



Swiss Tropical Institute  
Institut Tropical Suisse  
Schweizerisches Tropeninstitut

Swiss Centre for International  
Health

# HIV/AIDS:



## **Access to HIV/AIDS care in developing countries** A Focus on Africa

March 2001

Claudia Kessler Bodiang, MD, MPH

**A commissioned paper established in the context of the mandate  
t.751-14 of the Swiss Agency for Development and Co-operation (SDC)**

## **Contacts**

### **Swiss Agency for Development and Cooperation**

Daniel Mäusezahl

Daniel.Maeusezahl@deza.admin.ch

Sandra Bernasconi

Sandra.Bernasconi@deza.admin.ch

### **Swiss Centre for International Health**

#### **Swiss Tropical Institute**

Claudia Kessler-Bodiang

Socinstrasse 57, Basel

Telefon +41 61 284 81 87

E-Mail: claudia.kessler@unibas.ch

## **Disclaimer**

This paper was commissioned by the Swiss Agency for Development and Cooperation (SDC). The views and ideas expressed herein are those of the authors and do not necessarily imply or reflect the opinion of the Agency.

## Abstract

**This paper aims to give a short overview of the various care options with a focus on the actual situation concerning access to anti-retroviral therapy in developing countries. The elements of a comprehensive care package will be highlighted along with a rationale for care and support. Care elements will be separated into three levels according to need, complexity and cost. Essential drugs in managing HIV/AIDS patients will be presented and strategies to increase access and to reduce cost of anti-retroviral drugs discussed. In this context, the issue of international patent regulations will be dealt with. Finally, to provide examples drawn from the actualities, three case studies will be further explored: the agreement between Cipla (India) and MSF, the court case of 39 international pharmaceutical companies against the government of South Africa and the example of the Brazilian government and its successful AIDS treatment programme. Finally, some lessons learned of these three cases will be presented.**

## Introduction

As of today, AIDS is still an incurable disease. However, progress in treatment and care has led to a massive drop in HIV/AIDS related morbidity and mortality in the developed world. At the same time, in developing countries, where 95% of the HIV infected persons live and where 95% of AIDS related deaths have occurred so far, both morbidity and mortality due to the same cause are steeply increasing. This disparity is mainly explained in unequal access to effective treatment and good quality care. For most persons living with HIV or AIDS in Africa, the diagnosis is still equivalent to a death sentence preceded by a period of immense suffering, lacking much possibility to get relief.

The awareness of this fundamental injustice has led to public outcries and increased efforts in both the North and the South to improve access for those most in need. "To suffer from a disease with no treatment or cure is tragic. To know that a treatment exists, but is too expensive, brings the ultimate despair." (*G.H. Brundtland, director-general of the WHO in the International Herald Tribune, 14.2.2001*)

At the same time, reports from Brazil about a successful programme of providing access to anti-retroviral treatment and the offer of an Indian generic drugs company to massively cut drug prices hit the front pages of the international press. Today there is hope. However, at the same time, such news have triggered demands and requests and led to an increased uncertainty about what options there are and how they should be applied in a third world context.

As development workers are increasingly asked to respond to requests for support in providing anti-retroviral treatment, this paper aims to give a short overview of the various care options with a focus on the actual situation concerning access to proper anti-retroviral therapy in developing countries.

Before presenting the various aspects related to care of HIV/AIDS patients, it is however of utmost importance to stress that discussions about care should not lead to forgetting the priority in managing the epidemic being still the prevention of new cases. By having access to a care offer, HIV infected persons find the way to effective counselling which can lead to safer behaviour in terms of preventing further transmission and reduced mother-to child transmission. In addition, modern triple therapy reduces viral loads in the blood and thus infectiousness of an individual. All these effects of care are thought to contribute to prevention. On the other hand, from developed countries, where anti-retroviral therapy is widely accessible, reports of an increase of risky sexual behaviour are evolving as people perceive themselves at less risk of getting infected or falling ill and dying once infected.

The call for access to care should **not deviate the focus from condom use promotion and safer sexual behaviour of those most likely to contract and spread the virus** as the most cost-effective interventions in controlling the epidemic in the African context. **Strong and effective preventive strategies have to go hand in hand with efforts to improve care and treatment for those affected.** National HIV/AIDS programmes should be balanced in the need of both the community and the individual, and in prevention and care<sup>1</sup>.

## A comprehensive care package

HIV/AIDS is the leading cause of death in sub-Saharan Africa where 70% of all Persons Living with HIV or AIDS (PLHA) are found. World-wide, the main burden of disease in PLHA arises from a limited number of common infections –and their complications- to which PLHA are particularly susceptible, namely tuberculosis, pneumonia, diarrhoea and candida (thrush) infection of the mouth and throat<sup>2</sup>. For many of these conditions effective and inexpensive treatments are available also in developing countries. However, the needs of PLHA go beyond clinical care and treatment. Comprehensive care includes voluntary counselling and testing for HIV infection, social and psychological support and home based care. It also includes protection against stigmatisation and care for the orphans left behind.

Below, WHO lists a number of reasons why adequate and appropriate care should be accessible to all in need, regardless on which continent they live.

### **Rationale for care and support<sup>2</sup>**

- Health care is a human right
- Access to care and support contributes to the prevention of HIV infection (see above)
- Access to care and support decreases the spread of infectious diseases that are common among HIV-infected people, in particular TB and sexually transmitted diseases (STDs)
- Care givers can contribute to alleviate the community's fear of HIV infection and reduce stigma and discrimination
- When PLHA live longer and healthier, the economy will benefit from better workforce and the impact on families is likely to be less dramatic
- Care and support for PLHA leads to a greater involvement of people living with HIV/AIDS in the fight against the epidemic which is a prerequisite to success

A comprehensive care package includes numerous elements. Ideally, as in developed countries, all elements should be offered to affected individuals at a price accessible to them. But developing countries face enormous financial constraints. Public spending on health may be as low as 1\$ per person per year as in the case of Malawi.

Thus, even if drug prices are considerably falling, it may be out of reach of many African governments to subsidise anti-retroviral therapy when already faced with great difficulties in funding AIDS prevention and control activities and financing other health priorities. The cost of a care package is high and **drug costs are only a small part of the total costs needed for providing comprehensive care.** GTZ and Boehringer Ingelheim jointly plan an intervention where women in several Ugandan clinics should receive access to medical Prevention of Mother to Child Transmission. The pharmaceutical company would provide the drug Nevirapine for free and GTZ would come up for the costs of upgrading the health services to be able to deliver counselling and testing as well for the other related elements. They evaluated the drug costs to be 1% of the total investment needed for this programme. **Access**

**to affordable or free drugs is thus one element of the solution, but far from resolving the problem.** (*communication at the KfW AIDS day in Berlin, 29.3.01*)

WHO proposes therefore three levels of care and support activities according to the cost and complexity of the interventions. Where resources and organisational capacity are low, rationally one would propose to organise the elements of the basic level first before investing in the higher up levels. In reality, third world countries often invest in a mix from all three levels. The model should however serve as a guide to more efficient allocation of resources. On this base, each country will need to define together with the most important stakeholders the services that will be most effective at the lowest cost in the specific context. It is clear that this package has again to be split according to intervention levels. Each country should determine and organise a care package for the primary, the secondary and the tertiary health care level. Resource constraints will mean in most developing countries selecting some of the proposed elements according to the priority needs and cost effectiveness.

### **Care and Support activities, according to need, complexity and cost<sup>2</sup>**

<b>Essential Care Package</b>	<ul style="list-style-type: none"> <li>• HIV voluntary counselling and testing</li> <li>• HIV screening of blood for transfusion</li> <li>• Psychosocial support for PLHA and their families</li> <li>• Palliative care</li> <li>• Treatment of common HIV-related infections : pneumonia, diarrhoea, oral thrush, vaginal candidiasis and pulmonary TB</li> <li>• Nutritional care</li> <li>• STI prevention (including condom use) and care</li> <li>• Family planning</li> <li>• Prevention of mother to child transmission of HIV</li> <li>• Cotrimoxazole prophylaxis among HIV-infected people</li> <li>• Universal precautions</li> <li>• Health policy activities, such as the regulation of care delivery and drugs supply</li> <li>• Recognition and facilitation of community activities that mitigate the impact of HIV infection (including legal structures against stigma and discrimination)</li> </ul>
<b>Care and support activities of intermediate complexity and/or cost</b>	<p>ALL THE ABOVE PLUS</p> <ul style="list-style-type: none"> <li>• Intensified case finding and treatment for TB, including for smear negative and disseminated TB among HIV-infected people</li> <li>• Preventive therapy for TB among HIV-infected people</li> <li>• Systemic antifungals for systemic mycosis (such as cryptococcosis)</li> <li>• Treatment of HIV-associated malignancies : Kaposi's sarcoma, lymphoma and cervical cancer</li> <li>• Treatment of extensive herpes</li> <li>• Post exposure prophylaxis of occupational exposure to HIV and rape</li> <li>• Funding of community efforts that reduce the impact of HIV infection</li> </ul>
<b>Care and support activities of high complexity and/or cost</b>	<p>ALL THE ABOVE PLUS</p> <ul style="list-style-type: none"> <li>• Highly active antiretroviral therapy (HAART)</li> <li>• Diagnosis and treatment of HIV-related infections that are difficult to diagnose and/or expensive to treat, such as atypical mycobacterial infections, cytomegalovirus infection, multiresistant TB, toxoplasmosis, etc</li> <li>• Advanced treatment of HIV related malignancies</li> <li>• Specific public services that reduce the economic and social impacts of HIV infection</li> </ul>

## HIV/AIDS-Related Drugs

From the above discussed, it should have become clear that access to drugs is just one element in a comprehensive strategy to address the control of the spread of the HIV /AIDS epidemic and mitigate its impact on society and individuals.

### Essential drugs in managing HIV/AIDS patients are <sup>3</sup>:

1. Anti-infective agents to treat or prevent opportunistic infections (as tuberculosis, etc)
2. Palliative drugs to relieve pain, physical and mental discomfort
3. Anti-retrovirals (ARVs) to limit the damage that HIV does to the immune system and to prevent mother-to-child transmission

Anti-retrovirals are thus only the- so far- most expensive drugs amongst a set of pharmaceuticals (drugs and diagnostics) used in treating AIDS patients. Many of the other drugs can today be obtained at low cost through the public system. While anti-retroviral therapy is still expensive, it should be recognised that at individual level it represents the gold standard for the **treatment** of HIV infection. There are different options for providing access to ARVs. They can be made available only to people with full-blown AIDS, to all people infected with HIV or to pregnant women over a short period of time in order to reduce mother-to-child transmission<sup>4</sup>.

Regardless whether or not governments can afford to subsidise their availability to the general public, there is a need to monitor their use to protect their future usefulness. The threat of provoking drug resistance by incorrect use of ARV drugs is enormous and bears the potential for disastrous consequences. Every institution and organisation providing such drugs has thus to be responsible for setting up a sustainable supply and continuous monitoring of their use. But, rather than refusing to deal with these drugs for fear of having to fund them, governments should consider regulating their use and facilitating access to them by supporting human resource development and treatment monitoring infrastructure<sup>2</sup>. For those in charge of putting a programme of antiretroviral treatment in place, the WHO document *“Safe and effective use of antiretroviral treatment in adults- with particular reference to resource limited setting”*<sup>5</sup> provides a good overview of the most important issues.

In order to increase access to drugs and medical supplies the following strategies should be applied<sup>6</sup>:

1. **Rational selection and use:** there is a wide selection of ARV drugs (the 3 main categories being: nucleosid reverse transcriptase inhibitors, non-nucleosid reverse transcriptase inhibitor and protease inhibitor). Ideally, a combination of three ARV drugs (one or more protease inhibitors and two reverse transcriptase inhibitors), known as **HAART** (highly active anti-retroviral therapy) is used. Considerations about local morbidity patterns, drug efficacy, safety, quality and cost-effectiveness have to influence the choice.
2. **Affordable prices:** Huge disparities in prices for the same product are being observed on the world-wide market. Generics cut costs dramatically – this explains why it costs the Brazilian public health sector the same amount to treat 1000 PLHA as it does the Thai government to treat 350 (looking at drug costs only)<sup>3</sup>. On the other hand, even drugs of the same company are being sold at very different prices in different countries. Pfizer’s Diflucan® costs nearly 49% less in Thailand than in Guatemala. MSF has joined a UNICEF/UNAIDS/WHO/EDM initiative to create a database with relevant information for drug procurement to improve access to HIV/AIDS related drugs<sup>7</sup>. They have recently

updated the “HIV/AIDS Medicine Pricing Report”<sup>3</sup> which includes price information on various drugs for different countries. Governments, donors, NGOs, PLHA and other stakeholders have to negotiate “best prices” when purchasing AIDS related drugs. A number of strategies to reduce costs are listed below.

3. **Sustainable financing:** Financing for HIV/AIDS related care should come from additional funds and not out of a trade off between care, prevention and the management of other priority diseases. Any policy on public subsidy to ARVs should be based on a long-term analysis rather than a response to public pressure as prevalence rises. Subsidies begun during the concentration stage of an epidemic may be unsustainable and yet very difficult to withdraw at a later stage. The concentration stage is therefore the time when policymakers and their constituents need to consider how a government can best respond to the medical needs of people with HIV<sup>8</sup>.
4. **Reliable health care services and supply systems:** effective use of new HIV-related drugs and prevention of resistance depends on the ability of health care services to diagnose HIV infection and associated illnesses and adequately monitor treatment. This needs rather complex laboratory services of good quality and trained personnel. From many developing countries it is known that regular supplies of essential drugs pose problems. According to the World Bank only 35% of Kenyans or 10% of Nigerians have access to essential drugs<sup>\*9</sup>. Efforts to improve the logistics for drug supplies as well as to monitor patients’ compliance in regular drug intake is absolutely essential in order not to create resistance.

## **The struggle for reduced cost of HIV/AIDS anti-retroviral treatment**

A year ago, the medicines needed to slow the progression of AIDS were far beyond what most Africans, Latin Americans and Asians, or their governments could afford. At a cost of \$10’000 to \$15’000 per person year the drugs were out of their reach (*G.H. Brundtland, director-general of the WHO in the International Herald Tribune, 14.2.2001*). Of the estimated 25 million Africans who are HIV positive, the World Health Organisation says five million need treatment urgently. Globally, anti-retrovirals are only used by 1% of those with HIV<sup>10</sup>. Today, the situation has changed dramatically. AIDS drug therapy can now be available for developing countries for \$600 per patient per year (drug costs only) or less (see below the CIPLA case in India).

Various legal **mechanisms** that have been used **to reduce costs** are<sup>3</sup>:

- Use of generics
- Price studies (see above)
- Differential pricing (so called tiered pricing) for developing countries: some major pharmaceutical companies ( Glaxo Wellcome, Merck, Boehringer-Ingelheim, Hoffmann-La Roche and Bristol: Accelerating Access programme) have recently offered price cuts of up to 85% (which leaves their drugs still more expensive than generic drugs)
- International procurement (e.g. mass bulk procurement by WHO, UNAIDS, IDA etc)
- Technology transfer (eg Brazil offers technology transfer for South South cooperation)
- Safeguards on patents:

---

\* Access as defined by access to a minimum of the 20 most essential drugs continuously available and affordable at public or private health facilities within 1h walk

- a. **voluntary licensing** : the government, an individual, or an organisation can request a voluntary license, allowing life-saving drugs to be supplied by the generic industry (through import or by local production) and thereby reduce prices
- b. **compulsory licensing** :if a voluntary license cannot be obtained then a compulsory license can be granted by national governments. It means they seize a patent and manufacture or import a generic copy of the drug, paying the patent holder a reasonable royalty. This is what drug companies fear the most<sup>10</sup>.
- c. **parallel imports** :if a required drug is patented in the country, and is sold in other countries by the same company at a lower price, parallel importing could be considered.

In order to understand the last three strategies it is important to be aware of one essential factor which is today blocking access to essential drugs in developing countries: **international patent regulations**. The question, whether a drug is under patent protection is of significant importance for drug procurement. A patent is a title granted by the State in a specific country that gives exclusive rights over the manufacture and use of an invention to the owner of this invention in that country, in exchange of disclosure of the invention to the public. The patent regulations allow the pharmaceutical industry to recover investments made for R&D (research and development). R&D costs for a substance (not including production, marketing or distribution) are around 500million US\$. For marketing a substance, amounts of up to a million US\$ are spent. It explains why this industry is fighting so heavily against compulsory licensing and parallel import. **In other cases where pressure to reduce prices got too strong (malaria, bilharzia drugs,etc) it has pushed companies to drop continuing research in these fields.**

A patent is national and applications for patents must be filed in every country. There is no international patent<sup>5</sup>. Since the creation of the World Trade Organisation ( W.T.O.) in 1994 and the completion of the Trade Related Aspects of Intellectual Property Rights (TRIPS) Agreement, more and more countries are obligated to grant 20-year patent protection for drugs. According to TRIPS, this minimum standard must be enshrined in national law by 2006 in all signatory countries. Developing countries had a deadline of January 2000, with some exceptions, while least-developed countries have until 2006<sup>3</sup>. India, for example, does not recognise patents on medicine, and world trade rules do not require it to do so until 2005. Most drugs, including anti-retrovirals, have never been patented in most sub-Saharan African countries, so those countries are free to make or import generics. Paradoxically, one country that did respect patent regulations, South Africa, is now being punished by the lawsuit described below. However, there is a W.T.O. loophole, of which also South Africa makes use to defend its interests, that allows countries to make copies of patented items or import them in certain situations, including that of national emergency<sup>10</sup>.

To illustrate the successes and the highly sensitive and political conflicts which arise from these efforts to bypass patent regulations – aiming to provide HIV/AIDS drugs for accessible prices- three examples currently discussed in the media will be looked into. The Cipla offer to Médecins Sans Frontières (MSF), the court case against South Africa and the Brazilian success story will be further illustrated.

### **Cipla and their offer to MSF**

Cipla Limited is an Indian generic drug producer making use of the above-mentioned fact that India is not obliged to recognise patents until 2005. In the year 2000, Glaxo Wellcome had menaced Cipla with a law suit after the Indian manufacturer had proposed to sell generic versions of the anti-retroviral drug Combivir to Ghana. At first, Cipla took back its offer, but later its director general, Dr Youssouf Hamied declared “there is room for everyone in the fight against the holocaust in Africa”. (*La bataille des antirétroviraux, Jeune Afrique, N° 2092, February 2001*)

Then, in the end of February 2001, Cipla and MSF broke big news which created immense hope in the international community involved in the fight against AIDS. The two institutions agreed on the following: “governments of developing countries can immediately take advantage of the offer for its triple-combination anti-retroviral drugs for \$600 per patient per year by contacting Cipla directly. This offer is available without restriction in time, geography or quantity. MSF will integrate some of these drugs into existing protocols where these drugs are already registered by national health authorities. The organisation is beginning anti-retroviral pilot programs in approximately 10 countries. To expand the offer of a humanitarian price (\$350 per patient per year) which has been made to MSF (under the condition that they would distribute it for free), Cipla agrees to examine several additional possibilities.”([www.msf.org/accessmed](http://www.msf.org/accessmed) February 23,2001 Mumbai statement)

Shortly after, another Indian pharma major, Ranbaxy, has announced that it will start production of anti-retroviral drugs (*Cheennai Hindu, 23 Feb 2001*)

It is therefore likely that prices could fall even lower.

### **39 international pharmaceutical companies legally pursue South Africa**

The South African government had not been very famous lately for its position confronted with what is today the world’s largest AIDS epidemic (with 4,7 million persons infected by HIV). President Mbeki had publicly doubted HIV to be at the origin of AIDS and the government opposed the expansion of a programme to reduce mother to child transmission to all HIV-positive women attending state health services.

On the other hand, the South African government inherited a system of high medical prices from the apartheid regime and, as said above, is one of the rare African countries that respects patent regulations. Confronted with an AIDS epidemic of gigantic dimension, Nelson Mandela passed a law (the Medicines and Related Substances Control Amendment Act, Act 90 of 1997) in order to make medicine more affordable to patients. This allowed the Minister of health to apply measures such as parallel importation and generic substitution (*see above*), both measures that are legal under the WTO’s intellectual property rights rules and are widely used in Europe and the U.S. ([www.msf.org/accessmed](http://www.msf.org/accessmed) March 1,2001 Pretoria press release). For more than three years the pharmaceutical industry has blocked the implementation of the law. In these three years more than 400’000 South Africans have died of HIV/AIDS.

([www.msf.org/accessmed](http://www.msf.org/accessmed) March 8,2001 Pretoria press release).

On march the 5<sup>th</sup>, 39 international pharmaceutical companies (including the Novartis South Africa (Propriety) Ltd , Roche Products (Propriety) Ltd and F.Hoffmann-La Roche AG) opened a case against the South African government before the High Court in Pretoria. The pharmaceutical industry sought to postpone the case for an additional four months. Instead, the judge granted them three weeks to present data justifying their high prices, and the case will resume on 18 April. ([www.msf.org/accessmed](http://www.msf.org/accessmed) March 1 and8, 2001 Pretoria press release).

Since then, MSF and OXFAM have launched an international petition drive calling on the 39 companies suing the South African government to drop their court case.

## **Look at Brazil<sup>10</sup>**

On January 28<sup>th</sup>, 2001, a New York Times article brought the successful example of the Brazilian government's fight against the epidemic to international awareness. According to the writer, since 1997, virtually every AIDS patient in Brazil for whom it is medically indicated gets, free, the same triple cocktails that keep rich Americans healthy. The Brazilians have shown, that such an initiative can be built on the shaky foundations of a developing country public health service and that uneducated people are just as able to take their medicine regularly as patients in developed countries. A 1999 survey has shown 80% compliance rates of 69% of the Brazilian patients compared to 72% in San Francisco.

Several factors explain why Brazil was successful in mounting such a programme. In 1998, the government began making copies of brand-named drugs, which led to a price fall of an average of 79%. They manufacture 8 anti-HIV drugs that were patented before 1996, the year the country began observing international patent laws. Brazil now produces triple therapy for 3000\$ a year and the price could potentially drop as low as \$700 a year. Brazil has thus defied pharmaceutical companies and made drugs available to everyone who needs them by threatening to brake patents. In addition, Brazil had and has extremely committed governments. President Cardoso was under great pressure to cut the budget by abandoning the AIDS program. He rejected the advice, deciding that treating AIDS was a priority. The Health Ministry spent \$444 million on AIDS drugs in 2000 – 4 percent of its budget. As outputs, it is so far known that the treatment program has managed to cut death rates of the 530'000 HIV infected in Brazil by half and that between 1997 and 1999 the MOH saved \$422 million on hospitalisation fees for opportunistic infection treatments. This does not include the economic benefit of the increased productivity of those treated.

Recent reports, however, say that the government could not produce enough drugs to supply everyone in the country, let alone to export them<sup>11</sup>.

In the week of the 19<sup>th</sup> of March 2001, Cuba has stepped in with an offer to help South Africa and Brazil bypass patent laws to produce inexpensive generic drugs for AIDS patients. Cuban President Fidel Castro said on local television his country "is producing those famous cocktails" of AIDS drugs. "We will fully support Brazil and South Africa, encouraging them to ignore US patents and produce the drugs to save millions of lives that can be saved". (*South African Press Association/News24, 20 March*).

## **Lessons learned from the three case stories for the case of improving access to ARV drugs for HIV/AIDS care**

- 1. Developing countries (public and private sector) have to take an active and sometimes unconventional lead role in promoting change in drug imports/purchasing or production and –as a price to pay- need to be prepared to face sanctions.**
- 2. Strong leading and committed governments are a key factor in explaining the documented success stories.**
- 3. NGOs can play an essential role in lobbying and advocacy of the access to drugs campaign. They are well placed to provide support to governments of developing countries.**

4. **The international media has taken on an important role in agenda setting and informing the general public in order to get their support for pushing the access issue.**
5. **The issue of how to reduce prices of ARV drugs for developing countries is very sensitive and becoming increasingly political. The more stakeholders' interests get involved, the more political the debate gets.**
6. **Unconventional rulings on drug imports/production of developing countries pose an immense threat to the interests of pharmaceutical companies. The latter are prepared to go far to defend their interests.**
7. **AIDS treatment programmes can work in certain developing country contexts. But the developing world is not a uniform entity. There are differences in resources and infrastructure, which the approach to provision of treatment must reflect<sup>13</sup>. Countries with smaller epidemics and less economic difficulties may take the lead for the developing world.**
8. **AIDS is becoming an issue that promotes a South- South collaboration and technology transfer not seen before. 19 Latin American and Caribbean countries are involved in the Horizontal Technical Cooperation Group on AIDS<sup>12</sup>.**

In conclusion it can be said that the debate about whether poor countries can treat AIDS is over. The question now is how<sup>11</sup>.

It would be naive, however, to think that cutting prices of medicines is enough. Access to affordable or free drugs is one element of the solution, but far from resolving the problem. The prospect of cheaper medicines stimulates demand for care, and this will actually increase the need for resources. Additional sources and commitments of funds are therefore needed to provide better and comprehensive care to people living in the developing world at the same time as increasing the effort of keeping people free from HIV, which remains the primary goal. (*G.H. Brundtland, director-general of the WHO in the International Herald Tribune, 14.2.2001*)

The debate about access to care for those already infected should, however, not push back efforts to continue pursuing prevention strategies, which are still the priority approach at a population level. Preventing new infections to happen saves tremendous suffering of individuals and their families is much more cost effective and remains the gold standard for public health interventions.

Today, we have all the reasons for hope. The developments in the field are happening so immensely fast that this paper may be outdated by next week. Contemplation of the gulf between regions often leads to either despair at the vastness of the task or empty rhetoric. A better solution is to identify and implement achievable change in specific contexts<sup>13</sup>.

## List of references

1. Manning A; HIV/AIDS programmes should focus on improved access. *BMJ* Vol 321, 14 October 2000, 963
2. WHO/UNAIDS ; Key elements in HIV/AIDS care and support. WHO/UNAIDS December 2000.
3. Pérez-Casas C. HIV/AIDS Medicines Pricing Report, Update December 2000. MSF Campaign for access to essential medicines.
4. Forsyth S; The affordability of antiretroviral therapy in developing countries: what policymakers need to know. *AIDS* 1998,12 (suppl2): 11-18.
5. UNAIDS/WHO; Patent situation of HIV/AIDS related drugs in 80 countries. Geneva, January 2000.
6. World Bank; Confronting AIDS: Public priorities in an global epidemic. A World Bank Policy Research Report; Oxford University Press 1999.
7. UNAIDS; Update on country activities. Slide presentation.  
[www.unaids.org/publications/...](http://www.unaids.org/publications/)
8. World Bank; World development indicators 2000: Washington DC: WB,2000.
9. WHO; Safe and effective use of antiretroviral treatments in adults with particular reference to resource limited settings. WHO/HSI/2000.04; WHO Geneva, 2000.
10. Cohen J; Companies, Donors Pledge to Close Gap in AIDS Treatment. *Science*, Vol 289, 21 July 2000, 368-369
11. Rosenberg T.; Look at Brazil. *The New York Times*, 28.1.2001-03-27
12. UN General Assembly; Special session of the General Assembly on HIV/AIDS, report of the secretary general. 16.2.2001
13. UK NGO AIDS Consortium Working Group on Access...; Access to treatment for HIV in developing countries. *The Lancet* Vol 352, October 24 ,1998, 1379-1380