

BIOVISION PRE-CONFERENCE REPORT FORMAT

INTRODUCTION

BioVision introduces a NEW ARCHITECTURE by adding 9 Pre-conferences in 2006 and a web Forum hosted by BioVision NXT. and will take place between March and October 2006.

The Pre-conferences will ensure continuity, between the two successive forums by enlarging the circle of participants in order to better meet the needs of the key BioVision participants: Science, Society and Industry.

OBJECTIVE

The OBJECTIVE of Pre-conferences is to explore and develop the topics for debate and discussion at BioVision Forum.

The WORK PRODUCT of a pre-conference will consist of an EXECUTIVE SUMMARY of the discussion, RECOMMENDATIONS FOR ACTION and CONCLUSIONS recorded in table format specifically spotting the key issues in the field and the viewpoints of the communities: Science, Society and Industry.

METHODOLOGY

Pre-conferences will consist of small meeting of up to 10 participants to develop the key issues for the BioVision Parallel Conferences in three sectors: Health, Agriculture and Environment.

Each Pre-conference will have Host Partners. The Host Partners with BioVision support will organize the meeting, choose the participants.

The topic recommendations of the Pre-Conferences will be honed and refined for the BioVision Forum. Due to time limitations of the Forum, not all identified topics and issues may be covered in the Forum.

PRE-CONFERENCE TITLE: DISEASES OF POVERTY: Disease Burden, the MDG's and Child Survival

TOPIC DESCRIPTION: Diseases of Poverty

Disease burden and regulatory and legal issues with R&D for drugs for neglected diseases

LOCATION: New York, USA

DATE: September 18, 2006

HOST PARTNER: UNICEF

BIOVISION PARTICIPANTS:

Jean Michel Roy
ENS-LSH / BioVision Human Sciences Advisor

Dianna Derhak
Programme Director

MODERATOR:

Alain Court, UNICEF

PARTICIPANTS:

- ▶ **Marzio Babilie**, UNICEF India
- ▶ **Al Bartlett**, USAID
- ▶ **Zulfiqar Bhutta**, Agha Khan University, Pakistan
- ▶ **Mushtaque Chowdhury**, Bangladesh Rural Advance Commission
- ▶ **David Fleming**, Bill and Melinda Gates Foundation
- ▶ **Kul Gautam**, UNICEF NYHQ
- ▶ **Min-Whee Kang**, UNICEF NYHQ
- ▶ **Jean-Pierre Le Calvez**, GAVI Alliance
- ▶ **Chip Lyons**, US Fund for UNICEF

AGENDA:

1. Welcome by host partner and introduction of participants
2. Presentation of Biovision new architecture
3. Introduction by moderator
4. 3 topic presentations
5. Round table discussion

EXECUTIVE SUMMARY:

The correlation between poor health and poverty is a well established one. Poverty clearly favors the development of diseases, and children are the primary victims of this situation, especially the youngest ones. Nearly all deaths among children under five years of age (99%) occur in low-income countries or the poor areas of middle-income countries. But poor health is a also factor of poverty. Poor health and nutrition in the early years of life perpetuate the cycle of poverty and intergenerational underachievement. And recent studies show a strong link between reduction of child mortality and increase in economic growth.

In an unprecedented effort to break the circle of poverty and poor health, the MDGs have set as one of their priorities the reduction by two thirds of the mortality of children under 5 years of age by year 2015

(MDG 4). The preconference was centered around the discussion of this objective: is it realistically achievable? What progress has been made so far since the launch of the MDG's? What new initiatives or orientations are required in order to achieve it? What specific contributions can be expected from the life sciences research and industry?

A group of about twenty international experts representing the three sectors of science, industry and society gathered in New York on September 18 for a debate hosted by UNICEF in order to clarify these issues. This meeting was held in the context of a high level symposium jointly organized by UNICEF, the Norway Government and the Lancet for assessing the progress accomplished in the realization of MDG 4.

The current situation of child mortality remains dramatic. Every year, an estimated 10.62 million children are still dying before they reach the age of five years from largely preventable and treatable diseases. The primary causes of child deaths worldwide are pneumonia, followed by diarrhea, low birth weight and prematurity, asphyxia at birth and, in some regions, malaria and HIV/AIDS. Most under-five deaths are clustered in two regions: sub-Saharan Africa (44 per cent) and South Asia (32 per cent). In addition, half a million women die in pregnancy each year, most during delivery or in the first few days thereafter. The enormous death toll is only part of the burden. Hundreds of millions more women and children suffer under nutrition, illness and long-term disability. Although the last two decades have seen some progress in reducing post-neonatal deaths, much less attention has been paid to the almost 40 per cent of deaths that occur in the first week of life.

According to a recent report published by the Lancet, only seven countries are on track to meet MDG-4, 39 countries are making some progress, although they need to accelerate the speed, and 14 countries are cause for serious concern. Coverage of the key child survival interventions remains critically low, although some countries have made substantial improvements in increasing the proportion of mothers and children with access to life saving interventions by as much as ten percentage points in 2 years.

There is a large consensus among experts that the problem is not primarily one of scientific research, but one of strengthening health systems in resource limited environment in order to provide equitable access to affordable and well know effective interventions such as immunization, PMTCT and pediatric AID care and support, ITNs, exclusive breastfeeding, vitamin A supplementation or community based treatment of pneumonia. There is also growing consensus among experts that resolving a series of upstream policy-level constraints will be key to changing this situation. These constraints include: a) the lack of robust sectoral strategies, plans and budgets; b) weak linkages between the health sector and broader development processes (public sector reform, poverty reduction strategies, macroeconomic and fiscal planning etc.); c) weak domestic resource mobilization; d) limited attention to the staffing and systems issues that impede service delivery; e) inadequate monitoring systems for tracking resource flows, progress and outcomes; f) limited progress in translating global commitments on aid effectiveness into concrete action at country level - most particularly in relation to the provision of predictable long-term financing; and g) lack of a multisectoral approach to achieving health outcomes.

In addressing these constraints, it is important to apply the lessons learnt from recent evaluations of large scale implementation efforts such as the Accelerated Child Survival and Development program in West Africa, the Integrated Management of Child Illnesses (IMCI) approach, The integration of malaria prevention with antenatal care and child welfare clinics, or the implementation of PMTCT services at scale in Botswana. Based on evidence-based situation analysis, countries need to develop MDG-oriented and results-based policies, plans and budgets which put child survival and the maternal, newborn and child health continuum of care at the core of the health sector reform agenda. Country strategies need to allocate more resources to the strengthening of local health and nutrition services. The involvement of local communities and households in the delivery of care appears to be crucial, and training efforts should be amplified. In addition, in line with the Paris Declaration on Aid Effectiveness, development partners

must rally behind country-led policies, plans and budgets to achieve the health MDGs in general and MDG 4 more specifically. They must show greater commitment to harmonize their respective procedures in order to reduce the transaction costs for developing country governments.

The role of scientific and technological research remains however crucial for long term efforts in the fight against diseases of poverty and child mortality in particular. Vaccines to prevent pneumococcal and rotavirus infections, low osmolarity oral rehydration therapy, zinc treatments for diarrhea, long lasting treated bednets are examples of much needed new tools brought by medical research and development. Efforts should consequently be made to facilitate the dialogue between policy makers, care givers scientists and industry in order to better match the needs of afflicted populations and to help targeting scientific and technological research efforts more efficiently. For example, more research on the causes of pneumonia is a necessity for reducing its toll on children under 5, and efforts to develop anti-secretory drugs against diarrhea must be encouraged, such as the specific program initiated by The Institute for OneWorld Health. This institute was created to develop medicines for neglected diseases, and its portfolio includes a promising research and development program focused on the inhibition of the Cystic Fibrosis Transmembrane conductance Regulator chloride channel, that is now considered as a main source of fluid secretion in response to pathogens such as Cholera and enterotoxigenetic E. coli.

Ensuring universal access to these effective interventions, particularly in the 60 developing countries accounting for 90% of overall child deaths, will require an important financial effort on the part of developing country governments, donors, multilateral institutions, private foundations and NGOs. Financial resources are being mobilized as never before for global health thanks to global funds such as GFATM or GAVI, the contributions of major foundations like the Gates Foundation, or through innovative financing mechanisms such as the International Financing Facility for Immunization, UNITAID or the Advanced Market Commitments mechanism. But more needs to be done as the current levels of financing remain insufficient and far too unpredictable to achieve and sustain the health MDGs. Donor governments need to implement their commitments to earmark 0.7% of the GNP for development assistance. In this respect, the Norway initiative to allocate an additional 1bn USD for MDG 4 acceleration needs to be acknowledge with the hope that other donor countries will follow. Ways to further involve the private sector must be also invented, taking into account its business perspective and its management culture. This renewed financial effort will not be possible without a strong commitment from governments to make child survival a public health priority. Political will is considered a key determinant.

KEY QUESTIONS:

- ▶ What complementarities of action between the three BioVision constituencies are required at global and country levels in order to achieve the child survival MDG?
- ▶ How to ensure that the industry is encouraged to invest in new technical solutions while ensuring that these new technical solutions are introduced in developing countries using a fast track process?
- ▶ How to reconcile the need for new financing and programmatic initiatives with the imperative of simplifying the global health architecture and better harmonizing the actions of development partners?
- ▶ What are the promising areas requiring specific research efforts?