AccessNews

CAMPAIGN FOR ACCESS TO ESSENTIAL MEDICINES

MÉDECINS SANS FRONTIÈRES

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South Africa: Changing times

On 8th August 2003, after months of delays, mixed messages and increasing confrontation, the South African government caved in to growing pressure from all sides and announced that it will roll out antiretroviral treatment for people with HIV/AIDS. This is an immense victory for all South Africans living with HIV/AIDS, writes ***Eric Goemaere****, head of mission of the MSF project in Khayelitsha, South Africa. But our attention must now turn to the specifics of the implementation plan.*

In July, the situation looked bleak: the Medicines Control Council had just made it known that they would prohibit the use of nevirapine for prevention of mother-to-child transmission (PMTCT), unless the drug maker supplied new efficacy data. Given the government's strategy of hampering any move in the AIDS policy, the MCC decision was perceived by many to be driven by an unacceptable political interference on what should be the independent scientific work of a regulatory agency. On the ground, it is still creating tremendous confusion about the safety of continued use of nevirapine.

At the first national AIDS conference in Durban on August 3rd-6th, participants were overwhelmingly hostile to the government's refusal to implement a national antiretroviral treatment programme. Wearing an MSF T-shirt, Fareed Abdullah, head of AIDS services in the Western Cape, received a standing ovation when he announced that, "*In South Africa there are two options: treatment failure or treatment success. No treatment is not an option.*" UNAIDS director Peter Piot said the discussion about treatment in South Africa should be about the "how" and "when" rather than the "if". At the same time, the Treatment Action Campaign announced it was restarting its civil disobedience campaign. Elsewhere, the World Health Organization's new Director General, Dr Jong Wook Lee, was also openly criticising South Africa's policy.

With pressure mounting on all sides, the government called for a special Cabinet meeting on August 8th. After months of stonewalling, the outcome of the meeting was momentous: the Cabinet not only admitted for the first time that anti-retroviral drugs "*do improve the quality of life of those at a certain stage of the development of AIDS, if administered properly*", but instructed the Department of Health to develop a detailed HIV/AIDS plan including ARV provision in the public sector. The report by the Health and Treasury departments said that a national drug plan would defer the deaths of as many as 1.7 million people if implemented by 2008.

Among people living with HIV/AIDS, the atmosphere was joyful and optimistic. TAC suspended their civil disobedience campaign, and their spokesperson Zackie Achmat called it "*the best news in many years*". But the cabinet statement's vague wording has left many sceptical, particularly given the long history of frustration caused by the government's continuous delays and excuses. If fully implemented, a South African national ARV programme would be the largest in the world. An enterprise of this scale requires enthusiasm and focus, yet both attributes have been notably absent from the AIDS policy implemented for years by the current Minister. Is a change of leadership needed to implement the plan?

With the celebrations winding down, it's time to look at the practical details of the treatment plan and how it will be managed. Almost five million people are living with HIV/AIDS in South Africa. The health and treasury report estimated that the government will need to spend 17- 21 billion rand (US$2.3-2.8 billion) a year by 2010 in operating costs to provide antiretroviral treatment to all AIDS sufferers. Such a plan will require serious commitment from the government but also from the donor community to ensure its sustainability. To make efficient use of limited financial and human resources and treat the largest number of people possible, local production of ARVs will be key. The South African drug company Aspen has already started production of the ARV stavudine (d4T) and is selling it at prices up to 41% less expensive than the Bristol-Myers Squibb price. MSF is already using this stavudine in its clinics in Khayelitsha, and will continue to support local production and other strategies to ensure access to low-cost quality medicines.

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MSF distributed bright yellow T-shirts bearing the slogan "2 pills a day saves lives", in reference to the fixed-dose combination of stavudine + lamivudine + nevirapine which makes antiretroviral treatment easier to take.

It will also be important for the government to develop a plan that builds on current experience in South Africa and promotes constructive exchange of ideas and strategies. MSF has been treating people living with HIV/AIDS in Khayelitsha since 2001, and now treats 500 people, mostly with affordable quality generic ARVs from Brazilian and Indian manufacturers. This community-based programme has long demonstrated the feasibility of providing ARV treatment in public clinics in South Africa. In January this year, MSF and the Mandela Foundation also started a programme offering ARV treatment in Lusikisiki, a rural area located in the former Transkei. MSF is already sharing its experiences in Khayelitsha and Lusikisiki with the government's task team developing and implementing a treatment plan.

In its official statement on 8th August, the Cabinet claimed that the "*Government shares the impatience of many South Africans on the need to strengthen the nation's armoury in the fight against AIDS*" and requested the Department of Health to produce a plan for implementation. South Africans living with HIV/AIDS now eagerly await the concrete steps to make this happen. The rest of the world will also follow developments with keen interest: a national ARV plan would not only transform South Africa, it could have a catalytic effect throughout Africa and the rest of the developing world, teaching invaluable lessons about scaling up.

■ **Eric Goemaere**

What's in a patent?

Pascale Boulet, co-author of MSF report "Drug patents under the spotlight", speaks from experience

Patents impact the affordability of essential medicines in developing countries by blocking the public's access to generic drugs. A new MSF report takes a critical look at what pharmaceutical patents are, what they are not, and how the barriers they set to drug access can be overcome.

MSF has used its experience buying drugs around the world to set straight common misconceptions about patents and highlighting country efforts to overcome patent obstacles to access life-saving medicines. The information was compiled over the past two years, as MSF looked for the most appropriate and least expensive treatments for patients in its projects in developing

continued overleaf

Summary

ACT NOW

All over Africa, malaria drugs that have been used for decades are failing and deaths are on the rise. Artemisinin-based Combination Treatment (ACT) could help reverse this trend, but international donors are reluctant to fund the change. A new MSF report and accompanying film, both titled "ACT NOW", urge African governments to adopt ACT and calls on donors to put money on the table to fund the change.

Drug resistance on the rise

Malaria is gaining ground across all of Africa. In 20 years, the number of reported malaria cases has risen four-fold and there has been a striking increase in the number of severe epidemics.

Although population movements and climatic changes are thought to be partly responsible, many also point the finger at drug resistance, which is rife across the continent. If you happen to fall ill with malaria in Burundi, for instance, taking chloroquine is unlikely to help: in recent studies, MSF measured 93% resistance to chloroquine in Karusi. And if you're taking Fansidar in the Niger Delta region, chances are that 40% of the time, it won't work.

ACT: the most effective treatment against malaria

It is no secret that artemisinin derivatives, extracts of a Chinese plant, are the most potent anti-malarials the world has ever seen. Using them in combination with another effective drug (artemisinin-based combination therapy or ACT) makes treatment more efficient and keeps resistance at bay. The World Health Organization (WHO) recommends that African countries switch to ACT, but is doing little to push for this to happen. Some African governments want to implement ACT, but the vast majority can't afford it: while chloroquine is just US$0.10 per treatment, the current cost of an ACT is still around US$1.50. Yet the price difference that seems huge in terms of local spending does not represent much for international agencies: provision of ACT for all African countries that need it today would cost just US$100-200 million a year at current drug prices.

But international donors such as USAID and the UK's DFID have so far failed to support implementation of ACT. As a result, some countries are switching from one ineffective drug to another. For instance, Uganda has changed its national treatment protocol from chloroquine to a blister pack of chloroquine plus Fansidar (known as "*Homapak*"). USAID helped the government formulate this policy and supports national distribution of *Homapak*. In MSF's "ACT NOW" film, Albert Kilian, USAID representative in Uganda, defends the USAID position: "*If I have a drug that is 50% effective but 80% of people can get it, I have better community effectiveness than if I have a drug that is 95% effective but only 5% of people can access it.*" He fails to explain why only 5% of people can access ACT.

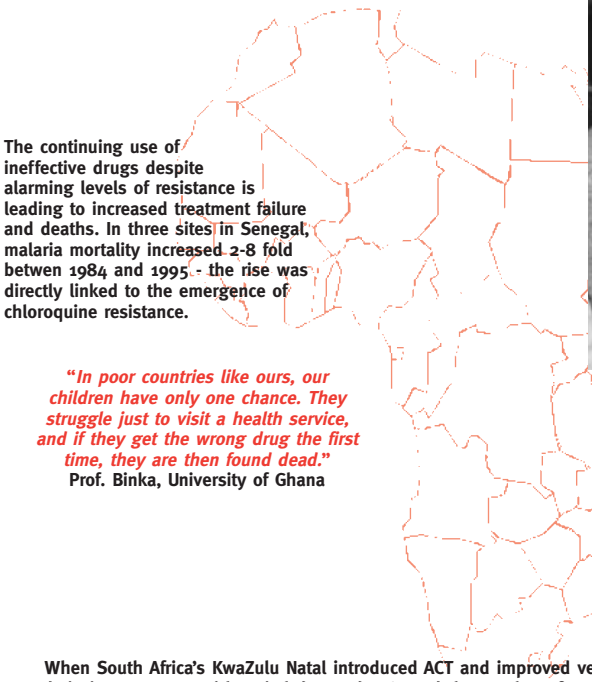
Homapak costs the Ugandan government just 11 cents per blister. In many countries, budget considerations come first. But, as MSF malaria coordinator Christa Hook explains: "Giving chloroquine to these children is as cheap as giving them smarties. Unfortunately, it's just as effective against malaria." If donors change their policy and help African governments plan the change to ACT, drug production will increase to meet need and prices will come down. Proper implementation of drug combination protocols would also ensure that artemisinin derivatives are used properly, so that their use is not compromised in the future.

MSF and ACTs

MSF has decided to implement ACT for first line treatment of all its malaria patients by the end of 2003. This change of policy was based on evidence of growing drug resistance in Africa and on previous experience of using ACT in Asian countries. In Africa, MSF is already using ACT in its projects in Angola, Congo-Brazzaville, DRC, Ivory Coast, Kenya, Liberia, Sierra Leone, South Sudan and Zambia.

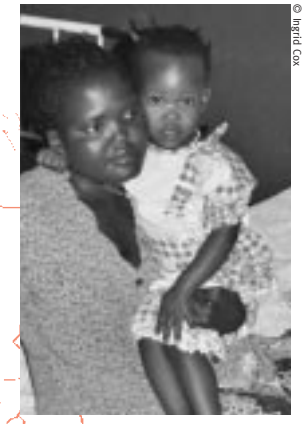
For more information, the full report "ACT NOW to get malaria treatment that works to Africa" is available on www.accessmed-msf.org. Copies of the MSF short film "ACT NOW" can be ordered from access@geneva.msf.org

■ **Ingrid Cox**



The continuing use of ineffective drugs despite alarming levels of resistance is leading to increased treatment failure and deaths. In three sites in Senegal, malaria mortality increased 2-8 fold betwen 1984 and 1995 - the rise was directly linked to the emergence of chloroquine resistance.

"In poor countries like ours, our children have only one chance. They struggle just to visit a health service, and if they get the wrong drug the first time, they are then found dead."
Prof. Binka, University of Ghana



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Amudat hospital, Uganda: A few weeks ago, Onika's daughter, Chellel was diagnosed with malaria and given Homopak (chloroquine, Fansidar). But when all the pills were gone, she still had fever. *"When I saw the baby was sick to that extent I had to rush her to hospital,"* Onika explains, *"Of course I was worried, I know malaria kills."*

When South Africa's KwaZulu Natal introduced ACT and improved vector control measures in 2000, admissions to Manguzi hospital dropped 82% and the number of reported deaths decreased by 87% within a year.

Supply issues

In many parts of Africa artemisinin derivatives are already widely available as single drugs in private pharmacies – or those who can afford them. But they must be made available in public health facilities in the form of combinations to set the right treatment standard. Blister packs combining artesunate and amodiaquine are now available from Sanofi (France) and Cipla (India) at the price of US$1.50 per adult blister. Blister packs of artesunate with SP or mefloquine are also slowly becoming available at around the same cost. All prices will come down as demand increases. MSF is also exploring future potential for extremely cheap artesunate (US$0.50 per adult treatment) in Vietnam, and is supporting selected manufacturers to upgrade their production to internationally acceptable standards.

Small increases in need can easily be met by current worldwide manufacturing capacity, but a dramatic increase will need timely preparation: Artemisia annua, the plant from which artemisinin derivatives are extracted, takes over six months to grow. MSF is making an inventory of future needs in Africa to give manufacturers an incentive to enlarge their production capacity.

In the future, ACT fixed dose combinations (FDC – two drugs combined into one pill) will improve ease of use. The only current FDC is Novartis' Coartem, available for US$2,40 (special price agreement). MSF is supporting DNDi in developing FDCs of artesunate/amodiaquine and artesunate/mefloquine, which should be available in 2005. Several European and Asian manufacturers are also working on the development of new co-formulations – some seem very promising in terms of price and rapid availability.

■ **Margriet den Boer**

continued from front cover

countries. "*We learned a lot from this experience*," explains Pascale Boulet, legal advisor to MSF and one of the authors of the report. "*We wanted to share this knowledge with a wider audience, to help others save time and money.*"

"*The first thing that struck us was how difficult and time-consuming it is to get information about drug patents*," says Pascale Boulet. At country level, MSF lawyers and pharmacists encountered one-man patent offices which offered copies of a patent on a drug against anxiety instead of the ARV drug patent that was sought. "*In some instances, we would be handed copies of WIPO international patent applications, not the local patent that the office itself had granted*," Boulet says. Having documents translated from the local language, which was necessary in Thailand and Ukraine, for example, added to the cost and complexity of the information hunt.

Challenges continued at the international level. The World Intellectual Property Organization (WIPO) would give details about a drug patent law that differed from those provided by the African regional office, ARIPO. International patent databases are far from complete and not 100% reliable. Some countries - such as Peru or Thailand - aren't included in them at all. MSF is urging WHO and WIPO to provide comprehensive data about drug patents in general, and about patents that have been invalidated in particular. Developing countries need this information to be able to assess existing patents and patent applications more confidently.

"*Countries need to make sure the public gets their share of the patent bargain. Appropriate checks and balances need to be put in place in national patent systems to ensure that only patents that are really valid are treated as such*," Boulet says.

Some developing countries are starting to question the validity of patents. In Thailand, AIDS activists and NGOs investigated and challenged an amended patent that Bristol-Myers Squibb had been granted on a particular formulation of ddI, a key AIDS drug. A Thai court subsequently found that the company's patent had been granted on the wrong grounds and was unlawful.

Another takeaway message emerging from the MSF report is that many countries are granting patents now that don't need to be granted. "*There is no rush for poor countries to grant patents on pharmaceutical products*," stresses Pascale Boulet. "*The Doha Declaration on TRIPS and public health gives least developed WTO members until 2016 to make their patent laws TRIPS compliant – they should take advantage of this breathing space to ensure the availability of generic versions of these drugs to their people. Keeping the total number of drug patents to an absolute minimum is in developing countries' interest.*"

MSF's report includes patent status data for 18 medicines in 22 countries in Africa, three in Asia, three in Latin America, and the Ukraine. Most of the medicines listed are antiretroviral (ARV) drugs, but some other essential medicines, e.g. malaria and antifungal drugs, are included as well.

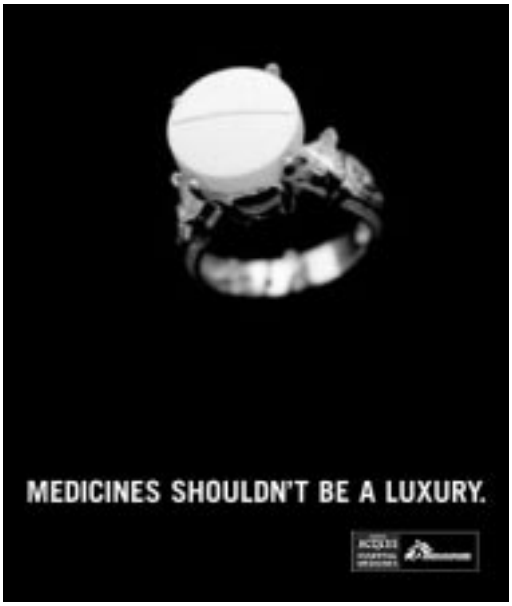
As an increasing number of developing countries are starting to provide antiretroviral treatment to people living with HIV/AIDS, information on drug patent status is in great demand. MSF has already distributed five thousand hard copies of the report to NGOs, activists and governments working on drug procurement in developing countries.

■ **Laura Hakokôngäs**

The report "Drug patents under the spotlight – sharing practical knowledge about pharmaceutical patents" can be found on www.accessmed-msf.org in English, and hard copies can be ordered by sending an email to access@geneva.msf.org. French, Spanish and Portuguese versions of the report are in production. An abbreviated version of the report along with the patent data MSF compiled will be posted on the WHO website soon.

Trading away health

In the last few years, generic competition has helped cut drug prices worldwide – but in Latin America and the Caribbean, this positive dynamic is being threatened by intellectual property provisions in the proposed Free Trade Area of the Americas (FTAA) agreement.



The slogan of MSF's FTAA campaign is 'Medicines shouldn't be a luxury. Don't trade away health in the FTAA!'. You can sign the petition on www.msf.org

If formally implemented, the Free Trade Area of the Americas (FTAA) will be the largest "free trade zone" in the world: a US$13 trillion market covering more than 800 million people in 34 countries in North, Central and South America and the Caribbean.

The proposed FTAA agreement contains a far-reaching set of proposals, including provisions on intellectual property (IP) rights which, as they have been drafted, could put essential medicines out of reach of those who need them most. Throughout negotiations, the US has been pushing to dramatically limit the circumstances under which compulsory licenses on pharmaceuticals may be issued, extend patent terms beyond the 20 years required by TRIPS, and give drug regulatory authorities a patent enforcing role. It is also pushing for exclusive rights on pharmaceutical test data, which would delay the introduction of generics even when there are no patents. Once signed, the agreement would be binding for all 34 FTAA countries (including Haiti, a least developed country), and could take primacy over the TRIPS Agreement and the Doha Declaration.

The proposed FTAA agreement is by no means the only attempt to impose TRIPS-plus measures on developing countries in the Americas. The US is also negotiating free trade agreements with Chile, Central American countries (in the CAFTA agreement), and the Dominican Republic, and these countries could be locked into TRIPS-plus arrangements well before the scheduled deadline for completion of FTAA negotiations.

What's at stake for people in the Americas? The example of HIV/AIDS

In wealthy countries like the US and Canada, antiretroviral (ARV) treatment has had a dramatic impact, cutting AIDS-related deaths by more than 70%. But in developing countries in the Americas, hundreds of thousands of people living with HIV/AIDS can't access these life-saving drugs simply because they are too expensive.

Drug prices are slowly starting to drop in the region, thanks primarily to generic competition. In Brazil, for example, all people living with HIV/AIDS have had universal access to treatment for the last six years, thanks to a governmental initiative that uses local generic production and competition to bring down prices. As a result, 90,000 AIDS deaths and 358,000 AIDS-related hospitalisations were avoided between 1996 and 2002, and the government saved US$2 billion. If FTAA had been in place six years ago, this programme might never have seen the light of day.

In Guatemala, where ARVs are not yet protected by patents, MSF uses generics in its programmes. Just one year ago, this meant that MSF paid 75-99% less for its ARVs than the Guatemalan government (which bought branded drugs). Although competition has brought originator ARV prices down dramatically in the past year, on average they are still twice as expensive as quality generic alternatives. Today, if Guatemala decided to launch a national treatment programme, it would have the right to buy the affordable generics that MSF is using. But if FTAA introduced new, more stringent rules, access to affordable medicines would be much more difficult and already strained health budgets would not stretch nearly as far.

By strengthening patent protection, FTAA will destroy the dynamic of generic competition. As a result, prices of new medicines will inevitably shoot up – this will be the case not just for new ARVs, but for all new medicines, for instance drugs to treat respiratory infections or cancer. The impact on people's health in the Americas could be catastrophic. This is why MSF is calling on countries of the Americas to exclude intellectual property provisions from the FTAA agreement altogether. Countries in the Americas have the right and the obligation to put their people's health before commercial and trade interests. Medicines shouldn't be a luxury and health shouldn't be negotiable.

MSF provides medical care for people in Argentina, Bolivia, Brazil, Colombia, Ecuador, Guatemala, Haiti, Honduras, Mexico, Nicaragua and Peru.

On 28 August, MSF launched an international petition campaign calling on ministers of trade to exclude IP provisions from the FTAA negotiations. "Trading Away Health", a report on the implications of FTAA on access to medicines, is available at www.accessmed-msf.org.

Rachel Cohen

"Marco, 28 years old, lives in Honduras. "In 2001 I started to get sick a lot - I had to be taken to hospital twice. That's when I was diagnosed with HIV/AIDS. When they told me the news, it affected me terribly. For me, my life was over. I had problems in my marriage when I told my wife that I was infected, and I had to quit my job because I did not have enough energy to continue."

"Marco has been receiving Triomune (d4T+3TC+nevirapine triple therapy) in the MSF clinic in Tela for the last four months. "The antiretrovirals make me feel like I have a second chance," says Marco. "Once I've recovered, I want to go back to work, and maybe train to become an electrician. I'm also participating in a self-support group – little by little, I've begun to recover emotionally."

"In the Tela clinic in the north of Honduras, MSF provides antiretroviral treatment using quality generic medicines that are four times less expensive than branded drugs in Honduras. This allows the MSF team to treat four times as many patients on the same budget.

New tricks to limit access to affordable medicines

Patents are not the only way that the FTAA could restrict access. In April 2003, under pressure to adopt US standards for protection of pharmaceutical test data, the Guatemalan government modified its national intellectual property bill by passing a decree that could seriously jeopardize access to life-saving medicines for the most vulnerable people in Guatemala. This law, a typical "TRIPS-plus" provision, gives originator pharmaceutical companies five years of exclusivity on the test data they must provide to get a drug approved by the drug regulatory authority. This means a five-year delay in the availability of generics even if the drugs are not under patent. MSF and Guatemalan civil society groups are urging the government to repeal the decree and do away with data exclusivity, in order to promote generic competition and improve access to quality medicines.

"Because of the new decree, registration of generics like the ones we use will be delayed and patients outside the MSF project will not be able to benefit from these cheaper alternatives," explains Luis Villa, MSF head of mission in Guatemala. "Five years can be a question of life and death for people with HIV/AIDS."

As it stands, Guatemala is the only country in Central America that gives five years of exclusive protection for test data, but the FTAA threatens to extend such a provision to all countries of the Americas.

In Guatemala, 67,000 people - including 4,800 children - are currently living with HIV/AIDS.

Thumbs Up, Thumbs Down – Company Actions on Drugs & Vaccines

Thumbs Up

Andean Agreement: Peru, Bolivia, Colombia, Ecuador, Venezuela, Chile, Argentina, Mexico, Paraguay and Uruguay successfully used bulk purchasing and joint negotiation strategies to establish reference prices for ARVs that are, in some cases, dramatically lower than existing prices (e.g. Governments will save up to 93% on one first-line triple combination). With the exception of Abbott Labs, no originator firm was willing to make regional offers for the requested products. Regional reference prices were lower as a result, as they were largely set by generic firms. With the exception of Merck and Roche, originator firms have no discounted pricing policies for middle-income countries. Yet even compared to discounts offered by Merck and Roche, reference prices obtained by the ten Latin American countries were on average 38% cheaper.

GlaxoSmithKline: Have agreed to respond to the emerging W135 meningitis strain by producing a trivalent vaccine. But it's not all good news: although they are standing by to begin production, the hold-up now is lack of funding. So far, donors have not responded to the call for funds. Governments argue that meningitis outbreaks cannot be funded until the outbreak begins, which is too late to produce the vaccines.

Cipla: Has developed and will soon begin marketing a combination co-blister of artesunate and amodiaquine for the treatment of malaria. This product will supplement Sanofi's limited available production and will be offered at a significant discount. This less expensive co-blister should become available in Autumn 2003.

Thumbs Down

Sanofi: Has been painstakingly slow developing and producing a combination co-blister of artesunate and amodiaquine for the treatment of malaria but continues to shamelessly market Arsumax (five-day artesunate monotherapy).

Aventis: Sold amodiaquine, an old malaria drug, to UNICEF for a price ten times higher than generic products. Unwilling to cut the price even though this was a large order for a government with no marketing expenses attached. The company also flatly refused to produce vaccines for the newly emerging W135 meningitis strain.

Boehringer-Ingelheim: CEO quoted in the Financial Times as saying that "only Uganda and Botswana [had] accepted [their] offer of free supplies of to prevent mother-to-child HIV transmission". In reality, the company has been asked for nevirapine by 71 programmes in 31 African countries.

Merck: Although their differential price programme is one of the industries' best, they recently misled the public in July by claiming that their new once-a-day 600 mg version of efavirenz would be available in developing countries at a sharp discount from the existing formulation's price. Didn't mention that at the time the new formulation had been registered in the US and several European countries, but had not yet been registered in developing countries. They refused to lower the price of the available formulation as an interim solution.

Daniel Berman

G8 betrays people in developing countries on medicines issue

© MSF

MSF organised a special G8 event 'Suspended Lives' to symbolise the crisis in access to medicines. Volunteers jumped from a platform trying – and failing – to reach a giant pill.

Evian was an insulting disappointment for the millions of people who need access to effective and affordable medicines. Despite repeated claims at this and past summits that developing world health is a major concern for the G8, it is clear that the greater concern of wealthy countries is to protect their own interests.

Access to medicines has been high on the agenda of G8 meetings for the past four years, and MSF was hopeful that this year's summit in Evian on 1-2 June would lead to concrete action. The group represents an enormous political, financial, and pharmaceutical potential. However, while several important commitments have been made to improve access to medicines since 2000, few have been achieved and many have been forgotten.

In 2000, G8 leaders in Okinawa had committed to setting up a "new" partnership aimed at reducing disease burden for HIV, tuberculosis, and malaria. The adjunct Okinawa Infectious Disease Conference led to support for a range of much-needed policies, including commitments to "increas[e] our support... for the R&D of international public goods" through mechanisms such as purchase funds or bulk procurement; and to "make key drugs, vaccines, treatments and preventive measures more universally available and affordable in developing countries". But none of these has been adequately followed through.

The G8 meeting in Genoa the following year took place in the context of growing international pressure to increase access to medicines, particularly for HIV/AIDS. The South African legal case had been dropped by the pharmaceutical industry in February; the WTO TRIPS Council had started to discuss access to medicines; and the UN General Assembly Special Session on HIV/AIDS in June had resulted in the launch of the Global Fund. But amid mounting evidence that patents result in high prices for drugs while doing little to stimulate R&D for diseases of the developing world, the G8 chose to emphasise the importance of strengthening intellectual property rights.

At Kananaskis in 2002, under the shadow of terrorism and security issues, the G8 reached for the lowest hanging fruit. R&D issues were again ignored and HIV/AIDS discussions focused exclusively on preventive measures, at a time when the need to ensure treatment for 6 million people in urgent need of it was gaining international acceptance.

Since the G8 meeting in Okinawa in 2000, the number of HIV-infected children has nearly tripled from 1.3 million to 3.2 million; 6 million more people have died from tuberculosis; and malaria mortality in children under 5 has increased up to 5-fold in some parts of Africa.

Health groups and activists who had followed the G8 preparations in early 2003 were encouraged by initial discussions. The early draft of the Action Plan on Health for Evian (the text that was negotiated in the run up to the G8) prepared by the French government put forward increasing access to affordable generics through implementation of the WTO's Doha Declaration on TRIPS and Public Health. It proposed improving access to expensive brand-name drugs through differential pricing, stimulating local production and technology transfer, and creating sustainable long-term financing for the Global Fund to fight AIDS, tuberculosis and malaria. Additional recommendations were made to address the gap in research and development (R&D) for neglected diseases.

"The funding deficit is magnified by US-sponsored policies that frustrate efforts to increase access to affordable medicines.

However, several weeks before the summit, the US government redrafted the Action Plan, removing anything of consequence. The result was a set of statements that effectively promoted the interests of Western industry while betraying the health needs of the developing world. Despite being in opposition to earlier intentions of some G8 members, this US draft went through unaltered to become the final G8 Communiqué – a statement so lacklustre that MSF concluded the Summit by denouncing it as a 'Plan of Inaction'.

Days before the Evian summit these issues concerning long term global policy were eclipsed in the news by the American announcement to provide $US 15 billion for HIV/AIDS over the next 5 years. While it is certainly welcome news that realistic figures are finally being presented, critical questions remain regarding how this money will be used and when it will be put on the table. Other G8 countries, meanwhile, failed to come up with any serious funding; pledges to the Global Fund to Fight AIDS, TB, and Malaria still fall way short of what is needed, which will mean that countries' proposals to expand treatment for these three diseases will be refused or postponed.

Worse, this funding deficit is magnified by US-sponsored policies that frustrate efforts to increase access to affordable medicines. These policies were reflected in two documents issued at the G8. The G8 Communiqué on Trade effectively blocks countries from ensuring that affordable generic medicines can be produced and exported efficiently. The G8 Action Plan for Africa, meanwhile, proposes as a key priority "pressing ahead with current work with the international pharmaceutical industry" to promote availability of life-saving medicines, rather than exploiting flexibility in current trade and intellectual property laws.

Once again, the G8 broke past promises by putting the interests of the Western pharmaceutical industry above the essential needs of the world's destitute sick.

Nathan Ford

In Evian, MSF called on the G8 to:

- **Make existing essential medicines affordable** to those who need them by supporting an equity pricing system centred on generic competition, and abandon reliance on voluntary, ad hoc efforts to increase access to medicines, which do more to protect the interests of the pharmaceutical industry than the lives of people in developing countries;
- **Fully fund the fight against major infectious diseases** through the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) and other financing mechanisms, and ensure that resources are spent wisely in order to treat the largest number of people possible;
- **Ensure that public health needs are prioritised over commercial interests** in international trade negotiations, so that patents no longer constitute a barrier to access to medicines;
- **Increase research and development (R&D)** into new essential medicines, diagnostics, and vaccines for neglected diseases such as sleeping sickness, kala-azar, malaria, TB, and HIV/AIDS and announce political and financial support for innovative global strategies to ensure needs-driven R&D for health.

Instead, the G8 Action Plan on Health:

- Expressed support for pharma discounts and donations and encouraged developing countries to reduce tariffs on discounts and donations;
- Emphasised the importance of preventing diversion of medicines back to developed country markets;
- Paid lip service to problems faced by countries with little or no manufacturing capacity;
- Failed to find new ways to support R&D for neglected diseases, focusing instead on creating incentives for industry; and
- Called on countries to "consider increasing their support to the Global Fund" but failed to convince them to do so.

In fact, the only section of the Action Plan that showed true determination is for SARS. Diseases that primarily affect poor people and occur in places of little consequence to the global economy were not treated with the same urgency.