Australia's contribution to global health fund provokes dismay

Bob Burton *Canberra*

The Australian government has announced it will contribute only $A25m (£10.4m; $19.4m; €15.4m) over the next three years to the Global Fund to Fight AIDS, Tuberculosis and Malaria.

While welcoming the government's participation, Malcolm Reid, spokesman for Oxfam Community Aid Abroad, the Australian arm of Oxfam, was dismayed by the small grant. "We calculated that based on the size of its economy… Australia should be contributing about $A40m this year alone," he said.

The director of Médecins Sans Frontières Australia's campaign to improve access to essential medicines, Kathryn Dinh, was also disappointed: "We are hoping that they are going to increase their contribution in the future."

An estimated 7.4 million people in the Asia Pacific region, an area stretching from Bangladesh through to Japan and China, and including the Pacific Islands, are infected with HIV or have AIDS, and the region has about three million cases of malaria. Of the 3.7 million cases of tuberculosis reported worldwide in 2002 about 60% were in the region.

The fund's target to be raised in 2004 from Japan, Canada, Australia, and oil rich countries such as Kuwait and the United Arab Emirates is $500m—a third of the total budget. The fund's executive director, Dr Richard Feachem, met Alexander Downer, Australia's minister for foreign affairs, to press its case. "We've already committed $400m over the next two years to work in this region, and that includes substantial investments in the Pacific Islands, in Papua New Guinea, in East Timor, and in Indonesia," Dr Feachem said.

Mr Downer acknowledges the problem in the region but points to Australia's current six year, $A200m bilateral programme to counter AIDS.

The global fund was established in 2002 as an independent foundation. While developed countries such as France immediately made major funding commitments, Australia withheld support. "We didn't join the global fund originally because we had bilateral programmes in all of those [disease] areas at the moment," Mr Downer said.

Dr Feachem pointed to the symbolic importance of the Australian government's contribution. "It's not just the numbers of dollars," he said. "It's the voice that Australia carries in international forums." □

Amounts ($m) pledged to Global Fund to Fight AIDS, Tuberculosis and Malaria for 2004, compared with "equitable contribution" (calculated as proportion of global fund's total budget relative to country's gross national product (GNP))

Country	GNP as % of world total	Amount pledged for 2004	Equitable contribution	Difference
United States	32.3	547	633	-86
Japan	12.3	100	242	-142
Germany	6.1	107	120	-13
United Kingdom	4.8	88	94	-6
France	4.4	235	86	149
Italy	3.7	163	72	91
Canada	2.2	25	43	-18
Spain	2.0	37	39	-2
South Korea	1.5	0	29	29
Australia	1.3	7	25	-18
Netherlands	1.3	72	25	47
Belgium	0.8	18	15	3
Switzerland	0.8	0	16	16

Sources: The Global Fund to Fight AIDS, Tuberculosis and Malaria (www.theglobalfund.org) and Aidspan (www.aidspan.org)

Framework shows countries' contributions

Bob Burton *Canberra*

A method to determine whether countries are contributing their fair share to the Global Fund to Fight AIDS, Tuberculosis and Malaria was drawn up in 2002 by experts in development aid.

The system, known as the equitable contributions framework, is used by organisations such as Oxfam, Médecins Sans Frontières, and Fund the Fund to persuade countries not to shirk their responsibilities.

The basis of the framework is that funding should be drawn from the 37 "most comfortably off" countries in the world.

The fund has stated that it needs to receive $1.56bn (£0.83bn; a1.24bn) during 2004. Consequently, the authors of the framework divided the $1.56bn between the 37 richest countries according to their percentage share of the total GNP.

The table shows that certain countries, such as France and Italy, have contributed more than their fair share and others, such as Japan and the United States, have contributed less. □

World Bank conference debates how to reach the poor

Jocalyn Clark *BMJ*

Health services designed to favour the poor do not necessarily reach the most needy in societies. That was the conclusion of a group of World Bank policy makers and programme officers working in developing and transitional countries who met last week in Washington, DC, to discuss better ways to reach the most vulnerable people.

Described as "taking stock" of how well the bank's programmes are reaching the poor, the conference reflected growing awareness in the international development community that "health systems are unconsciously regressive and tend to bias against the poor and most needy."

In his opening address, Davidson Gwatkin, principal health and poverty specialist at the World Bank and organiser of the conference, said the focus must be on not just the presence or absence of health and nutrition services but also on their distribution. Programmes aimed at preventing or alleviating HIV infection, tuberculosis, and malaria, for example, are often assumed to reach the poor merely because these are seen as diseases of the poor, but that assumption is increasingly questioned, he said.

Delegates at the conference, which was funded by the Bill and Melinda Gates Foundation and the Swedish and Dutch governments, learned that many health, nutrition, and population services, because they favour the better off, themselves contribute to disparities in health status. Such disparities are found not only in routine health services but often also in programmes run especially to benefit the poor.

In a series of case study presentations commissioned by the bank—one third of them from the developing world—Joel Selanikio of the American Red Cross described a collaborative project in which the distribution of insecticide treated bed nets was "piggy backed" to measles campaigns in Ghana and Zambia. He said this resulted in over 90% coverage. Researchers from the University of Cape Town and the London School of Hygiene and Tropical Medicine described how the multidisciplinary nature of two large scale voluntary counselling and treatment programmes for HIV/AIDS in South Africa contributed to comprehensive coverage among disadvantaged socioeconomic and ethnic groups.

But these successes were said to have been achieved in the face of severe challenges to adequately reaching the poor, such as the lack of infrastructure and efficient health systems. □