stop AIDS campaign

How the G8 can keep the promise of Universal Access by 2010

February 2007

Overview

At the G8 Summit in 2005, the UK Government led world leaders in committing to "develop and implement a package for HIV prevention, treatment and care, with the aim of as close as possible to universal access to treatment for all those who need it by 2010." In June 2006, all UN member states further promised "universal access to comprehensive prevention programmes, treatment, care and support by 2010".

The 2007 G8 process, hosted by Germany, is a critical opportunity to keep these promises and deliver life-saving services to communities affected by HIV and AIDS across the world. With HIV and AIDS included in Germany's priority agenda items, comprehensive measures to meet the Universal Access target must be delivered. This opportunity cannot be missed if leaders are serious about stopping a pandemic that has already claimed over 30 million lives.

The need for urgent and decisive action is clear. Despite the promises made, with less than 3 years to go until the target date for Universal Access, over 75% of people, including over 90% of children, are not receiving the HIV treatment they urgently need[1]. As a result, almost 3 million people died of AIDS-related illnesses in 2006.

The Stop AIDS Campaign has identified four key areas that the G8 *must* deliver on to make the goal of Universal Access real. These are:

- Financing universal access
- Strengthening health systems
- Ensuring affordable medicines
- Supporting women and children

It is morally and politically imperative that the G8 deliver on ***all*** these areas for an effective, comprehensive and sustainable response. The UK must advocate strongly in the G8 process to ensure that 2007 does not betray the promises of Universal Access, but finally delivers for communities across the world.

What the G8 must do:

Financing Universal Access

Ensure the scale-up to universal access is fully and sustainably financed by:

- Agreeing a comprehensive, long-term funding plan for Universal Access
- Commit to fully supporting an enlarged Global Fund.

Strengthening Health Systems

Ensure health systems can effectively and equitably deliver comprehensive services by:

- Ensuring sustainable long-term financing for scaling-up health systems
- Addressing the health worker shortage by investing in and supporting systems that link public services and the community

Ensuring Affordable Medicines

Increase access to generic medicines by:

- Removing trade barriers blocking access to medicines
- Supporting the collective management of intellectual property rights through patent pools for essential medicines
- Supporting the WHO's investigation on IP legislation and R&D initiatives

Supporting Women and Children

Support women and children by:

- Achieving Universal Access to pMTCT services by 2010 by fully supporting and funding national pMTCT plans.
- Supporting children and families affected by HIV and AIDS.

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[1] WHO, July 2006
www.who.int/hiv/toronto2006/FS_Treatment_en.pdf

1. Financing universal access

Meeting the commitment to Universal Access to HIV Prevention, Treatment, Care and Support by 2010 hinges upon it being fully financed. Sufficient resources must be made available to fund each nationally agreed HIV and AIDS strategy in full, as promised by all UN member states in June 2006[2].

Whilst a number of national plans are still being designed and costed, UNAIDS estimates the *minimum* total resource needs for a comprehensive response to HIV & AIDS in low- and middle-income countries at approximately $18bn in 2007[3], rising to over $23bn in 2010[4].

Whilst conservative, this UNAIDS estimate highlights the need for funding to dramatically increase if Universal Access is to be achieved. For instance, in 2005, an estimated $8.3 billion was spent on HIV and AIDS in low- and middle-income countries[5]. Even though this is expected to rise to $10 billion in 2007, a funding shortfall of $8.1bn will remain for this year.

1.1 Agree a comprehensive funding plan

A comprehensive, long-term, G8 funding plan is crucial to the delivery of Universal Access. It would show genuine intent on the part of donors to honour their commitments, and would provide greater incentives for countries to develop ambitious national targets. Developing countries need to know how and when this money will appear in order to begin implementing these plans in full.

This funding plan should map out how donors plan to rapidly increase revenue, both from traditional overseas aid and from innovative funding mechanisms. It should channel additional resources beyond existing aid commitments to fully fund all national targets, and should not be taken from other key aid requirements. The plan should ensure funding is predictable to enable national governments to plan long-term investment, as well as being aligned with national priorities.

- *G8 members must* ***agree a comprehensive, long-term funding plan*** *that will deliver sufficient resources to achieve their commitment to Universal Access.*
- *The funding agreed must be* ***additional, predictable, strictly aligned to national priorities and free from conditions*** *beyond those necessary to ensure the aid is spent for its stated purpose.*

1.2 Commit to fully supporting an enlarged Global Fund

To ensure greater coherence and coordination, existing funding mechanisms must be scaled up and strengthened, rather than supplemented by a proliferation of small, uncoordinated initiatives.

The Global Fund to fight AIDS, Tuberculosis and Malaria in particular has played a key role in the international response to HIV and AIDS. So far it has committed $7bn to combating all three diseases and accounts for 21% of global HIV and AIDS spending – the successful result of its transparency, flexibility and ongoing consultation with stakeholders.

The continued success of the Global Fund is central to achieving Universal Access. Both the scale of the Global Fund's activities and the level of donor support must increase significantly to meet the financial demands of scaling up towards Universal Access by 2010.

The Global Fund itself estimates that in order to meet the 'top-down' resource needs of the three diseases, and increase its role to provide 35% of global resources for HIV and AIDS, funding must reach $11bn per year by 2010[6]. The G8 funding plan must ensure the Global Fund receives the predictable funding required.

- *G8 members must support the* ***enlargement of the Global Fund*** *to $11bn per year by 2010.*
- *G8 countries should* ***make long-term, predictable commitments to fully finance the Global Fund*** *and pay their fair share of its resource needs.*

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[2] UN General Assembly Political Declaration on HIV/AIDS, June 2006
[3] UN Secretary General, Declaration of Commitment on HIV/AIDS: five years later, A/60/736, March 2006.
[4] The Global Fund, *Resource need for the Global Fund* 2006-2007 and 2008-2010, Geneva, 2006.
[5] UN Secretary General, March 2006 *op cit.*

[6] The Global Fund, *Options Paper on the Size of the Global Fund,* GF/PSC4/04, March 2006

2. Strengthening health systems

Well-functioning public health systems are essential to achieve the internationally-agreed target of Universal Access to Prevention, Treatment, Care and Support by 2010.

2.1 Ensure sustainable long-term financing

Health systems in developing countries have been severely under-funded for decades. Few developing country governments commit a substantial proportion of their budget to their health system to deliver a basic package of services. Only two member states of the African Union have reached their commitment to devote 15% of national budgets to health.

The WHO Commission on Macroeconomics and Health estimated that an additional $27bn per annum in aid is needed to strengthen the capacity of health systems in low-income countries so that they can deliver basic health-care packages effectively. Meeting this target would require a five-fold increase in donor spending on health and does not include free access to HIV treatment for everyone in clinical need[7].

The uncertainty of aid commitments undermines long-term planning and presents serious clinical and ethical problems in relation to financing scale up of treatment, which once initiated must be guaranteed over the course of a patient's lifetime.

G8 members must ensure that health systems are financed sustainably and predictably over the long-term by:

- ***Increasing bilateral budget support to the health sector****, particularly through SWAps, in order to support long term national plans for scale up of basic health services in developing countries.*
- ***Opposing user fees for basic health services,*** *and providing support to developing country governments to ensure that the health sector is buffered to deal with fees abolition.*
- ***Ensuring WHO is sufficiently resourced*** *to provide the technical capacity-building needed to strengthen health systems.*
- *Leveraging their positions on the IMF board to* ***ensure that macro-fiscal policy allows greater flexibility for countries*** *to undertake expanded investment in the public sector.*
- ***Supporting the Global Fund to enhance its role in integration of services*** *to bring wider benefit to health systems.*

2.2 Address the health worker shortage

There is a crisis in skilled health workers in the face of enormous demand for public health services. Factors that force health workers to leave public sector jobs to migrate or work in the private sector include low pay, poor occupational health and safety, lack of training and prospects of career advancement, poorly supplied medical facilities, too few staff, and poor management and overall health system governance. The health worker shortage is particularly complex in countries most affected by HIV and AIDS. Alongside a comprehensive programme for recruiting, training and retaining health workers, they must also be targeted for prevention and treatment programmes. Ambitious workforce planning must be aligned with efforts towards broader health systems strengthening.

Public health planning centres on the management of clinics and hospitals, laboratories and health technologies but in resource-poor communities health care is often provided outside of the formal health system by community organisations and community health workers (CHW's). Community home-based care (CHBC) is well-recognised as a key factor in the response to HIV and AIDS. However the work of CHW's tends to be unrecognised, unpaid, and is often exploitative. Building on existing CHBC initiatives in a way that supports carers rather than burdens them further is vital. Critical to the sustainability of these services is the ability to link them with public health services.

G8 members should take a lead in supporting health workers by:

- *Working with developing country governments and civil society organisations* ***to improve training, support, remuneration, and career opportunities in order to curb health worker migration***
- ***Investing in short term plans for increased salaries and improved working conditions*** *for health workers, including 'volunteer' community caregivers*
- ***Investing in national and/or regional health training institutions*** *in countries with widespread shortages of workers*

[7] Working Together for health, The World Health report, WHO, 2006

3. Ensuring affordable medicines

Ensuring medicines are affordable for all is critical to achieving Universal Access to Treatment. Drastic reductions in the price of key drugs are needed to increase access, and also to maximise and sustain the impact of funding for HIV and AIDS. Market competition, through the production and distribution of generic medicines, is the most effective way to achieve price reductions.

Generic competition has reduced the price of 1st line ARVs from $10,000 per patient per year to the current level of $130. Yet this will not be the case for newer and future ARVs, which remain under patent protection[8]. New Intellectual Property (IP) legislation in countries like India[9] is pricing treatment beyond the reach of poor countries and people. Switching just 10% of patients in Africa to newer second-line treatments would double their national drugs bills[10].

3.1 Remove trade barriers blocking access to medicines

'Flexibilities' within the TRIPS Agreement are meant to allow countries to import and export generic medicines to protect public health. Yet their technical complexity, alongside political pressure, has meant that few countries have been able to use them, while others have been actively prevented from doing so.

The agreement to enable compulsory licensing for export, for example, is extremely difficult for generic manufacturers and developing countries to use.[11] It operates on a drug-by-drug, country-by-country basis, ignoring both the flexibility and rapidity of response needed to manage health programmes, and the economies of scale needed to encourage manufacturers to produce for export.

Of additional concern are regional and bilateral Free Trade Agreements that include even higher levels of IP protection than TRIPS, and undermine both the Doha Declaration on TRIPS and Public Health, and the 2003 August 30th Decision.

- *The G8 must provide all necessary financial, political and technical assistance to **ensure that the TRIPS flexibilities can be used.***
- *G8 countries and the EU must openly **exclude conditions that restrict the use of TRIPS flexibilities,** or otherwise impair access to medicines, in bilateral trade agreements.*
- *The G8 must **urgently review the effectiveness of the TRIPS flexibilities**, including the August 30th Agreement, to identify and resolve all obstacles to their use.*

3.2 Support patent pools for essential medicines

The development of 'patent pools', which allow the collective management of intellectual property rights, offers one way of overcoming some of the barriers to generic drug production. In this model, pharmaceutical companies submit patents for their products to a 'pool', in return for an appropriate royalty. The pool then provides licenses to generic manufacturers, based on pre-agreed, objective criteria. This 'one-stop shop' to manage patents and grant licenses would reduce transaction costs, promote transparency and provide technical assistance, while rewarding investment in research and development.

- *The G8 should **support the collective management of intellectual property rights** through patent pools for essential medicines for developing countries.*

3.3 Support the WHO's investigation on IP legislation and R&D initiatives

The WHO Intergovernmental Working Group on Public Health, Innovation and Intellectual Property is currently debating a global strategy to increase access to existing treatments and future essential health R&D[12]. This is a unique opportunity to consider access and innovation together.

Yet the IGWG`S ability to discuss recommendations on key IP access issues is being challenged by a number of Northern Governments, whilst R&D priorities and funding proposals are not being actively reviewed

- *The G8 must **support the IGWG`s right to include actions related to IP in its global strategy**, encourage it to **discuss all the recommendations of WHO Commission on Intellectual Property Rights, Innovation, and Public Health** (CIPIH), and to **provide opportunities for serious discussion of R&D priorities, and funding mechanisms** that promote both innovation and access.*

[8] Newer ARVS may be safer, more effective and/or needed as 2nd line for patients developing side effects or resistance.
[9] Over 50% of patients on ART in the developing world rely on generic medicines from India.
[10] MSF, *Untangling the web of price reductions* (2006)
[11] Medecins Sans Frontier's paper *'Neither Expeditious nor a Solution'* (2006) documents their difficulties in sourcing generic HIV drugs from Canadian companies using these procedures. After 2 years of trying, MSF had to abandon the effort.

[12] The IGWG's mandate is given in resolution 59.24 www.who.int/gb/ebwha/pdf_files/WHA59/A59_R24-en.pdf

4. Supporting women and children

HIV and AIDS in Africa increasingly has a woman's face. Across sub-Saharan Africa, women bear a disproportionate part of the HIV and AIDS burden: not only are they more likely than men to be infected, but in most countries they are also most likely to be the ones caring for people living with HIV and AIDS.

The numbers are startling, with 19.2 million women currently living with HIV and caring for millions of children. In South Africa, women aged 15-24 years are four times more likely to be HIV infected than young men. In Ethiopia, prevalence among adult women is double that of men.

These women risk passing on the virus to their children. Mother to child transmission (MTCT) is the principal cause of infections in children. Children living in households with HIV infected mothers are also likely to have inadequate care and access to support services. A study in Uganda found that death is four times greater among infants born to HIV-positive mothers, sometimes because the child is infected and sometimes because their mother is simply too sick to look after them[13].

4.1 Ensure Universal Access to pMTCT services by 2010

The transmission of HIV from mother to child in pregnancy and childbirth drives the rapidly increasing number of HIV-positive children. Globally, 90% of all HIV-positive children are infected through MTCT[14]. Without prevention of mother-to-child-transmission (pMTCT) services, about 35% of infants born to HIV-positive mothers will acquire the virus during pregnancy, labour, delivery or breastfeeding[15].

Yet this can be stopped. Providing a mother with a full range of pMTCT services can reduce the risk of transmission to less than 2%[16]. But only 9% of HIV-positive pregnant women in low and middle income countries currently receive pMTCT drug therapies[17]. This is a gross violation of the rights of both these women and their children.

In May 2006, African Heads of State issued the Abuja Call for Accelerated Action Towards Universal Access to HIV/AIDS, Tuberculosis and Malaria Services in Africa. They set clear goals for 2010, including that 80% of pregnant women have access to facilities to prevent mother-to-child-transmission (pMTCT)[18].

- *The G8 must provide national governments with the resources to develop and implement national pMTCT plans to* ***reach universal access to pMTCT for all pregnant women by 2010.***

4.2 Support children in families affected by HIV and AIDS

The millions of children living with parents infected with HIV risk not being adequately cared for as their parents' health declines. Children who lose their mothers have less chance of getting enough food to eat, are more likely to miss out on school, and often end up having to care for themselves and the rest of their families. It is essential that a comprehensive programme to prevent and treat HIV addresses the care and support of children in HIV affected families in order to prevent family breakdown and to enable adequate care for children. The G8 leaders must fulfill the commitments made in 2005 at Gleneagles: that they would provide proper support to all children orphaned and made vulnerable by AIDS.

- *The G8 must* ***provide resources to produce and implement National Plans of Action for the care and protection of orphans and vulnerable children*** *in all highly affected countries.*

[13] Nakiyingi JS, Bracher M, Whitworth JA, Ruberantwani A, Busingye J, Mbulaiteye SM, Zaba B (2003) 'Child survival in relation to mothers' HIV infection and survival: evidence from a Ugandan cohort study', AIDS, 17(12):1827–1834.
[14] UNICEF (2002) ' A UNICEF Fact Sheet, Mother-to-Child Transmission of HIV'
[15] UNAIDS (2005) 'AIDS Epidemic Update: December 2005' Joint United Nations Programme on HIV/AIDS, Geneva.

[16] UNICEF (2005) 'A Call to Action: Children, the Missing Face of AIDS'
[17] UNICEF (2007) ' Children and AIDS: A Stocktaking Report
[18] African Union (2006) Special Summit of African Union on HIV/AIDS, Tuberculosis and Malaria (ATM) Abuja Nigeria, 2–4 May, 2006