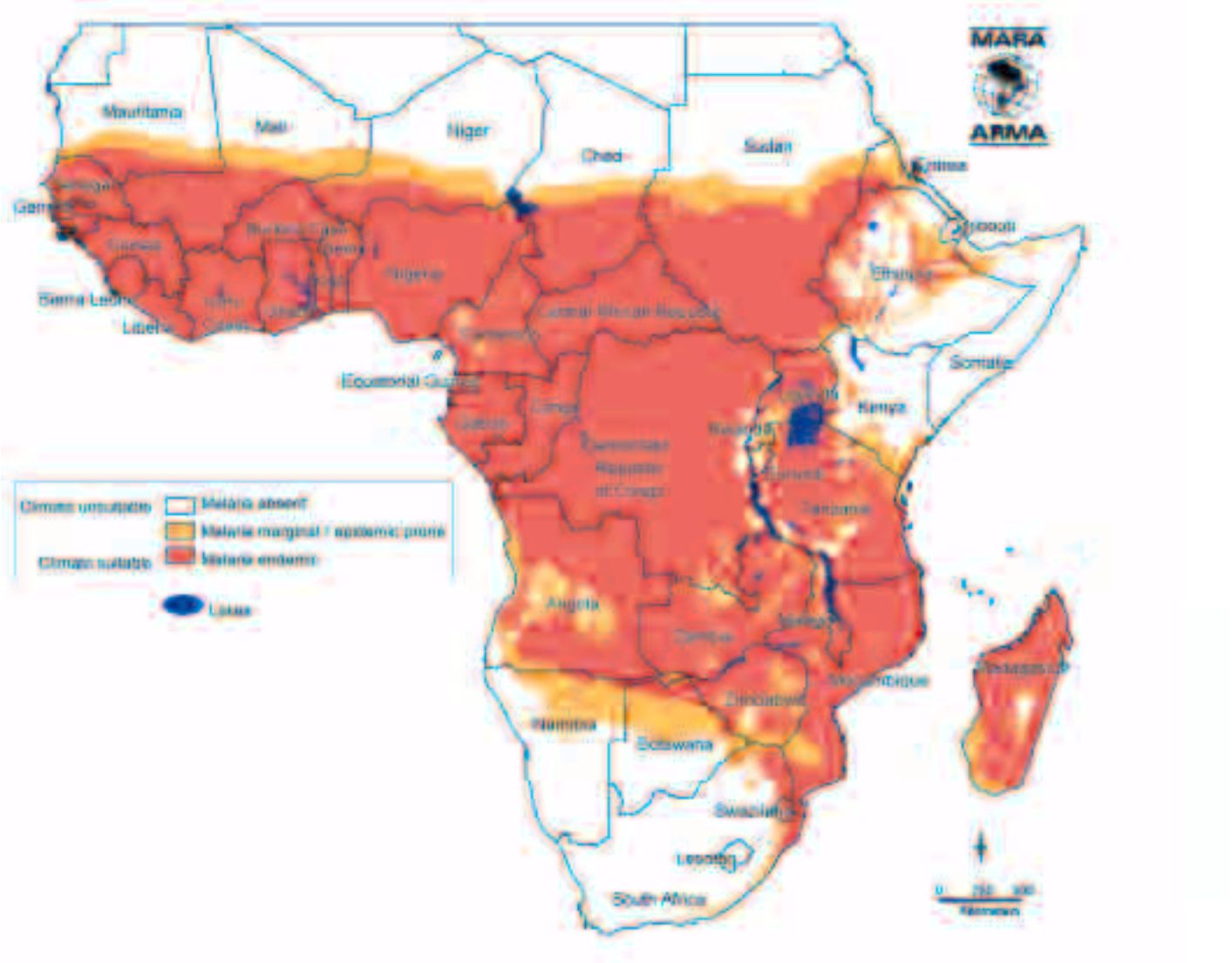
(4) Macroeconomics and Health: Investing in Health for Economic Development. Report of the Commission on Macroeconomics and Health, WHO, 20 December 2001.

▼ **Number of orphans by region, year, and cause.**



Source: UNAIDS, 2002

▼ **Distribution of Endemic Malaria**



Tuberculosis

One-third of the world's population is infected with tuberculosis. Eight million people develop the disease and two million die every year. The global incidence rate is growing at approximately 0.4% per year, but much faster in sub-Saharan Africa and in countries of the former Soviet Union(5). Between 2000 and 2020, nearly one billion people will be newly infected with tuberculosis, 200 million people will become sick, and 35 million will die unless current efforts to control the disease are greatly strengthened and expanded.

Ninety-nine per cent of all tuberculosis sufferers live in developing countries, where the largest majority is poor people aged 15 to 54. Some 80% of all tuberculosis cases are found in 22 'high burden' countries concentrated in Africa and Southeast Asia.

Tuberculosis primarily affects the poorest in society. Crowding, poor hygiene and malnutrition are important risk factors, closely linked to poverty. Access to prompt case detection, diagnostics and treatment is the main tool for controlling transmission and reducing the spread of the disease. Those most vulnerable have less access to health services and effective diagnosis and treatment.

HIV and tuberculosis speed up each other's progress. Tuberculosis accounts for about 15% of all HIV/AIDS-related deaths worldwide, twice as many in sub-Saharan Africa. The number of people infected with both tuberculosis and HIV has already soared to more than 10 million. These cases are more difficult to diagnose and treat, contributing to the expansion of tuberculosis multi-drug resistant (MDR) strains.

(5) Global TUBERCULOSIS Control Report 2002.

▼ **Estimated TB incidence rates, 2001**

Source:
WHO, Report 2003

Response has been inadequate in scale and scope

The European Commission's early response starts in 1987

Since 1987, the European Commission has developed an innovative strategy to confront HIV/AIDS, tackled as a developmental problem in need of a multisectoral approach aiming to reduce the spread of HIV/AIDS in the developing world. It has since co-operated with governments, NGOs, international agencies, the United Nations, the private sector and people living with HIV/AIDS.

The European Commission HIV/AIDS Programme has implemented interventions at national, regional and international level in at least 90 developing countries. These include preventive and care measures, multisectoral support, research studies and communication initiatives. In 1993, health sector support became increasingly important for the European Commission and the fight against HIV/AIDS and other communicable diseases was dealt with through support to that sector.

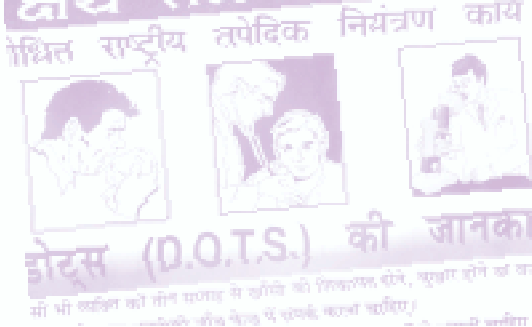
The European Commission's total support to health in more than 100 developing countries from 1994 to 2001 amounts to some €5 billion, through a variety of complementary financing mechanisms. This makes an average annual expenditure of €625 million(6). The breakdown of financial instruments channelling health aid during this time period was: 60% from country and regional programmes, 25% from humanitarian aid, 9% from research, 3% from special budget lines, and 3% from NGO co-financing.

The breakdown by regions was: 59% for African, Caribbean and Pacific (ACP) countries (which includes most of the least developed countries), 17 for MEDA (Community assistance programme to the countries of the Mediterranean basin), 11% for Asia, 9% for Latin America, 2% for CARDS (Community assistance programme to the countries around the western Balkans) and 1% for TACIS countries (Community Assistance Programme to the Commonwealth of Independent States).

European Commission support in the areas of health, HIV/AIDS, and population (HAP) has strengthened systems and provided for health services. It has also involved extensive support granted to improving capacity for procurement and distribution as part of wider efforts to reform health systems.

There are many challenges that need to be overcome if developing and developed countries are to make substantial progress in confronting HIV/AIDS, malaria and tuberculosis, which continue to pose threats to global security, prosperity and development, as well as to the lives of millions of people.

(6) Data from the ongoing population and development evaluation, and several services in EuropeAid, ECHO and DG RTD.



The three epidemics remain out of control

The three epidemics are out of control, despite the global efforts over past decades.

Some success stories are overshadowed by the expanding epidemics.

In HIV/AIDS there are some success stories that may lead the way: Thailand directed early preventive efforts at injection drug users and commercial sex establishments and decreased annual infection rates (cohorts from military recruits) by a factor of five during this last decade.

Uganda developed preventive education campaigns that mobilised leaders at all levels and in all sectors and reduced HIV prevalence among pregnant women in urban areas from a high of 29% in 1992 to 11% in 2000.

Globally, HIV/AIDS is still expanding and access to essential and affordable interventions is inadequate: the use of condoms with non-regular partners remains very low, only 12% of the population has access to Voluntary Counselling and Testing services (6% in Africa) and just 5% of pregnant women have access to prevention of mother-to-child-transmission (only 1% of the 27 million annual births in Africa)(7).

Malaria prevention and effective treatment is still very weak. The proportion of children under five sleeping under insecticide-treated nets is on average below 10%. Adequate preventive treatment for pregnant women is high in countries such as Malawi and Kenya (up to 68% of pregnant women). However, in the rest of the malaria endemic countries in Africa, fewer than 5% of pregnant women have access to prevention.

With respect to malaria treatment, several studies reveal that nearly 90% of all malaria treatment takes place at home and in the majority of cases the anti-malarial treatments were not appropriate. The present extent and trend towards resistance to the main pharmaceuticals used in Africa for malaria treatment is further increasing.

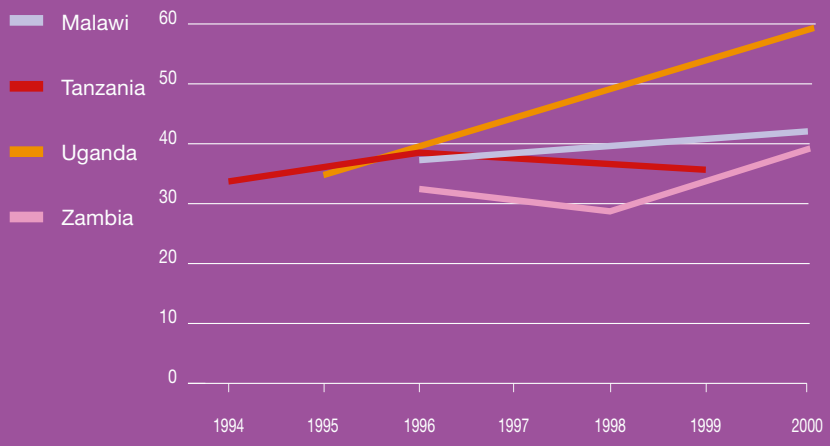
More than half (55%) the world's population lives today in parts of countries providing supervised treatment for tuberculosis (DOTS). However, these cases detected and treated through DOTS represent only one quarter of the estimated total. In fact, Vietnam was the only high-burden country to have reached targets for case detection and cure by the end of year 2000.

The high association with HIV/AIDS, low detection rates and low compliance rates in some regions, threatens to expand multi-drug resistant (MDR) tuberculosis, an almost incurable disease for most people in developing countries(8).

(7) Coverage of selected health services for HIV/AIDS prevention and care in less developed countries in 2001, WHO, November 2002.

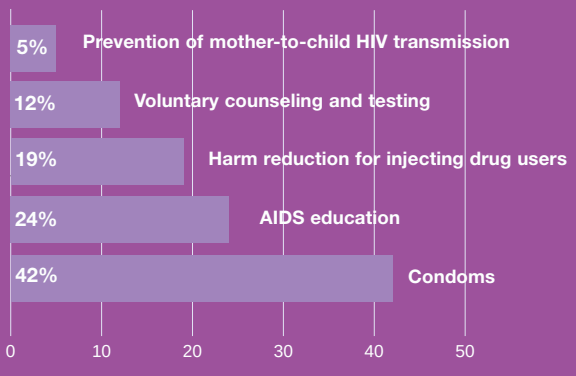
(8) WHO Report 2002 Global Tuberculosis Control, Surveillance, Planning, Financing WHO/CDS/TUBERCULOSIS/2002.295

▼ **Condom use among men with non-regular partners in selected sub-Saharan African countries, (%) : 1994-2000**



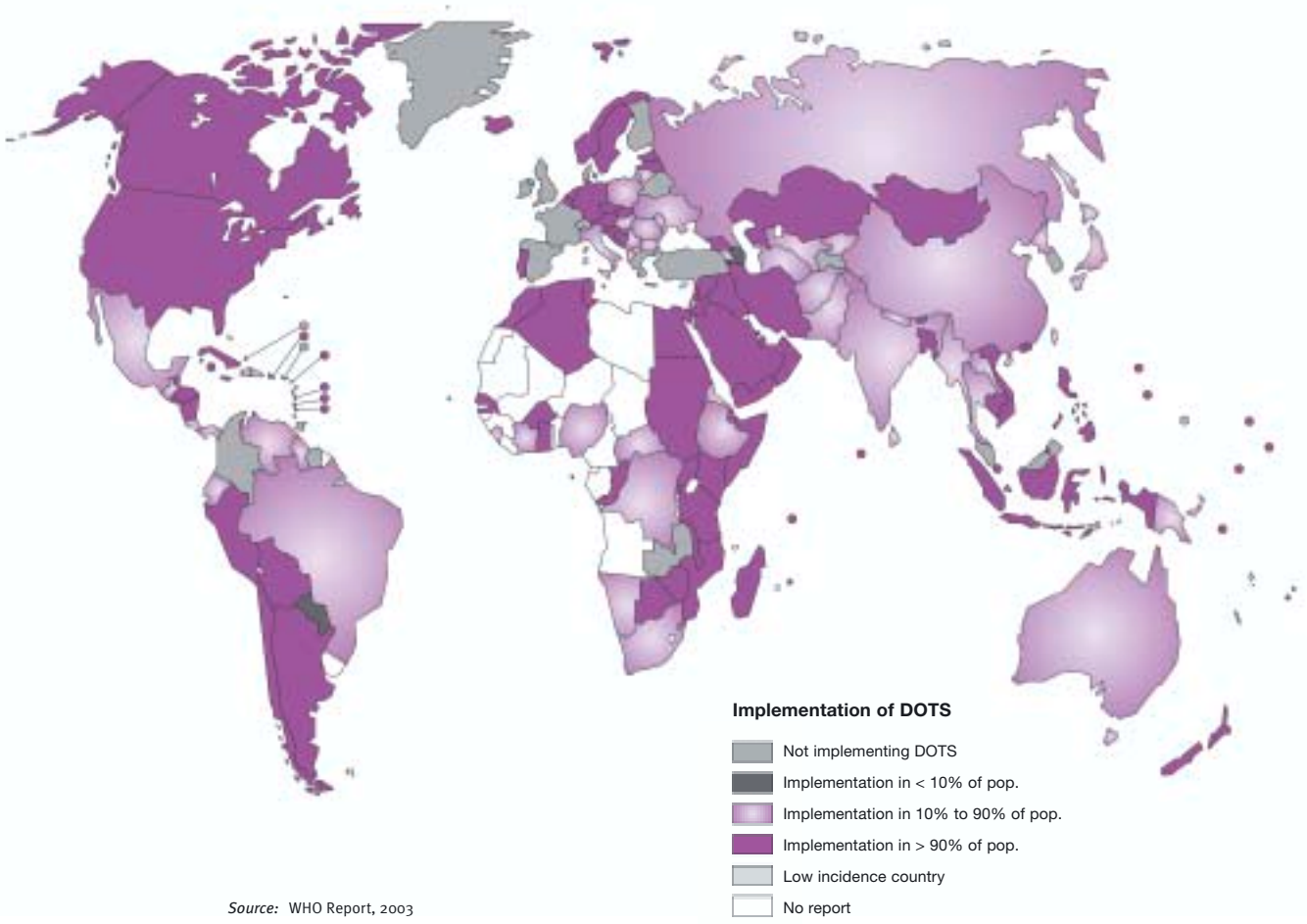
Source: Macro International (1994-2000) Demographic and Health Surveys; Measure Evaluation

▼ **Percent of individuals at risk with access to select interventions, 2001**

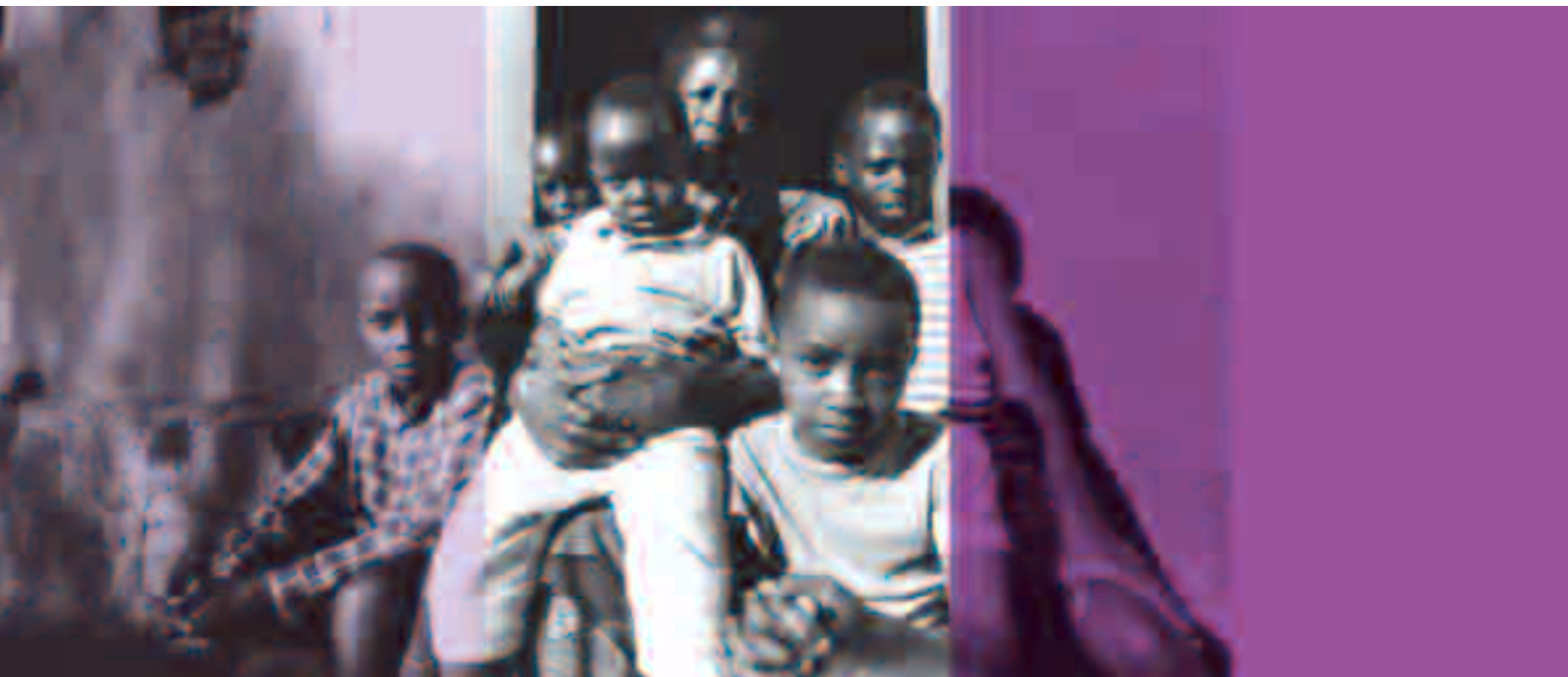


Source: UNAIDS, 2002

▼ **Implementation of DOTS, 2001**



Source: WHO Report, 2003



Scale of intervention must be increased

African countries have agreed to allocate 15% of their national budgets to health (Abuja, April 2000), but reality is still a long way from that target.

In the recent decade, Official Development Assistance (ODA) has been decreasing. Overall, ODA to social development and especially health and education has often been characterised by piece-meal approaches, lack of scale and slow administrative procedures.

The WHO-led Commission on Macroeconomics and Health calculated that current actual spending on health in the least developed countries(9) (approximately €13 per person per annum) needs to be increased to at least €30 to €40 per person per annum. This will require approximately €27 billion per annum in donor grants by 2007, compared with the €6 billion per annum currently available, and an additional budgetary outlay from developing countries of €23 billion by 2007.

The same Commission also provided a detailed estimate of annual financial needs to cover HIV/AIDS, malaria and tuberculosis, totalling €9.2 billion. This is a minimum estimate for investments with immediate possible levels of delivery with an emphasis on expanding the lower levels of district health systems, such as health posts and outreach services.

Subsequent studies have estimated rising global resources needed for the three diseases. For HIV/AIDS alone, the global resources needed for prevention, care and orphan activities would be above €11.74 billion annually by 2007. Despite many international agreements and commitments, at present only a quarter of the funds needed to fight HIV/AIDS, malaria and tuberculosis are available annually, some €2.68 billion: €1.51 for HIV/AIDS, €0.67 for tuberculosis, and €0.5 for malaria.

The research paradigm

The paradigm of just 10% of the world's investments on health research allocated to health problems causing 90% of the world's burden of disease applies to HIV/AIDS, malaria and tuberculosis needs in developing countries. One clear example is the HIV/AIDS vaccine.

Just €430-470 million is invested worldwide in HIV/AIDS vaccine research and development. This means only about 2% of what the world spends annually on HIV/AIDS prevention, research, and treatment (€16.77 billion) and less than 1% of spending on all health and pharmaceutical-related research and development (over €58.68 billion).

Increasing current financing by at least €1.1 billion would pay for developing 25 novel HIV/AIDS vaccine candidates and testing the relevant candidates in large-scale efficacy studies and establishing infrastructure for trials in a diversity of regions. This would set the conditions to aim at developing the effective HIV/AIDS vaccine the world needs today (possibly the most valuable global public good) within this decade.

(9) The Least Developed Countries are presently 49: Afghanistan, Angola, Bangladesh, Benin, Bhutan, Burkina Faso, Burundi, Cambodia, Cape Verde, Central African republic, Chad, Comoros, Democratic Republic of Congo, Djibouti, Equatorial Guinea, Eritrea, Ethiopia, Gambia, Guinea, Guinea Bissau, Haiti, Kiribati, Lao People's Democratic Republic, Lesotho, Liberia, Madagascar, Malawi, Maldives, Mali, Mauritania, Mozambique, Myanmar, Nepal, Niger, Rwanda, Samoa, Sao Tome and Principe, Senegal, Sierra Leone, Solomon Islands, Somalia, Sudan, Togo, Tuvalu, Uganda, United Republic of Tanzania, Vanuatu, Yemen and Zambia (UNCTAD 2001 - http://www.unctad.org/en/pub/ldcprofiles2001.en.htm).

Listening to the voices of civil society and the importance of private sector engagement

The determination of NGOs and civil society has been very valuable in raising awareness, triggering political commitments and countering the shortcomings of institutions and governments. Their voices are crucial in keeping up the commitments and directing resources in the most efficient and equitable way. The involvement of People Living with HIV/AIDS has also been groundbreaking([10]).

Amongst those affected, children bear the main burden of malaria and when HIV/AIDS and tuberculosis affect their parents, their fragile livelihoods are threatened, especially when they become orphans([11]). The voices of children should also be heard loud and clear in their call for a global commitment to confront these epidemics.

Because often they affect employees and their families during their most productive years, these diseases add to labour costs and slow down growth rates in many developing countries. As a result, corporations have begun to understand the importance of providing health prevention and care schemes for their employees.

Strategies on how to promote access to prevention, treatment and care as well as on codes of conduct by corporations operating in developing countries are ongoing through the European Commission's Corporate Social Responsibility (CSR) initiatives.

(10)
Declaration of Commitment on HIV/AIDS. United Nations General Assembly. Special Session on HIV/AIDS, June 2001.

(11)
A world fit for children. United Nations Special Session on Children, May 2002.

The Millennium Development Goals

The international community has reached consensus around key goals for the new millennium. Three out of the seven Millennium Development Goals (MDGs) are related to health:

- 'Reduce child mortality': reduce the proportion of children who die before the age of five, by two thirds between 1990 and 2015.
- 'Improve maternal health': reduce by three quarters, between 1990 and 2015, the maternal mortality ratio.
- 'Combat HIV/AIDS, malaria and other diseases': have halted by 2015, and begun to reverse, the spread of HIV/AIDS, and the incidence of malaria and other major diseases.

Further targets more specific to each of the major poverty-related diseases have been agreed to by the international community:

1. The UN General Assembly Special Session on HIV/AIDS set additional specific targets. It focused on national strategies for HIV/AIDS-related issues (prevention, treatment, care and multi-sectoral strategies) by 2003, and on reducing HIV infection among 15 to 24-year-olds by 25% in the worst affected countries and globally by 2010. In addition, the proportion of infants infected with HIV should be reduced by 20% by 2005 and by 50% by 2010.

2. Because 90% of the world's malaria burden is in Africa, additional targets for the continent were defined on 25 April 2000 at the African Roll Back Malaria Summit in Abuja, Nigeria. The targets set include ensuring access for at least 60% of those suffering from malaria to affordable and appropriate treatment within 24 hours of the onset of symptoms and access for at least 60% of those at risk for malaria to protective measures (such as insecticide-treated nets for under-fives or chemo-prophylaxis for pregnant women) by 2005. These targets would lead to halving 1998 malaria mortality levels by the year 2010.

3. Tuberculosis targets for 2005 were endorsed at the World Health Assembly on 5 May 2000. They aim at detection of 70% of all cases and successful treatment of 85% using the DOTS strategy by 2005, and a reduction in prevalence and mortality rates to half of the year 2000 estimate, by 2010.

Strategy for communicable diseases revisited in 2000

Despite earlier efforts, it became clear that the policies, strategies and methods had to be reformulated and refocused. Poor health and communicable diseases received increasingly recognition as serious impediments to development and a cause, not only a consequence, of poverty.

In 2000, the European Commission developed a comprehensive, more strategic approach towards confronting HIV/AIDS, malaria and tuberculosis. The High Level Round Table held in September 2000 had the dual purpose of initiating a broad-based consultation on a new policy framework on communicable diseases and exploring more precisely how the European Commission could use its comparative advantage to complement existing global and national initiatives on all levels.

The Round Table was remarkable because of the co-operation it fostered amongst six different Directorates General of the Commission in charge of different policy areas in producing the European Commission's new comprehensive, coherent and synergistic policy framework. The consultations led to the European Commission's programme for action[12] in February 2001. This new Programme for Action: Accelerated action on HIV/AIDS, malaria and tuberculosis in the context of poverty reduction, established a broad and coherent Community response for 2001-2006. It also marked a new era in the Commission's approach to tackling the three major poverty-related diseases.

The strategy builds on the experience of a coherent comprehensive approach, the principle of country-led development process, ownership, the interrelationship of health and poverty and the importance of regional and global action in support of countries efforts. It is based on a multi-pronged strategy.

1. Obtaining maximum impact of existing interventions, services, and access to commodities targeted at the major communicable diseases affecting the poorest populations

In principle, the major communicable diseases are largely preventable/and or readily treatable using existing low cost, effective multisectoral interventions. However, these do often not reach the most vulnerable people in some developing countries struggling to deliver essential healthcare with less than €4.19 per capita per year.

Optimising the impact of existing interventions, services and commodities requires increased support to strengthen health systems and a continuum of prevention, care and treatment efforts. It also requires scaled-up, multisectoral, targeted support through innovative partnerships that reach beyond the traditional health sector and services.

(12) COM(2000) 585.

2. Increasing affordability of key pharmaceuticals through a comprehensive and synergistic global approach

Increasing affordability of key pharmaceuticals can only be achieved through a comprehensive global approach that addresses the current global emergency. Developing countries, in particular poor populations, have inadequate access to affordable services and key pharmaceuticals for several reasons, including the effects of international and national pricing policies, tariffs, taxation, and implementation of intellectual property rights agreements.

Options for further improving access and affordability include: strengthening pharmaceutical policies, developing local manufacturing capacities, tiered pricing, voluntary licensing agreements, parallel trading, technology transfer and increase in the local capacity for production, use of both generic and patented products, and review of tariff and taxation options at country level.

3. Increasing investment in research and development of global goods targeting the three major communicable diseases

Research and development in the pharmaceutical industry is generally driven by the demands of the industrialised countries' markets. Those diseases prevalent in developing countries, where markets are perceived to be small, are neglected. Just 10% of global health research efforts target the diseases that account for 90% of the global disease burden.

Research for tuberculosis and malaria reflect this imbalance: while they account for 5.4% of the global burden of disease, they only benefit from 0.41% of global health research.

4. Increasing regional co-operation and global partnerships

Efforts to confront the three diseases at country level have to be strengthened and supported through more regional co-operation if to be successful. Global multilateral action and partnerships are needed for developing countries: consensus to be taken into account in global governance and rules for instance as related to prices of products, priorities for research and development co-operation.

There has been considerable progress made to date in the areas defined under the Commission's strategy. Following is a brief summary of some key elements.

European Commission Support for Health, AIDS and Population in Country and Regional Programmes

The bulk of the European Commission's development assistance for health and communicable diseases is committed within regional and country indicative programmes covering periods of four or five years. These are developed as part of the European Commission's regional and country strategy papers (CSPs) – instruments for guiding Community assistance which are developed by the Commission and the authorities of the recipient country or region, in consultation with the Member States and other development partners. CSPs may be accessed on the Commission's website at: http://europa.eu.int/comm/development/body/csp_rsp/csp_en.cfm.

The European Commission still provides support for health, communicable diseases and population in some countries through traditional project-type assistance, however, the European Commission's current policy stresses investment in sector programmes or general budget support. Unlike traditional project-type aid, budget support provides additional funding for recurrent expenditure, which makes up the major part of the health budget.

The European Commission supports the development of a sector-wide approach (SWAP) in health wherever feasible, combined with investment in sector or sub-sector pooled (or 'basket') funds. This approach has several advantages, including:

- Nationally owned and led.
- Potential for donors to invest in one single, prioritised national health plan.
- Based on dialogue involving all key stakeholders.

The European Commission regards HIV/AIDS as a specific and pernicious threat to development in many developing countries and is increasingly highlighting HIV/AIDS in its dialogue with national authorities. The European Commission recognises that AIDS is not simply a health issue and that an effective response requires actions in all sectors. This is borne out in the CSPs of several of the worst affected countries in Africa, which reinforces the case for multisectoral actions to confront the HIV/AIDS epidemic. They include HIV/AIDS prevention and care activities in the strategies for the focal sectors for European Commission co-operation

ACP countries have an additional allocation of funds for all countries together (intra-ACP funds) that are available to support programmes aimed at tackling problems and issues facing all of them.

European and international consensus

In addition to country and regional actions, the European Commission has been proactive with respect to its mandate for more coherent and co-ordinated policy and actions pertaining to development, health and communicable diseases at global level. New trends in trade relations agreed to under the Doha Development Agenda, new commitments to increased Official Development Assistance (ODA) agreed to at the 2002 International Conference on Financing for Development in Monterrey, innovative public and private research initiatives and stronger partnerships in global initiatives and with the UN have resulted from this.

Strengthening pharmaceutical policies

Optimal use of key pharmaceutical products in confronting HIV/AIDS, malaria and tuberculosis is essential to maximise the impact of interventions. The European Commission is supporting WHO to improve its essential drug policy and regulatory schemes pertaining to the three diseases.

Untying of aid

'Tied aid' is given under certain conditions, for example, that the recipient will use aid to purchase goods and/or services from suppliers based in the donor country. Untying aid means opening up those purchases to suppliers based elsewhere. The European Commission and the EU are in the process of untying all ODA following the Communication on untying of aid[13] and the Conclusions of the European Council[14]. This is already resulting in greater efficiencies in some countries.

Tiered pricing schemes have lowered drug costs

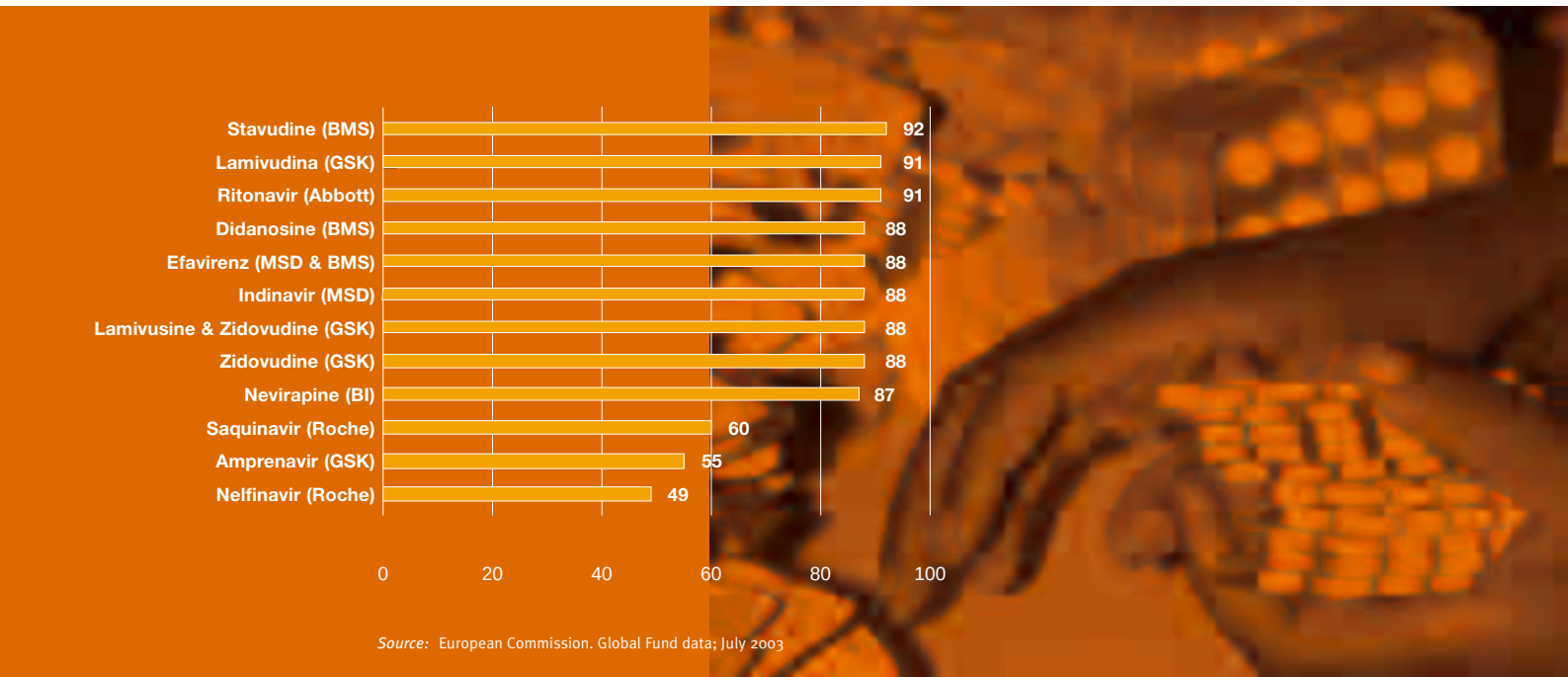
The Commission's proposal to examine how tiered pricing can be used as a way to make on-patent medicines more affordable within developing countries, while taking into consideration the concerns of the pharmaceutical companies was welcomed at the Round Table in 2000.

Since then, global dialogue and visibility around the issue of price for key pharmaceuticals still under patent and competition of generic pharmaceuticals have lowered prices of some of those products. At the Round Table, price announcement was made by a company of an annual cost of €500 per year for anti-retrovirals. This was a major step forward from the €10,000 annual cost previously estimated for treatment including anti-retrovirals. For now, tiered pricing is not used as widely as needed. Only 2% of

(13) 18th November 2002 - Communication on Untying: Enhancing the Effectiveness of Aid.

(14) Council Conclusions of May 2003 on Untying: Enhancing the Effectiveness of Aid. Doc. nr. 9575/03.

▼ **Estimated price reductions offered to certain developing countries compared to retail price VAT excluded in Switzerland (November 2002)**



Source: European Commission. Global Fund data; July 2003

patients in need from developing countries have access to anti-retroviral treatments (1% in Africa).

This may change through the implementation of May 2003 Regulation that seeks to prevent the re-importing of reduced price pharmaceuticals into Europe, which could allay industry's fears. This Regulation prohibits imports back to Europe of pharmaceutical products that have been exported to the poorest countries at prices reduced by at least 75% of the OECD average price or sold at production cost plus maximum 15%.

Developing local manufacturing capacity

The European Commission is committed to support initiatives promoting the local production of condoms, long-lasting insecticide treated nets, antiretrovirals, anti-malarial combination protocols and anti-tuberculosis pharmaceuticals.

Taxes, tariffs and TRIPS

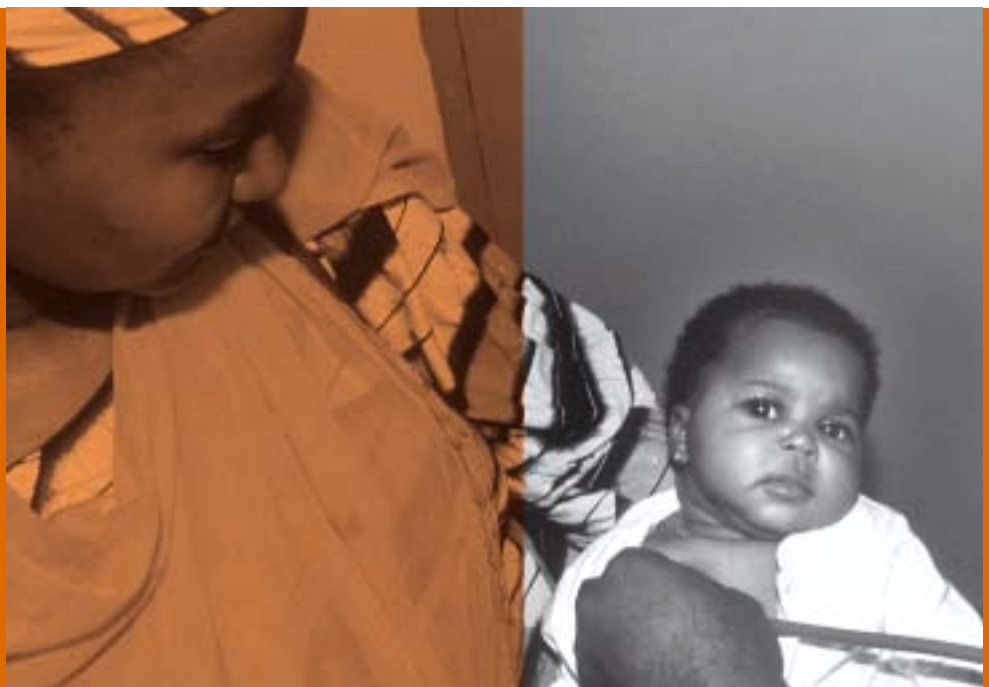
The European Commission is working closely with developing countries to reduce or abolish taxes and tariffs on imported key pharmaceutical products and commodities.

The position of the European Commission and the EU on the TRIPS agreement (Trade-Related Aspects of Intellectual Property Rights) led to the adoption of the Doha Declaration on the relationship between TRIPs and public health. The Declaration, among other things, gives Least Developed Countries the right to postpone the implementation of patent protection until 2016. In addition, the European Commission negotiated within the TRIPS Council a solution for those countries unable to make use of compulsory licensing exceptions due to insufficient or absent manufacturing capacities.

In addition, the European Commission negotiated within the TRIPS Council a solution for those countries unable to make use of compulsory licensing exceptions due to insufficient or absent manufacturing capacities. The Doha Declaration on the TRIPS Agreement and public health from 2001 gives developing countries certain freedom and security in their choices of health policies. The Least Developed Countries have also been authorised an extension to provide for patents on pharmaceuticals until 2016. The decision passed in August 2003 supplements the Doha Declaration by giving World Trade Organisation member countries the freedom to export pharmaceuticals under a compulsory license to countries which are not in a position to produce the products under such a license loyally.

Public and Private Research priorities

To achieve the international targets for each disease and the related Millennium Development Goals, the world needs diagnostics, microbicides, vaccines and pharmaceuticals that are more effective for malaria, of shorter duration for people with tuberculosis, and more user friendly for those suffering from HIV/AIDS. This can be achieved through better-targeted research in public institutions and private industry.



The 6th Research Framework Programme and EDCTP

In July 2002, the European Commission adopted the 6th Framework Programme for Research (SFP 2002-2006). Some €400 million will target HIV/AIDS, malaria and tuberculosis research projects (2.5% out of a total €17.5 billion). Of the €400 million allocated under the 6th Research Framework, €200 million will be allocated to the European and Developing Countries Clinical Trials Partnership (EDCTP). The EDCTP includes strong elements of capacity building in developing countries, particularly in the areas of networking and co-operation, technology transfer, strengthening clinical research capacities, and initiating and developing clinical testing facilities.

Direct or indirect incentives for private sector increased investments in the development of products to counter the three diseases are also further pursued.

In particular, incentives need to be strengthened for private sector investments in new 'economically orphan' medicines for communicable diseases with highest burden in developing countries.

Despite widespread recognition of the problem, a multitude of ideas, and some years' discussion of the need to promote and create stronger R&D incentives for 'economically orphan' medicines for communicable diseases, there is little if any evidence that existing or proposed incentives have had a significant impact. Existing treatments remain woefully inadequate and communicable diseases remain responsible for one in two deaths in developing countries, often among the young and most productive population – 90% of these deaths are due to the six most prevalent communicable diseases: tuberculosis, malaria, diarrhoeal diseases, pneumonia, measles, and HIV/AIDS.

The EU Co-ordination and Global Partnerships

Revisiting the strategy for EU aid in 1999, the European Community concluded that the scope and the size had to be increased. At the same time, it was decided that the EU should also work in closer partnership with key stakeholders and institutions. If the three epidemics are to be successfully tackled, we must share responsibility and work together.

As a result, activities have been undertaken to foster stronger partnerships with EU Member States; civil society; the private sector; the UN; the World Bank, and the European Investment Bank.

The European Community and its Member States have been proactive in confronting the three diseases at international level such as at G8([15]) Summits, the follow-up to the Cairo Plan of Action within the European Union/African Union forum, the Least Developed Countries' Conference in Brussels in 2001, the UNGASS on HIV/AIDS in 2001, the Barcelona AIDS Conference in 2002, the Doha WTO Ministerial, the Monterrey Conference and the Johannesburg World Summit on Sustainable Development.

Dialogue with civil society is stronger at policy and programme level. Pharmaceutical companies are increasingly involved as partners in policy and implementation, in particular in areas such as corporate social responsibility, tiered pricing and research and development. Other private sector partners, such as Investors for Africa, are working with the European Commission/European Union on confronting communicable diseases in developing countries.

A number of EU policy documents and Communications adopted by the European Parliament([16]) call for a greater and improved co-ordination and effectiveness in the delivery of development assistance. The EU Council in Barcelona agreed to take concrete steps in this area by 2004.

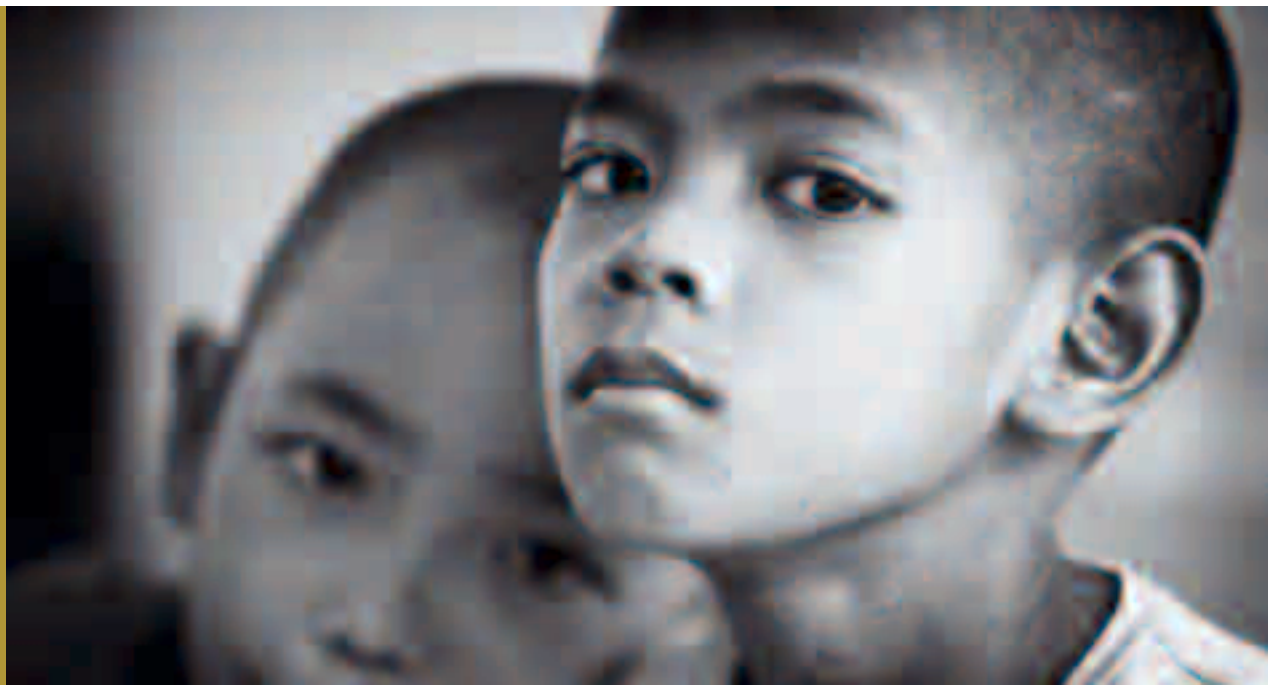
The EU and the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria

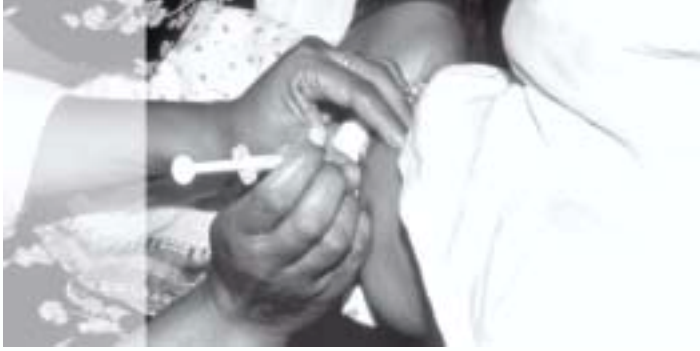
UN Secretary General Kofi Annan and the global community called for increased financial resources to scale up and confront the three diseases through a Global Fund to Fight HIV/AIDS, Malaria and Tuberculosis (GFATM([17])). The Global Fund was created at the G8 in 2001, with the European Commission and most Member States taking an active part in shaping and financing the new global partnership. The Global Fund pays special attention to the demand of the developing countries, the participation by civil society, people living with the diseases and private partnerships. It encourages the supply of low-cost, high-quality products to countries of the South, including distribution of generic products. It aims at ensuring openness, transparency and innovation in administration, in co-operation with all the main players.

(15)
The European Commission / G8 EU Member States consensus was clearly demonstrated during the negotiations leading to the G8 Summits in Okinawa (2000), Genoa (2001), Kananaskis (2002) and now preparing for Evian (2003), with the Okinawa Communiqué presenting the most comprehensive global approach to tackling the three diseases.

(16)
1999: 'Complementarity between Community and Member States policies on development co-operation', 2000: 'European Community development policy' and 2002: 'Health and poverty reduction in developing countries'.

(17)
www.gfatm.org





Global public goods in health

In an increasingly globalised world, populations are more at risk, more dependent on each other and more aware of the shared risk. Recently, global public goods in health have been the subject of increased international attention because of HIV/AIDS and other global risks caused by diseases prevalent mainly in developing countries.

The European Commission's Programme for Action identifies a number of ways in which the EU intends to develop better rules, incentives and financial instruments for the development of specific global public goods. For example:

- Incentive package for the development of new products to confront the major communicable diseases in developing countries.
- Economic research into the demand for specific global public goods for developing countries.
- Co-operation with other partners on developing an AIDS vaccine.

In the European Commission's Communication on Health and Poverty Reduction in Developing Countries ([18]) 'investing in the development of specific global public goods' is identified as one of four objectives of health and poverty policy. Further work is ongoing.

(18) Communication of the Commission to the Council and European Parliament. Health and Poverty reduction in Developing Countries Brussels, 22.03.2002. COM(2002) 129.

Working in partnership with IAVI and the IPM

The International AIDS Vaccine Initiative (IAVI) and the International Partnership for Microbicides (IPM) are global organisations working to speed the development and distribution of preventive AIDS vaccines and microbicides. They focus on mobilising support through advocacy and education, accelerating scientific progress, encouraging industrial participation in AIDS vaccine and microbicides development, and assuring access in developing countries.

IAVI and IPM are key partners in the European Commission's Programme for Action, and the European Commission is member of the policy advisory board for both organisations.

The European Commission is supporting the South African Aids Vaccine Initiative (SAAVI), through a programme where IAVI is a partner with € 1.35 million to intensify the vaccine preparedness programme in South Africa, building on the previously European Commission -funded SA HIVAC project.

The European Commission has also programmed support with €3 million to IAVI for vaccine preparedness programmes (ethical criteria, regulatory aspects, preparedness of communities) for the introduction of phase III trials of an effective and safe HIV/AIDS vaccine (DNA MVA) in East Africa.

Corporate Social Responsibilities (CSR)

A European Multi-stakeholder Forum was recently launched by the Commission to promote CSR through fostering a dialogue among the business community, trade unions, civil society organisations and other stakeholders (44 member organisations plus 10 observers). It has the specific aim of raising awareness on and possibly promoting CSR practices and instruments, taking into account existing EU initiatives and internationally agreed instruments.

The Forum's work is organised through four area-based Round Tables, including one on development aspects of CSR. Confronting the three diseases is a key concern of this forum.

Increased financial resources mobilised

Towards increased ODA aiming at social development

Donor countries committed to increasing official development assistance (ODA) to developing countries in March 2002 at the International Conference on Financing for Development held in Monterrey, Mexico. According to OECD estimates, fulfilling these promises would raise ODA in real terms by 31% (about €13.42 billion) and the ODA/GNI (gross national income) ratio to 0.26%. The EU Barcelona commitment is 0.39% by 2006.

Member countries of the OECD's Development Assistance Committee increased their official development assistance to developing countries by 4.8% in real terms (EU: 2.8%), accounting for inflation, from 2001 to 2002. The total amounted to €47.8 billion (more than 60% from the EU), equivalent to 0.23% (EU: 0.34%) of their combined resources, measured as gross national income (GNI) and some ¤10 per capita. This marks the beginning of a recovery from the all-time lows of 0.22% of GNI in each of the last three years. The spending on health, education and populations accounts for 15% of the global ODA.

Leading up to the International Conference on Financing for Development in Monterrey, the EU made a commitment at the European Council in Barcelona 2002 to increase allocations for ODA, especially for aid supporting social development, as well as improved co-ordination of polices and programmes.

European Commission country programming in health

The new generation of EC Country Strategy Papers programme ODA in partnership with developing countries for a total almost€13 billion through 2004 to 2007, depending on the region. Seventeen developing countries have identified health as a focal sector in Country Strategy Papers for 2002-2007 that, as of July 2003, have been approved. Overall allocations for health in national indicative programmes are 3.3% of total programmable resources or €431 million. In ACP countries allocations specifically for health account for 4.1% of programmable resources (€288,1 million).

However, European Community funds are increasingly devoted to general budget support – especially in the ACP countries where 24.4% of total programmable resources (€1.73 billion) are allocated to it. The Commission's guidelines on health sector programming and monitoring of indicators aim at ensuring the links between poverty reduction budget support strategies and improved health outcomes.

Regional contribution from intra ACP funds have increased since the adoption of the programme for action, especially regarding the ACP countries: for the period 2003-2007, almost €300 million is envisaged to support inter-regional health initiatives, a large proportion of it related to HIV/AIDS, malaria and tuberculosis.

The European Commission increases resources to control HIV/AIDS, tuberculosis and malaria

In addition to the European Commission's support to health and specific programmes on HIV/AIDS, malaria and tuberculosis through country and regional strategies, the European Community has other financial tools that support specific actions:

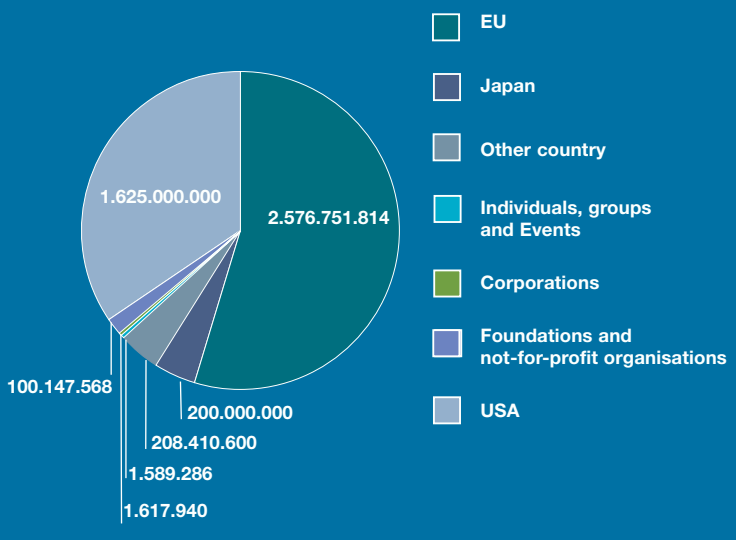
- The budget line to support innovative initiatives to control HIV/AIDS, malaria and tuberculosis.
- The European Commission's co-financing budget line for NGOs selects some projects in regions or situations where other EC instruments are not feasible.
- Various European Commission humanitarian aid programmes specifically target actions on poverty-related diseases.
- The European Commission's support for research activities specifically allocates resources to the fight against these diseases, focusing on their development approach and in partnership with developing countries.

Overall, the total estimated allocation to European Commission programmes specifically targeting HIV/AIDS, malaria and tuberculosis over the last nine years (1994-2002) has been €660 million[19]. This annual average of €73 million per year represents 13% of the European Commission's annual support to health in developing countries (annual average of €625 million for the same period).

The breakdown during the period is: 40% from geographical budget lines, 32% from research, 15% from NGO co-financing and 13% from the special budget line on HIV/AIDS and population. The distribution of this specific support to poverty-related diseases by type of disease is: 71% for HIV/AIDS, 17% for malaria and 12% for tuberculosis.

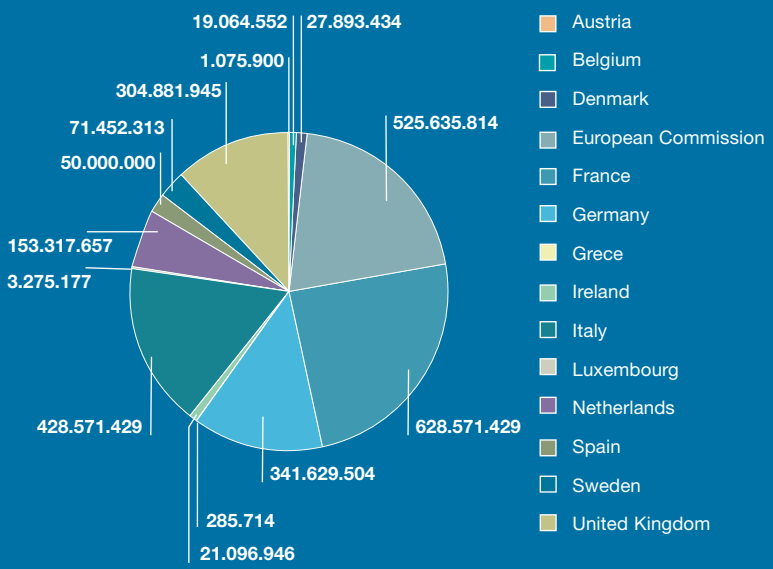
(19) This figure is an under-estimate as there is a proportion of the Repro-ductive Health Programmes that targets HIV/AIDS, such as that preventing MTCT or controlling STDs, neither of which is included in this calculation.

▼ **Total pledges to the Global Fund (US dollars, 23 july 2003)**



Source : European Commission. Global Fund data, July 2003

▼ **EC/EU pledge to the global Fund (US dollars, 23 july 2003)**



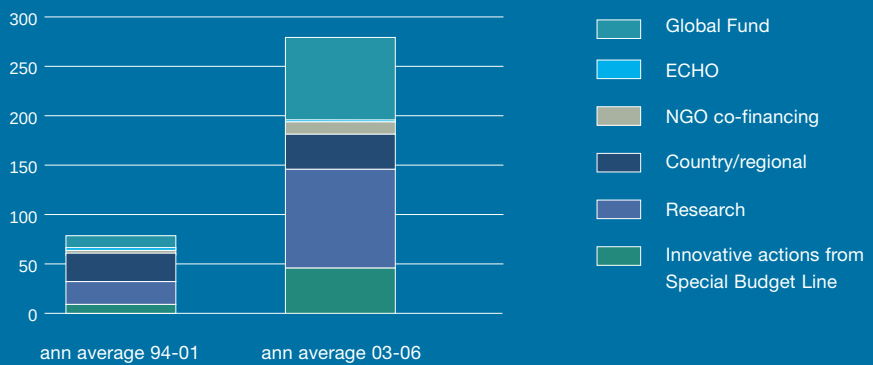
Source: European Commission. Global Fund data, July 2003

Total pledges to the Global Fund by July 2003 reached €3.93 billion , of which €2.20 billion (55% of total pledges) comes from the 15 EU Member States together with the European Commission and €1.38 billion from the United States. The European Commission has disbursed €120 million for 2002 and has announced an additional sum of €340 million for years 2003-2006.

The total European Commission's pledge of €460 million corresponds to more than one tenth of the current total pledges (as of July 2003), and reconfirms the European Commission as an important contributor.

Altogether, the various development, humanitarian and research European Commission's financial instruments to confront HIV/AIDS, malaria and tuberculosis, will total €1117 million (an annual average of €280 million) during the period 2003-2006, representing an almost four fold increase.

▼ **Trend in EC annual average financial support to control HIV/AIDS, TB and malaria in developing countries**



Source: European Commission. July 2003

Examples of European Commission support to control HIV/AIDS, malaria and tuberculosis

European Commission support to innovative initiatives

A €22 million programme aimed at young people

In August 2002, the European Commission announced a further contribution of €22 million for the fight against HIV/AIDS in developing countries in a call for proposal under the AIDS Budget Line 2002. This programme aims primarily at young people in the areas of prevention, care and treatment. Special attention is given to the needs of young women who are especially vulnerable to HIV/AIDS infection.

The objective of this initiative is to ensure that operations aimed at confronting HIV/AIDS are made more effective, particularly by improving education and information and strengthening health systems. It comes as an additional contribution to the implementation of the Programme for Action adopted early in 2001 to fight against HIV/AIDS, malaria and tuberculosis.

European Commission support involves the following activities:

- Information, education and communication contributing to a change of behaviour while taking into account the constraints of the socio-economic and cultural context.
- Improvement of access to and quality of health services benefiting the young, particularly young women, and decreasing the vulnerability to infection by HIV through a combination of action, research and training aimed at organising and developing health services.
- Integration of the gender equality strategy at the level of health systems and in favour of programmes to fight HIV/AIDS benefiting the young. Tackling the questions related to sexual relations, particularly where young women are at risk due to biological*, social and economic factors, including diverse forms of violence at home, at school and in the workplace.

The implementation of this additional program is being carried out through private, public, national or/and international non-profit organisations such as DANCHURHAID, World Vision Netherlands, OXFAM UK, Population Concern, Care Austria, and Institute of Tropical Medicine of Antwerp.

* Women are at higher risk than men for HIV transmission through unsafe heterosexual contacts.

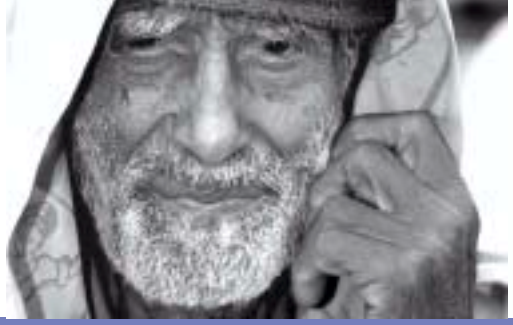
Responding to post-epidemic needs in Burundi

After assisting several partners in their emergency response to the malaria epidemic in Burundi during 2001, ECHO continues to support the post-epidemic response. In July 2002, Burundi amended its malaria national treatment protocol due to very high resistances to the medications used up until that point (pirimethamine-sulphadoxine and chloroquine).

New medications (arthemether and amodiaquine) are to be introduced after a period of health staff training and public awareness campaigns. The introduction presents a formidable challenge, not only because appropriate use of the drugs is essential to avoid the development of new resistances, but also because of the financial side of the operation, which carries a price tag of from €0.20 to €1.60 per treatment.

ECHO financed interventions range from preventive to curative efforts. Preventive efforts are financed mainly through UNICEF and include such measures as distribution of insecticide-treated nets and awareness campaigns focusing on water and sanitation in conjunction with several NGOs. Curative efforts involve the financing of anti-malarial drug stocks for routine treatment in health centres and as emergency stocks in the event of epidemics (contingency stocks of CO-artem, the most effective anti-malarial).

The fight against malaria will remain a priority for ECHO interventions in the country. ECHO will support the introduction of the new malaria protocol through several UNICEF and NGO partners. It will also finance new medications for use in health centres and as stock in the event of epidemics, as well as diagnostic tools such as the rapid test called ‘par-check’).



Co-financing budget line supports NGOs

Supporting NGOs in Nepal

In early January 2001, International Nepal Fellowship, a Christian relief and development charity registered in Birmingham (UK) since 1963, started the Tuberculosis Leprosy Project in Birendranagar, Surkhet Nepal, together with Tear Fund Ltd., another UK development NGO. The duration of the project is 60 months and the total cost slightly more than €5 million, to which the European Commission is contributing €1.9 million.

The project is providing cost-effective health education, early detection and treatment. Target beneficiaries include women of reproductive age, men in the working sector and children within the context of healthy families. (Direct beneficiaries: 300,000 outpatients and 20,000 treated patients, 500 trained volunteers, and 28 scholarship-funded staff members. Indirect beneficiaries: 14,000 families with two surviving parents around 70,000 people, TB/Leprosy awareness seminars presented to 15,000 women and AIDS/HIV seminars for 2,000 students).

This project incorporates the national tuberculosis programme established by WHO, the national comprehensive leprosy training and control programme of HMG Nepal, and will operate in close conjunction with the Regional Health Directorate. DOTS strategy and the EPI Centre reporting system are the working tool references for TB, and LEC and SAPEL will be followed, both promoted by WHO as appropriate programmes for fighting leprosy.

Various national and international NGOs involved in leprosy work in Nepal have formed the network of Leprosy NGOs. In addition, the TB network has recently facilitated a successful international conference (TB Net).

Preventive and therapeutic products ready for trial

The European Commission's 5th Research Framework Programme has pushed new preventive and therapeutic products that are ready to benefit from the European and Developing Countries Clinical Trials Partnership (EDCTP) and other sources.

The most relevant advances on HIV/AIDS research supported by the 5th Research Framework is the progress of HIV/AIDS vaccine candidates to human trials. Three promising candidates of the type DNA-virus carrier (MVA and NYVAC) are now ripe for Phase I in China (seroptype C), Europe (serotype B) and Tanzania (serotype C), and will most likely be ready for Phase II early in 2004. They will be well positioned for further Phase III trials within the upcoming EDCTP in the coming years, signalling potential progress within this decade towards an effective HIV/AIDS vaccine. This is being carried out in close co-ordination with other global initiatives, particularly IAVI (the International AIDS Vaccine Initiative).

Progress has also been made on three candidate TB vaccines based on fusion proteins and protein subunits. These vaccines will also enter human trials and hopefully result in an effective TB vaccine.

As regards malaria, the main achievement has been the pre-clinical trials of new families of potentially effective anti-malarials, such as the phospholipid synthesis inhibitors, which will also enter human trials.

The way forward

While the effects of HIV/AIDS, malaria and tuberculosis are felt most acutely by affected individuals families and communities, the extent and severity of these diseases means that they undermine development efforts in many countries and indeed are global threats to public health and security.

To confront these three and other emerging diseases effectively we need an effective, co-ordinated response at all levels. The new millennium has brought a renewed international commitment to this response, and the international community has agreed ambitious targets to be achieved by 2015.

The European Community wholeheartedly supports the Millennium Development Goals and has placed the fight against poverty at the centre of its development policy. The European Commission's development principles place a high premium on national ownership of development programmes and partnership with all key stakeholders, including the major donors. In this vein, the European Commission has striven to use its comparative advantage in specific areas – such as development, trade policy and research – to help create more favourable conditions for developing countries to be able respond effectively to three diseases. The set of actions described in this brochure comprises the core of the European Commission's response as set out in the EU Action Programme in February 2002.

The new approach is only just beginning to bear fruit. The European Commission's policy on tiered pricing of key medicines has already facilitated dramatic price reductions in key anti-retroviral and anti-malarial drugs for developing countries. The European Union has strongly supported the right of countries to override intellectual property rights when public health is under threat. However, it will be several years at least before European Commission support for essential research into global public goods such as an AIDS vaccine or new anti-malarial drugs will lead to the manufacture of usable products that are available and accessible for those with the highest need.

We continue to face many challenges. First, we must recognise that the three diseases will only be effectively confronted where there are effective public systems in place to do so. Households, communities and even countries will not be able to take effective action on alone. Only concerted national and international efforts will make the achievement of the Millennium goal of confronting HIV/AIDS, malaria and tuberculosis a reality.

A related challenge is to provide adequate resources to enable countries to scale up programmes to confront the three diseases, and to take full advantage of reduced priced medicines and other commodities. Health expenditure in the world's poorest countries remains far below what is needed to sustain effective basic health services. At Monterrey in March 2002, the worlds' leaders agreed to revitalise efforts to mobilise resources, recognising that a 'substantial increase' in overseas development assistance (ODA) was required, especially to the world's poorest countries. They reaffirmed the United Nations' target of developed countries committing at least 0.7% of their GNP as ODA. The leaders of the European Union Member States at the Barcelona summit subsequently endorsed this commitment.

In Barcelona EU leaders also made a commitment to intensify efforts to harmonise policies and operational procedures, to untie aid, to work with nationally driven and owned development frameworks, and to improve targeting of the poor. Much work remains to be done to carry forward these commitments for the benefit of developing nations.

The need for concerted and co-ordinated international action to confront communicable diseases was recognised over a hundred years ago, when the first international sanitary conferences were organised in the face of the cholera pandemics. The HIV/AIDS pandemic, the growing threat posed by tuberculosis, the worsening malaria situation – as well as the other diseases such as polio and the possibility of emerging threats such as SARS – all once again reinforce the case for robust international public action and, indeed, action all levels.

We cannot afford complacency . . .

. . . even for a moment.

Useful web-links

European Commission regional and country strategy papers (CSPs):
http://europa.eu.int/comm/development/body/csp_rsp/csp_en.cfm

Information on calls for proposals under the budget-lines:
http://europa.eu.int/comm/europeaid/index_en.htm

Millennium Development Goals:
http://www.un.org/millenniumgoals/

Programme for Action (PfA), 'Accelerated action on HIV/AIDS, malaria and TB in the context of poverty reduction', February 2001:
http://europa.eu.int/eur-lex/en/com/cnc/2001/com2001_0096en01.pdf

Progress Report on the PfA, February 2003:
http://europa.eu.int/eur-lex/en/com/cnc/2003/com2003_0093en01.pdf

Reports from the Commission on Macroeconomics and health:
http://www.who.int/macrohealth/en/

WTO and TRIPS:
http://www.wto.int/english/thewto_e/minist_e/min01_e/mindecl_trips_e.htm

Regulation 'to avoid trade diversion into the EU market of certain key medicines':
http://europa.eu.int/eur-lex/pri/en/oj/dat/2003/l_135/l_13520030603en00050011.pdf

European and Developing Countries Clinical Trial Partnership (EDCTP) programme (DG Research):
http://europa.eu.int/comm/research/info/conferences/edctp/edctp_fp6_en.html

The Global Fund to fight AIDS, TB and Malaria (GFATM):
http://www.globalfundatm.org

Human and Social Development Unit (DG Development):
http://europa.eu.int/comm/development/development_old/sector/social/health_en.htm

Abbreviations

AIDS
Acquired Immune Deficiency Syndrome

ARV
Anti-Retroviral

CSPs
Country Strategy Papers

CSR
Corporate Social Responsibility

DOTS
Directly Observed Treatment, Short-course

ECHO
European Community Humanitarian Aid Office

EDCTP
European and Developing Countries Clinical Trials Partnership

G8
Group of G7 most industrialised countries and Russia

GFATM
Global Fund Against AIDS, Tuberculosis and Malaria

HAP
Health, AIDS and Population

HIV
Human Immune Deficiency Virus

HIVAC
HIV vaccine

IAVI
International AIDS Vaccine Initiative

IPM
International Partnership for Microbicides

ITNs
Insecticide Treated Nets

MDGs
Millennium Development Goals

MDR
Multi-drug resistant

ODA
Official Development Assistance

OECD
Organisation for Economic Co-operation and Development

R&D
Research and Development

RTD
Programme for Research and Technological Development and Demonstration

SAAVI
South African Aids Vaccine Initiative

SARS
Severe Acute Respiratory Syndrome

TB
Tuberculosis

TRIPS
Trade-Related Aspects of Intellectual Property Rights

UNAIDS
United Nations Joint Programme on HIV/AIDS

UNCTAD
United Nations Conference on Trade and Development

WHO
World Health Organisation

WTO
World Trade Organisation

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