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From Durban to Barcelona:

Overcoming the Treatment Deficit

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1 Introduction

95% of people who have HIV/AIDS live in the developing world. Every day, thousands of people are dying because they do not have access to life-extending antiretroviral therapy. Treating people with AIDS in the developing world is not a choice – it is a necessity. We know it is difficult, but we also know it is feasible. Governments and the international community must now scale up treatment by taking measures to continue bringing down the price of AIDS medications, significantly increase funding, introduce easier-to-use combinations of drugs, and support and carry out operational research to adapt care models to resource-poor settings. This document outlines recommendations to increase access to treatment for people with HIV/AIDS so that they can live longer healthier lives.

AIDS is the world's most disastrous pandemic and it requires bold unhesitating action. There is no reason to be satisfied with the small advances we've seen since Durban; no reason to remain silent or polite about the more than 8,000 people we lose to AIDS every day. We must strive collectively to make effective HIV/AIDS treatment a reality for the millions of people who need it.

2 Defining the treatment deficit

“ *The doubters said it was impossible, too expensive or impractical. Let them say that to our patients who are under ARV treatment and thriving in Khayelitsha. The challenge now is to repeat this and to use successful pilot programmes as a guide to scale up.* **”**

Dr Tito August, medical doctor working in Khayelitsha township near Cape Town, South Africa

“ *The important thing is to start somewhere. We can never cover everybody at the same time. But, this is no excuse for doing nothing.* **”**

Jeanne Gapiya, President of l'Association Nationale de Soutien aux Séropositifs et aux Sidéens, Burundi

Two years ago, at a time when the price of antiretroviral (ARV) therapy was considered intractable at US\$10-15,000 per person per year, MSF challenged the status quo by setting US\$200 as an objective for annual treatment cost. Two years later, that objective has almost been reached, yet 96% of people in developing countries who need treatment still go without. Six years after the

advent of triple therapy revolutionised AIDS care in wealthy countries, only 4% of people in developing countries who need treatment have access to it. How can this massive treatment deficit be overcome?

As of July 2002^[1], the World Health Organization (WHO) estimates that, in developing countries, only 230,000 people of the 6 million who are sick enough to need ARVs are receiving them. Half of them live in one country, Brazil. This leaves more than 5.7 million people in developing countries – 96% of those in urgent need – without treatment.

A concerted effort is required to adapt and finance treatment so that we are able to reach a large share of the 5.7 million people who need care today and the millions more that will need it in the coming years.

3 Demonstrating feasibility: treatment is possible in developing countries

The potential for extending life with ARVs in developing countries has long been demonstrated. In Brazil, providing treatment for people with AIDS has transformed a death sentence into a chronic disease. Universal access to AIDS treatment led to a 54% reduction in AIDS deaths between 1995 and 1999^[2].

Experience from pilot projects in African, Asian and Latin American countries now shows that providing effective treatment has concrete clinical benefits as well as dramatic effects on the lives of individuals and their communities.

In the last two years, MSF has initiated nine treatment projects in seven countries – as of July 2002, there are approximately 1,000 patients under treatment. MSF will significantly expand the number of projects and the numbers of patients receiving treatment in the coming year. The intention of MSF's programmes is not to replace health authorities, but rather to improve and extend the lives of people living with HIV/AIDS and to gain experience that can help inform activities to establish and expand national programmes.

At the XIVth International AIDS Conference in Barcelona, consolidated data from these projects in South Africa, Malawi, Kenya, Cameroon, Cambodia, Thailand and Guatemala is being presented. Patients in MSF projects enter the programmes in advanced stages of AIDS (median CD4 cell counts of 48 cell/mm³) and are treated in diverse health care settings, including primary health clinics in poor townships, rural clinics, and outpatient units at district and capital hospitals. The probability of survival for the 743 patients followed was estimated at 93% at six months^[4]. At six months, patients who were weighed^[5] had gained an average of three kilos; patients who had CD4 cell counts^[6] taken had an increase of 104 cells/mm³ on average. In the three projects that systematically tested viral load at six months of treatment^[7], 82% of patients showed undetectable levels of virus in their blood (<100 copies/ml).

[1] According to UNAIDS 40 million people are infected with HIV worldwide, 95% of whom live in developing countries.

[2] National AIDS Policy, Ministry of Health of Brazil, National STD/AIDS Programme, Brazilia, 2001. http://www.aids.gov.br/assistencia/aids_drugs_policy.htm

[3] n=684

[4] Detailed data to be presented at 'Time to Treat: Transforming AIDS Treatment from Right to Reality', Satellite Meeting Co-sponsored by Médecins Sans Frontières (MSF) and Health GAP (Global Access Project), July 7, 2002, XIV International AIDS Conference 2002, Barcelona.

[5] n=228

[6] n=200

[7] n=118

Patients' compliance to treatment has also been impressive, with 95% of patients taking their treatment properly at six months. *"We're not surprised that patients are living longer – after all, we know the medicines work – and we were confident that people would be able to take their medicines consistently, although others expressed scepticism. But we've nonetheless been particularly pleased with how conscientious people have been about keeping appointments at the clinics and taking their medicines,"* says Dr Jean-Michel Tassie, MSF/Epicentre.

These projects and others across the developing world clearly demonstrate the feasibility of administering treatment within public health care structures in resource-poor countries. In an attempt to make these projects reproducible, MSF has tried to keep drug prices as low as possible and maximise the use of existing capacity, including human resources. For example, in several projects, lab technicians conduct CD4 counts using Dynabeads® technology with a microscope, eliminating the need for both expensive flow cytometry equipment and highly trained personnel.

4 Many declarations but little action: political will has not translated into adequate funding

In the developing world, some countries are increasing prevention and care programmes and joining forces with the international community to begin reaching people in need of care. In other countries, while local and national NGOs struggle to alleviate suffering, governments continue to develop strategic plans and create national frameworks without treating opportunistic infections or providing ARVs. Dramatic changes have only been achieved when political will has been matched with funding, the fortification of health care systems and the wide availability of affordable medicines – Brazil, Cameroon, Uganda, Botswana, and Thailand are some examples. With a concerted effort and sufficient international support, many countries confronted with low or medium prevalence levels, such as those in Eastern Europe or Central America, would be able to move toward universal coverage. On the other hand, many countries where HIV/AIDS is endemic are developing their own objectives for increasing access but face stalled implementation because of lack of funds.

Alphabet soup of good intentions

- **G8 Summit in Okinawa, July 2000:** "We have widespread agreement on what the priority diseases are, and basic technologies to tackle much of the health burden are in place. We therefore commit ourselves to [...] mobilising additional resources ourselves [...] and working to make existing cost-effective interventions including key drugs, vaccines, treatments, and preventive measures more universally available and affordable in developing countries [...]"^[8]
- **EU Commission "Access" Meeting, September 2000:** The EU adopted a new Communication on "Accelerated action targeted at major communicable diseases within the context of poverty reduction."^[9]
- **OAU Abuja Summit, April 2000:** "We pledge to set a target of allocating at least 15% of our annual budget to the improvement of the health sector."^[10]
- **UNGASS June 2001:** UN Secretary General Kofi Annan announced the creation of a global fund and called for US\$7-10 billion annually in donations from rich countries, foundations and private donors (a Harvard University study estimated that US\$10 billion a year would be required to tackle AIDS alone).

[8] <http://www.g7.utoronto.ca/g7/summit/2000okinawa/finalcom.htm>

[9] European Commission DG Development press release, Brussels 28 September 2000

[10] <http://usinfo.state.gov/topical/global/hiv/01050401.htm>

- **G8 Summit in Genoa, July 2001:** Leaders pledged US\$1.5 billion to the Global Fund over a number of years.
- **4th WTO Ministerial Conference, November 2001:** *Declaration on the TRIPS Agreement and Public Health* is adopted, outlining measures to protect public health and promote access to medicines for all.

Between July 2000 and July 2002 high level meetings and political declarations proliferated. Although the attention of world leaders resulted in the creation of the Global Fund to Fight AIDS, TB and Malaria and led to WHO and UNICEF developing a series of useful tools (see below), most promises remain unrealised.

WHO and UNICEF work to help access affordable AIDS drugs

- **12 ARVs added to essential medicines list:** “12th Model List of Essential Medicines, WHO^{[11, 12]”.}
- **Treatment guidelines issued:** “Scaling up antiretroviral therapy in resource limited settings: guidelines for a public health approach”^[13]
- **Some generic AIDS drugs pre-qualified by WHO:** “Access to HIV/AIDS Drugs and Diagnostics of Acceptable Quality, Pilot Procurement Quality and Sourcing Project”^[14]
- **Detailed pricing information on AIDS drugs disseminated:** “Sources and prices of selected drugs and diagnostics for people living with HIV/AIDS”^[15]

The Global Fund illustrates the extent of the funding deficit. So far only US\$2.08 billion^[16] have been pledged and only US\$700-800 million will be available for disbursement in 2002^[17]. This figure is less than a tenth of what is estimated to be required each year to tackle AIDS alone^[18]. It is instructive to examine how closely country contributions match their share of the total need. A recent analysis of country pledges versus their share of the total UN-assessed annual need shows the extent of the funding deficit (in the study, need is defined as US\$10 billion, with \$1 billion coming from the private sector). A review of the G7 and other high Human Development Index countries showed that only Sweden and Italy contributed 15% or more of their share for 2002, while the three wealthiest countries – the US, Japan and Germany – all contributed 7% or less than their share^[19]. If the countries had funded at the \$9 billion level, this would have represented only 0.035% of each country’s Gross Domestic Product (GDP).

In addition, many developing countries’ political declarations have not led to significant increases in health allocations. Health ministers are often stymied by a lack of funds, both because health funding is not prioritised, and because national resources are insufficient to meet the overwhelming need.

[11] April 2002 <http://www.who.int/medicines/organization/par/ed/>

[12] The additions to the essential drugs list are abacavir, didanosine, efavirenz, indinavir, lamivudine, lopinavir, nelfinavir, ritonavir low-dose, saquinavir and stavudine. Zidovudine and nevirapine were already on it for mother-child transmission, but are now listed as well for HAART.

[13] http://www.who.int/HIVAIDS/HIVAIDSCare/ScalingUpARVGuidelinesFinal_E.pdf

[14] <http://www.who.int/medicines/organization/qsm/activities/pilotproc/pilotproc.shtml> April 2002

[15] Fourth Edition May 2002, available on the websites of all four organisations

[16] http://www.globalfundatm.org/files/Financial_contributions280502.htm

[17] The Global Fund: Which Countries Owe How Much? 21 April, Tim France, Gorik Ooms and Bernard Rivers. Available in publications section of <http://www.accessmed-msf.org>

[18] Attaran A, Sachs J. Defining and refining international donor support for combating the AIDS pandemic. January 6 2001, *Lancet* 357, 9249.

[19] *Ibid.* 18

5 Lack of funding leads to a false treatment versus prevention dichotomy

“ When public health experts from the US and Europe tell us that we should exclusively focus on prevention because it is more cost-effective, we have to ask them to consider: if this epidemic was ravaging your community, would you recommend exclusively focusing on prevention and letting the already infected die? ”

Dr David Evans, MSF Mozambique

“ I have a patient who is a rickshaw driver and he recently gave me a lesson in cost-effectiveness. Before he began treatment he said he only had the energy to work for part of the day and he earned the equivalent of US\$1.50. Since he began ARVs he works a full day and earns US\$4.50. Not only can he now afford to care for his family but he said he could also afford to contribute to his own care (his drug cost is less than a dollar a day). ”

Dr Catherine Quillet, MSF Cambodia

The dramatic deficit in AIDS funding has led to debates about how to allocate scarce resources, and some have argued that prevention is more cost-effective than treatment^[20, 21]. One observer stated that “to maximise health benefits, the next major increments of HIV funding in sub-Saharan Africa should be devoted mainly to prevention and to some non-HAART treatment and care”^[22].

Not only is it medically unethical to deny people living with HIV/AIDS existing treatments, it is also ineffective to separate prevention and treatment interventions: access to treatment creates conditions that improve the effectiveness of prevention programmes. MSF teams working in Malawi, for example, report that providing AIDS treatment has helped to break a pattern of denial and stigma towards people living with HIV/AIDS. For the first time people are disclosing their HIV status and a dynamic has been created that has greatly increased voluntary counselling and testing – an important step for all prevention activities.

Cost-effectiveness studies are economic analyses that are never used to exclusively guide health care policy in the developed world. For example, although we have clear evidence that smoking is responsible for 50% of all avoidable deaths^[23] yet, we have not shifted resources away for cardiac care to smoking prevention. It is a gross double standard to recommend this decision-making approach for sub-Saharan African countries and other developing countries.

In Brazil, treatment provision has resulted in overall cost-savings for the government thanks to avoided hospitalisations and a reduction in the burden of opportunistic infections. Savings totalled US\$472 million between 1997 and 1999, and 146,000 avoided hospital stays were avoided^[24]. Moreover, the enormous social and economic benefits of treatment cannot be ignored – fewer children are orphaned, people live longer and, because they are healthier, can remain productive members of their communities and societies at large.

[20] Creese A, Floyd K, Alban A, Guinness L: Cost-effectiveness of HIV/AIDS interventions in Africa 359, 9318, 11 May 2002.

[21] Marseille E, Hofmann P, Kahn J HIV prevention before HAART in sub-Saharan Africa. Lancet 359, 9319, 25 May 2002.

[22] Ibid.22

[23] European Heart Journal p 1434-1503, Volume 19, Number 10, October: Prevention of coronary heart disease in clinical practice. Second Joint Task Force of European and other Societies

[24] National AIDS Policy, Ministry of Health of Brazil, National STD/AIDS Programme, Brazilia, 2001. http://www.aids.gov.br/assistencia/aids_drugs_policy.htm

The international community should not support a logic that justifies denying people with HIV/AIDS life-saving treatment because it is not “cost-effective.” Physicians in the developing world should not have to tell their patients that effective treatment exists but that they cannot have access to it.

6 Moving beyond the status quo

There are currently two co-existing approaches to increasing access to AIDS medicines. One is the industry-led Accelerating Access Initiative (AAI). In this system, UNAIDS and WHO help countries to develop HIV/AIDS plans and then play a facilitator role between countries and companies to negotiate discounted prices. Companies set the rules and offer different levels of discounts to selected types of purchasers. Country eligibility restrictions for these prices vary widely between companies. MSF’s report “Untangling the web of price reductions”^[25] details company-specific eligibility restrictions.

An alternative to the industry-led approach is already being utilised in countries such as Brazil, Thailand and Cameroon. These countries have taken advantage of several strategies simultaneously – including local production, importation of generics and forceful negotiations with proprietary companies – to bring prices down.

While AAI has led to some systematic price reductions by some companies in sub-Saharan Africa, on a global level the approach has been ad hoc. The result is that while significant numbers of patients are benefiting from treatment under AAI, countries that have produced or sourced the most affordable drugs on the worldwide market have been able to get treatment to significantly more people. After more than two years, the 11 countries receiving discounted drugs through the AAI framework have brought approximately 27,000 patients under treatment^[26]. In contrast, Brazil alone has more than 115,000 patients under treatment. Countries are treating more people using generic versions of some first-line regimens than they would using AAI discounted drugs.

Below are two graphs showing the dramatic difference between prices of generic and originator versions of AZT/3TC and nevirapine, two possible components of recommended first-line treatment.

[25] Untangling the Web of Price Reductions: A Pricing Guide for the Purchase of ARVs for Developing Countries, 2nd Edition, 26 June, 2002. <http://www.accessmed-msf.org/prod/publications>.

[26] Accelerating Access – Summary Status for the 4th Meeting of Contact Group, 28th May 2002

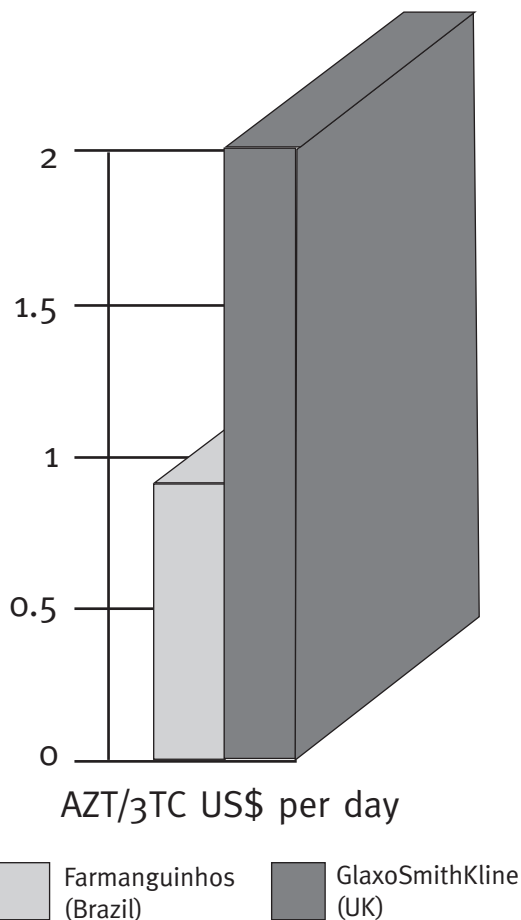
The Brazil and South Africa Cases

For countries with large markets and the ability to produce medicines, a compulsory licence can be a powerful tool to lower prices. In Spring 2001, Brazil threatened to override Roche's patent on nelfinavir and produce the drug locally. Faced with this credible threat, Roche capitulated and offered the Brazilian government a price of US\$2,101 per year per patient. This was at a time when Roche's lowest worldwide price for LDCs and African countries was US\$3,087 (a difference of 32%).

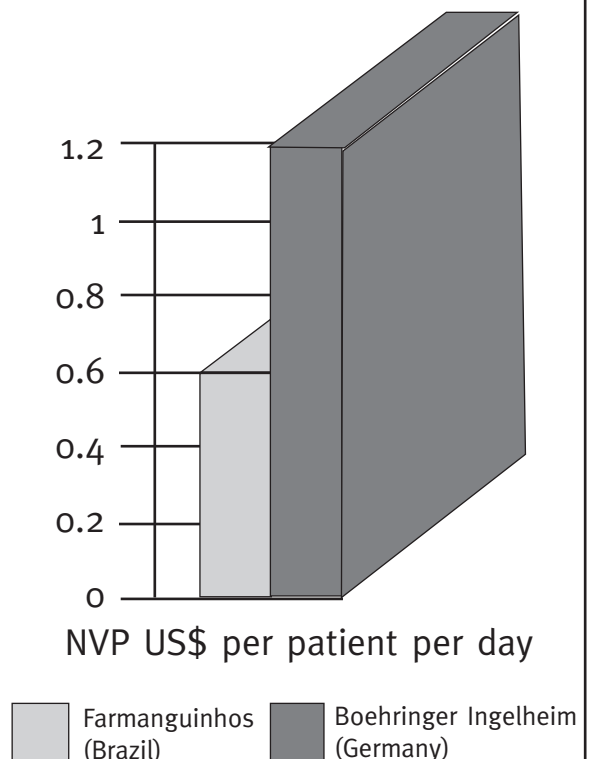
In South Africa, MSF received special authorisation from the Medicines Control Council to use Brazilian drugs, bringing the cost of triple therapy down by 50% (see graph below). This means that twice as many people can be treated on the same budget. Prices could be brought down even more, 2.7 to 3.5 times, if the South African government practised equitable pricing by sourcing from other generic manufacturers^[27].

However, since ARVs are under patent in South Africa, accessing low cost drugs would require the South African government either to negotiate a better price with originator companies or to override the companies' patents with a compulsory licence. The legal mechanisms to issue compulsory licences are already in place in South Africa – it is up to the government to use them.

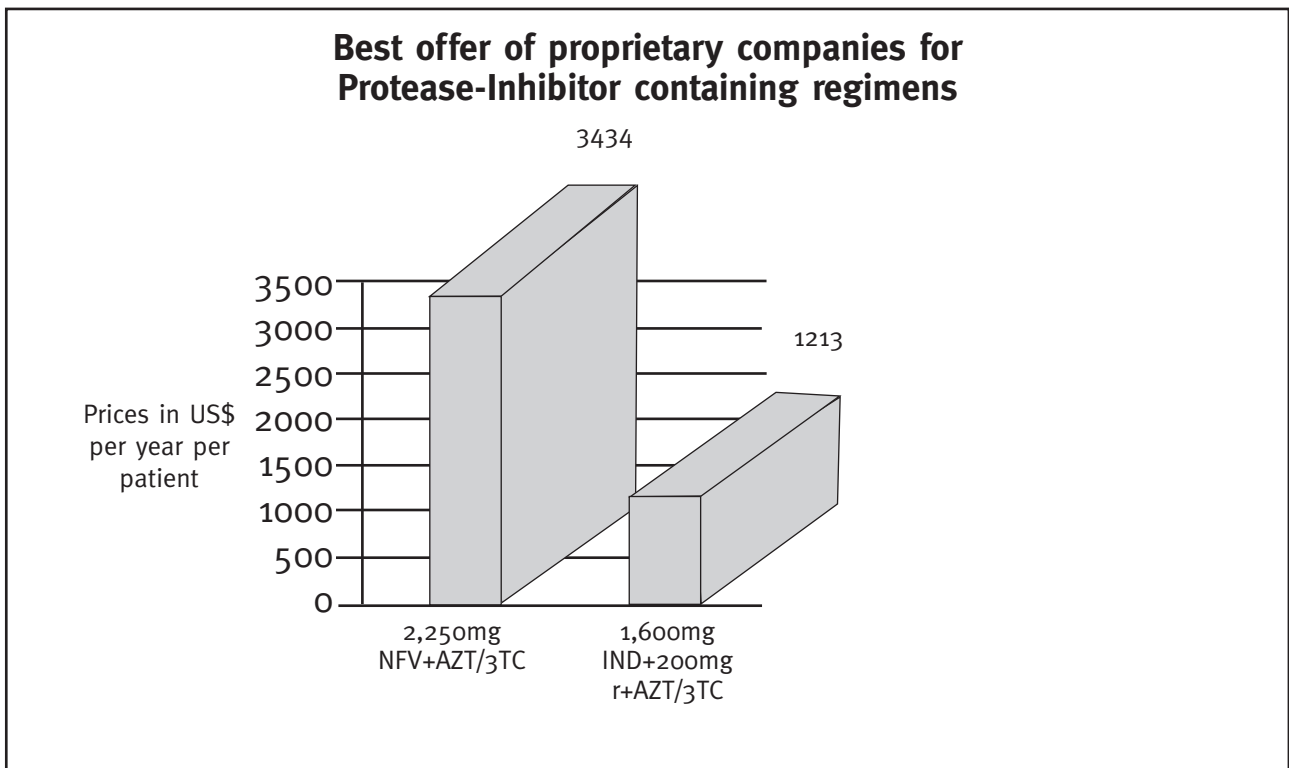
Difference in price of AZT/3TC in South Africa



Difference in price of NVP in South Africa



However, this option does not exist for protease-inhibitor based regimens, because there are few generic versions available and the originator drugs are often far too expensive, even under AAI. Significant price reductions in originator products are essential to make protease-inhibitor based regimens more widely available. Some companies are doing better than others. For example, today's best offer from Roche for nelfinavir, after over two years of participating in AAI, is US\$2,704^[28] per year per patient; in contrast Merck's price for a drug of the same class (indinavir) is US\$600^[29] per year per patient, which leads to an important difference when comparing the annual costs of the recommended regimen as shown in the graph below^[30]. Because of the side-effect profiles of the two drugs, there is significantly more demand for nelfinavir in developing countries. However, Roche's current price blocks access to this drug.



Another limitation of AAI is that most of the originator companies do not have clear policies concerning countries outside sub-Saharan Africa. Bristol Myers Squibb, for example, applies its discounts to wholesale and retail purchasers in sub-Saharan Africa, but refuses to offer significantly discounted products to Central American national programmes, and places arbitrary restrictions and burdens on potential recipients.

A similar challenge exists with diagnostic and monitoring tools. A significant part of the cost of tests comes from reagents, the chemicals that are used to run the tests. Like drugs, these reagents are expensive in part because they are only produced by a handful of pharmaceutical companies. In the absence of competition, diagnostic companies often sell at monopoly prices. For example, one viral load test costs US\$250 in Honduras for an individual and US\$180 when bought in quantity. However in Guatemala City, Guatemala, individuals pay US\$140 and volume purchases cost US\$70 per test. To put these numbers in perspective, in Geneva, Switzerland, the same test costs individuals US\$141.

[27] Untangling the Web of Price Reductions: A Pricing Guide for the Purchase of ARVs for Developing Countries, 2nd Edition, 26 June, 2002. <http://www.accessmed-msf.org/prod/publications>.

[28] Roche decreased the price of nelfinavir in April 2002 for all Least Developed Countries and countries of sub-Saharan Africa to US\$2102 per patient per year. But this new offer is only available when procuring more than 5,500 packs, which is a bigger volume than is actually being purchased by most entities buying ARVs.

[29] For a daily dose of 2,400mg for indinavir.

[30] Annual costs, including ritonavir booster for indinavir, were calculated according to WHO's "Scaling up antiretroviral therapy in resource limited settings: guidelines for a public health approach", http://www.who.int/HIVAIDS/HIVAIDSCare/ScalingUpARVGuidelinesFinal_E.pdf

7 Equitable access: competition as a driving force

“ Twenty-five years ago, the United Nations Children’s Fund and its partners created a model that could be used in the AIDS fight when we found a way to immunize millions of desperately vulnerable children against preventable diseases in the developing world. Now UNICEF is prepared to step forward as the lead UN agency in the procurement of antiretroviral drugs on behalf of individual countries. We were able to develop effective strategies for funding, procurement, and distribution of vaccines – and these same approaches can help the world fight AIDS.^[19] ”

Carol Bellamy, Executive Director, UNICEF

MSF supports an “Equitable Access” approach to keeping down the price of drugs, where policies are implemented to ensure that the price of a drug is fair, equitable and affordable, both to individuals and the health systems that serve them. Equitable pricing is based on the principle that the poor should have access to, and pay less for, essential medicines. To ensure this, developing country patients and communities, governments, UN agencies and the newly established Global Fund to Fight AIDS, TB and Malaria must all participate in encouraging purchases from the lowest cost reliable supplier through competition and local production. WHO and UNICEF should offer technical support, including pre-qualification of medicines, bulk purchasing and assistance in overcoming patent barriers to access more affordable medicines.

An important element of equitable pricing is generic competition, a strategy that has proven to be the most effective means of lowering drug prices. During the last two years, originator companies have only consistently cut the prices of their drugs when faced with generic competition and international public pressure.

An Equitable Access approach would need to include clear guidelines for differential pricing of new drugs, technology transfer and support to scale up local or regional production and address intellectual property barriers effectively. The UN has in fact begun to develop strategies that could fit into this model, for instance pre-qualification of medicines to help national governments identify quality producers^[31]. They must also show leadership to make affordable drugs widely available, including bulk ARV procurement and clear guidelines for price reductions of new drugs. Such a system will lead to a significant increase in volume and could move us quickly to a first-line treatment cost of US\$50-100 per patient per year. Recent experience shows that this level of price reduction is possible. For example, in three years, the price of fluconazole (used to treat AIDS-related meningitis and other fungal infections) dropped 84-fold^[32]. Vaccines and contraceptives have also experienced dramatic drops in price (see box below).

Decrease on prices attained with UNICEF procurement of Vaccines			
Cost of vaccination	US retail price	UN price	Differential
Polio Vaccine (per dose)	\$10.93	\$0.087	125 x
Hepatitis B Vaccine (per dose)	\$24.20	\$0.54	45 x
Oral Contraceptives (per cycle)	\$30.00	\$0.14-0.23	130-214 x

[31] 4th edition, May 2002. Pilot procurement, quality and sourcing project; Access to HIV/AIDS drugs and diagnostics of acceptable quality. <http://www.who.int/medicines/organization/qsm/activities/pilotproc/pilotproc.shtml>

[32] Minimum prices for fluconazole 200mg tablet in different surveys (2000, 2001, 2002) of UNICEF-UNAID Secretariat-WHO-MSF joint project “Sources and Prices of Selected Drugs for People Living with HIV/AIDS”. The lowest price included in this comparison corresponds to recent offers for developing countries by a generic company (US\$ 0.10/tablet).

[33] 4th edition, May 2002. Pilot procurement, quality and sourcing project; Access to HIV/AIDS drugs and diagnostics of acceptable quality. <http://www.who.int/medicines/organization/qsm/activities/pilotproc/pilotproc.shtml>

The Effects of Generic Competition

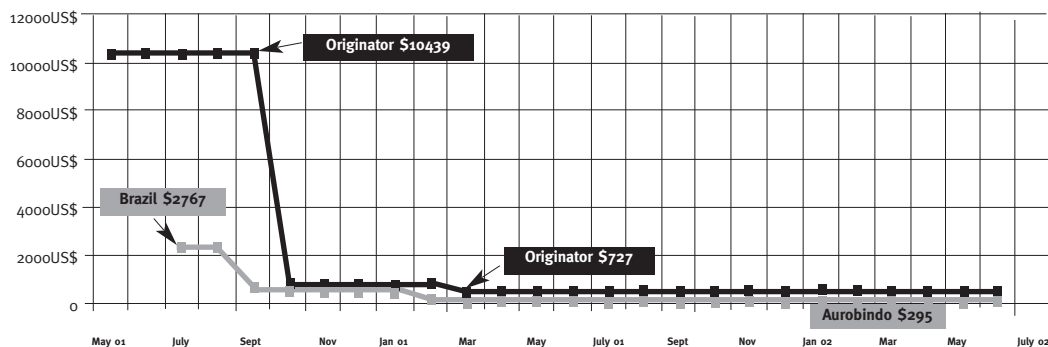
Sample of ARV triple-combination:

Lowest world prices per patient per year

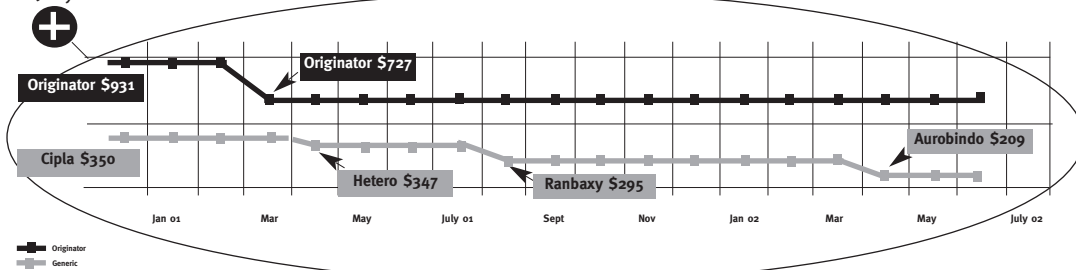
(stavudine (d4T) + lamivudine (3TC) + nevirapine (NVP))

Generic competition has shown to be the most effective means of lowering drug prices. During the last two years, originator companies have often responded to generic competition.

May 2001-July 2002



January 2001-July 2002



Supporting equitable pricing

Pre-qualification. For developing countries that do not have strong regulatory authorities, creating a reliable process to assess the quality of generics of HIV/AIDS related medicines may be difficult. For this reason, WHO's pre-qualification^[33] system is an essential service. When countries are forced to buy drugs at a premium from originator companies because they do not have systems to assure quality of generics, drug prices are kept artificially high. Pre-qualification facilitates the ability of poor countries to pursue the best offers on the world market.

Regional and local production through licensing and technology transfer. The capacity to produce quality antiretrovirals exists today in many developing countries. Brazil and Thailand have dramatically increased affordability of ARVs by producing within government manufacturing organisations. Existing capacity should be enhanced, and used to produce the drugs that are needed. This can be achieved through voluntary licensing agreements with originator companies, or compulsory licensing if multinationals choose not to cooperate.

Aggregating demand and organising purchases through global/regional procurement. Experience with vaccines and contraceptives show that prices dramatically fall with large volume purchases and centralised procurement. UNICEF, in collaboration with UNAIDS and WHO, could play a critical role by organising centralised procurement of antiretrovirals on behalf of individual countries. UNICEF has a proven track record for funding and distribution. Prices would also be brought down by pooled procurement at regional level.

Regional procurement in Central America

Unfortunately for people with HIV/AIDS in Central America, originator drug companies have decided, with the exception of Merck (which defines countries based on their United Nations indexes of HIV prevalence and Low and Middle Human Development) to handle discounts on a case-by-case basis.

In Guatemala and Honduras, where most ARVs are not protected by patents, MSF has received Ministry of Health authorisation to use generics for pilot projects and is paying dramatically less than originator companies are charging.

However, because these governments have chosen to buy exclusively from originator companies, they are paying 75-99% more than MSF. For instance GSK Institutional offer in Guatemala is US\$ 4,198/year for AZT/3TC, while MSF is importing a generic equivalent at US\$284/year (93% less); meanwhile the National AIDS Programme has reported to buy stavudine to BMS at US\$4,416/year, while MSF was paying US\$45 (99% less).

UNAIDS and WHO, which have been helping countries negotiate within the context of the Accelerating Access Initiative, could change this dynamic. They should insist that the originator companies act consistently – that is, establish a pricing policy for all developing countries and not only for sub-Saharan Africa. They could also include generic companies in the UN-sponsored negotiations.

Making use of the Doha Declaration

“ *The TRIPS^[34] agreement does not and should not prevent members from taking measures to protect public health.* ”

Doha Declaration, November 2001

The 4th Ministerial Conference of the World Trade Organisation (WTO), which took place in Doha, Qatar, in November 2001, was a breakthrough in the international debate about the impact of the TRIPS Agreement on access to medicines. One hundred and forty two countries adopted a Declaration on the TRIPS Agreement and Public Health,^[35] driven largely by developing countries, which firmly placed public health needs above commercial interests and offered much needed clarifications about key flexibilities in the TRIPS Agreement related to public health^[36].

Although the Declaration is a strong political and legal document, countries will only benefit from it once they have enacted pro-public health intellectual property rights legislation and started routinely issuing compulsory licence provisions to encourage the availability of more affordable medicines.

However, the US and other wealthy countries are quickly renegeing on the historic commitment they made in Doha in several ways. The Doha Declaration left one issue unresolved that could potentially hamper poor countries access to medicines. In 2005, once the TRIPS Agreement is fully implemented, countries such as India and Thailand, which produce generic medicines and export them to other developing countries may no longer be able to do so for new drugs. This is because the TRIPS Agreement limits compulsory licences “predominantly for the supply of the domestic market”. Today, a significant portion of antiretrovirals in Africa are generics. But how will countries

[34] More information about the WTO Agreement on Trade-related Aspects of Intellectual Property Rights (TRIPS) can be found at: http://www.wto.org/english/tratop_e/trips_e/trips_e.htm

[35] Full Declaration available at http://www.wto.org/english/thewto_e/minist_e/mino1_e/mindecl_trips_e.htm

[36] Ellen 't Hoen, TRIPS, Pharmaceutical Patents and Access to Essential Medicines: A Long Way from Seattle to Doha. Chicago Journal of International Law, vol.3, no.1, Spring 2002.

that do not have the capacity to produce themselves find suppliers of affordable medicines after 2005, when producing countries must become TRIPS-compliant? Along with other NGOs, MSF proposes a patent exception rule to allow countries to produce for export in order to fulfil a compulsory licence or a health need in a country that does not have production capacity^[37], but the US and the EU are opposing such a solution. In addition, the US is attempting to undo the gains in Doha through negotiations on bilateral and regional trade agreements, such as the Free Trade Area of the Americas (FTAA). It is clear in information in the FTAA negotiating objectives of the US^[38], for example, that the US is pushing to impose “TRIPS-plus”^[39] requirements, and that these standards directly contradict the spirit and letter of the Doha Declaration.

8 Adapting treatment to clinical reality

There is an urgent need for a new simplified model that will facilitate reaching significant proportions of people in need of treatment in developing countries. This entails the quick introduction of affordable monitoring tools and fixed-dose, once-a-day formulations, as well as operational research to explore adapting treatment to clinical reality. For example, rather than doing individual resistance testing, sentinel sites can be set up to monitor resistance on the societal level. Developing country physicians and researchers should lead this process with people living with HIV/AIDS, together with the support of the international community.

Fixed-dose combinations (FDCs). FDCs can improve compliance and avoid development of resistance, and are recommended by the WHO’s 12th Expert Committee on the Use of Essential Medicines^[40]. Ongoing pharmaceutical industry development focused on the needs of people with HIV/AIDS in the US and Europe will lead to new combinations that could potentially be used in developing countries. Of particular interest are the ongoing studies of once-a-day formulations^[41], and single once-a-day formulations being approved^[42]. Generic producers of ARVs are, on the other hand, particularly well placed to develop fixed-dose combinations of recommended regimens. In fact, the only currently affordable fixed-dose formulations in developing countries are being produced by generic manufacturers.

Moving toward a simplified approach. On a parallel track to new formulation development, institutions and physicians working in resource-poor environments should be supported to develop simplified treatment protocols. Research focused on ways to better use clinical markers to reduce dependence on biological monitoring should be supported. At the same time, tests which require less investment and operator expertise, such as Dynabeads and TRAx CD4, should be further developed. Other promising strategies such as structured treatment interruptions that could potentially reduce both the burden of side-effects and the cost of treatment, should also be further investigated.

Among the additional research priorities, there is an urgent need for paediatric formulations adapted for use in developing countries. For example, syrups are often very difficult to store and are packaged in a manner that makes dosing complicated. Solid dosage formulations are often not available in strengths designed for children. One example is the antifungal drug fluconazole, which does not exist as a syrup and is difficult to dose with available capsule strengths.

[37] See joint NGO letter to TRIPS Council (January 2002), available at <http://www.accessmed-msf.org/prod/publications.asp?scntid=12220021732142&contenttype=PARA&>

[38] See <http://www.ustr.gov/regions/whemisphere/intel.pdf>

[39] “‘TRIPS-plus’ is a non-technical term which refers to efforts to: extend patent life beyond the 20-year TRIPS minimum; limit compulsory licensing in ways not required by TRIPS; and limit exceptions which facilitate prompt introduction of generics. Since the public health impact of TRIPS requirements have yet to be fully assessed, WHO recommends that developing countries be cautious about enacting legislation that is more stringent than the TRIPS requirements” (WHO Policy Perspectives on Medicines, No. 3, March 2001).

[40] April, 2002, <http://www.who.int/medicines/organization/par/edl/>

[41] Landman R, Schiemann R, Thiam S, et al. Evaluation at 6 months of a once-a-day HAART regimen in treatment-naive HIV-infected adults in Senegal (ANRS 12-04 Study). 8th Conference on retroviruses and opportunistic infections. Chicago 2001; Abstract 491. Molina J, Ferchal F, Rancinan C, et al. Once-daily combination therapy with emtricitabine, didanosine, and efavirenz in HIV-infected patients. *J Infect Dis* 2000; 182:599-602.

[42] Merck has recently gained approval for a once-a-day formulation of EFV 600 mg, and GSK for a once-a-day version of 3TC 300 mg.

It is not an option to rely exclusively on the private sector which has no incentive to adapt treatments to developing countries. Developing country researchers, along with groups of people living with HIV/AIDS, must have the support of their governments and the international community to further define and implement a research agenda.

9 Recommendations

• Time to Scale Up

The widespread implementation of AIDS treatment programmes remains a huge challenge, but one that we cannot afford to ignore. While NGOs like MSF can help show that AIDS treatment can and must be implemented in resource-poor settings, it is a job for governments and the international community to tackle the pandemic on a global level.

• Deliver On Promises: Put The Money On The Table

One of the most significant barriers to scaling up treatment programmes is the failure of both donor governments and national governments in developing countries to mobilise promised resources for the Global Fund to Fight AIDS, TB and Malaria and other financing mechanisms. Donors have abandoned their responsibility and repeatedly broken promises made over the last two years by pledging just 8% of the estimated funding necessary to scale-up the global response to HIV/AIDS. The time is long overdue for donors and other governments to deliver on their promises.

• Fight False Dichotomy

The dramatic funding deficit has led to debates about how to allocate scarce resources, and some have argued that since prevention is more cost-effective than treatment, treatment should not be a significant emphasis of international efforts. This logic is medically and ethically unacceptable – we cannot stand by and watch millions of people already living with HIV die because treating them is not considered cost-effective. Furthermore, this logic disregards the mutually dependent nature of prevention and treatment in disease control.

• Move Toward Equitable Access

The price of treatment continues to be too high for people with HIV/AIDS in developing countries. The target price of ARV treatment for patients in developing countries should be US\$50-100 and the cost of the treatment monitoring must also drop. This will only happen if Equitable Access, an emerging alternative to the industry-led Accelerating Access Initiative, is fully supported. Equitable Access means: generic competition; clear guidelines for differential pricing of proprietary name drugs; support for technology transfer and scale-up of local or regional production; and UN-led bulk procurement and distribution (including pre-qualification). Implementation of Equitable Access strategies will require involvement and support of people living with HIV/AIDS, leadership from national governments, and support from UN agencies such as WHO and UNICEF.

• Put Lives Before Profits

The WTO Ministerial Declaration on the TRIPS Agreement and Public Health adopted in Doha must be implemented to overcome barriers to access resulting from intellectual property protection. UN agencies such as WHO and WIPO should step up technical assistance to countries to give legislative teeth to the Doha Declaration at the national level. WTO members must implement the Doha

Declaration in good faith by supporting patent exceptions for export of medicines that are produced under a compulsory licence and by showing a clear commitment to the Doha Declaration as the ceiling for negotiations of bilateral and regional trade agreements, such as FTAA.

- **Simplify Treatment**

Treatment must be further simplified: once-a-day fixed-dose combinations should be developed for WHO recommended regimens as soon as possible. In addition to originator pharmaceutical companies, companies in the developing world should be supported to develop easier-to-use formulations. There is also an urgent need to support operational research to develop protocols and efficient low-cost monitoring tools adapted to the reality of resource-poor settings.