L'Istituto Superiore di Sanità e la Salute Globale

Definizione di Salute Globale

La “Salute Globale” è un'area emergente e intersettoriale di studio, ricerca e azione, orientata al miglioramento della salute di tutta l'umanità, che trascende e supera le prospettive, gli interessi, le frontiere e le possibilità delle singole nazioni e le classiche politiche settoriali.

Come cambiano i paradigmi nella salute

La salute delle persone che vivono sul nostro pianeta

non deve più essere considerata soltanto come un obiettivo dello

sviluppo, quanto piuttosto un investimento necessario e prioritario

per lo sviluppo e la crescita economica dei popoli.

Il nuovo contesto per la Salute Globale nell'era post-2015

- *Demografia;*
- *Globalizzazione;*
- *Urbanizzazione;*
- *Nuove diseguaglianze;*
- *Nuovi poteri economici;*
- *Geo-politiche multi-polari;*
- *Fenomeni migratori;*
- *Commercializzazione;*
- *Connessioni virtuali*

Per una nuova visione della Salute Globale

- *La "politica" deve accettare che, oggi, in un mondo sempre più globale, esistono interessi che travalicano gli interessi nazionali*

- *La governance del mondo deve saper rispondere sia agli interessi nazionali che a quelli globali*

- *Dobbiamo avere il coraggio di pensare oltre la salute ed abbracciare una nozione più ampia di sviluppo sostenibile.*

La Salute nelle agende politiche e commerciali

La salute è ormai parte integrante – talvolta conflittuale - delle agende politiche transnazionali di molti Paesi, e delle "agende" di molti settori produttivi:

- *Sicurezza: paura di pandemie globali o diffusione intenzionale di malattie;*
- *Foreign policy: priorità per interessi nazionali;*
- *Economia: il settore salute visto come industria, con un potenziale di crescita economica;*
- *Giustizia sociale: la salute come un valore sociale e un diritto umano.*

Gestire le nuove sfide:
Salute Globale ed interessi in conflitto

- *Dobbiamo riuscire a negoziare la Salute Globale contro interessi conflittuali;*
- *La scienza e i ricercatori hanno un ruolo fondamentale in questo processo di negoziazione;*
- *La ricerca ha il compito di dimostrare le evidenze per informare le scelte politiche;*

L'ISS e la Salute Globale: il contesto e i principi (1)

La Dichiarazione Universale dei Diritti dell'Uomo e la nostra Costituzione indicano la salute come un diritto fondamentale, garanzia per la collettività, e strumento necessario di convivenza e civiltà.

Malgrado questa convergenza, nel mondo permangono intollerabili diseguaglianze in termini di accesso alla salute e ai servizi sanitari, aspettativa di vita, e mortalità per malattie sia trasmissibili che non trasmissibili, molte delle quali prevenibili e curabili.

Questo fenomeno non è limitato ai Paesi a risorse limitate, ma include anche Paesi più ricchi, soprattutto in questo particolare momento storico, caratterizzato da un difficile contesto economico-finanziario, complesse questioni geopolitiche, e processi migratori di enorme portata.

Esiste quindi la necessità di lavorare sull'appropriatezza e su nuovi modelli di cura e intervento basati sull'evidenza, che mirino a innovazione ed eguaglianza distributiva, in grado di fornire cure adeguate e assistere le disabilità, e tutelare il benessere psicofisico di tutta la popolazione, anche in contesti sociali e ambientali complessi e difficili.

I principi che guidano le attività dell'ISS partono quindi dal concetto che in un mondo globalizzato, il diritto alla salute e all'accesso universale alle cure deve rappresentare una priorità di intervento, alla quale il nostro Paese e il nostro Istituto non possono sottrarsi.

L'ISS e la Salute Globale: il contesto e i principi (2)

Anche i Sistemi Sanitari dei Paesi più economicamente sviluppati, attraversano un'importante crisi di sostenibilità finanziaria. Le cause sono diverse e includono: il cambiamento demografico con il positivo aumento dell'aspettativa di vita, tuttavia collegato con un aumento esponenziale della prevalenza delle malattie croniche e della polimorbidità.

Il progresso scientifico della biomedicina e lo sviluppo tecnologico, che sta portando benefici impensabili fino a qualche tempo fa, ma anche ad un'esponenziale aumento dei costi; l'aumento della consapevolezza e delle giuste richieste di salute dei cittadini.

Per evitare che questa crisi influisca negativamente sull'efficienza dei servizi, e colpisca in modo rilevante la parte più fragile della popolazione, in pratica le persone più povere e marginalizzate, la via è quella di lavorare sull'appropriatezza e su nuovi modelli di cura e intervento basati sull'evidenza, che mirino a coniugare innovazione ed eguaglianza distributiva, in grado di fornire cure adeguate, assistere le disabilità, e tutelare il benessere psicofisico di tutta la popolazione.

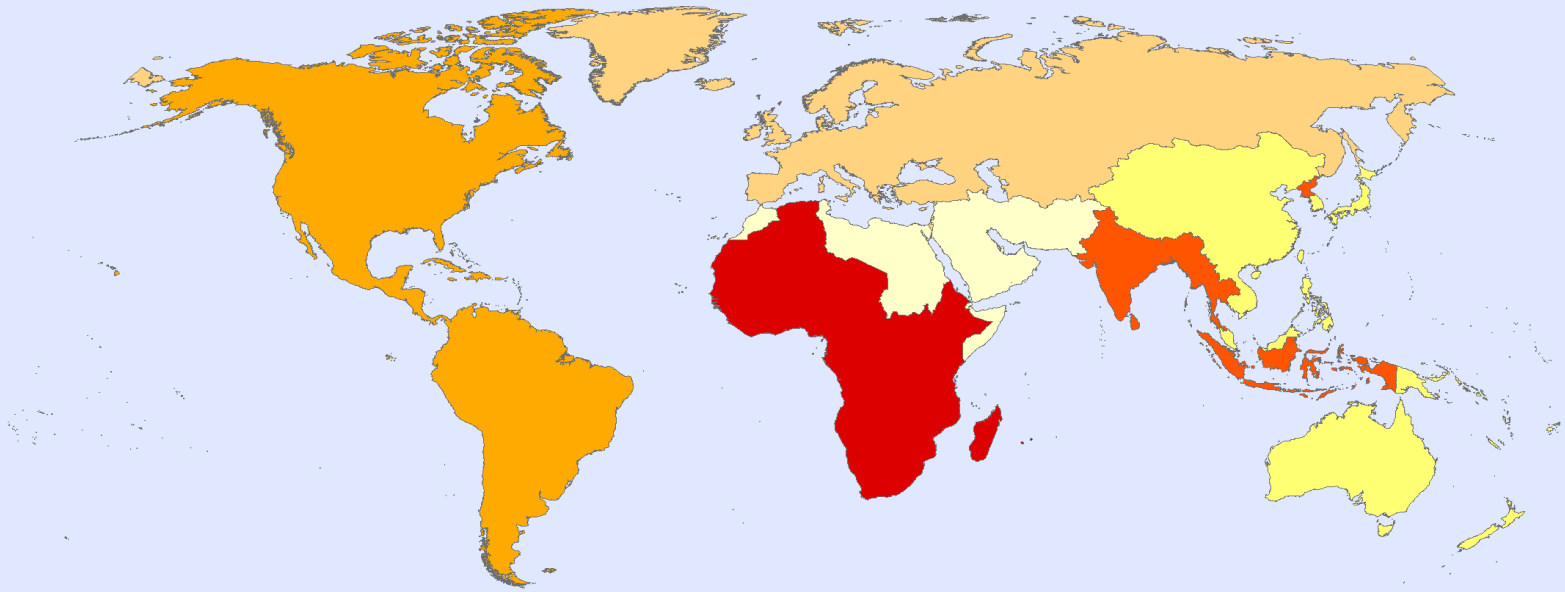
Health inequalities

- At least 20 million people die prematurely (half of then before the age of 5) in developing countries for lack of adequate access to basic health care
- They die for causes **preventable or treatable**
- Health disparities arise from the lack of capacity of countries to provide accessible healthcare
- It largely depends on the poor availability and use of national resources to finance health systems, health infrastructure, the health workforce, medicines, research, monitoring and control

Life expectancy at birth

Health inequalities around the world: Diseases of poverty

Estimated adult and child deaths from AIDS, 2013
By WHO region



Estimated number of deaths by WHO region

- Eastern Mediterranean: 16 000 [11 000–22 000]
- Western Pacific: 56 000 [40 000–81 000]
- Europe: 61 000 [52 000–74 000]
- Americas: 77 000 [65 000–110 000]
- South-East Asia: 190 000 [160 000–220 000]
- Africa: 1 100 000 [1 000 000–1 300 000]

Total: 1 500 000
[1 400 000-1 700 000]

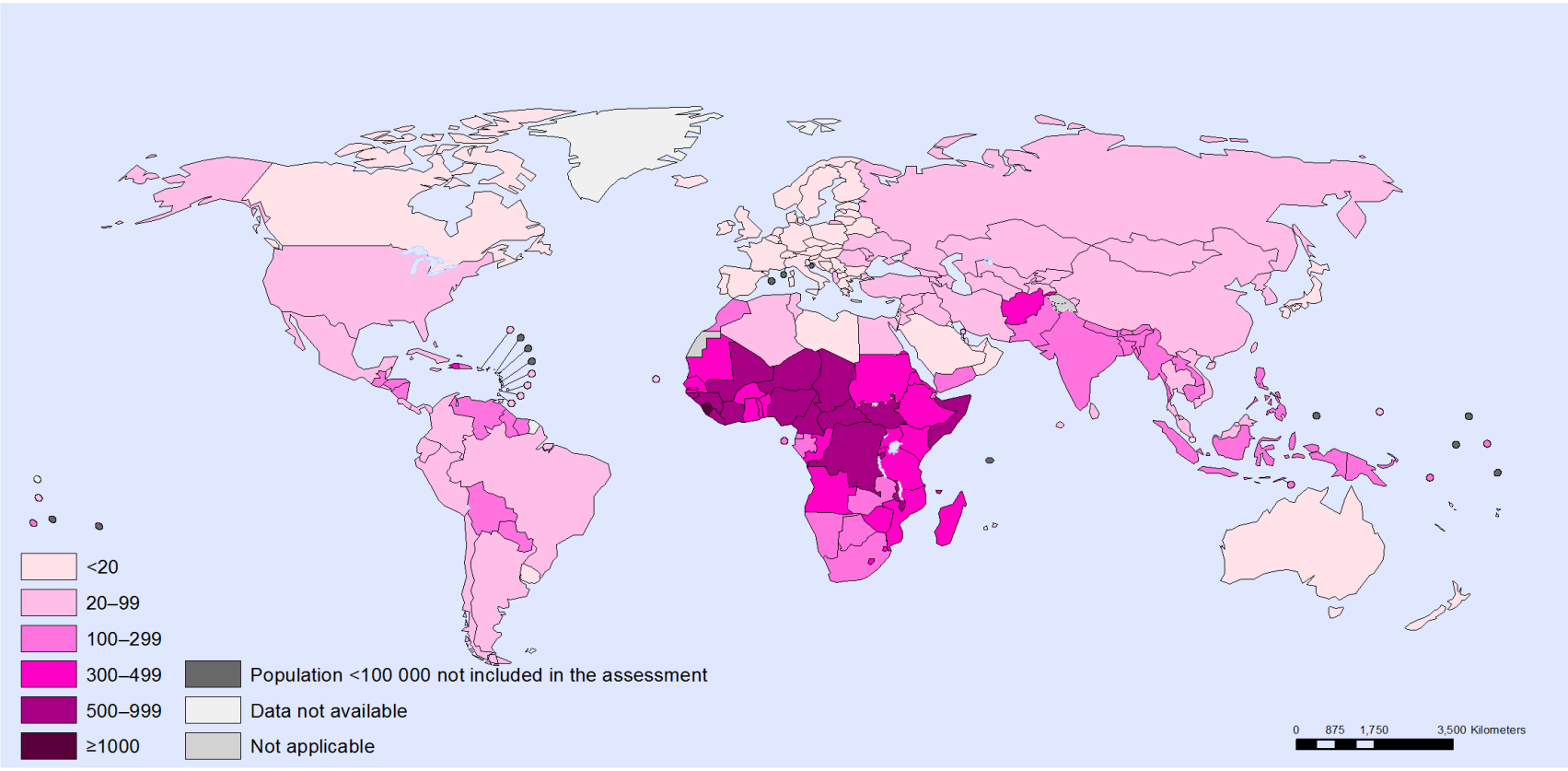
0 875 1,750 3,500 Kilometers

Data Source: World Health Organization
Map Production: Health Statistics and Information Systems (HSI)
World Health Organization

World Health Organization

Health inequalities around the world: Diseases of poverty

Maternal mortality ratio (per 100 000 live births), 2013



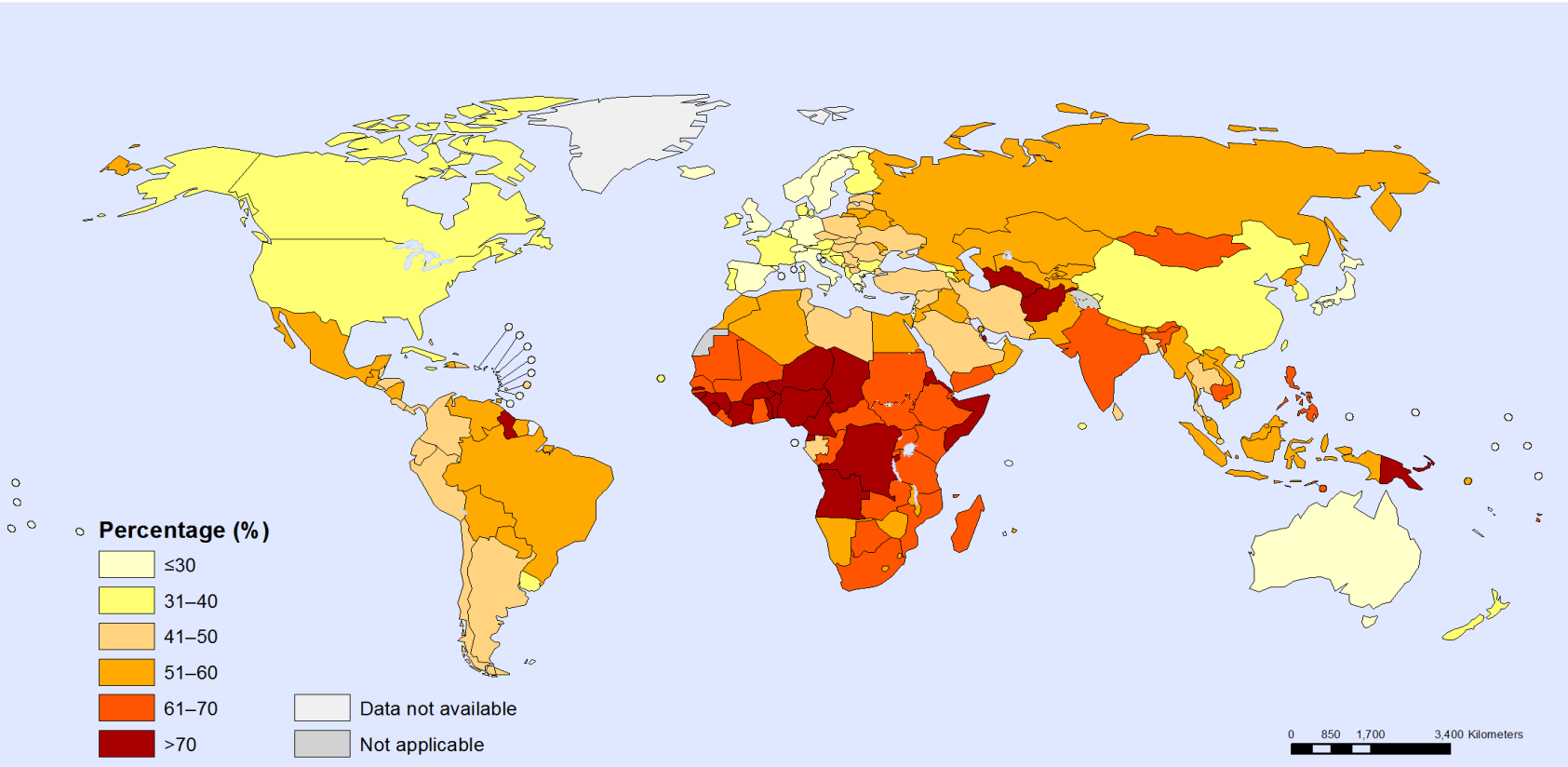
The boundaries and names shown and the designations used on this map do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted and dashed lines on maps represent approximate border lines for which there may not yet be full agreement.

Data Source: World Health Organization
Map Production: Health Statistics and Information Systems (HSI)
World Health Organization

World Health Organization

Health inequalities around the world: Noncommunicable Diseases

Percentage of deaths due to noncommunicable diseases occuring under age of 70
Male, 2012



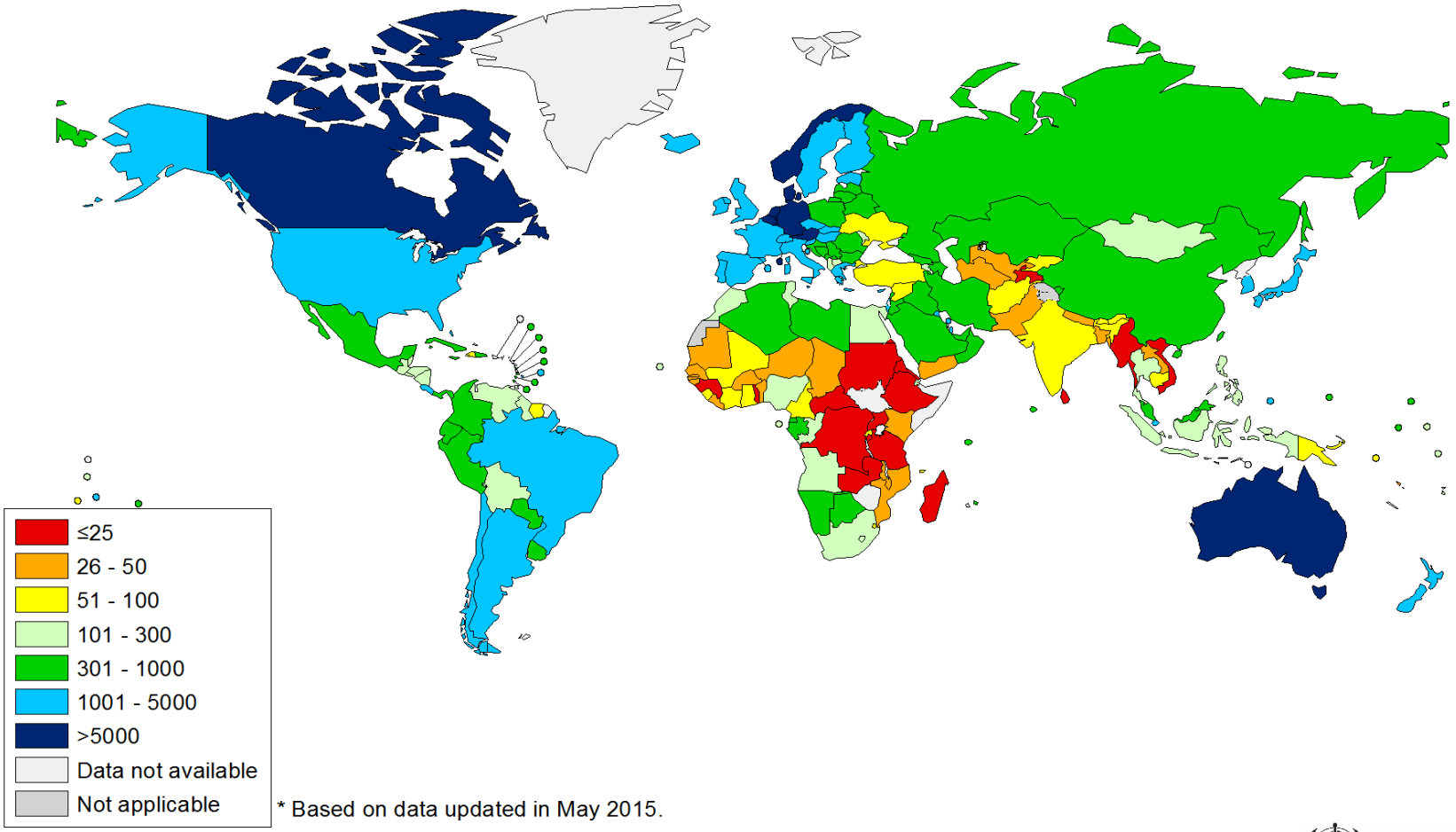
The boundaries and names shown and the designations used on this map do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted and dashed lines on maps represent approximate border lines for which there may not yet be full agreement.

Data Source: World Health Organization
Map Production: Health Statistics and Information Systems (HSI)
World Health Organization

World Health Organization

Health inequalities around the world: Economic reasons behind inequalities

Per capita total expenditure on health at average exchange rate (US$), 2013 *



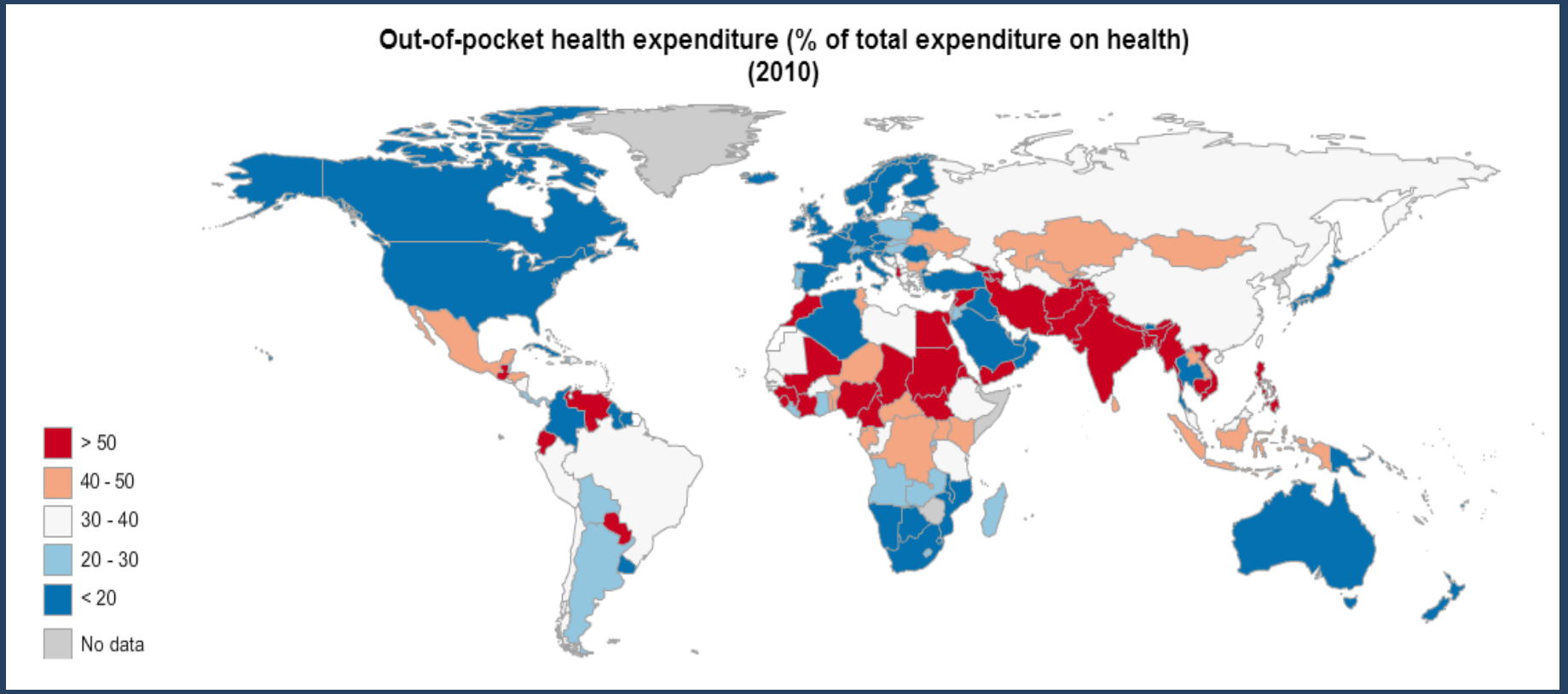
* Based on data updated in May 2015.

Data Source: Global Health Observatory, WHO
Map Production: Health Statistics and Information Systems (HSI)
World Health Organization

World Health Organization

Health inequalities around the world: out-of-pocket expenditure

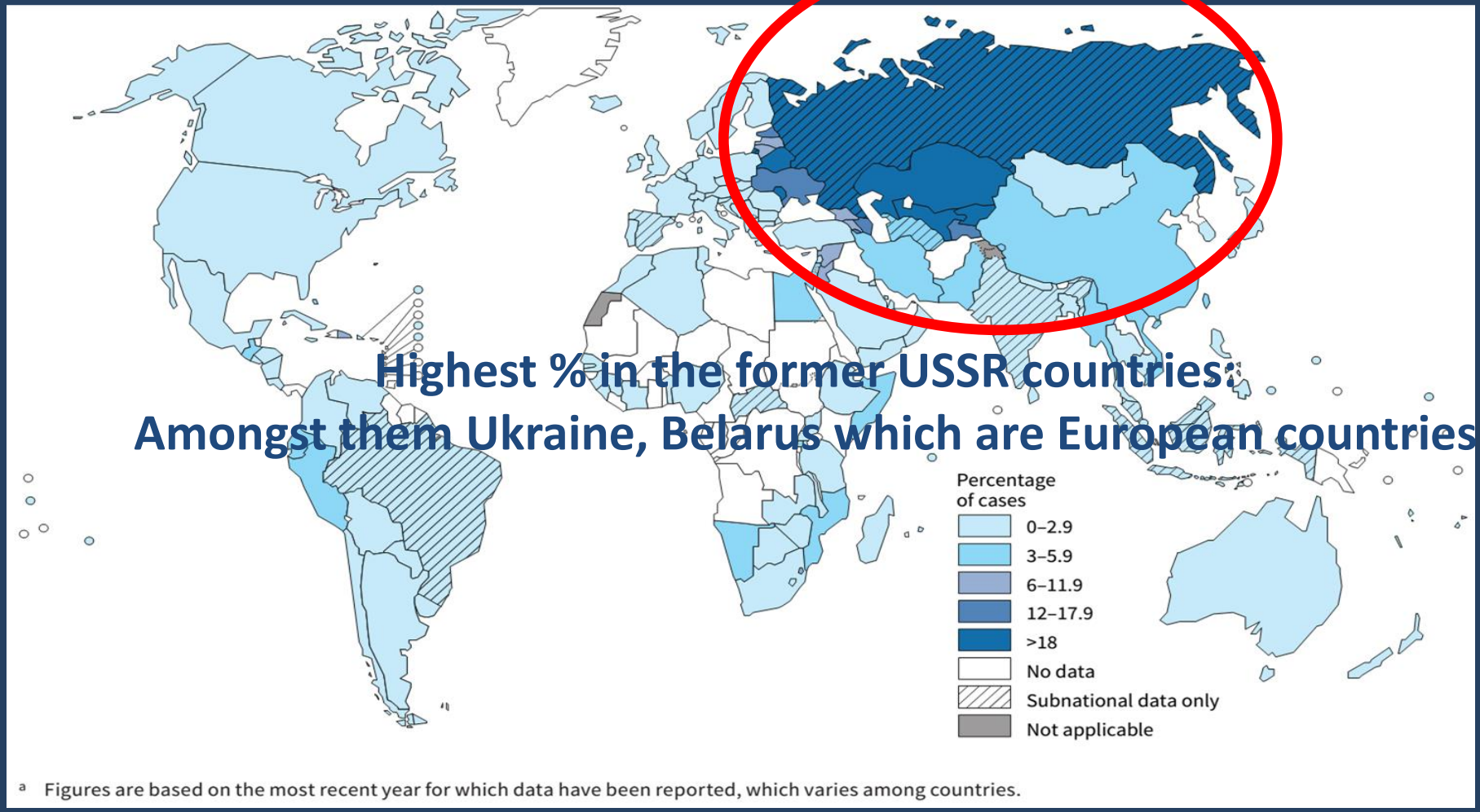
Out-of-pocket expenditure on health affects mainly ill people from the poorest countries



Source: World Bank (http://www.statsilk.com/maps/statplanet-world-bank-app-open-data/)

EUROPEAN REGION: Health disparity between Countries

Percentage of new TB cases with MDR-TB



Ref: Global TB Control Report 2014

World Health Organization

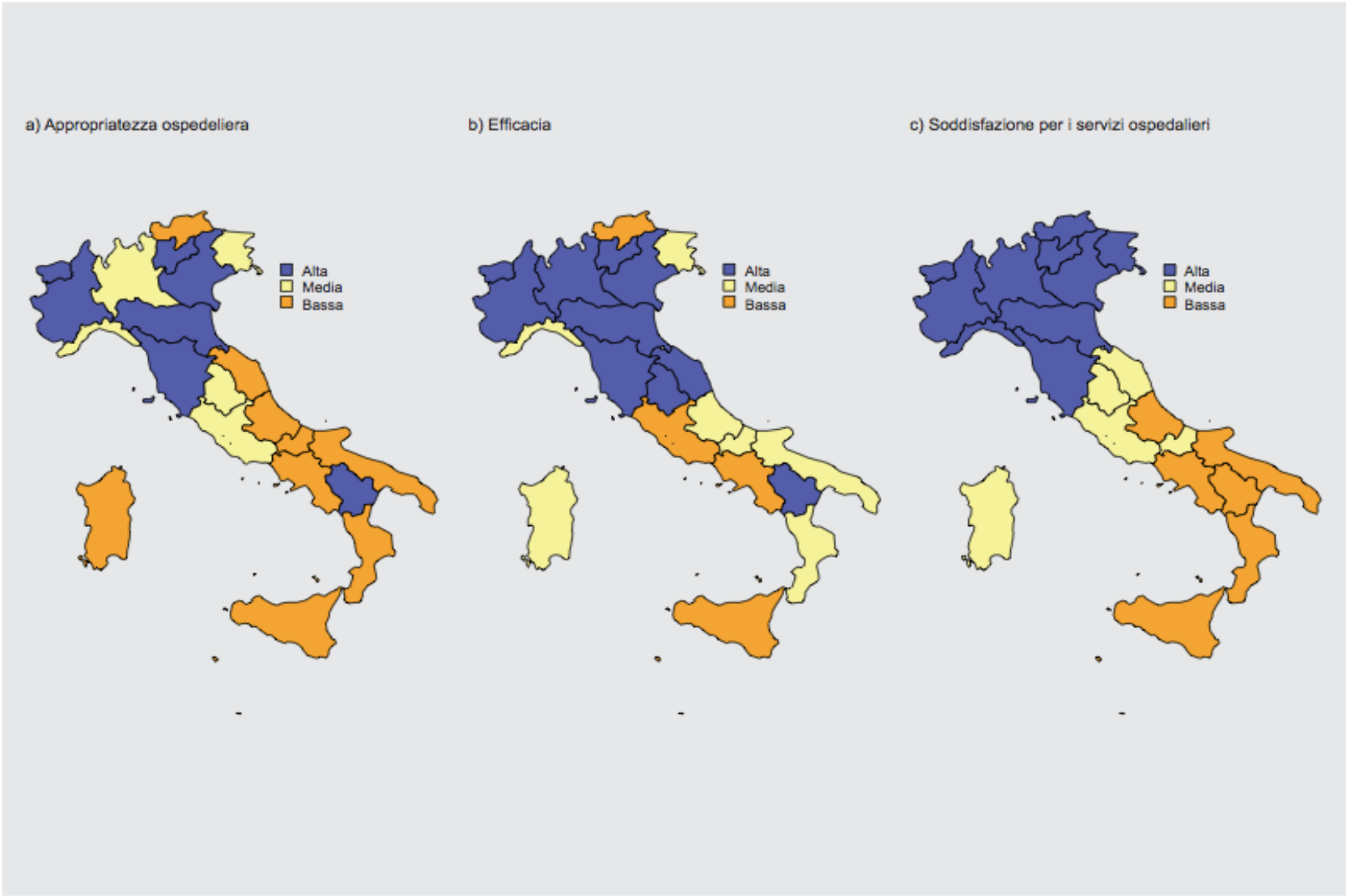
ITALY AS A CROSSROAD

- Italy is a global crossroads and serves as an excellent prism for understanding global health issues.
- The Italian context in the era of globalization provides a rich background for engaging in global health initiatives, both locally and internationally.
- Indeed, all that is “global” in global health – as opposed to “Southern” or “International” – is manifest in Italy’s rich past and dynamic present.
- Immigrant and minority health, the divide between rich and poor, North and South, are all present in the Italian setting.

ITALY: Health disparity between Regions

Indicators of quality of health services years 2009-10

Figura 4.25 Indicatori sintetici della qualità dei servizi sanitari per dimensione della qualità e regione - Anni 2009, 2010

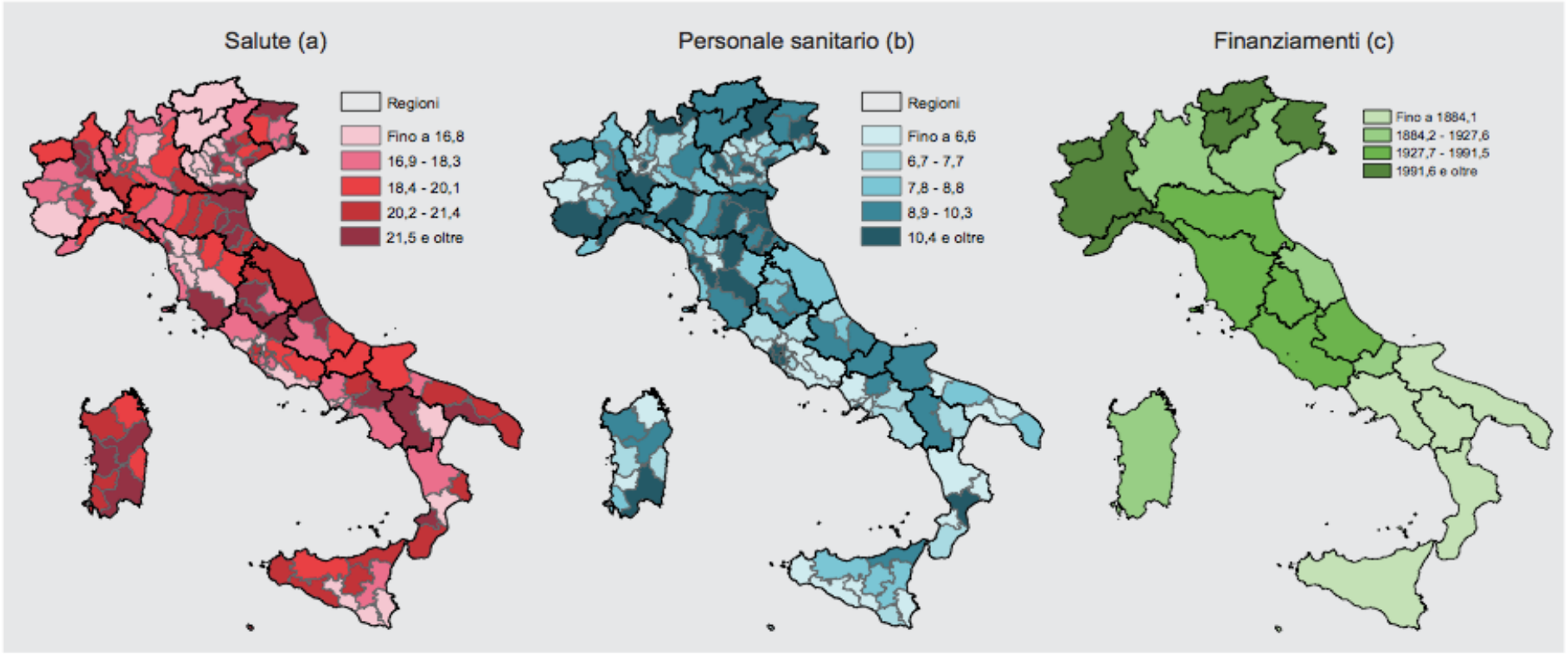


Fonte: Elaborazione Istat su dati del Ministero della salute

ITALY: disparity between Regions – Health Indicators:

a) n. of people in bad health conditions (per 100 people)
b) health personnel (per 1000 people)
c) Financing per Region (per capita)

Figura 5.6 **Persone in cattive condizioni di salute per Asl - Anno 2013** (per 100 persone), **personale sanitario per Asl - Anno 2012** (per mille persone) **e finanziamento del Ssn per Regione - Anno 2012** (valori pro capite)



Fonte: (a) Istat, Condizioni di salute e ricorso ai servizi sanitari; (b) Ministero della salute, Nuovo sistema informativo sanitario, Banca dati del Servizio sanitario nazionale; (c) Ministero economia e finanze, Relazione generale sulla situazione economica del Paese 2014

L'ISS e la Salute Globale: attività

*L'ISS svolge **attività di ricerca, sia nei paesi economicamente sviluppati che in quelli meno sviluppati**, affrontando il "come applicare" le conoscenze della medicina e della biologia moderne per contribuire, insieme ad altri attori nazionali e internazionali, a combattere le disuguaglianze nell'accesso alla salute di tutte le persone, in Italia e nel Mondo, attraverso:*

- ***ricerca fondamentale, clinica e operazionale sulla terapia e prevenzione delle grandi malattie globali,***
- ***ricerca sui sistemi sanitari,***
- ***progetti di cooperazione internazionale,***
- ***collaborazione con le organizzazioni internazionali che si occupano di salute,***
- ***attività di formazione, advocacy e networking**.*

La Salute Globale e l'ISS: le principali aree di intervento

Aree di attività (1)

Ricerca clinica e operazionale su terapia e prevenzione delle grandi patologie a respiro globale (malattie trasmissibili e croniche non trasmissibili)

Ricerca sui Sistemi Sanitari, con particolare riguardo a modelli innovativi per Il contrasto delle diseguaglianze di accesso alla salute

-

Appropriatezza clinica e terapeutica

-

Formazione degli Operatori Sanitari

Ricerca sugli outcomes e sui determinanti di salute (*health e non-health*)

-

Health Foresight

-

Valutazione di Impatto sulla Salute (VIS)

Aree di attività (2)

Ricerca innovativa nella prevenzione (biomedica e vaccinale) e nella terapia delle grandi patologie globali

Studio delle caratteristiche e dei meccanismi di resistenza farmacologica

Innovazione nella Information Technology

Sostanze Naturali,

Medicina Tradizionale e Integrata

Relazioni con gli organismi internazionali che si occupano di salute (UN)

-

Produzione di policy documents e di Linee Guida Internazionali

-

Comunicazione e advocacy

-

Reti nazionali e internazionali

-

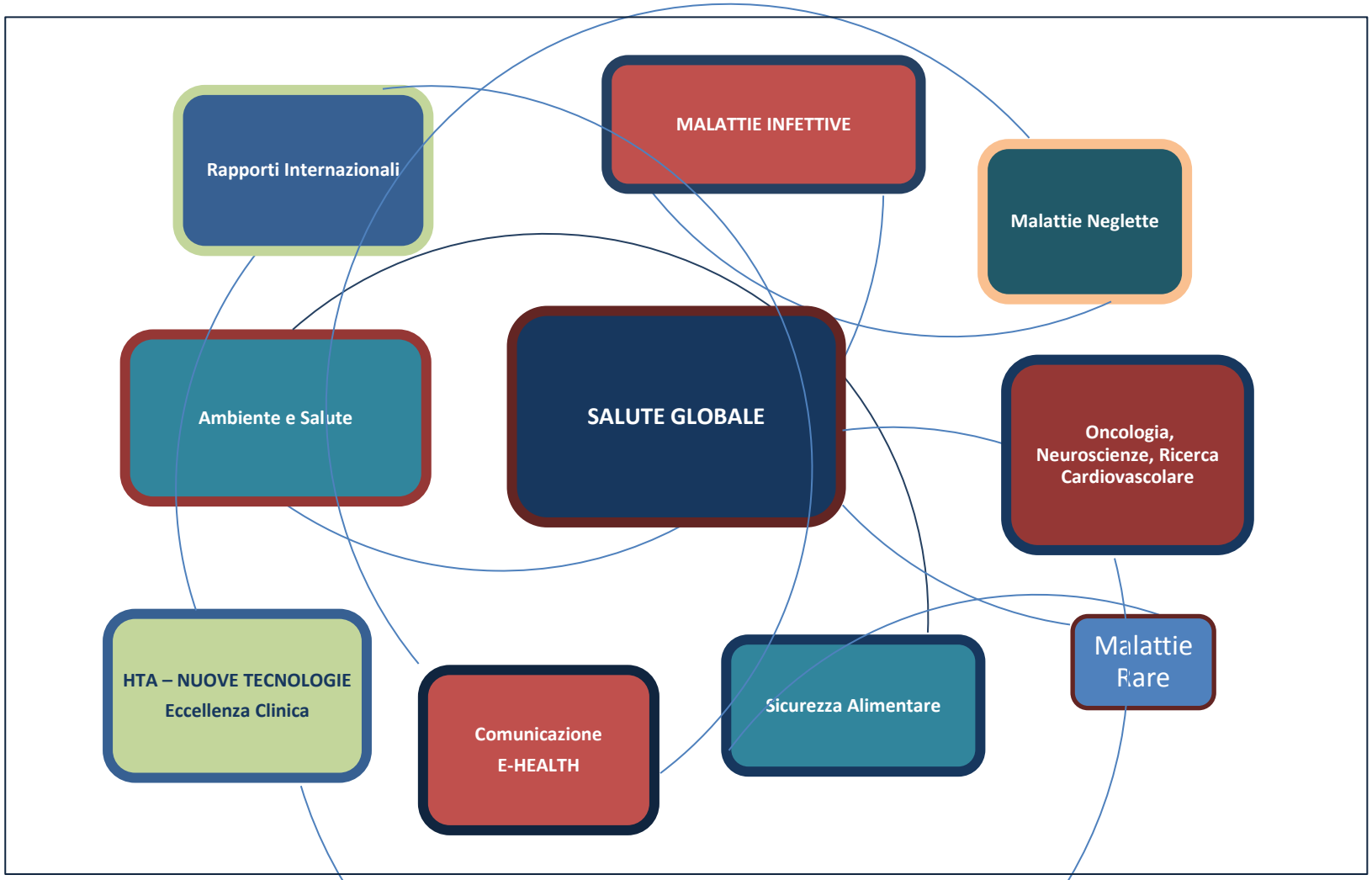
Coinvolgimento della comunità, della società civile e delle associazioni di pazienti

Salute Globale: ruolo nel Paese e collaborazioni

L'ISS si propone come riferimento indipendente e terzo delle attività di Salute Globale nel nostro Paese.

L'ISS collabora con le Organizzazioni multilaterali delle Nazioni Unite che si occupano di salute (OMS, UNDP, WORLD BANK, UNAIDS, UNICEF, UNICHRI), con le grandi Istituzioni nazionali (Ministero della Salute) e internazionali, come il Global Fund, con le organizzazioni non governative, con le comunità e le associazioni di pazienti, con l'Agenzia Italiana per la Cooperazione allo sviluppo e il Ministero Affari Esteri, con le strutture che fanno ricerca sulla Salute Globale a livello Nazionale, Europeo e Internazionale, e con le competenze presenti all'interno dell'Istituto Superiore di Sanità sulle grandi patologie - infettive e non-infettive - le malattie rare e neglette, l'epidemiologia ambientale, la sicurezza alimentare.

AREE DI POTENZIALE COLLABORAZIONE TRA LE DIVERSE COMPETENZE PRESENTI NELL'ISS



Riferimenti

UN Resolution on Universal Health Coverage (2012)

- *Reaffirming* the right of every human being to the enjoyment of the highest attainable standard of physical and mental health, without distinction as to race, religion, political belief, economic or social condition, and the right of everyone to a standard of living adequate for the health and well-being of oneself and one's family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond one's control.

- *Noting with particular concern* that for millions of people the right to the enjoyment of the highest attainable standard of physical and mental health, including access to medicines, remains a distant goal, that especially for children and those living in poverty, the likelihood of achieving this goal is becoming increasingly remote, that millions of people are driven below the poverty line each year because of catastrophic out-of-pocket payments for health care, and that excessive out-of-pocket payments can discourage the impoverished from seeking or continuing care.

Research for Universal Health Coverage

Key messages from *the WHO World Health Report 2013*

Universal health coverage, with full access to high-quality services for health promotion, prevention, treatment, rehabilitation, palliation and financial risk protection, cannot be achieved without evidence from research. Research has the power to address a wide range of questions about how we can reach universal coverage, providing answers to improve human health, well-being and development.

All nations should be producers of research as well as consumers. The creativity and skills of researchers should be used to strengthen investigations not only in academic centres but also in public health programmes, close to the supply of and demand for health services.

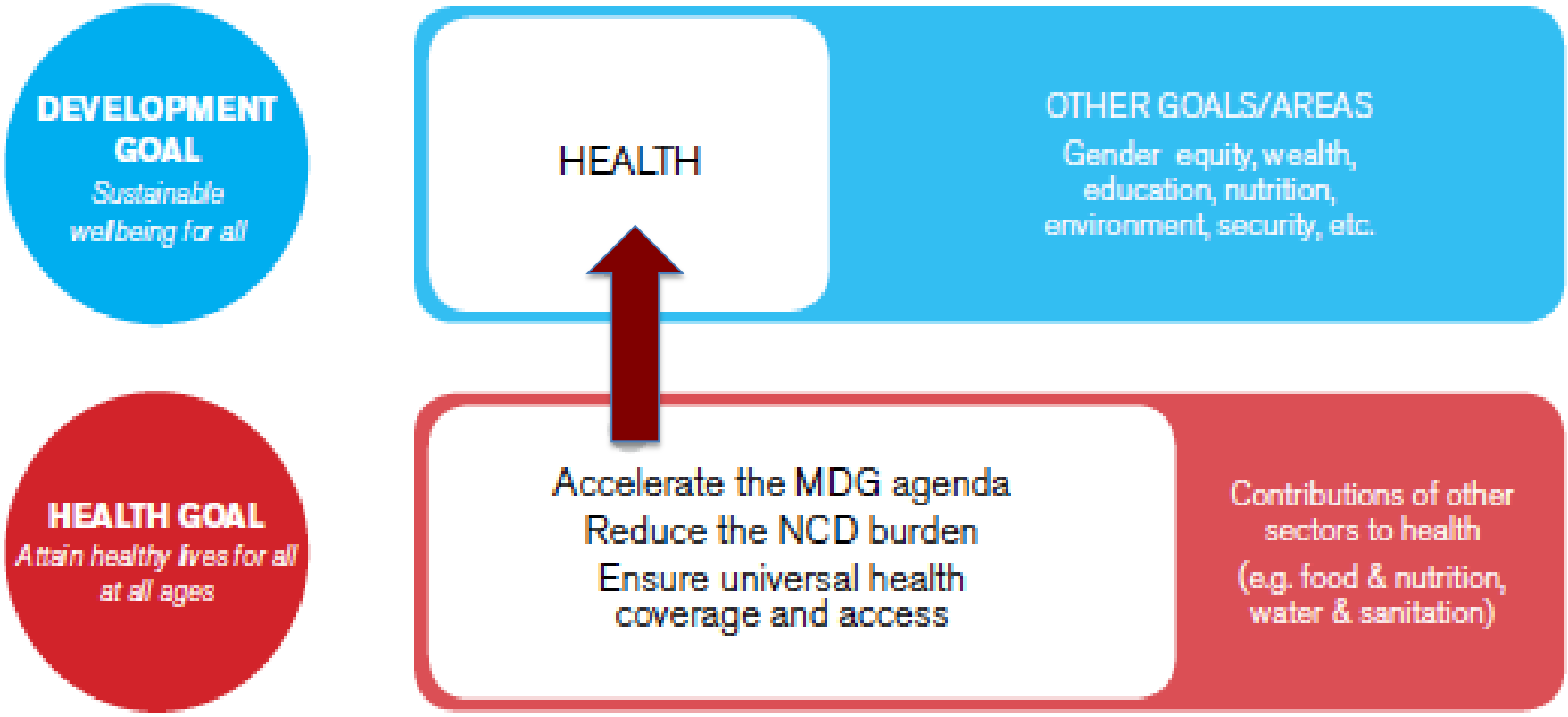
Research for universal health coverage requires national and international backing. To make the best use of limited resources, systems are needed to develop national research agendas, to raise funds, to strengthen research capacity, and to make appropriate and effective use of research findings.

Open Working Group proposal for

Sustainable Development Goals

Figure 1:

Health in the post-2015 development agenda, adapted from the thematic consultation on health[13]



Universal health coverage and the post-2015 agenda

Published Online
September 19, 2014
http://dx.doi.org/10.1016/
S0140-6736(14)61419-7

Most of us have lost count of the number of times we have visited a doctor or health facility. It is something we take for granted: nothing exceptional, simply routine. Yet in our 21st-century world, 1 billion people have never seen a doctor or received quality health services.[1] Furthermore, given that health has not been guaranteed as a global public good, hundreds of millions of people have had to sell assets and take out loans to pay for the health care they need to stay alive and healthy, resulting in 100 million people falling below their countries' national poverty lines each year.[1] No matter how many times governments have acknowledged the right to the highest standard of health, good quality health services remain a luxury available only to those who can afford them.

Today, it is possible to change this reality and ensure that nobody is denied access to the quality health services they need. The global community is working to establish a new international agreement that would commit the world to universal health coverage (UHC). UHC implies that all people have access to nationally determined sets of needed quality health services and essential medicines, without discrimination or risking impoverishment. UHC provides a crucial opportunity not only to end one of the biggest injustices of our time, but also to ensure healthier lives for future generations by strengthening our fight against child and maternal mortality, HIV/AIDS, malaria, and non-communicable diseases.

14 years ago, the leaders of 189 nations signed the Millennium Declaration, committing their countries to fight poverty and promote development by 2015. The Declaration included eight Millennium Development Goals (MDGs) that have since shaped development policies around the globe. Much has been achieved during these years: new HIV infections fell by more than a third between 2001 and 2012,[2] mortality rates from malaria fell by more than 25% between 2000 and 2010, and a total of 51 million patients with tuberculosis were successfully treated between 1995 and 2011, saving 20 million lives.[3] Worldwide, the mortality rate for children younger than 5 years decreased by 41% from 1990 to 2011, and the maternal mortality ratio similarly declined by 47% between 1990 and 2010.[3]

We are now approaching the original deadline for fulfilment of the MDGs, but there is still much to be done. While we are committed to the unfinished health development agenda until 2015, global leaders must now produce a new blueprint for the post-2015 development agenda. Health is a precondition, consequence, and indicator of all three dimensions of sustainable development: economic, environmental, and social. Health is also an essential part of people's lives and a driver of poverty reduction.

As Ministers of Health of both developing and developed countries, we have seen that when the right to health is not fulfilled, the poor and most vulnerable are affected the most. Children from the poorest 20% of households are nearly twice as likely to die before their fifth birthday as children in the richest 20%.[4] For women in one African country, the rate of caesarean sections and the use of modern contraceptive methods are, respectively, 200% and 72% higher in the wealthiest income quintile than in the lower income quintile.[5] The way a health system is organised and financed can help to limit these injustices and inequities.

On Dec 12, 2012, the United Nations General Assembly (UNGA) unanimously adopted a landmark resolution endorsing UHC as a global priority for sustainable development. The General Assembly called upon governments to "urgently and significantly scale up efforts to accelerate the transition towards universal access to affordable and quality health-care services".[6] UHC means that life expectancy and health standards improve for everybody, and that rural poor families,

Hugh Stran/Corbis

Women, children, and adolescents: the post-2015 agenda

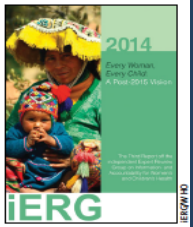
As the global health community and government representatives gathered in New York this week to review progress towards the Millennium Development Goals (MDGs) and considered their successors the Sustainable Development Goals (SDGs), there is some good news to share and some not so good. Child mortality in under-5-year-olds worldwide has fallen from 12·7 million in 1990 to 6·3 million in 2013. Although the present rate of decrease is still not enough to meet MDG 4 (a reduction of under-5 child mortality by two thirds by the end of 2015), it is still remarkable progress. UNICEF released its progress report last week *Committing to Child Survival: A Promise Renewed* and called for maternal, newborn, and child survival to remain at the heart of the post-2015 global development agenda. It argues that newborn survival needs a specific focus to further accelerate progress in under-5 mortality, with 44% of under-5 mortality now among newborn babies.

Progress for maternal mortality and reproductive health (MDG5) is less encouraging. The maternal mortality ratio has fallen by only 22% between 1990 and 2013, which is far off the target of a 75% reduction. Moreover, this average hides increases in some countries. Universal access to reproductive health is patchy at best, with a substantial unmet need for family planning persisting in most low-income and middle-income countries, and important inequities remaining within countries. On Sept 26, World Contraception Day, women and girls everywhere are reminded by the slogan: "it's your life; it's your future; know your options". For many women or girls, however, it is not that simple. Options are either not available or cultural, social, or behavioural factors make true choices impossible. However, there is still some good news. The convergence of reproductive, maternal, newborn, child, and adolescent health, with advocates in these areas seriously trying to talk to each other, form partnerships, and respect and work with each other's focus and agenda is a welcome advance. Programmes with broad support and attention, such as the UN Secretary General Ban Ki-moon's Every Woman, Every Child initiative, the Every Newborn Action Plan, and the Partnership for Maternal, Newborn, and Child Health, ensure that women and children remain at the centre of global health discussions.

However, some areas do not get enough attention. They are either met with deafening silence or insufficient urgency: stillbirths; unsafe abortions; child marriage; violence against women and girls, including female genital mutilation, rape and violence in conflict situations, and rape and violence within marriage; and gender inequality perpetuated by religious beliefs. Yet all these issues have profound implications and immediate consequences for the health and wellbeing of women, adolescent girls, and ultimately their children. The discussions, targets, and interventions need to include these topics, even if some find them uncomfortable; otherwise, progress will not reach those who need it most.

While there is still much to do, now is the time to go a step further beyond rallying behind the common goals that were the MDGs. On Sept 21, the independent Expert Review Group on Information and Accountability for Women's and Children's health (iERG), co-chaired by Richard Horton and Joy Phumaphi, released its 2014 annual and third report and has made proposals towards a new perspective post-2015. It argues that "high-quality health care for women and children should be a right not a privilege" and that two neglected aspects need to come to the forefront. First, the report proposes that the continuum-of-care concept that has integrated reproductive, maternal, newborn, child, and adolescent health needs to be rethought as a lifecycle of wellbeing that is of great importance for sustainability and economic development. The second neglected aspect with the utmost importance for such a broader, more inclusive strategy is the involvement of other non-health sectors to address determinants of health that are outside the health sector, such as education.

A new concept of health that moves away from the notions of absence of disease and survival towards wellbeing, resilience, and capability could be integral to, and unify the many domains of, the currently proposed SDGs. However, iERG warns that we cannot afford to wait for the SDGs to be fully developed and agreed, and argues for a more inclusive Global Strategy for Women's and Children's Health now. Starting this agenda now, with women, children, and adolescent girls at the centre of sustainable development, and the discussions about goals taking this into account, would be a truly remarkable step towards a sustainable future. ■ *The Lancet*



For the **UNICEF report** see http://www.unicef.org/publications/index_75736.html

For the **iERG report** see http://apps.who.int/iris/bitstream/10665/132673/1/9789241507523_eng.pdf

Goal #3 - Ensure healthy lives and promote well-being for all at all ages

- ✓ By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births
- ✓ By 2030, end preventable deaths of newborns and children under 5 years of age
- ✓ **By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases**
- ✓ By 2030, reduce by one third premature mortality from non-communicable diseases
- ✓ By 2030, through prevention and treatment promote mental health and well being
- ✓ By 2030, ensure universal access to sexual and reproductive health-care services.

SDG - Goal #3 - Ensure healthy lives and promote well-being for all at all ages

By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births

By 2030, end preventable deaths of newborns and children under 5 years of age

By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases

By 2030, reduce by one third premature mortality from non-communicable diseases

By 2030, through prevention and treatment promote mental health and well being

By 2030, ensure universal access to sexual and reproductive health-care services.

SDG - Goal #3 - Ensure healthy lives and promote well-being for all at all ages

- Achieve **universal health coverage**, including financial risk protection, **access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines**
- Support the **research and development of vaccines and medicines for the communicable and non-communicable diseases** that primarily affect developing countries, provide access to affordable essential medicines and vaccines.

The NEW ENGLAND JOURNAL of MEDICINE

REVIEW ARTICLE

GLOBAL HEALTH

Response to the AIDS Pandemic — A Global Health Model

Peter Piot, M.D., Ph.D., and Thomas C. Quinn, M.D.

From the London School of Hygiene and Tropical Medicine, London (P.P.); and the National Institute of Allergy and Infectious Diseases, National Institutes of Health, Bethesda, MD (T.C.Q.). Address reprint requests to Dr. Piot at the London School of Hygiene and Tropical Medicine, Keppel St., London SW6 6RE, United Kingdom, or at director@lshtm.ac.uk.

N Engl J Med 2013;368:2210-8.
DOI: 10.1056/NEJMra1201533

JUST OVER THREE DECADES AGO, A NEW OUTBREAK OF OPPORTUNISTIC INfections and Kaposi's sarcoma was reported in a small number of homosexual men in California and New York.[1,2] This universally fatal disease, which was eventually called the acquired immunodeficiency syndrome (AIDS), was associated with a complete loss of CD4+ T cells. Within the first year of its description, the disease was also identified in patients with hemophilia, users of injection drugs, blood-transfusion recipients, and infants born to affected mothers. Soon thereafter, a heterosexual epidemic of AIDS was reported in Central Africa, preferentially affecting women.[3,4] Little did we know at the time that this small number of cases would eventually mushroom into tens of millions of cases, becoming one of the greatest pandemics of modern times.

Within 2 years after the initial reports of AIDS, a retrovirus, later called the human immunodeficiency virus (HIV), was identified as the cause of AIDS.[5] Diagnostic tests were developed to protect the blood supply and to identify those infected. Additional prevention measures were implemented, including risk-reduction programs, counseling and testing, condom distribution, and needle-exchange programs. However, HIV continued to spread, infecting 10 million persons within the first decade after its identification.

An interactive graphic including a prevalence map, a timeline, and details of HIV structure and life cycle is available at NEJM.org

The second decade of AIDS was marked by further intensification of the epidemic in other areas of the world, including the southern cone of Africa, which saw an explosive HIV epidemic. Asia and the countries of the former Soviet Union also reported a marked increase in the spread of HIV. However, by the mid-1990s, with the discovery of highly active antiretroviral therapy, rates of death in developed countries started to decline. The use of antiretroviral drugs during pregnancy also resulted in a substantial decline in mother-to-child transmission of HIV in high-income countries. However, without access to antiretroviral drugs in low- and middle-income countries, rates of death and mother-to-child transmission continued to increase, with 2.4 million deaths and more than 3 million new infections reported in 2001. Of these new infections, two thirds occurred in sub-Saharan Africa.[6]

INTERNATIONAL RESPONSE TO AIDS — A GLOBAL HEALTH MODEL

It was not until the third decade of the epidemic that the world's public health officials, community leaders, and politicians united to combat AIDS. In 2001, the United Nations General Assembly endorsed a historic Declaration of Commitment on HIV/AIDS, a commitment that was renewed in 2011.[7] These actions resulted in the formation of the Global Fund to Fight AIDS, Tuberculosis, and Malaria, which was established to finance anti-AIDS activities in developing countries. In 2003, President George W. Bush announced the President's Emergency Plan for AIDS

Contatto:

Stefano Vella

Istituto Superiore di Sanità (ISS)
Viale Regina Elena 299 - 00161 Roma
Tel.: (+39) 06 4990 6015
stefano.vella@iss.it