

Remarks by Professor Michel Kazatchkine at the International Forum on MDG 6 in Eastern Europe and Central Asia

Plenary Session 3: Doing More with Less: The Era of Limited Financial Resources

Title of talk: *Scaling Up Political and Financial Commitment for Sustainable Impact on AIDS, TB and Malaria*

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Distinguished Chairs, fellow speakers and delegates:  
Dear Friends and colleagues:

Good afternoon. Thank you very much for this opportunity to speak today.

*Dobri dien.*

It is my privilege to speak as Executive Director of the Global Fund to fight AIDS, TB and malaria, an institution that was created ten years ago specifically to mobilize international financing for MDG 6.

Let us remember where we were at that time. In 2001, there was virtually no-one on AIDS treatment in the developing world. Malaria was a neglected disease; it was accepted that children dying of malaria was an inevitable part of life in endemic countries. TB control efforts were stagnant. Together, the three diseases were taking at least 6 million lives, every year.

By any measure, it has been a remarkable decade of progress against these diseases, and one that has given tremendous hope to millions of people.

Today, around 7 million people are on antiretroviral treatment in the developing world. HIV mortality and prevalence is falling in the highest burden countries. Malaria is actually in rapid retreat, with such dramatic reductions in morbidity and mortality that we can now hope for a world almost without malaria deaths by 2015 and we speak of elimination in some countries - including in this region - in the next few years. And TB mortality has continued to fall worldwide thanks to the rapid expansion of DOTS.

So at the global level, we have made truly impressive gains. Indeed, we have shown that it is actually feasible to reverse major global epidemics. But we should not underestimate the task ahead, especially in this region, where the HIV epidemic continues to expand and TB and MDR-TB pose such a threat. But here too, with a decade of experience in scaling-up, we know more than ever what needs to be done.

The successes we've achieved on MDG 6 have come because of political commitment at the highest levels.

Because civil society and communities have mobilized in ways we have never seen before.

Above all, they are due to the unprecedented resources that have become available: more than \$22 billion approved by the Global Fund alone in the last ten years, \$2.6 billion in this region.

These resources are the result of a significant and targeted effort of the donor community, especially the G7/G8 countries. It is also because implementing countries themselves are playing their part: let us not forget that 80 per cent of global TB funding, for example, comes from domestic sources. And it is because we have seen significantly increased co-investment in global health by the private sector and significant progress in the area of innovative financing.

There is no doubt that we are now in a very different economic climate to the one that prevailed ten years ago. A recent high level panel report to the Global Fund called it "an era of austerity". A number of the Global Fund's major, public donors today face severe economic constraints. To make the most of the funds that are available, and maximize impact and value for money, we clearly need to change the way we work and invest these funds more strategically.

Let me illustrate this with the example of the new strategy that the Global Fund is developing for the next five years.

Until now, the Fund has maintained a relatively passive role in influencing investments and shaping demand. In the last decade, we have been able to fund virtually all proposals submitted, provided they were technically sound.

A key pillar of the Fund's new strategy will help the Fund to invest more strategically. This means that we will focus far more closely on the highest-impact countries, interventions and populations, at the same time as we work to keep the Global Fund global. Specific country context - such as disease burden, financing gap, income level, absorptive capacity and risk for the Global Fund - will become far more relevant in considering what is funded. More emphasis will also be placed on funding national strategies and working through national systems, and the Fund will proactively promote the uptake of underutilized interventions and new technologies. We will be also working to better leverage the impact of our funding on health and community systems and on maternal and child health.

Nearly 40 per cent of spending by Global Fund recipients is on drugs and other commodities. In this more austere climate we also have a responsibility to ensure that countries secure products at the best possible prices. This is an issue of particular relevance to this region. We have established a high quality database on the prices of drugs and commodities which allows us to monitor drugs and service delivery costs more closely. It is also a tool for negotiation. And we will be working more actively to shape target markets and strengthen the Voluntary Pooled Procurement mechanism.

Let me be clear: I fully recognize the priority to increase efficiency, impact and value for money, and to better integrate interventions. But I wish to make the case today that simply “doing more with less” is not enough.

Rather, there is a strong case to be made that now is precisely the time to increase our political and financial commitment to fighting the three diseases.

There are four reasons for this.

First, we have never been so close to achieving major global health goals. If we continue to scale-up, we can achieve the MDGs for TB. We can come close to universal coverage of bed nets for malaria by 2015 and actually eliminate it in a number of regions, including Eastern Europe and Central Asia. We can do the same for mother-to-child HIV transmission in this region and around the world.

In the next five years, we could truly be able to say that we are in control of these epidemics, rather than that the epidemics control us.

So let us not lose this unprecedented opportunity. Let us not lose sight of the targets that are now within our reach. Let us not forget MDG 6!

The second reason for us to continue scaling up is economic. There is substantial evidence to show that funding health is actually an investment and that investments in AIDS, tuberculosis and malaria are cost-effective and entirely rational from an economic perspective.

Not investing in them does not make sense!

Take the example of antiretroviral therapy. Recent studies show that earlier initiation of treatment based on CD4 count of 350 or less is cost effective in most resource-limited settings.

We have also learnt this year of the substantial preventive benefit of effective AIDS treatment.

Clearly we will need further price reductions for laboratory testing and more recent antiretroviral drugs, but the experience of the last decade should encourage us. The average cost of the most commonly used, first-line, generic, antiretroviral treatment regimen, for example, has fallen from around \$600 ten years ago, to \$70 per year today. In just the last five years, the average price of insecticide treated bed nets has fallen by around a third.

Obviously, we still face serious challenges in pricing for some commodities, such as for MDR-TB drugs in this region, which today cost around \$6,000 per patient. But scaling-up this intervention to create a market and achieve economies of scale has to be seen at least as part of the solution.

At the same time, we must make every possible effort to ensure that free trade agreements do not hamper competition, but rather, further facilitate price reductions.

The third reason to continue our efforts is that we should not underestimate how rapidly and dramatically the gains of the recent past can be lost. We need only look at Rwanda, where an aggressive nationwide campaign against malaria launched in 2006 had achieved impressive results, and yet, malaria surged again in 2009 when procurement delays led to a prolonged stock-out of bed nets.

That resurgence serves as a strong reminder that interventions themselves do not alter a country's intrinsic potential for transmission, and that high coverage and sustainable financing must be maintained.

Finally, I believe that further scale-up is possible because the resource outlook is not universally bleak.

Let's look at the public sector. At the same time as the United Kingdom struggles to emerge from the worst recession in recent memory, it has also strongly affirmed its commitment to increase development funding and to support multilateral mechanisms like GAVI and the Global Fund. France has essentially done the same.

These countries remind us that even in times of economic uncertainty, it is to a large extent a matter of political will whether donors sustain and honour their commitments in global health.

I am also hopeful that other public donors - specifically the G20 group of countries - can do much more. Australia, for example, that shows continued economic growth, has signaled that it is ready to do so. China, India, Brazil, Turkey and Malaysia are all countries that can do more. Such opportunities were clearly evident and expressed at a meeting hosted by the World Bank here in Moscow two years ago, and we have to take advantage of them.

Many developing countries have also committed to do more, as seen, for example, in the Abuja commitment by African Union countries in 2001 to spend at least 15 per cent of national budgets on health. So far, of the 53 Abuja signatories, six have reached this target: Rwanda, Botswana, Niger, Malawi, Zambia and Burkina Faso. We should continue to hold countries to these commitments and provide incentives for them to increase their health spending. The Global Fund's new eligibility criteria, which now request all countries receiving Global Fund financing to co-invest in their disease programs according to their economic status.

There is much more potential to expand the scope and scale of private sector co-investment in health. Initiatives by Chevron in South Africa, Marathon Oil in Equatorial Guinea, Coca Cola in Tanzania and Standard Bank in several countries, for example, convince me that private sector co-investments in Global Fund-supported programs can occur on a wider scale.

And finally, we need more innovation in health financing. Product (RED), Debt2Health and Deutsche Bank's Exchange Traded Funds have together channeled substantial new revenue to the Global Fund in recent years. Unitaid has shown that a sustainable source of funding can be generated through a tax that is designed not for the good of the citizens on whom it is levied, but for a global cause. We need to pursue other opportunities - such as the proposed Financial Transactions Tax - to do the same.

In summary, let us not just think simply of “doing more with less”.

Of course, we have to be more strategic and achieve more value for money.

But we can't allow the climate of austerity to serve as an excuse for doing less.

Let's remember how close we are to achieving our goals, and how close we may be achieving MDG 6.

Let's remember that fighting disease is hugely cost-effective.

Let us fear the terrible cost of scaling back.

And let's think of how much more we could do with a determined effort to pursue new funding opportunities.

I want to conclude with a few words to recognize the efforts that Russia has made to achieve MDG 6, at home and abroad.

This country, as we know, has among the highest burdens of TB and MDR-TB in the world. It is also investing heavily in the fight against TB, and has one of the world's largest cohorts of patients receiving MDR-TB treatment.

The Global Fund has supported Russia in responding to TB and MDR-TB through a Round 4 grant. Funding for HIV has supported civil society responses in Russia that we know from experience are so important, and have given a huge boost to prevention, especially for people who use drugs, who comprise 65 per cent of prevalent cases.

From 2007, Russia decided to reimburse funding received from the Global Fund and has since become a net donor to the Fund. This has been a very strong precedent in the history of global health. And it is really what I see as the future of Global Fund funding. I am initiating discussions in other countries in this region including Kazakhstan, Azerbaijan and Georgia with a view to them increasing their support for the Fund as their economic positions improve.

Like Russia, this region as a whole can lead the way in breaking the old dichotomy between donor and recipient, and can help to forge a new type of global solidarity in the fight against global epidemics.

*Spasiba.* Thank you very much.