

The logo for the Student Global AIDS Campaign features the words "Student Global" in a smaller font above "AIDS" in a large, bold font, with "CAMPAIGN" in a smaller font below. A red ribbon is integrated into the design, passing through the letters of "AIDS".

**Student Global
AIDS
CAMPAIGN** | **Targets**



Universal Access 2010: The Health Care Workers Crisis

If we are to talk seriously about reaching Universal Access to AIDS treatment any time soon we have to deal with the critical shortage of doctors, nurses, and trained community health workers in Africa. While Africa has 24% of the world's disease burden, it has only 2.5% of its healthcare workers. While the US has 549 doctors for every 100,000 people many African countries have less than 5.

WHY?

Brain-Drain is a major and complex issue, and is driven not by health workers wanting to emigrate but by failures of policy and practice. In Ghana, research indicates that 50% of graduates of medical schools emigrate within 5 years, and 75% within 10 years. Active recruiting by wealthy nations pull trained health care workers out of Africa.

Broken Health Systems, though, are the key factor in the shortage. Faced with very low wages, overwhelming patient loads, poor and unsafe working conditions, and not enough supplies and technology to do their jobs, is it a surprise that many who would like to stay feel they must leave Africa? And wealthy countries are not investing the resources to change this situation or replace the health workers recruited to meet our needs.

Poor Economic Policy is a major driver of this brain drain. For decades international economic institutions have forced impoverished nations to adopt policies that dismantle existing public health systems and prevent the development of new infrastructure. The International Monetary Fund (IMF) is among the most problematic—imposing policies that require a public sector “ceiling” that prevents countries from hiring enough health workers or paying them enough to retain them.

Community Health Workers—family and community members who are doing the bulk of care-giving in many nations—are filling some of the massive gaps, but receive little or no compensation or training.

HIV/AIDS also has a massive direct effect the health workforce. In South Africa, it is conservatively estimated that 16% of the existing health worker force is HIV+ and in Malawi the government figures they will lose nearly 3% of their workforce each year to the disease.

We need one million new health care workers in sub-Saharan Africa immediately!

How Do We Get There?

SGAC Demand 1: Members of the U.S. Congress and President Bush must commit \$650 millions in 2007 to address the health care workers crisis, with increasing amounts in subsequent years, totaling \$8 billion in 5 years.

This money must be invested in programs and initiatives that work with national governments to develop and implement training and retention plans. This amount represents the United States' fair share, one third (in accordance with its share of global Gross Domestic Product), of the total need. This financial commitment is essential in increasing the size, skill, motivation, and support for the health workforce. A serious investment of resources is necessary, both by the U.S. and other donor countries around the world to reverse the tides of the shortage.

SGAC Demand 2: Support the Durbin bill calling for a comprehensive approach to addressing the health care workers crisis. Call on your representatives and senators to co-sponsor the bill and become champions on the issue.

In the U.S. Senate, Dick Durbin (D-IL) introduced the African Health Capacity Investment Act of 2006 (S. 3775) in August focused on

recruiting and training an expanded health workforce and assembling a coordinated US plan to address the issue. Although the current version of this bill entails a smaller financial commitment than the total need, its articulation of principles in tackling these issues is commendable and a crucial first step in educating the rest of Congress on a comprehensive approach to addressing the health care worker shortage.

SGAC Demand 3: The President must become a leader on this issue and launch a broad and comprehensive initiative focused on addressing the healthcare worker shortage.

Stemming from activist pressure, there is momentum arising out of the Office of the Global AIDS Coordinator to take significant actions, particularly surrounding community-based health care workers. However, there is much to do to ensure that the final version of any such initiative reflects the demands shaped by people living with AIDS and activists worldwide. A comprehensive approach would address not only the issue of funding health care workers, but also need to assure that the initiative strengthens public health systems and that their work is not inhibited by ideological restrictions.

SGAC Demand 4: The US must push the International Monetary Fund to eliminate policies such as spending and wage ceilings that limit countries' ability to adequately fund priority health and education programs.

Budgetary constraints placed on individual countries by the IMF force low salaries for highly trained health professionals and prevents countries from investing sufficiently in their health systems. The IMF, in placing conditions on their loans, demands that countries meet highly restrictive budget targets that put ceilings on how much they can spend on the “public sector” (read: healthcare system). Kenya, for example, currently has 5,000 unemployed nurses who the government is unable to hire due to these restrictions. These “structural adjustments” prevent governments from independently setting their spending priorities to reflect the importance of combating the AIDS epidemic. Without massively scaled up spending to meet the AIDS crisis, Universal Access is a joke. The US government has a controlling vote on the IMF board and so could reverse these policies if it so chose.

TAKE ACTION NOW

Talk to your members of Congress and call the White House! Check out the Take Action section of the kit for further ideas on how to:

- Demand \$650 million from the US government to invest in the health workers shortage
- Demand support and co-sponsorship of the African Health Capacity Investment Act
- Demand that the President launch a comprehensive global health workers initiative
- Demand the US government push the IMF to eliminate wage and spending ceilings

If you have any questions about the issues or ways to take action, feel free to email the Grassroots Action Coordinators on the steering committee, Matt Rehrig (matt@fightglobalaids.org) or Anuja Singh (anuja@fightglobalaids.org). For advice on media work, contact Media Coordinator Caiti Schroering (caiti@fightglobalaids.org)

Health care workers talking points:

- African countries' ability to address their own AIDS pandemic is currently being impeded by the role of IMF conditions and a lack of funding and support from developed countries like the U.S. \$650 million from the U.S. Congress is a necessary first step in addressing the shortage.
- An approach to the global health worker shortage must be a comprehensive one, with support from the U.S. and other donor countries to increase the skills, size, and support of health work forces.
- The U.S.'s role in the IMF is powerful enough to reverse the policies imposed on poor countries that restrict investment in health systems. It is time that the U.S. take their roles seriously and commit to changes with IMF policies.

¹ Friedman, Eric A. “An Action Plan to Prevent Brain Drain: Building Equitable Health Systems in Africa.” Physicians for Human Rights, 2004, p.19. Available www.healthactionaids.org.

² Physicians for Human Rights, “G8: What Would an Effective Health Care Worker Plan Look Like?” Available www.phrusa.org/campaigns/aids/scenario.html *Principe, Sudan, and Yemen*. 25 October, 2005.



Putting Profit before Patients: Abbott Laboratories

In recent years the price of first-line AIDS drugs has fallen dramatically, from US\$10,000 to US\$140/patient/year.¹ But with growing resistance to these first-line drugs and side-effects, there is an urgent need for new “second-line” drugs. Unfortunately affordable global access to these drugs is nearly non-existent.

Abbott’s Kaletra (a combination of drugs Lopinavir and Ritonavir [LPV/r]) is among these critical second-line drugs. Abbott received FDA approval in October, 2005 for a new version of Kaletra (also referred to as Aluvia) that makes huge improvements for use in resource-poor settings. This newer version of Kaletra:

- Does not require refrigeration
- Can be administered without regard to meals
- Requires fewer pills per day (2-4 tablets a day vs 3-6 capsules)

Sadly, this new formulation—perfect for saving lives in Africa and other regions—is not getting to people living with AIDS in the Global South. Instead of getting affordable drugs to people dying in need, Abbott has focused on seeking public acclaim for its largely illusory ‘Accelerated Access Initiative’ while making this drug available only in wealthy markets in the US and Europe.

Background

Abbott Laboratories is among the top drug companies in the world, with \$22.3 billion in sales in 2005, \$3.4 billion in profits, and a profit margin of over 50%. Marketing and administrative costs accounted for nearly \$5.5 billion of Abbott’s operating expenses while research and development accounted for just \$1.8 billion.² The company spent \$27.6 million on lobbying over the past seven years.³ Abbott’s CEO is paid over \$5 million a year.

In 2000, due to the high cost of AIDS drugs, a tiny percentage of people in developing countries had access to life-saving HIV/AIDS treatment. With patent monopolies under increasing scrutiny and the call for generic competition growing, a handful of drug companies (later including Abbott) sought to protect their reputation and their profits by launching a project called the Accelerating Access Initiative (AAI) in conjunction with UNAIDS. While companies promised to cut drug costs, many activists criticized the project as simple PR.

In a campaign against Abbott, lead largely by SGACers all across the US, we have made important progress. A recent announcement by Abbott promised “a sustainable pricing structure that reduces the price of lopinavir/ritonavir tablets to \$2,200 per patient per year in low-income and low-middle-income countries.”⁴ However, SGAC and global activists are neither satisfied nor convinced of Abbott’s statements and continue their commitment to ensuring access in the Global South.

SGAC DEMAND #1: AFFORDABLE PRICING FOR NEW KALETRA, MORE COUNTRIES

Immediately establish affordable prices for new Kaletra for all low- and middle-income countries, which includes many in Southeast Asia, the Caribbean, Latin America, and Eastern Europe left out of Abbott’s program.

Abbott’s announcement to initiate “a sustainable pricing structure that reduces the price of lopinavir/ritonavir tablets to \$2,200 per patient per year in low-income and low-middle-income countries” is nowhere near an affordable price. Both \$500 and \$2,200 are prohibitively high for people throughout the Global South. “Middle income” countries like Brazil and Thailand include tens of millions living on less than \$2 a day, yet Abbott insists that \$2,200/patient/year is sustainable and affordable.

Since 2001 Abbott has offered lower prices for Kaletra at \$500/patient/year, and after pressure from SGAC and other activists, the price was extended to include new Kaletra/Aluvia. However, this price is offered to only 69 countries—leaving out millions who live in countries deemed not poor enough by Abbott. Based on UNAIDS/WHO proposals, there are now about 117 countries that should be eligible for the program. Abbott has said that they will ‘expand’ their initiative to include 114 countries, but Abbott has simply modified the program instead of expanding it. The new countries included in the initiative will not be given the \$500/patient/year discount but must pay the \$2,200/patient/year price tag Abbott has announced.

SGAC DEMAND #2: REGISTER KALETRA & MAKE IT AVAILABLE

Register Kaletra/Aluvia in all ACCESS countries and publish a timeline for country registrations; seek temporary waivers until registration is complete!

Use of Kaletra in the Global South, like any drug, requires registration in country drug regulatory agencies (NDRAs)—the equivalent of the US FDA—or it requires negotiation of temporary waivers. Registration of drugs is the responsibility of the manufacturer, yet Abbott has only filed for registration in a small handful of countries since U.S. FDA approval was granted in Oct 2005.

Activist pressure since February has resulted in Abbott beginning the registration process in South Africa, and receiving approval in the European Union. However, much more is needed. Of the 114 countries that are now part of Abbott's 'expanded' ACCESS initiative, new Kaletra/Aluvia is registered in none of them. This simply means there is no access to it in any of these countries. Abbott has made no concrete commitment to increased resources to make sure that registration occurs, nor have they offered a timeline for the filing of country registrations.

SGAC DEMAND #3: VOLUNTARY OPEN LICENSING & NO NEW PATENTS

Offer a voluntary open license to governments and companies to produce generic Kaletra/Aluvia in the Global South, and do not pursue any new patents.

There are currently no widely-available generic versions of new Kaletra—and we know that generic production has the potential to decrease prices up to 95%! A few generics of the old version are available only in India.

Abbott has so far refused to provide licenses for Kaletra to interested generic producers, including producers in Brazil. A voluntary, open license would allow governments and other companies to make affordable generic medicines and bring prices down through fair competition.

SGAC DEMAND #4: PEDIATRIC FORMULATIONS

Create a half-dose tablet and syrup that is more palatable and doesn't require refrigeration, and publish a timeline for development.

The current pediatric version of Kaletra (a syrup) tastes so bad and must be taken in such large quantities by children that it makes them sick. In addition, it must be refrigerated and so cannot reach rural populations. Abbott announced in August that they would be working on a tablet version of Kaletra in a pediatric form. However, they have not offered a timeline for production or accountability of their commitment to develop the tablet.

TAKE ACTION ON ABBOTT NOW

Contact Abbott: Chairman and CEO, Miles D. White, 100 Abbott Park Road, Dept 392 Bldg. AP61-2
Abbott Park, IL 60064. (p) 847-937-6100 or 847-937-3417 (f) 847-937-1511 or 847-938-6277

Contact the CEO and demand real, affordable access. Here are some talking points:

- Resource poor nations in Africa and elsewhere are the first places new Kaletra should be available—besides greed why would Abbott wait to make it available and affordable?
- Abbott must expand its Access program price of \$500/patient/year to include millions dying without access to treatment in Southeast Asia, the Caribbean, Latin America, and Eastern Europe!
- A real commitment to the poor by Abbott in the Global South would recognize that \$2,200/patient/year is far too high a price tag for new Kaletra. The price must be immediately lowered to one that is affordable to people in low- and middle-income countries.
- Abbott must offer open and voluntary licenses to produce Kaletra and allow for generic production.
- A pediatric formulation of Kaletra that doesn't make kids sick and doesn't have to be refrigerated is needed to save the lives of the 500,000 children currently in need of ARVs.

¹ Clinton HIV/AIDS Initiative, <http://www.clintonfoundation.org/pdf/080706-chai-arv-price-list.pdf>, 7 Aug. 2006

² Abbott Proxy Statement 2005.

³ Center for Public Integrity, Pushing Prescriptions, 2005, www.publicintegrity.org/rx.

⁴ Abbott Laboratories, http://abbott.com/global/url/pressRelease/en_US/60.5:5/Press_Release_0341.htm, 13 Aug. 2006



Putting Profit before Patients: US Bilateral Trade Agreements in Thailand, Malaysia & Korea

The United States is currently negotiating Free Trade Agreements (FTAs) with Thailand, South Korea, and Malaysia that threaten to undermine each country's ability to buy and produce low-cost generic versions of life-saving medicines. Opposition among people living with HIV and AIDS and their allies has been extensive.

In Thailand, for example, at the Chiang Mai negotiation round in January 2006, 10,000 Thai activists—half of them living with HIV/AIDS—converged on the meeting and forced their way in to demand that their lives be valued over corporate profit. A subsequent movement ousted the Prime Minister and halted the talks—which are likely to restart shortly, after elections. In South Korea the opposition is so intense that negotiators are planning to have the portions of the negotiations dealing with medicines in a third country for fear of protests in the US and South Korea.

Trade and AIDS/HIV

While there is still no cure for HIV disease, death rates from AIDS have been slashed in the US and other wealthy nations through effective antiretroviral therapy. In poorer parts of the world, paying market prices for these drugs is simply not an option. Low cost generic versions of these drugs, however, have reduced prices by up to 95%. This has made it possible for many countries to provide universal access to these drugs. Thailand, for example has created a program of government-subsidized antiretroviral drugs that now reaches 80,000 of 170,000 Thai people living with HIV and AIDS. And the program is working—AIDS deaths are 1/3 of what they were a year ago!

Nonetheless, the US government is pushing intellectual property provisions for new FTAs at the expense of people's lives—provisions that would keep the costs of new drugs in these countries prohibitively expensive by ruling out generic competition. There is no need for bilateral deals that expand intellectual property rights, since they are already governed by the WTO—of which Thailand is a member. Indeed, under pressure the US signed the 2001 Doha Declaration that clarified the ability of nations to use trade law flexibilities to ensure access to medicines. Yet because drug companies did not get what they wanted at the WTO, the US is now pushing these new damaging provisions on a bilateral basis.

The US government has consistently refused to release the draft text of its FTA proposals, keeping all of us in the dark and limiting democratic review and civil society participation. However, a copy of the US position on the Thai agreement was leaked last year and confirmed that the US is seeking the same boiler-plate provisions as they have in the past:

- Extend patent terms beyond the basic 20 years agreed to at the WTO.
- Restrict Thailand, Malaysia, and South Korea's right to make or import affordable generic medications.
- Stop these countries from using trade law flexibilities to protect public health – provisions the US agreed to in the 2001 Doha Declaration addressing public health and medicines.
- Prevent these governments and companies from using clinical trial data collected by drug companies to show that equivalent generic drugs are safe and effective.

The Student Global AIDS Campaign Demands:

- Suspend the negotiations on the FTA as demanded by activists in Thailand, South Korea, and Malaysia.
- Put patients over profits: Publicly take Intellectual Property Rights (IPRs)—already governed by the WTO—off the table in negotiations with these three countries and all other nations in the Global South.
- Publish US proposed text for the entire FTA so that the US, Thai, Malaysian, and South Korea people have a chance to hold public consultations on the proposed agreement before any trade agreement moves ahead.

WHO TO CONTACT

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