“AIDS is not an African problem alone,” UN Secretary-General Kofi Annan has declared. “AIDS is a global problem. But if we do not win in Africa, we are not going to win anywhere else.” He was speaking to African leaders, policy-makers and activists who met recently in Nigeria to map out the continent’s strategy to combat a disease that already has taken 17 million African lives and infected tens of millions more. That effort is a key component of the global fight against AIDS, to be furthered at a special session of the UN General Assembly 25-27 June, as Africa Recovery goes to press with this double issue focusing on HIV/AIDS.

Drug price plunge energizes AIDS fight

Africa and the United Nations mobilizing political leadership

By Michael Fleshman

After 20 years and millions of agonizing deaths from AIDS in Africa, the logjam over the high prices of drugs for treating the disease has been broken. In recent months, under mounting public pressure and through the “quiet diplomacy” of the UN, the pharmaceutical industry has reduced prices for many drugs by 80-90 per cent. In early June, Botswana became the first African country to take advantage of these lower prices, announcing that in the new year it will seek to provide the full range of HIV and AIDS therapies to as many as 100,000 infected citizens.

Until very recently, Dr. Peter Piot, executive director of the Joint UN Programme on HIV/AIDS (UNAIDS), said in late May, the idea of providing costly life-saving drugs and complex medical care to sufferers in developing countries was considered controversial, even radical, by many donor governments, private-sector actors, humanitarian organizations and health care professionals.

Since the introduction of the first life-prolonging treatments for AIDS in 1987, many sufferers in the industrialized North, even among the poor, gained access to the drugs and often lived longer than they would have otherwise. But the afflicted in the impoverished South, aside from the very rich or the very lucky, could not get the medicines and soon died. Critics bitterly termed this disparity “medical apartheid.” UN Secretary-General Kofi Annan has spoken of an “ethical imperative” to treat the sick regardless of means.

Since its launch in 1996, UNAIDS has advocated a two-pronged attack on the disease: combining education
Drug price plunge energizes AIDS fight

and prevention for those not yet infected, with care and treatment for the tens of millions of people around the world who are.

However, many donor officials and health professionals regarded proposals to treat carriers of the Human Immunodeficiency Virus (HIV) that triggers Acquired Immune Deficiency Syndrome (AIDS) as unrealistic, saying that such a course would divert painfully scarce resources away from more cost-effective education and prevention programmes.

The extremely high cost of the drugs put them beyond the reach of all but the wealthiest individuals in developing countries, they noted. Nor were public health systems in poor countries able to cope with the complexity of the treatments, some analysts asserted, or the need for ongoing testing and follow-through.

When UNAIDS called last year for an international multi-billion dollar programme of prevention and treatment for Africa, which now accounts for 70 per cent of all infections worldwide and nearly 80 per cent of fatalities, Dr. Piot noted, “the word ‘irresponsible’ was not far away.”

But no more. In recent months a combination of market forces and mounting political pressures on the pharmaceutical industry have seen prices for many drugs drop drastically. Some now are even provided free to developing countries. Although the discounts still price many of the medicines beyond Africa’s means, the reductions have transformed the debate about costs — which the World Health Organization (WHO) has identified as the principal obstacle to the wider availability of AIDS medicines (see table, this page).

Concerns about delivery in poorer countries have also been challenged. On 4 April, more than 100 medical and development experts at Harvard University in the US declared that “objections to HIV treatment in low-income countries are not persuasive,” and issued a detailed blueprint for a widespread treatment programme (see box, page 11). “Poor infrastructure,” they asserted, “can be overcome through well-designed and well financed international efforts.”

The final element — external financing — received a boost in Abuja, Nigeria, in late April with Mr. Annan’s announcement of a Global AIDS and Health Fund to increase funding for AIDS, malaria and tuberculosis programmes in developing countries from its current level of under $2 bn annually to the $7-10 bn needed.

Although the world has yet to commit the resources and political will needed to win the battle against AIDS in Africa and other developing regions, the “paradigm” as Dr. Piot noted, has now shifted from whether to treat the infected in developing countries to how.

Public outrage, private diplomacy
The turning point in the effort to ensure wider availability for anti-AIDS drugs came in March, when 39 Northern pharmaceutical companies went to court in South Africa to block legislation permitting the government to lower the cost of AIDS-related medications — steps the companies asserted would infringe on their patent rights (see page 14). The suit proved to be a public relations disaster. A month later, amid a firestorm of criticism and worldwide protest actions, the “paradigm” as Dr. Piot noted, has now shifted from whether to treat the infected in developing countries to how.

### Prices of daily doses of AIDS drugs (SUS)

<table>
<thead>
<tr>
<th>Drug</th>
<th>Brazil</th>
<th>Uganda</th>
<th>Côte d’Ivoire</th>
<th>US</th>
</tr>
</thead>
<tbody>
<tr>
<td>3TC (Lamivudine)</td>
<td>1.66</td>
<td>3.28</td>
<td>2.95</td>
<td>8.70</td>
</tr>
<tr>
<td>ddlC (Zalcitabine)</td>
<td>0.24</td>
<td>4.17</td>
<td>3.75</td>
<td>8.80</td>
</tr>
<tr>
<td>Didanosine</td>
<td>2.04</td>
<td>5.26</td>
<td>3.48</td>
<td>7.25</td>
</tr>
<tr>
<td>Efavirenz</td>
<td>6.96</td>
<td>n/a</td>
<td>6.41</td>
<td>13.13</td>
</tr>
<tr>
<td>Indinavir</td>
<td>10.32</td>
<td>12.79</td>
<td>9.07</td>
<td>14.93</td>
</tr>
<tr>
<td>Nelfinavir</td>
<td>4.14</td>
<td>4.45</td>
<td>4.39</td>
<td>6.47</td>
</tr>
<tr>
<td>Nevirapine</td>
<td>5.04</td>
<td>n/a</td>
<td>n/a</td>
<td>8.48</td>
</tr>
<tr>
<td>Saquinavir</td>
<td>6.24</td>
<td>7.37</td>
<td>5.52</td>
<td>6.50</td>
</tr>
<tr>
<td>Stavudine</td>
<td>0.56</td>
<td>6.19</td>
<td>4.10</td>
<td>9.07</td>
</tr>
<tr>
<td>ZDV/3TC</td>
<td>1.44</td>
<td>7.34</td>
<td>n/a</td>
<td>18.78</td>
</tr>
<tr>
<td>Zidovudine</td>
<td>1.08</td>
<td>4.34</td>
<td>2.43</td>
<td>10.12</td>
</tr>
</tbody>
</table>

Source: UNAIDS, 2000
in Abuja. “People no longer accept that the sick and dying, simply because they are poor, should be denied drugs which have transformed the lives of others who are better off.” That revolt — plus an offer by an Indian pharmaceutical manufacturer to sell generic anti-retroviral therapies in developing countries for as little as $350 per year instead of the $10,000-$15,000 annual cost of patented versions — meant that the impasse over pricing was broken.

These developments are the culmination of years of dialogue and “quiet diplomacy” by the Secretary-General and UNAIDS with the pharmaceutical industry and donors over patent protection, drug pricing and other treatment access issues. In the face of private-sector concerns over the loss of patents and the absence of clinical facilities for the proper administration of drug therapies, initial discussions focused on a number of pilot drug treatment programmes in Uganda, Senegal and other developing countries.

These limited efforts, part of UNAIDS’s Accelerating Access Initiative, together with a growing number of private sector and philanthropic research and charitable programmes, were intended to identify practical impediments to care and treatment. They also helped establish a working relationship and a common frame of reference among the stakeholders. In early April, Mr. Annan was able to emerge from a meeting with six major drug companies to announce both substantial new drug price reductions for the least developed countries and UN support for patent rights as a “key to bringing forth new medicines, vaccines and diagnostics urgently needed for the health of the world’s poorest people.”

In response the US pharmaceutical giant Pfizer announced in early June plans to provide fluconazole, widely used to combat a range of opportunistic infections in AIDS patients, to 50 of the poorest countries free of charge — among a range of private sector initiatives launched in the run-up to the General Assembly special session on AIDS.

**Quick fix**

AIDS, Dr. Piot has said, “is a tale of globalization, of the rapid global spread of a mainly sexually transmitted disease, of global inequities and of the need for a truly global response.” Nowhere have those inequities been more tragically played out than in Africa, where despite 2.4 million AIDS deaths last year alone, researchers estimate that fewer than 10,000 people have access to the anti-retroviral medicines that in developed countries have largely transformed AIDS from a death sentence into a chronic illness.

Access to drugs is meaningless, however, without the ability to deliver and administer the complex treatments and offer voluntary testing and counselling — services also deemed vital to effective education and prevention programmes. Public health services in much of Africa are desperately under-funded, often inaccessible, especially to the vast majority of people in rural areas, and are sorely lacking in trained health care professionals and diagnostic and testing facilities. While there is general agreement among development and health specialists on the need to rebuild the public health system in Africa, activists argue that such long-term fixes will come too late for Africa’s 25 million AIDS sufferers.

One possible solution has been developed at Harvard University, where over 100 faculty members have signed a statement arguing that both anti-retrovirals — drugs that attack the HIV virus itself — and treatments for the many “opportunistic diseases” caused by the viral assault on the body’s immune system, can be delivered to patients in developing countries almost immediately. The Harvard blueprint is based on a pilot project the university initiated in Haiti in 1998. It utilizes community-based monitors with minimal training to administer medications, backed by modest investments in expanded blood testing and diagnostic facilities.

By targeting patients in the late stages of HIV infection for treatment with highly active anti-retroviral therapy (HAART), which has proven extremely effective in suppressing the virus in the body, the study asserts that 3 million Africans could be on the life-saving treatments within five years, at a cost of some $6 bn.

As new and simpler medications are developed and economies of scale lower drug prices still further, Harvard researchers anticipate that the cost of the programme will decline. They also note that community monitors can also administer drugs for other common diseases, including tuberculosis and malaria, serving as frontline medical personnel while national public health
services are refurbished and expanded.

Vastly more counselling and testing for HIV is central to both prevention and treatment efforts, UNAIDS asserts, an issue that can get lost in the sometimes polarized debate between advocates of prevention and those of treatment. In 1993, for example, scientists discovered that a single dose of a common anti-AIDS drug, AZT, could cut the transmission of the HIV virus from mother to child at birth. Eight years later just 1 per cent of African women have access to the testing needed to identify pregnant HIV-positive women for treatment, UNAIDS reports. The absence of testing and counselling facilities thereby hampers making broad use of this simple and inexpensive means of preventing the transmission of the disease to future generations.

Without widespread and confidential testing, researchers note, people will not know that they are infected until they become sick, increasing the likelihood that they will inadvertently infect others. In any event, if the only outcome of a positive HIV test is pronouncement of a death sentence and social ostracism, individuals have little incentive to be tested even where testing is available.

When the first cases of a mysterious new disease were reported in 1981, “I never imagined I was looking at the first sign of an epidemic that in just 22 years would have infected 60 million people, killed 22 million and achieved the status of the most devastating epidemic in human history.”

— Dr. Peter Piot, executive director
Joint UN Programme on HIV/AIDS (UNAIDS)

Medical apartheid
In 1981, a brief entry in an obscure US medical publication noted the cases of five young men whose immune systems had been unaccountably destroyed. A young doctor named Peter Piot was one of just a handful of people around the world who noticed. “At the time I read the report with great interest,” he recalled. “But I never imagined I was looking at the first sign of an epidemic that in just 22 years would have infected 60 million people, killed 22 million and achieved the status of the most devastating epidemic in human history.”

In Africa, it was also long ignored — by African leaders, Northern donors and international financial institutions, which continued to gut African health and education budgets while the body count climbed into the millions.

Only in mid-1999, Dr. Piot noted, did donors first meet to consider the escalating tragedy in impoverished Africa. And only now, 17 million deaths later, does the world seem finally prepared to muster the resources needed to save the survivors and prevent new infections.

The initial response to the Global AIDS and Health Fund has been modestly encouraging, with the US announcing an initial $200 mn contribution, followed by a French contribution of €150 mn and a $1 mn contribution from the Winterthur Insurance Company, an affiliate of the Credit Suisse Group. As Africa Recovery went to press, the Bill and Melinda Gates Foundation announced a $100 mn contribution to the fund.

In early June, representatives from more than 50 countries, multilateral agencies and non-governmental organizations and private philanthropies met in Geneva to discuss the structure and priorities of the fund, which is expected to begin operating at the end of the year. Initial indications suggest that the fund will focus primarily on education and prevention, with drug access and treatment efforts limited to pilot projects.

Advocates for greater emphasis on treatment, including some in the private sector, anticipate that the fund will eventually become a significant source of funding for medicines in developing countries. On 11 June, Mr. Jean-Pierre Garnier, the head of the European drug company GlaxoSmithKline, announced a new round of price cuts in developing countries for some of the company’s most commonly prescribed HIV/AIDS medications, but acknowledged that the discounts still left the drugs beyond the reach of the poor. “We’re not naïve about the fact that, compared to the means in these countries, everything is overpriced,” he told reporters. He added that he expected the international community, through mechanisms like the health fund, to make up the difference. “The ball,” he asserted, “is more in their camp than ours.”