Stopping mass murder: action against AIDS

UNAIDS estimates that USD 10.5 billion will be needed by 2005 just to support a "bare bones" effort against AIDS. This huge sum is thrown into dramatic relief by what one country alone can manage when it comes to war. By the end of 2003, the cost of the war on Iraq to US taxpayers was more than USD 200 billion. One "mad" cow in North America can command sustained headlines in the land of the rich and powerful, while millions of humans die silently abroad.

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"It's mass murder by complacency. …the time for polite, even agitated entreaties is over. This pandemic cannot be allowed to continue, and those who watch it unfold with a kind of pathological equanimity must be held to account. There may yet come a day when we have peacetime tribunals to deal with this particular version of crimes against humanity."

Stephen Lewis, UN Secretary-General's Special Envoy for HIV/AIDS in Africa[2]

Human security does not mean much if the human beings concerned are not alive to enjoy it. Preoccupied with the "threat of terrorism", citizens in wealthy countries are becoming more and more conscious of their vulnerability to disease, just as those in poorer lands have been vulnerable to a greater degree. The scourge of "flu" in poultry threatens the livelihood of millions of Asians. The appearance of a small number of SARS cases throws the economy of Canada's metropolis into a tailspin. One or two "mad" cows in North America lead to major ruptures in trade in beef internationally. Not only "no man is an island" but no region, nationality or species is invulnerable in our biosphere (although some make claims for the cockroach).

Regarding AIDS the United Nations Security Council broke precedents in examining the need for action, the General Assembly held a Special Session committing the world's leaders to a dramatic response, the Secretary-General sparked the creation of a Global Fund for AIDS, Tuberculosis and Malaria, the Millennium Development Goals (MDGs) make a modest pledge to halt and reverse the spread of the disease by 2015.

Adults and children estimated to be living with HIV/AIDS, December 2003

Source: UNAIDS. *AIDS Epidemic Update. December 2003.* At www.unaids.org/en/default.asp

The present

- Three million dead in 2003, a world total of approximately 30 million to date.
- Five million new infections in 2003, they continue at approximately 14,000 per day.
- Forty million living with HIV/AIDS.[3]

The vast majority - 95% - of people living with HIV/AIDS live in the developing world. The majority of these are women and girls, made more vulnerable by the ongoing feminisation of poverty. Women represent 50%-58% of HIV-positive adults in sub-Saharan Africa, North Africa and the Middle East and the Caribbean. Life expectancy has been cut dramatically in sub-Saharan Africa: in Zimbabwe by 35 years, in Botswana and Swaziland by 28 years.

Prevalence rates have risen dramatically in some sub-Saharan countries: to 38.8% in Botswana, 31% in Lesotho, 33% in Swaziland and Zimbabwe. Twenty-four African countries have a prevalence rate greater than 5% among adults. Where prevalence rises above 1% of a population, there is potential for a more generalised epidemic. A 5% rate threatens exponential growth in the general population.

The future

The UNDP Human Development Report 2003 states "China, India and the Russian Federation - all with large populations and at risk of seeing HIV infection rates soar - are of particular concern. About 7 million people are infected in these countries, and in sub-Saharan Africa 7 million cases exploded to 25 million in a decade. …[E]ven in a moderate scenario, by 2025 almost 200 million people could be infected in these three countries alone."[4]

There are areas where even now too little is known about the extent of infection; denial and stigma retard effective surveillance and treatment as well. There is the potential for a considerable rise in infections in the Middle East and North Africa, but in a number of countries the data is scant. UNAIDS states that speedy action on prevention is urgently required, particularly among groups that

1 John W. Foster is Principal Researcher, The North-South Institute, Ottawa, Canada and chair of the Coordinating Committee of Social Watch.

2 Lewis, Stephen. "AIDS, Gender & Poverty: A United Front Against the Pandemic", *Social Development Review*, 7:1. London: International Council on Social Welfare (ICSW). 2003. From a press briefing given at the United Nations, New York, 8 January 2003.

3 UNAIDS. *AIDS Epidemic Update.* Geneva: UNAIDS, December 2003. These figures are estimates. The number of deaths is between 2.5 million and 3.5 million, for example.

4 UNDP. *Human Development Report 2003: Millennium Development Goals: A compact among nations to end human poverty.* New York and Oxford: UNDP/Oxford University Press, 2003, p. 4.

could be drawn into the next phase of spread of the disease. Reluctance to deal with men who have sex with men, sex workers and injection drug users has hampered response. Condom promotion is largely absent in the region, but some countries are developing more substantial prevention programmes. These must be extended to deal with migrant workers, young people, refugees and displaced persons and transport route workers, among others.[5]

HIV/AIDS, development and human security

Where AIDS is highly prevalent, the impact goes far beyond the already incredible suffering and loss of life, undermining human security in many dimensions. In such countries the prospect of achieving the MDGs is faint, in fact life expectancy, economic and social security are moving backward.

- Economic security: the UNDP Human Development Report 2003 notes that AIDS "can throw development off course."[6] A World Bank study indicates that an adult HIV prevalence rate of 10% can reduce the growth of national income by up to one third.[7] UNICEF estimates that by 2010, the South African economy will be 20% smaller than it would have been without HIV/AIDS.[8]
- Food security: As 2002 ended, some 14.4 million people in six southern African countries were at risk of starvation. Agricultural production and food supply have become tenuous. The UN Food and Agriculture Organization (FAO) estimates that seven million agricultural workers in 25 severely affected African countries have died from AIDS. Some 16 million more could die in the coming 20 years unless the impact of the disease is reversed.[9]
- Families and social structure: HIV/AIDS not only destroys "human capital" but threatens societal collapse because the function of the family by which knowledge and abilities are transmitted from one generation to the next is interrupted or destroyed. Children are left without one or more parents to love, raise and educate them. The MDG objective of reducing infant mortality by two-thirds by 2015 is virtually impossible in countries with high rates of infection.
- National security: Many military forces in Africa have infection rates five times that of the civilian population, in some cases rates as high as 50% or 60%. In reducing the operational capacity of many of Africa's armed forces, HIV/AIDS contributes to vulnerability to both internal and inter-state conflict.
- Governance: HIV/AIDS prevalence puts governments in affected countries under incredible strain. Having been weakened by decades of structural adjustment, and under ever increasing strictures administered by the World Bank, IMF and WTO, governments now need to be radically strengthened in their capacity to serve their citizens' needs. But they are stalked by the threat of "state failure". For example, a recent study of the Ministries of Finance, Economic Planning and Development and Public Services and Information in Swaziland, documents that "solely as a result of HIV/AIDS the three ministries will lose 32% of their staff complement" over a twenty-year period. To replace teachers lost to the pandemic, Swaziland will have to train 13,000 people between 1999 and 2016 instead of the 5,093 that would normally be needed.[10]

Saving lives: prevention, treatment and care

The work of prevention, treatment and care requires education, community engagement and functioning health care systems. As UNAIDS notes "in Africa, where two-thirds of the world's HIV-positive people live, health-care systems were already weak and under-financed before the advent of AIDS. They are now buckling under the added strain of millions of new patients. In many places facilities for diagnosis are inadequate and drug supplies are erratic, even for HIV-related conditions that are easy to diagnose and inexpensive to treat."[11] A comprehensive approach to health, for healthy populations, demands the rehabilitation and in some cases recreation of public health systems. To sustain healthy populations, of course, will require other basics as well - decent nutrition, clean water and decent housing. A successful response to the pandemic will be sustainable only if part of a more general development strategy.

It is only in the last few years that the prospect of access to treatment has become a reality, about a decade ago in affluent countries, and frustratingly in the distant future elsewhere. It was frequently argued that it was impossible to successfully and sustainably administer new anti-retroviral treatments in poorer countries, because they required a level of sophistication and economic development that was simply not there. The prohibitive cost of the so-called triple-therapy was clearly another block. The price of therapy for one patient in early 2000 was USD 10,000-12,000 per year.

Yet by the end of 2000 the price had dropped to USD 500-800 per person for first-time anti-retroviral treatment in low-income countries, and by 2003, the prices of the least expensive generic combination recommended by the World Health Organization (WHO) was under USD 300 per person per year.[12]

Perhaps the single most important step forward was taken by the government of Brazil, with strong pressure from civil society organisations. From 1996 Brazil has provided universal free access to triple anti-retroviral treatment. Even in the first year it extended survival to an average of 58 months from an average of 5 months in the 1980s. "It is the first time a study has demonstrated that universal free access to triple anti-retroviral treatment in a developing country can produce benefits on the same scale as in richer countries."[13] But the study also indicated that perhaps only 40% of the 600,000 HIV-positive patients in Brazil are aware of their infection. "The rest just fear the social and physical consequences of this disease and prefer not to undergo the test."

Other countries have not been even this lucky. In South Africa the resistance of the government to anti-retroviral treatment and the obduracy of drug companies in protecting their patents delayed response to a rapidly escalating number of infections for years. The persistence of such civil society activists as the Treatment Action Campaign, with the support of international NGO networks has made significant progress, but the delays have had tragic consequences on a mass scale.[14]

Drugs

"Today, at least 400 die every day in Kenya from AIDS. …This is the genocidal action of the cartel of pharmaceutical companies which refuse to provide affordable medicines in Africa at the same time as they declared USD 517 billion in profits in 2002."[15]

5 UNAIDS. "The Middle East and North Africa". *AIDS Epidemic Update.* December 2003.

6 UNDP, *op cit*, p. 41.

7 Bell, Clive, Shantayanan Devarajan and Hans Gersbach. *The Long-Run Economic Costs of AIDS: Theory and an Application to South Africa.* June 2003. World Bank Research Report.

8 Cited in Standing Committee on Foreign Affairs and International Trade (SCFAIT), House of Commons, Canada. *HIV/AIDS and the Humanitarian Catastrophe in Sub-Saharan Africa.* June 2003, p. 16.

9 Cited in International Crisis Group. *HIV/AIDS as a Security Issue.* Washington/Brussels: International Crisis Group, 29 June 2001, p. 11.

10 Whitside, Alan, et al. *What is driving the HIV/AIDS epidemic in Swaziland, and what more can we do about it?* National Emergency Response Committee on HIV/AIDS (NERCHA) and UNAIDS, April 2003.

11 UNAIDS. *Access to HIV Treatment and Care*, Fact Sheet. Geneva: UNAIDS, July 2003.

12 *Ibid.*

13 Pio Marins, Jose Ricardo. University of Campinas. Quoted in "Free HIV Drugs in Brazil Have Boosted AIDS Survival", Reuters (25 July 2003), in CDC HIV/STD/TB Prevention News Update, 30 July 2003.

14 CSOs have demonstrated that treatment can be actualised. In the township of Khyelitsha, near Capetown, Medecins Sans Frontieres clinics helped people stabilise their condition, developing simple ways to assure regular use of complex dosages and training community nurses to supervise and support patients. In Soweto, mother-to-child transmission has been reduced with help from OXFAM, involving the drug Nevirapine, the provision of powdered milk and a supervised community care system. These initiatives need to be scaled up on a massive basis. They also must be supported by basic needs provision, clean water, adequate nourishment and stable housing.

15 Statement by American Jesuit Angelo D'Agostino, at a press conference held by Archbishop Paul Josep Cordes, President of the Vatican humanitarian agency Cor Unam. From "Le Vatican part en guerre contre les companies pharmaceutiques", *Le Soleil*, Quebec, 30 January 2004.

The fight to open up access to life-saving drugs has been going on virtually since their availability was announced. The creation of the WTO in the mid-1990s was accompanied by a phenomenal extension in protection of privately - largely corporately - held patents, via the international agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS). The agreement commits participating countries to extend 20-year patent protection to the owners of patents on medicines, a tremendous victory for the large pharmaceutical firms holding many of the world's drug patents, and funding or controlling much of continuing research.

The TRIPS Agreement contains provisions which should, in theory, provide the flexibility for countries to balance these protections with action for public health, for example through issuing a compulsory license to permit the manufacture of lower-cost generic copies of the patented products. In practice, however, some countries, under pressure from corporations or more powerful producer countries, either forbad compulsory licensing or simply did not take advantage of the possibility.[16]

A saw-off of interests occurred at the WTO Ministerial Conference in Doha, Qatar. On 14 November 2001, a declaration on the TRIPS Agreement and Public Health affirmed that TRIPS "does not and should not prevent members from taking measures to protect public health" and "in particular, to promote access to medicines for all".

The declaration left unresolved the situation of countries that lacked the capacity to produce generic medicines themselves. It committed countries to find an "expeditious" solution for this problem. Negotiations ground on for almost two years, and only when the lack of a deal threatened to upset the next WTO Ministerial planned for Cancun, Mexico in September 2003, did negotiators resolve the deadlock. It permits countries with productive capacity to export via a compulsory license to an eligible importing country. Of course, the TRIPS Council of the WTO retains the right to be notified of countries' intentions and monitor and supervise a number of conditions. The right to drugs, and one might say, the right to health, can be accessed only under the TRIPS Council's authority. Property rights are honoured over those of people.

The agreement is only an "interim waiver" regarding TRIPS provisions, pending agreement to amend the TRIPS Agreement itself. Meanwhile, in negotiations like those for the proposed Free Trade Area of the Americas, the large pharmaceutical corporations are seeking TRIPS+, something more than 20 years' protection.

Treatment advocates found the agreement "seriously flawed", giving WTO bodies an intimate and potentially intrusive and complicating role which could delay or prevent progress. Importing countries remain beholden to the decision-making of the wealthy.[17]

16 Development and human rights NGOs, organisations of People Living with AIDS and their allies undertook a persistent and globe-girdling campaign to expand the legal windows for access and offset corporate and big power pressure.

AIDS does not travel alone

Malaria kills more than a million people a year, 700,000 of them African children. New treatments - the three-day two-drug combination therapy - cost USD 0.40 for a child's treatment, USD 1.50 for an adult. But many families cannot afford even this, and the Global Fund to Fight AIDS, Tuberculosis and Malaria remains strapped for cash. WHO estimates it would cost USD 1 billion to cut in half the 1.1 million annual deaths due to malaria. This is roughly what Pfizer pharmaceuticals made from the sales of one drug, Viagra, in 1999.

The imbalance in research priorities and expenditures continues to bedevil progress against diseases that attack poor people. The World Watch Institute notes that between 1975 and 1997, 1,223 new medical drugs were developed, largely to target diseases of affluence and over consumption. In the same period only 13 of the new drugs aimed to treat malaria, schistosomiasis and other "tropical diseases" affecting developing countries. Germán Velásquez, Coordinator of the Drug Action Programme at WHO states "After Doha, it is clear that if drugs are considered as goods, health will remain an extension of the market, with remedies and treatments available only to those with enough purchasing power."[18] The United Kingdom's recent Commission on Intellectual Property Rights went on to ask whether a drug which makes it possible for people to exercise a fundamental human right - the right to health - can be bound by rules which thwart access for 20 years. Essential drugs, it could be said, are a global public good, something with benefits that extend to all countries, people and generations.[19]

"This AIDS drug thing is simple. It's a chance to dip our well-fed toes in the water, by actually using our collective discoveries and inventions to benefit humanity. Maybe we shall find that it isn't so dangerous and that our economic system doesn't collapse. And the health benefits will be immediate and spectacular."[20]

Scale

"Whatever else, the war in Iraq and the aftermath is going to cost this world in excess of USD 100 billion and I want someone to explain to me why there is always so much money for conflict and pennies for the human condition."[21]

17 Nevertheless treatment advocates are seeking by a variety of means to make sure that every opening created by the agreement is utilised in pursuit of access for those needing treatment.

18 Velásquez, Germán. "Drugs Should be a Common Good: Unhealthy Profits", *Le Monde Diplomatique*. English Edition, July 2003.

19 Commission on Intellectual Property Rights. *Integrating Intellectual Property Rights and Development Policy. Report of the Commission on Intellectual Property Rights*. London: Commission on Intellectual Property Rights, September 2002, p. 48.

20 Sulston, John (Nobel Prize for Medicine (shared), 2002). "The Rich World's patents abandon the poor to die", *Social Development Review*, 7:1. London: ICSW, 2003. Originally published in *The Guardian*, 18 February 2003.

The huge numbers of infected and dying people may deaden our sensitivities and threaten a sense of futility. In 2001 the WHO Commission on Macroeconomics and Health estimated that costs of responding to HIV/AIDS could reach USD 14 billion by 2007 and USD 22 billion by 2015. It would have distributed funds one-third to each of prevention, treatment of opportunistic infections and antiretroviral therapy. These are based on very conservative estimates.[22] UNAIDS estimates that USD 10.5 billion will be needed by 2005 just to support a "bare bones" effort against the disease.[23] These may seem large numbers, but they are thrown into dramatic relief by what one country alone can manage when it comes to war. By the end of 2003, the cost of the war on Iraq to US taxpayers was estimated at more than USD 200 billion, most of it allocated in one year.[24]

Scaling up

An estimated 40 million people live with HIV/AIDS today. WHO has attempted to build world support and resources for the provision of treatment to three million of them by 2005: a modest beginning, but one that thus far seems out of possible grasp.

In sub-Saharan Africa only 50,000 people were estimated to have treatment in 2002. In Asia and the Pacific, only 43,000. In Latin America and the Caribbean the picture is slightly better, in good part due to Brazil's example, with close to 200,000 getting treatment by the end of 2002.

The Global Fund to Fight AIDS, Tuberculosis and Malaria was created with high expectations in 2001, designed not to replace existing monies but to raise additional funds. In its first two rounds of funding it spent USD 1.5 billion of which 65% went to HIV/AIDS. For 2003-2005 the Fund called for a budget of USD 9.7 billion, but only had pledges of USD 1.5 billion by mid-2003.

Official Development Assistance (ODA) should be playing a significant role, and the Monterrey Financing for Development Conference (2002) was taken as a sign that the long decline in commitments from wealthy countries was being reversed. Ireland, Belgium, the Netherlands and Sweden all committed to significant increases in the next two to six years. Canada confirmed a yearly increase of 8%, but it will take five years to reach 1991 spending levels.

21 Lewis, Stephen, see footnote 2.

22 The Commission assumed, for example, that only 5% of Africans affected are currently aware of their status and therefore in a position to know whether or not treatment is appropriate. World Health Organization (WHO). *Macroeconomics and Health*. Geneva: WHO, 20 December 2001, p. 53.

23 UNAIDS. "Despite substantial increases, AIDS funding is still only half of what will be needed by 2005." Press release. 26 June 2003.

24 This amount is over and above the regular US Department of Defense expenditure of roughly USD 400 billion. These amounts dwarf what is needed for HIV/AIDS and indicate that effective funding is not a matter of capacity but of political choice.

Debt cancellation

Debt cancellation could also be a significant source of relief. Conditionalities on loans, whether obvious or subtle, continue to encourage limitations on public spending, pressure governments to privatise public services - including health services - and conform to WTO agreements such as TRIPS. The UN Population Fund examined the extent to which the World Bank's Poverty Reduction Strategy Papers (PRSP) process had been used to optimise opportunities to respond to HIV/AIDS as part of an integrated response to poverty. The report concludes "most PRSPs completed have generally missed the opportunity for effectively assessing the links between poverty, population and HIV/AIDS."[25] The report provides a checklist on mainstreaming HIV/AIDS in poverty reduction strategies.

The gap between the need to save lives through treatment and adequate support now and the leadership and commitment necessary on the part of those who control resources and the pricing of treatment remains immense. The expenditure commitments made by some wealthy countries on "reconstructing" Iraq have come within months after the defeat of Saddam Hussein. The effort to cajole or embarrass governments into committing increased resources to combat the global pandemic grinds on slowly. Some dream of something like the "Marshall plan" which aided Europe after World War II.

Turning point

Speaking at the United Nations early in 2003 UN Special Envoy Stephen Lewis referred to signs of "determination and hope" he had discovered in Africa. "What has changed," he stated, "is the maturity, vehemence and confidence of the organisations of People Living with HIV/AIDS…they know the cost of generic drugs; they know about the treatment regimes; they know that WHO has undertaken to have three million people in treatment by 2005; they know that the rich members of society vault down to South Africa for treatment, while the poor remain helplessly behind; they know about Doha and intellectual property rights and the WTO; they know, from bitter experience, about all the false political promises. Increasingly, we're dealing with sophistication and determination in equal measure."[26]

Are we, in fact, at a turning point in the fight against the pandemic? A very few years ago only one or two African governments had developed strategies to deal with the disease, today many have at last begun to implement such strategies and the African Union's Maputo Declaration (July 2003) commits African governments to a comprehensive approach and seeks international support.[27] Some countries, like Uganda, and some districts within countries are showing remarkable progress in prevention and reduction in infections. Generic drug manufacturers in low- and middle-income countries, like Brazil, India and Thailand, are producing some anti-retroviral drugs at a reasonable cost. The pre-Cancun agreement on export of generic drugs to countries lacking productive capacity belatedly offers the potential of fulfilling commitments made at the Doha WTO two years earlier. Canada, among wealthy countries, has begun an initiative that would permit firms to produce and export such drugs as well.

Nevertheless the fundamentals necessary to reach millions - strengthened health systems in developing countries with trained and adequately supported staff, adequate supplies of medicines for universal access, sustained security in basic needs - remain tragically out of reach. Just as important is the lack of leadership among the wealthy - whether in the North, among the petroleum rich or in emerging wealthy classes in middle-income countries - in ramping up the level of resources and organisation equal to the task. What is required is a multiplication of dollars, francs, pounds, marks or yen. What is offered is usually a small percentage increase, if that.

Stephen Lewis has raised the prospect that someday those who prevent the delivery of life-saving drugs and the health systems and basic needs which would enable them to be effective and sustainable may face a tribunal, like the authors of the Holocaust at Nuremberg after World War II or the sponsors of genocides today at Arusha and The Hague. Who would be in the dock facing justice? Those who foisted an unnecessary and costly war on Iraq? Those who strive by all possible means to protect the privilege of patents? Or those who permit through complacency or worse the continuation of this human waste and the misallocation of the globe's resources?

The provision of universal access in Brazil, the move toward provision of treatment in South Africa, the Doha Declaration and the pre-Cancun compromise on generic drug provision have all been due, in good part, to mobilised networks of activists, of People Living with HIV/AIDS, of spirited physicians and healthcare workers and of a few - too few - politicians who caught the fire of urgency.

It is time for a wildfire of action to free the resources and the ingenuity to save millions of lives and right the grotesque wrong that condemns them and future millions more to suffering and death. ■

Taking action

What sorts of action are required?

- Access on affordable terms to life-extending drugs.
- Recognition and reinforcement of human rights, particularly the right to the "highest attainable standard of physical and mental health." (CESCR).
- Radically increased resources via the Global Fund, other multilateral and bilateral channels, ODA, debt cancellation and relief, to support public health services and other essential components of immune ability like clean water, adequate food and housing.
- Enhancement of public health services and support including training, public education, support for community-based prevention and care initiatives.
- Continued research for vaccines for HIV/AIDS, and drugs and treatment regimes suitable for other large-scale diseases affecting the world's poor majorities.
- And, above all, a vigilant, persistent and creative alliance of civil society organisations without which the other actions are unlikely to be fulfilled.

25 United Nations Population Fund (UNFPA). *The impact 2003*. pp. 85-92.

26 Lewis, Stephen, see footnote 2.

27 African Union. *Maputo Declaration on HIV/AIDS, Tuberculosis, Malaria and other related infections diseases.* AU Declarations. Assembly/AU/Decl. 1-5. Addis Ababa: African Union, July 2002.