Global Fund calls for increased AIDS funding

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As heads of state and government prepare for the upcoming 2005 World Summit in New York on 14-16 September, marking the 60th anniversary of the United Nations, there are concerns that many of the millennium development goals are seriously off track, especially those concerned with reversing the spread of HIV and AIDS.

The UN Human Development Report Office released preliminary figures in June projecting that the UN millennium development goals will be missed by a wide margin in Africa (*BMJ* 2005;330:1350, 11 Jun).

Last week, the Global Fund to Fight AIDS, Tuberculosis, and Malaria held a conference in London, chaired by the UN secretary general, Kofi Annan, and hosted by the United Kingdom's international development

secretary, Hilary Benn.

Announcing a shortfall of £1.6bn (\$2.9bn; €2.4bn) for 2006 and £2.3bn for 2007, a spokesman said, "Donor governments need to at least double their contributions in order to close the gap between what is pledged and what is actually needed to ensure the Global Fund is effective."

The G8 meeting in July at Gleneagles in Scotland committed to getting "as close as possible to universal access to HIV/AIDS treatment for all who need it by 2010" and called for improved health systems in Africa and also for the replenishment of the Global Fund.

Paul Somerfield of TB Alert told the *BMJ*, "Last week African health ministers declared [tuberculosis] to be a continental emergency; HIV and Malaria already are. Given the terrible interaction between [tuberculosis] and HIV, the work of the Global Fund is more crucial than ever and requires sufficient funding."

The Stop Aids Campaign, a UK consortium of charities on AIDS and international development, commented that "the Global Fund obtains virtually all of its money from donor coun-

Children in Uganda—where the Global Fund recently suspended funding—learn of the risk of HIV/AIDS

tries. Additional money should be new money, not funding from other health or development budgets. If we are to achieve universal access to treatment by 2010, at a minimum the Global Fund must meet its fundraising targets."

UNAIDS, the Joint United Nations Programme on HIV/AIDS, estimates a total funding gap of \$18bn between the resources available for all HIV and AIDS efforts and those

needed for 2005-7.

According to the charity Action Aid, "The World Summit presents an opportunity for all member states to commit to universal AIDS treatment by 2010."

The Global Fund has said that it plans to lift its suspension of activities in Uganda next month (*BMJ* 2005;331:475, 3 Sep) after a reorganisation of the country's HIV programme and the installation of outside auditors. □

Newer antihypertensive therapy reduces cardiovascular events

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Antihypertensive therapy based on the calcium channel blocker amlodipine, with the angiotensin converting enzyme inhibitor perindopril added as required, reduced cardiovascular events compared with treatment based on the β blocker atenolol, according to the final results from the Anglo-Scandinavian cardiac outcomes trial—blood pressure lowering arm (ASCOT-BPLA) trial published online this week in the *Lancet* (www.lancet.com, doi: 10.1016/S0140-6736(05)67186-3).

The trial randomised 19 257 hypertensive patients aged 40-79 years with at least three other cardiovascular risk factors to one of two antihypertensive regimens—amlodipine (5-10 mg) with or without perindopril (4-8 mg), or atenolol (50-100 mg) with or without the thiazide diuretic bendroflumethiazide

(1.25-2.5 mg). Additional antihypertensives could be added to achieve a target blood pressure of at most 140/90 mm Hg.

The blood pressure lowering trial was stopped prematurely after a median follow-up of 5.5 years on the recommendation of the trial's data and safety monitoring board after they observed a significant advantage in favour of patients taking amlodipine based treatment.

The final results reported this week at the European Society of Cardiology's annual congress showed a 10% reduction in the primary end point of non-fatal myocardial infarction or fatal coronary heart disease with amlodipine based therapy. This did not reach statistical significance, which the investigators attributed to the study

being stopped early, but showed that fewer individuals on the amlodipine based regimen had a non-fatal myocardial infarction or fatal coronary heart disease compared with atenolol based treatment (429 *v* 474; unadjusted hazard ratio 0.90, 95% confidence interval 0.79 to 1.02, $P=0.1052$).

Further results showed that patients treated with the amlodipine based regimen had significantly lower rates of fatal and non-fatal stroke (327 *v* 422; 0.77, 0.66 to 0.89, $P=0.0003$), total cardiovascular events and procedures (1362 *v* 1602; 0.84, 0.78 to 0.90, $P<0.0001$), and death from any cause (738 *v* 820; 0.89, 0.81 to 0.99, $P=0.025$). The incidence of developing diabetes was lower on the amlodipine based regimen (567 *v* 799; 0.70, 0.63 to 0.78, $P<0.0001$) and new onset renal dysfunction was reduced by 15% ($P=0.02$).

One of the study's authors, Neil Poulter, professor of preventive cardiovascular medicine, Imperial College, London,

and president of the British Hypertension Society, considered that the findings were likely to change the management of hypertension and influence guidelines. " β blockers will no longer be the first choice in uncomplicated hypertension. I think [angiotensin converting enzyme] inhibitors will probably be recommended first line for younger patients and calcium channel blockers or diuretics for older patients." He noted that that the British Hypertension Society is meeting with the National Institute for Health and Clinical Excellence (whose guideline currently recommends initial treatment of hypertension with a diuretic, followed by a β blocker for patients not at risk of diabetes) later this month with the hope of developing a shared set of guidelines for the United Kingdom.

ASCOT was sponsored by Pfizer, New York, with support from Servier Research Group, Paris, and Leo Laboratories, Copenhagen. □