No man is an island:

HIV/AIDS and the G8

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No man is an island

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"No man is an island, entire of itself... any man's death diminishes me, because I am involved in mankind; and therefore never send to know for whom the bell tolls; it tolls for thee."

John Donne

Summary

The HIV/AIDS epidemic is nothing short of another Holocaust. Each year, during the G8 summit, ActionAid International (AAI) urges G8 countries to uphold the commitments they have made on HIV/AIDS, and mobilise the political will and financial resources necessary to mount a credible response to the epidemic. Each year, we remind G8 leaders that their annual summits offer an unparalleled opportunity for the world's wealthiest nations to boldly meet goals set and transform commitments and declarations into real interventions. Yet, each year, G8 members fail to fully deliver on previous commitments, and instead proudly announce new empty promises.

G8 members at the Genoa summit in 2001 officially launched the Global Fund to Fight AIDS, TB and Malaria to mobilise additional resources and ensure coordination between donors. Three years later, and after the deaths of 6.1 million people from AIDS, an effective fight against HIV/AIDS is still frustrated by a lack of coordination and transparency in bilateral aid and insufficient resources for multilateral initiatives.

ActionAid International recommends that at the 2004 G8 summit, G8 members:

- **Provide additional long-term financial support to the fight against HIV/AIDS through making equitable contributions to the Global Fund.**
- **Urge other donor governments to apply the equitable contribution approach to their Global Fund pledges.**
- **Support current multilateral HIV/AIDS initiatives, untie bilateral HIV/AIDS funding, and harmonise and improve the reporting of their bilateral HIV/AIDS work.**

In 2000 at Okinawa, G8 members vowed to make key drugs universally available and affordable in developing countries. In 2003 at Evian, they promised to find a solution to the problems that developing countries faced in accessing essential AIDS medicines. In 2004 less than 7% of the six million people in urgent need of treatment have access to it. Meanwhile, the UNAIDS/World Health Organisation (WHO) target of treating three million people living with HIV/AIDS in developing countries with antiretroviral (ARV) medicines by 2005 may go unmet owing to a lack of adequate funding.

ActionAid International recommends that at the 2004 G8 summit, G8 members:

- **Fund the WHO "3 by 5" technical assistance budget to support the sustainable expansion of HIV/AIDS care programmes in developing countries.**
- **Use the mid-June TRIPS Council meeting to amend the 30 August 2003 decision to ensure a workable solution to the issue of access to medicines.**
- **Agree on measures to avoid any reduction in generic pharmaceutical product availability after January 2005, by extending the 2005 TRIPS implementation deadline for all developing countries to 2016 while supporting the development of pharmaceutical industries in developing countries.**
- **Commit to amending national patent laws to allow production of generic medicines for export to countries lacking manufacturing capacity.**
- **Agree that the Doha Declaration set the maximum level for patent protection and enforcement in developing countries in bilateral and regional trade agreements.**

Section 1 Introduction

Over the last four years, G8 members have made or reaffirmed many HIV/AIDS commitments and declarations. Over the three-day span of the 2004 G8 Sea Island summit, whilst G8 leaders ponder what new pledges to make, the bell will have tolled for 24,000 people living with HIV/AIDS in developing countries. The lack of concerted action by G8 members on previous commitments on the HIV/AIDS epidemic is allowing a genocide, on a scale not unlike the Holocaust, to ravage Africa.

The lives and livelihoods of 40 million people living with HIV/AIDS (PLWHA) in developing countries[1] continue to be devastated. Sub-Saharan Africa alone is home to over 26 million PLWHA, of which 15 million are women, the backbones of societies.[2] In 2003, while WTO members, including G8 countries, argued the finer points of international trade agreements limiting access to life-prolonging medicines, 3 million people, 2.3 million from sub-Saharan Africa, died of AIDS.[3, 4] AIDS deaths in the same region have left 11 million AIDS orphans under the age of 15 destined for a lifetime of poverty.[5] At the end of 2003, UNAIDS estimated that there were over two million people living with AIDS in the Latin America and Caribbean region. National HIV prevalence has reached or exceeded 1% in 12 countries within the Caribbean basin. The fact that in 2003, five million people were newly infected with HIV, of which one million were from the Asia-Pacific region – the world's most populous region – provides a stark warning of things to come.[6, 7] Yet if G8 members made true on their commitments and immediately scaled-up HIV/AIDS interventions, 29 million new infections could be prevented by 2010 alone.[8]

HIV/AIDS, poverty and discrimination

ActionAid International's experience of working with people and communities affected by HIV/AIDS has demonstrated that vulnerability to HIV/AIDS is exacerbated by poverty and social exclusion. Both poverty and discrimination are barriers to accessing essential HIV/AIDS related care. Inequalities in the relationships between men and women and adults and children mean that women and children, especially girl children, are particularly vulnerable.

AAI believes that responses to the epidemic must recognise the rights of poor and marginalised people to receive HIV/AIDS related care that goes beyond basic treatment to include their social, psychological and economic needs. Such care must counteract the forces of stigma and discrimination to ensure that women, children and other marginalised groups are given equitable access to care services.

1 UNAIDS, "AIDS epidemics update", December 2003.
2 UNAIDS, "Report on the Global HIV/AIDS epidemic", July 2002.
3 UNAIDS, "AIDS epidemic update", December 2003.
4 UNAIDS, sub-Saharan Africa fact sheet, 25/11/2003.
5 UNAIDS, sub-Saharan Africa fact sheet, 25/11/2003.
6 Of those, two million were women and 700,000 were children.
7 UNAIDS, AIDS epidemic update. December 2003.
8 Stover, J., et al., "Can we reverse the HIV/AIDS pandemic with an expanded response?" The Lancet, Vol. 360, July 2002.

Section 2 G8 commitments to fight HIV/AIDS

Over the last few years, G8 members have made several commitments on HIV/AIDS:

- **In 1999, the G8 affirmed the need to combat AIDS at the international and national level through a combined strategy of prevention, vaccine development and appropriate therapy.**
- **In 2000, at the G8 Okinawa summit, a commitment was made to strengthen stakeholder partnerships to deliver the UN target of reducing the number of HIV/AIDS infected young people by 25% by 2010 [9].**
- **Also in 2000, G8 countries signed the Millennium Declaration, committing to action to reverse the spread of HIV/AIDS by 2015 [10], including through the provision of affordable essential drugs in developing countries.**
- **In 2001, the G8 Genoa summit launched the Global Fund to Fight AIDS, TB and Malaria, an independent, public-private partnership designed to attract, manage and disburse new resources to fight these diseases.**
- **In 2002, the G8 summit in Kananaskis recommitted to supporting the Global Fund and increasing the effectiveness of its operations [11].**
- **At the 2003 Evian summit, the G8 agreed on measures to strengthen the Global Fund financial capacity. Members also committed to resolve the issue of access to medicines for least developed countries before the WTO meeting in Cancun [12].**

Although G8 members have readily made commitments to address the HIV/AIDS epidemic, progress on those commitments has been inexcusably slow given that more than 8,000 people are dying of AIDS per day.[13] The following sections assess the extent to which G8 pledges and statements to support the fight against HIV/AIDS have been fulfilled.

A measure of the G8 long-term financial commitment: the Global Fund to Fight AIDS, Tuberculosis and Malaria

G8 leaders have repeatedly issued statements supporting the Global Fund. They have been the main donors to the Fund and, though these contributions are welcomed, G8 financial support must increase substantially in order to address the scale of the HIV/AIDS epidemic.

While there have been problems around speed of funding disbursements and ensuring genuine civil society participation, ActionAid International strongly supports the principles behind the Global Fund. Since inception, it has mobilised unprecedented, though still inadequate, levels of resources. Its participatory approach has fostered higher levels of ownership and commitment amongst developing country governments and affected communities, as for the first time they are directly involved in key decision-making processes [14]. The work of the Global Fund acknowledges that any effective response to HIV/AIDS requires both health system strengthening and society-wide action beyond the health sector, principles that AAI fully endorses.

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9 G8 Communiqué Okinawa, 23 July 2000.

10 UN Millennium Declaration, http://www.un.org/millennium/declaration/ares552e.pdf.

11 G8 Communiqué Genoa 2001, G8 Communiqué Kananaskis 2002.

12 http://www.g8.fr/evian/english/navigation/2003 g8_summit/summit_documents/health_-_a_g8_action_plan.html

13 UNAIDS, AIDS epidemic update. December 2003.

14 http:/www.theglobalfund.org/en/files/publicdoc/Framework_uk.pdf.

Table 1: 2005 Global Fund resource needs and pledges made (US$million)[19]

Global Fund financial needs for 2005	Total donor pledges for 2005	G8 pledges for 2005
3,300	841.7	691

The Global Fund has thus far approved three rounds of proposals with a total commitment of US$2.1 billion over two years to 122 countries and three territories.[15] The fourth round began in January 2004, and requests for funding have exceeded amounts requested in previous rounds, increasing the likelihood that the Fund will have insufficient resources to fund all approved proposals.[16]

Given that the Global Fund has no credit facility, it must base approval of grants on funds currently available. As of May 2004, the Global Fund expects that pledges for 2004 will allow it to meet its financial needs for the year. However, since two thirds of this money, approximately US$1 billion, has not yet been paid in, the Fund will be unable to approve grants for the majority of proposals approved for funding in its current funding round[17].

As the Global Fund's largest donors, G8 members should demonstrate their commitment to fighting HIV/AIDS by converting their 2004 pledges into actual funds without further delay. As minimal proof of genuine commitment, G8 members should immediately issue promissory notes to the Global Fund in order to allow it to approve and disburse grants. For 2005 and beyond, G8 leaders should ensure that contributions are made in the first quarter of the year.

The Global Fund's resource requirements are set to increase as HIV/AIDS programmes broaden to include treatment, such as provision of antiretroviral medicines. Sustainable financing will become crucial given that, once patients begin a course of treatment, it must continue for the duration of their lives. For 2005 the Global Fund estimates that it will need approximately US$3.3 billion[18]. As shown in Table 1, to date, recorded pledges for 2005 amount to just over US$839 million, significantly less than has been pledged for 2004.

One main reason for this shortfall is that the US government has slashed its pledge to the Fund by 64%, from the US$547 million pledged in 2004 to a mere US$200 million in 2005. The higher pledge in 2004 resulted from the US congress' enabling, in the run up to the 2003 Evian summit, of a 2004 contribution of up to US$1 billion to the Global Fund. This promise was conditional on US$1 billion being committed from European Union members and a further US$1 billion from other countries including Canada and Japan. As shown in Table 2, these conditions were not met.

ActionAid International calls on the US, EU countries and other major donor countries to stop using each other as excuses for inaction and meet these targets in 2005.

The October 2004 and January 2005 Global Fund replenishment conferences are opportunities for G8 governments to ensure that the Global Fund meets its resource needs for 2005.

Jenny Matthews/Network/ActionAid UK

Table 2: Pledges and contributions to the Global Fund trust account (US$)

Country	Total pledges to date		2001-2002		2003		2004	
	Pledges	Period	Pledges	Contributed	Pledges	Contributed	Pledges	Contributed
Canada	100,000,000	2002-2005	25,000,000	25,000,000	25,000,000	25,000,000	25,000,000	0
Germany	300,000,000	2002-2007	11,995,200	11,995,200	37,427,325	37,427,325	45,954,372	12,186,600
Japan	259,993,442	2002-2004	80,000,000	80,000,000	79,993,442	79,993,442	100,000,000	69,732,790
France	668,971,098	2002-2006	58,702,805	58,702,805	61,487,805	61,487,805	182,926,829	182,926,829*
Italy	443,902,439	2002-2005	100,000,000	108,618,673	100,000,000	106,541,600	121,951,220	0
Spain ***	100,000,000	2003-2006	-	-	35,000,000	35,000,000	15,000,000	0
UK	313,211,532	2001-2007	78,215,278	78,215,278	40,032,750	40,032,750	54,744,526	0
USA	1,969,725,000	2001-2008	300,000,000	300,000,000	322,725,000	322,725,000	547,000,000	0
G8 **	-	-	791,977,668	800,996,678	721,885,835	728,427,435	1,346,946,284	478,502,719
EC	556,787,958	2001-6	137,064,385	137,064,385	51,219,512	51,219,512	263,626,012	212,406,500

Source: http://www.theglobalfund.org/en/files/pledges&contributions.xls Update of 16 April 2004. (*) In the process. (**) Including EC contribution. (***) Though not a G8 member, included in tables 2 and 3 as Spain is one of the donor countries in which AAI is based.

[15] http://www.theglobalfund.org/en/files/grantsstatusreport.xls

[16] Global Fund Observer, "Newsletter", Issue 23, May 16 2004.

[17] http://www.theglobalfund.org/en/files/factsheets/resource_needs.pdf

[18] http://www.theglobalfund.org/en/files/factsheets/resource_needs.pdf Accessed May 25, 2004.

[19] Aidspan, Updated analysis of the Equitable Contributions Framework regarding the Global Fund, 21 May 2004.

Table 3: 2005 G8 pledges to the Global Fund (US$ million)

Country	% world GNP	current pledges	fair share pledge	shortfall
Canada	2.2	51.1	115.1	64
France	4.3	177.7	175.4	-
Germany	5.9	85.3	241.6	156.3
Italy	3.5	118.5	141.8	23.3
Japan	13.6	-	709	709
Spain [21]	1.9	25	76.8	51.8
United States	32.2	200	1,100	900
United Kingdom	4.8	58.4	194.6	136.2
G8 total	**66.5**	**691.0**	**2,677.5**	**1,988.8**

Source: AIDSPAN equitable contribution: update of 21 May 2004

The delay in G8 conversion of pledges to contributions recorded in 2004 and increased resource needs for 2005 reinforces the fact that the fight against HIV/AIDS requires long-term assured funding. G8 leaders must acknowledge this by making long-term pledges of fixed amounts to the Global Fund. AAI proposes that the amount paid into the Fund by any individual country be at least equivalent to that country's share of world GDP[20]. For instance, France's GDP represents 4.3% of world GDP, thus France's contribution should meet at least 4.3% of the Global Fund's resource needs. As shown in Table 3, if G8 contributions to the Global Fund were made according to this formula, significantly more resources would be made available to the Global Fund in 2005.

A measure of the G8 commitment to ensure access to medicines: the UNAIDS/World Health Organisation target of treating three million people by the end of 2005

In 2001, UNAIDS estimated that three million people living with HIV/AIDS in developing countries could be treated with ARVs. In 2003 at Evian, the G8 stated: "We will work to develop an integrated approach that will facilitate the availability and take-up of discounted medicines for the poorest in a manner that is fair, efficient and sustainable." Despite this, only a fraction of people in developing countries actually has access to treatment. For example, in Africa, less than 2% of those people requiring ARVs actually have access to them[22]. In December 2003, UNAIDS and the World Health Organisation set the ambitious target of treating three million PLWHA in developing countries (approximately half of those urgently needing treatment) with ARVs by 2005.

[20] See Equitable Contribution Framework.http://www.fundthefund.org /documents/AIDSPAN_equitable_contribution.doc

[21] Not included in G8 total calculations

[22] WHO, Treating three million by 2005 (Strategy). December 2003.

[23] Presentation to the 7th board meeting of the Global Fund to Fight AIDS, TB and Malaria by Dr. Jack C. Chow. March 2004.

[24] http://www.who.int/3by5/publications/documents/en/cost_of_3by5.pdf

[25] WHO, Treating three million by 2005 (Strategy). December 2003.

[26] Notes for press briefing by Stephen Lewis, United Nations, New York: 3 March 2004.

[27] Presentation to the 7th board meeting of the Global Fund to Fight AIDS, TB and Malaria by Dr. Jack C. Chow, 19 March 2004.

[28] DFID Press release, International development minister announces £3 million for fight against HIV/AIDS, 05 March 2004.

[29] WHO. Press Release, World Health Organisation welcomes Canada's landmark contribution to the global 3 by 5 AIDS initiative. 11 May 2004.

Table 4: UNAIDS/WHO 3 by 5 treatment targets

Date	Number of PLWHA treated
June 2004	500,000
December 2004	700,000
June 2005	1.6 million
December 2005	3 million

Source: WHO, 2003

The "3 by 5" initiative aims to coordinate the different existing multilateral and bilateral AIDS initiatives, including the World Bank Multi–Country HIV/AIDS Programme and the Global Fund, through provision of technical assistance from the WHO to developing countries willing to expand their treatment programmes. Lack of technical assistance has been identified by developing countries and donors alike as a major obstacle to the effective use of existing HIV/AIDS funding and scaling-up treatment efforts in developing countries.

Support from developing countries for the 3 by 5 target is clear as, since the launch of the strategy, more than 47 countries have asked to be part of the initiative. Already, the WHO is assisting 32 countries with the preparation of their current round of Global Fund grant proposals and the development of national treatment implementation plans.[23] A key element in achieving the treatment target will be the provision of WHO technical assistance to poor countries as they design, implement and monitor progress of systems that can deliver treatment.

ActionAid International welcomes the 3 by 5 target as an ambitious proposal that gives emphasis to providing treatment to people living with HIV/AIDS in developing countries.

WHO has estimated that successfully achieving the 3 by 5 target will require a total of US$5.5 billion in funding[24] (35% of which is for AIDS drugs) in addition to current HIV/AIDS spending levels.[25] Of this total, the WHO estimates that the provision of technical assistance to implement the plan will require US$200 million over 2004-2005.[26] This is additional to the US$15 million the WHO has allocated out of its regular budget and the US$10 million UNAIDS has contributed to meet this 'core' 3 by 5 budget.[27]

Despite previous commitments to ensure access to medicines, support from G8 countries has been weak. In fact, the UK and Canada are the only G8 countries that have pledged any funding whatsoever to the US$200 million needed by the WHO to provide technical assistance. The UK pledge (US$5 million)[28] is largely a symbolic sign of support whereas the Canadian pledge of Cdn$100 million over two years[29] is a major step towards ensuring that reaching the 3 by 5 target becomes a reality.

ActionAid International calls on the G8 leaders to commit to the 3 by 5 target and ensure that appropriate technical assistance can be provided to developing country governments, enabling them to strengthen the infrastructure necessary to deliver care to those living with HIV/AIDS.

Bilateral HIV/AIDS initiatives

Although funding for HIV/AIDS work in developing countries from G8 countries has increased steadily in the last few years,[30] it is far from adequate. UNAIDS estimates that by 2007 US$15 billion will be needed annually to fund key HIV/AIDS programmes in developing countries.[31]

In 2003, donor governments spent an estimated US$2 billion[32] on HIV/AIDS through bilateral aid channels, the majority coming from G8 member countries. G8 member contributions to the Global Fund comprise a small proportion (21%)[33] of G8 overall spending on global HIV/AIDS. There are concerns, however, that in some cases contributions to the Global Fund do not constitute "new" money, but are reallocations from bilateral HIV/AIDS funding. It must be noted that estimating and directly comparing bilateral commitments is a challenging task. For instance, G8 reporting mechanisms do not distinguish between actual expenditure and commitments, expenditure classification and accounting systems differ, and an accurate financial estimation of HIV/AIDS components in integrated projects is extremely difficult.[34]

Table 5: Estimated HIV/AIDS funding from G8 countries in 2003[35] (US$ million)

Country	Bilateral funding[36]	Bilateral funding as % of total G8 bilateral funding	G8 member bilateral funding as a % of total donor bilateral funding
United States	852[37]	51.5	42.6
United Kingdom	408	24.6	20.4
Germany	134	8.1	6.7
Japan	95	5.7	4.75
Canada	94	5.7	4.7
Italy	36	2.2	1.8
France	36	2.2	1.8
Total	1,655	100	82.75

Source: AIDSPAN equitable contribution: update of 21 May 2004

US bilateral funding: quantity versus quality

US bilateral funding accounts for almost 43% of total donor (G8 and non-G8) bilateral funding. As such, the quality of the US government's bilateral HIV/AIDS programme is a key determinant of success in the fight against HIV/AIDS. Consequently,

ActionAid International has serious concerns regarding the US five year US$15 billion President's Emergency Plan for AIDS Relief (PEPFAR) initiative, including:

- **That PEFAR fails to adequately address the issue of equity in HIV/AIDS related care service delivery.**
- **That one third of expenditure on prevention is allocated for projects promoting abstinence – a largely unsuccessful approach[38] that imposes unrealistic views and undermines local decision-making capacity.**
- **That PEPFAR does not fully endorse WHO pre-qualification as the international standard for assessing safety, quality and efficacy for urgently needed AIDS medicines. Generic ARVs pre-qualified by the WHO have been procured for as little as US$140 per person per year. In contrast, patented medicines from US pharmaceutical companies cost a minimum of US$562 per person per year. Purchase of patented drugs with PEPFAR funding will allow treatment of five million people**

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for six years – if used to purchase generic drugs it will allow five million people to be treated for twenty years.

- That PEPFAR does not commit to the 3 by 5 target, neither through funding of the core WHO budget, nor through explicit delineation of how PEPFAR activities will be coordinated with the 3 by 5 strategy.
- That PEPFAR allows for only US$200 million to be contributed to the Global Fund in 2005.

ActionAid International calls on the US government to revise and reform the PEPFAR initiative and ensure that it:

- Clearly identifies how marginalised and vulnerable groups will have equitable access to HIV/AIDS care services through PEPFAR.
- Makes available comprehensive sex education and condom distribution interventions to vulnerable groups and to the general public.
- Uses WHO pre-qualified generic medicines to ensure that the maximum number of people possible can benefit from treatment.
- Commits to and coordinates with the UNAIDS/WHO 3 by 5 target.
- Allows for a US fair share contribution to the Global Fund in 2005.

Proliferation of uncoordinated initiatives such as PEPFAR risks undermining the effectiveness of HIV/AIDS efforts in Southern countries. Bilateral initiatives such as PEPFAR may:[39]

- Result in donor-driven approaches, rather than bottom-up solutions.
- Increase the administrative burdens of recipient countries.
- Hamper the development of coherent national strategies on HIV/AIDS.
- Drain resources away from existing, experienced, multilateral initiatives.
- Result in lack of transparency.

The recently agreed "Three Ones" framework[40] commits key stakeholders such as donors and national governments to one agreed national framework as the basis for coordinating the work of all partners, one national AIDS coordinating authority, and one agreed national level monitoring and evaluation framework.[41] Though the framework is a step in the right direction, it neither mentions the involvement of people living with HIV/AIDS, nor the role of civil society, nor puts enough emphasis on addressing issues of stigma and discrimination. ActionAid International calls on all G8 members to support current multilateral initiatives such as the Global Fund and 3 by 5, untie bilateral aid (including funding for HIV/AIDS), and improve and harmonise the reporting of their bilateral HIV/AIDS work.

[30] Russia, as a net recipient of such aid is not included though Russia is a contributor to the Global Fund.

[31] UNAIDS, Report on the state of HIV/AIDS Financing. Revised March 2003.

[32] Ibid.

[33] Kaiser Family Foundation. Factsheet: Global Funding for HIV/AIDS in Resource Poor Settings. January 2004.

[34] ActionAid International, " UK AIDS Aid". Harinder Janjua, December 2003.

[35] Russia is excluded from all calculations in Table 5.

[36] UNAIDS, Report on the state of HIV/AIDS financing. June 25, 2003.

[37] Kaiser Family Foundation. Factsheet: Global funding for HIV/AIDS in resource poor settings. January 2004.

[38] Stanecki, K. The AIDS pandemic in the 21st century. Draft report. U.S Census Bureau. July 2002.

[39] A. Acharya, A. Fuzzo de Lima, M. Moore, 'The proliferators: transactions' costs and the value of aid', IDS, January 2004.

[40] http://www.unaids.org/en/other/functionalities/ViewDocument.asp?href=http://gva-docwl/WEBcontent/Documents/pub/UNA-docs/Three-Ones_KeyPrinciples_en.pdf

[41] UNAIDS, Clearing the common ground for the "Three Ones". 2004

Section 3

The HIV/AIDS fight

and the debt relief weapon [42, 43]

Donor countries must recognise that the lingering debt crisis in the world's poorest countries continues to undermine even the best efforts to increase work on fighting HIV/AIDS. The UN estimates that the world community needs to invest US$15 billion every year to effectively fight HIV/AIDS, while currently sub-Saharan Africa alone pays out almost US$15 billion each year in debt service to foreign creditors.

The Heavily Indebted Poor Countries (HIPC) debt relief initiative has offered a limited amount of debt cancellation for some countries and this has shown to be very helpful in the fight against HIV/AIDS. When a nation has more access to its own resources as a result of debt relief, there are dramatic results. The most successful countries have been able to increase their expenditure in health and education between 40-90%.

Since some countries began receiving debt relief, many have devoted more resources to the fight against HIV/AIDS. Malawi received a cut in debt service of 30% per year, used mainly to enhance the health care system. Uganda's US$1.3 million of debt relief money has been specifically earmarked for their national HIV/AIDS plan. Cameroon launched a comprehensive national HIV/AIDS strategic plan of US$114 million with help from debt savings.

The HIPC programme shows that debt relief can help, but the pace of HIPC debt relief is neither fast enough nor deep enough, and not enough countries have benefited. These flaws are mainly due to the IMF and World Bank's economic measure of 'debt sustainability'.

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The United Nations Development Programme (UNDP) has suggested that a new measure of debt sustainability should be based upon the estimated costs of halving and reversing the trends of the epidemic by 2015 in affected countries. For many countries this would require full debt cancellation.

ActionAid International believes that if donors, including G8 countries, are genuinely committed to fighting HIV/AIDS, the impact and prevalence of the epidemic have to become overarching criteria for debt relief.

[42] IMF, HIPC Initiative – Statistical update, March 2004.

[43] Jubilee 2000, "Debt relief success stories". January 2003.

Section 4

Access to drugs:
the patent use

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The cost of AIDS medicines remains a major obstacle to increasing access to HIV/AIDS care in developing countries. Many AIDS medicines have been prohibitively expensive, partly because of patent protection enforced by the World Trade Organisation through the agreement on Trade Related Aspects of Intellectual Property Rights (TRIPS).[44] Production of generic versions of these drugs by countries like India and Brazil in the late 1990s dropped the price to a fraction of that of their patented counterparts. This success was built on in the DOHA discussions of 2001, which reaffirmed the right of countries to use compulsory licensing [45] to allow local manufacture of drugs to address public health problems. However, for countries with insufficient or no local manufacturing capacity, access to sources of cheaper generic copies of patented medicines was set to be cut off in 2005 as developing countries such as India became TRIPS compliant.[46]

At the 2003 Evian summit, the G8 committed to working towards a multilateral solution to address the problem of access to medicines for countries with insufficient local manufacturing capacity.[47] On August 30 2003, an agreement was reached that seemingly brings to an end a two-year standoff on access to medicines in poor countries. The agreement exists as a temporary waiver and actual amendment of the TRIPS agreement is slated for later this year.

ActionAid International believes that the agreement reached does little to encourage competition between generic and patented drug manufacturers – competition that is crucial in making AIDS medicines more widely available in developing countries.

The present arrangements for availing medicines to poor countries without manufacturing capacity is so cumbersome for potential suppliers and importing countries that they are hardly encouraged to adhere to the agreement. For example, to import drugs, any importing country must undertake twelve time-consuming steps[48]. Such a complex and bureaucratic system tends to favour the patent owners; and as such, they have no incentive to lower their prices – leaving medicines still out of reach for poor people living with HIV/AIDS.

Legislative reform in G8 countries allowing the production of generic medicines for export to developing countries lacking local manufacturing capacity is a short-term method of addressing the problem of limited access to HIV/AIDS medicines in these countries. Such reform should not, however, be even more restrictive than the TRIPS agreement itself, as in Bill C-9 passed by the Canadian government.[49] Alongside such reforms, G8 members must also seek a long-term solution to the problem through concrete measures to increase pharmaceutical manufacturing capacity in developing countries.

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44 ActionAid International, "Access to medicines: ensuring people's rights", July 2003.

45 The practice of issuing a licence to use the subject matter of a patent without the authorisation of the patent holder.

46 R.V. Van Puymbroeck, "Exportation of drugs under compulsory licenses", GHAP, October 2003.

47 A G8 action plan to health, point 3, access to medicines, Evian summit 2003.

48 Canadian HIV/AIDS Legal Network, Global access to medicines: will Canada meet the challenge? February 2004, Canada.

49 http://www.aidslaw.ca/Maincontent/issues/cts/patent-amend.htm Accessed 20 May 2004.

Section 5 Conclusion

Despite being signatories to the TRIPS agreement, many G8 countries are pursuing regional or bilateral agreements on intellectual property rights as well. Known as TRIPS-plus, such agreements go well beyond the WTO rules. For example, in the US negotiated Free Trade Agreement of Americas, TRIPS-plus proposals include: limits on the circumstances in which compulsory licences can be issued; extension of patent terms beyond the 20 years required by TRIPS; and prohibition on the export of drugs produced under compulsory licence[50]. Such bilateral TRIPS-plus agreements will erode any multilateral gains made on access to medicines. ActionAid International calls on G8 members to:

- **Agree on measures that will guarantee generic product availability after January 2005. This could be done by extending the deadline for implementation of TRIPS in relation to pharmaceutical products to 2016[51], the date when TRIPS is due to be implemented by Least Developed Countries, for all developing countries.**
- **Firmly commit to amending their own national patent laws to allow the issuance of compulsory licences for export.**
- **Develop concrete proposals regarding how the G8 can support the development of national pharmaceutical industries in countries affected by HIV/AIDS.**

[50] Love, James, "Comment on the draft text of the Agreement of the Free Trade Area of the Americas", Human Rights Watch, February 2003.

[51] Under TRIPS, the Least Developing Countries are granted till 2016 to fully enforce the standards provided in the treaty.

ActionAid International calls on G8 leaders in Sea Island to ensure that their previous commitments and declarations are transformed into real action.

The G8 must not waste this opportunity to support the fight against HIV/AIDS, change the course of history, and make good on their promises. The Global Fund has received more funding proposals than ever, and projects it has funded in the past are making the crucial transition from pilot project to nationwide programmes. Already 47 developing countries have subscribed to the 3 by 5 initiative. However, the bell is still tolling for commitments made in Okinawa. Without urgent, concerted and significantly scaled-up action in line with G8 commitments already made, the Global Fund resources needs may go unmet, the WHO's 3 by 5 initiative may fail, and availability of AIDS medicines for poor and vulnerable people will still remain a pipedream.

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ActionAid is a unique partnership of people who are fighting for a better world – a world without poverty.

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