Access to AIDS treatment in developing countries: A global issue of equity and human rights[1]

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A global AIDS related bio-medical technology transfer initiative, perhaps driven by UNAIDS, is the crying need of the next millennium. Such an initiative should foster an enabling partnership between governments, industry and international organisations and be based on:

a maximalist perspective of the ethics of access to treatment
global equity considerations,
a global perspective on the rights of individuals and communities.

The political will of global institutions and agencies to provide strategic leadership in exploring the global dimensions of shared rights and shared responsibilities in facilitating access to optimum treatment for PWAs in developing countries will remain as the great challenge faced by the global AIDS leadership in the next millennium.

Tremendous optimism has been generated by the recent developments in combination anti-retroviral therapy for HIV/AIDS. There is renewed hope for people living with HIV/AIDS (PWA) of effective treatment, prolonged survival and improvement in quality of life. However, it is increasingly evident that this optimism is really only shared by a few who live in developing countries. Access to advanced anti-retroviral therapy for HIV/AIDS in resource -scarce settings is a subject that is not even discussed in certain forums where issues related to AIDS prophylactics are discussed at length.

Access to optimum AIDS treatment in developing countries presents unique global challenges to AIDS activism, public health advocacy and global leadership in AIDS prevention and care efforts. It is also a frustrating experience for health care providers and PWAs in developing countries. Many well-meaning people in the AIDS fields are even beginning to regard access for all to optimum AIDS care as a utopian ideal, not worth pursuing.

The basic premises of this article is that a proactive approach to facilitate access to care for all PWAs, particularly PWAs from developing countries, requires imaginative and radical steps. Most importantly, in my opinion, all the possible avenues to address this crisis have not yet been explored. At root, what is required is the political will, similar to that which resulted in the setting-up of unique UN organisation (UNAIDS) to address the AIDS pandemic.

Access to AIDS related treatment in Asia

According to the WHO, by late 1997 Asia was home to a reported 70,949 people living with AIDS. It is also estimated that there are about five to seven million people living with HIV/AIDS in the region. However, through a Delphi method of calculation, it is estimated that perhaps only 2,000-2,500 PWAs are currently getting optimum treatment in all of Asia.

Taiwan is one of the rare countries which offers advanced anti-retroviral

[1] Source: AIDS Analysis Asia Volume 4 (2), March 1998

combination therapy for all of its PWAs. Curiously, such a decision was galvanised mostly out of cultural pride and the resource-rich settings of the country. When the Taiwan-born Dr. David Ho, the leading proponent of combination therapy, was named as the man of the year by Time Magazine, the local government could produce no further argument against offering advanced treatment to PWAs.

In Japan, although the most advanced AIDS treatment options are available, the consumer is expected to pay a considerable portion of the medical bills.

In Hong Kong, the government offers advanced AIDS treatment for almost all those who request it, but less than a quarter of the approximately 6000 or so PWAs in Hong Kong are using such treatment.

In China, advanced anti-retroviral combination therapy is not an option for PWAs

The recently announced draft national AIDS policy in India is critical of the efficacy of anti-retroviral treatment, apparently to shield the government from any demands from the PWA population for subsidising the treatment.

Global efforts to get access to care for PWAs in developing countries. A brief review of existing efforts to secure access to optimum care for PWAs presents interesting insights, even though there have been only a few such efforts.

- The US-Cuba medical Project (USCUMED) has a campaign entitled 'Life without Borders' which is working to send World AIDS Day Shipment of $1 million worth of advanced combination therapies for treating HIV/AIDS.
- French President Jacques Chirac launched an initiative on AIDS drug access for six selected countries, and for an 'International therapeutic assistance fund'.
- UNAIDS is sponsoring access to treatment in selected countries. Bear in mind that advanced combination therapies also require sophisticated technological facilities for viral load and CD4 count monitoring, plus experienced and trained health care workers).

But most global initiatives on access to care are have yet to take concrete shape. Actual data and experience on the process of facilitating access to care for PWAs in developing countries are yet to come.

UNAIDS sponsored a global review of NGO collaboration in improving access to HIV- related treatments. However, only very limited data has emerged from this exercise. It appears that the reviewers were overwhelmed by the complexity of the situation and handicapped by the methodological and conceptual challenges of the exercise.

The current global efforts to address the issue of inequality of access to care are characterised by both a poverty of ideas and a poverty of leadership. Those efforts are essentially based on models of patronage and relief which are non-sustainable, and on ad hoc arrangements. Efforts must be made to explore more creative means to address the issue of access to care for PWAs in developing countries in the next millennium.

The challenges

A. Issues of global equity

Equity in health is often understood and explained as the responsibility of national governments towards their citizens. The problem of access to advanced treatment for PWAs in developing countries presents both conceptual and practical challenges to our notions of equity. Factors which influence access to care in developing countries are multiple and frequently inter-related. For instance, protease inhibitors and other advanced antiretroviral medications are produced mainly by US companies and are therefore completely controlled by US trade policies.

To take no more than one example, it is commonly believed that Most Favoured National (MFN) status in trade relations is often used as a political tool by many of the world's governments to achieve their geo-political objectives. Whatever the truth of that, the fact is that a concerted global effort has yet to be made to exclude AIDS- related medication and technology from such trade rules . There is at present an urgent need to review all trade policies that affect the affordability and the accessibility of AIDS-related technology and medications in developing countries.

B) Maximalist/ minimalist perspectives of ethics and human rights.

Often, AIDS-related ethical issues are presented in a minimalist perspective. The common denominator of most of the discussion about the ethics of treatment is a minimal requirement on ethics. The issue of prophylactic trials in developing countries presents an interesting case of such a minimalist perspectives of ethics.

A recent study carried out by the US Centers for Disease Control & Prevention (CDC) in Thailand on AZT use compared a few weeks of AZT treatment to a placebo. Nine percent of the mothers given AZT passed HIV on to their infants, compared to 19 percent in the placebo group. It is concluded therefore that the use of AZT for less than a month at the end of a pregnancy can halve the rate of AIDS transmission from mother to child in developing countries.

The CDC study marks a watershed in our ability to begin controlling HIV transmission in the 90 percent of the world where more costly and lengthy AZT courses are simply not available. This news is likely to lead to increasing demand for effective AIDS drugs by people with AIDS from around the world. However, many people in the developing world believe that, in reality, this finding will be almost like a license to print money issued to one single company. This is because the U.S. Supreme Court has ruled that the patents assigned to Glaxo Wellcome covering use of AZT for treatment of HIV-infection and AIDS cannot be challenged. The Supreme Court has recognised Glaxo Wellcome as the sole inventor and assignee for the main US patents covering use of AZT (Retrovir).

So the AZT trials on ante-natal mothers in developing countries may well adhere to notions of ethics in a minimalist perspective. But perhaps a maximalist perspective on ethics should also suggest ways and means to provide continuing preferential access to the technology and medications refined through such trials for the subjects of such trials and for their communities.

In such a maximalist perspective on ethics, the global trade policy which allows a single company to retain the patent rights of AZT into the next millennium would be questioned in a search for constructive solutions. Such policies and practices are increasingly becoming critical determinants in access to optimum AIDS treatment in developing countries.

Many pharmaceutical companies in developing countries are capable of producing AZT in a more cost-effective way. But the trade policies and barriers, and other associated deterrents, are preventing them from producing many of the advanced AIDS prophylactic and complementary technologies.

C. Global dimensions of inter-sectoral collaboration

Inter-sectoral action is promoted as the key to the AIDS prevention and care in most developing countries, where the success of such initiatives depends upon decisions and actions of other sectors. A major goal of inter-sectoral collaboration is to achieve a greater awareness of the health consequences of policies and actions in other sections. The challenges presented by access to care for PWAs in developing countries offer a unique opportunity to understand the global dimensions of inter-sectoral collaboration.

D. Technology transfer and health care capacity in developing countries

In the AIDS field some of the mechanisms that make technology transfer possible already exist, such as joint vaccine research, co-operative agreements for field trials, technical meetings such as global AIDS conferences, trade shows by pharmaceutical companies, and various electronic and other means of information dissemination.

The pattern and process of AIDS-related technology transfer from developed countries to the developing countries is a major factor in the health care capacity of many developing countries. Specific efforts for the diffusion of innovations in technology should also be part of the global effort to address the issue of access to treatment.

AIDS related Bio-medical technology transfer

Biomedical technology transfer is a mechanism by which many countries ensure rapid diffusion of technology within their own country. Specific legislative and institutional mechanism facilitate the rapid diffusion of much-desired technologies. Some of the US laws which govern federal technology transfer offer much needed insight into the process of a country specific experience of biotechnology transfer.

In the USA, the Stevenson-Wydler Technology Innovation Act of 1980, the Bayh-Dole Act of 1980, the Co-operative Research Act of 1984, the Trademark Clarification Act of 1984, the Federal Technology Transfer Act of 1986, the Executive Order 12591 of 1987, the Omnibus Trade and Competitiveness Act of 1988

-- all these offers a legislative framework to facilitate the access to technology in a country specific context.

The WHO experience in developing an essential drugs initiative also offers a unique perspective on global efforts to facilitate access to treatment in developing countries.

A global AIDS trade protocol

One of the best ways ahead to address the global equity and subsequent human right issues involved in facilitating access to AIDS prophylactics in developing countries is to initiate a UNAIDS-directed Global AIDS Related Biotechnology Transfer Protocol (GARBTTP).

UNAIDS could initiate a process by which existing AIDS-related biotechnological knowledge, facilities or capabilities are rapidly utilised to fulfil the needs in developing countries. This process would involve:

- identifying all the currently available AIDS-related bio-technical resources
- identifying potential users in developing countries (e.g., government labs and
- bio-technology companies in developing countries),
- a UNAIDS mediated bio-technology transfer protocol to interface the two. Some of the key global stakeholders of such an initiative would be the World Intellectual Property Organisation (WIPO), World Trade Organisation (WTO), UNDP, World Bank and UNC.

The guiding principles of such an effort would be an acknowledgement of global interdependence, and the acceptance of AIDS related medical and biotechnological advances as a global heritage. The primary goal of GARBTTP would be to expedite the transfer of technology from the numerous laboratories throughout the world to the end-users. The services to be eventually provided by GARBTTP would fall into the following categories:

- An effort to identifying those policies relating to intellectual property rights, global trade agreements, and product management and production that hinder AIDS related biotechnology transfer.
- Services to assist clients in getting technology and/or products to the commercial marketplace and developing mechanisms to make it affordable. This also might involve a global fund to finance the acquisition of the advanced technology to be transferred, plus services designed to expand knowledge about treatment options, about the types and status of technology available for transfer and the mechanisms for promoting this process.

The question of political will

The Political commitment of many northern governments and agencies will remain the key question in facilitating a global AIDS related biomedical technology transfer initiative. Many of those governments wish to portray themselves as being in the vanguard of promoting human rights in developing countries. However, it may not be easy for some of them to acknowledge that that their trade policies are at the same time becoming a source of violations of human rights of PWAs in developing countries.

Ideas that challenge dominant trade policies and practices inevitably produce conflict between different sectors, agencies, and interest groups. Reconciling such conflicts in ways which promote better access to care for those who are in need, require considerable resources and skills in global advocacy for health. Many hope that UNAIDS can produce such advocacy skills.

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