AIDS, Development and Canadian Policy

Achieving universal access by 2010

Paul Thomas
and John W. Foster
The North-South Institute is a charitable corporation established in 1976 to provide professional, policy-relevant research on relations between industrialized and developing countries. The Institute is independent and cooperates with a wide range of Canadian and international organizations working in related activities.

The contents of this document represent the views and the findings of the author alone and not necessarily those of The North-South Institute’s directors, sponsors or supporters or those consulted during its preparation.

The North-South Institute thanks the Canadian International Development Agency for providing a core grant. NSI would also like to thank the International Development Research Centre for providing financial support to help produce this document.

Managing Editor: Lois Ross
Editorial team: Wayne Harding, Peter Thornton, Lois Ross
Design and layout: Green Communication Design inc.

© The North-South Institute/L’Institut Nord-Sud, 2006
55 Murray Street, Suite 200
Ottawa, Ontario, Canada  K1N 5M3
Tel: (613) 241-3535  Fax: (613) 241-7435
Email: nsi@nsi-ins.ca  Web: www.nsi-ins.ca

Available on the web at: www.nsi-ins.ca
## Table of Contents

**Acknowledgement and appreciation** 2

**Time is of the essence** 3

1. **Introduction** 4

2. **Context of the epidemic** 6

3. **Reaching the goal of universal access** 7

4. **The policy environment for universal access** 8

5. **Improving the financial resources available for HIV/AIDS interventions** 10

6. **Human resources: ensuring stable, able and sustained prevention, care and treatment** 18

7. **Saving lives: the crunch** 22

8. **Innovative sources: securing sustained and predictable funding for treatment** 28

9. **Strategy and implementation** 30

10. **Political leadership** 31

11. **Conclusion** 34

**Endnotes** 35

**List of persons interviewed** 39

**Annex 1. Abbreviations and acronyms** 40

**Annex 2. The North-South Institute, HIV/AIDS and Development** 41
Acknowledgement and appreciation

The authors would like to acknowledge the great deal of information, references and orientation received from members of the Global Treatment Action Group (GTAG), particularly, John Dillon, Richard Elliott and Michael O’Connor. We also recognize Valerie Percival of the Department of Foreign Affairs and International Trade Canada (DFAIT) for her advice. We would also like to express our appreciation to The North - South Institute and Social Watch who facilitated Dr Foster’s participation in the United Nations General Assembly Special Session on HIV/AIDS (UNGASS) Review at the UN (June 2006). We also thank these organizations and Senator Yoine Goldstein for facilitating our joint participation in the XVI International AIDS Conference in Toronto (August 2006).
### Time is of the essence

The total number of deaths due to AIDS, 2.9 million, divided by 525,600 minutes is between five and six a minute. How long did it take you to read this paper? How long will it take you to act?

<table>
<thead>
<tr>
<th>Number of persons living with HIV in 2006</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total .................................................. 39.5 million (34.1–47.1 million)</td>
</tr>
<tr>
<td>Adults .................................................. 37.2 million (32.1–44.5 million)</td>
</tr>
<tr>
<td>Women .................................................. 17.7 million (15.1–20.9 million)</td>
</tr>
<tr>
<td>Children under 15 years ..................... 2.3 million (1.7–3.5 million)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Persons newly infected with HIV in 2006</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total .............................................. 4.3 million (3.6–6.6 million)</td>
</tr>
<tr>
<td>Adults .............................................. 3.8 million (3.2–5.7 million)</td>
</tr>
<tr>
<td>Children under 15 years ................... 530,000 (410,000–660,000)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>AIDS deaths in 2006</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total .................. 2.9 million (2.5–3.5 million)</td>
</tr>
<tr>
<td>Adults .................. 2.6 million (2.2–3.0 million)</td>
</tr>
<tr>
<td>Children under 15 years .... 380,000 (290,000–500,000)</td>
</tr>
</tbody>
</table>
1. Introduction

This paper examines Canada’s international policy with regard to HIV/AIDS from the point of view of the resources needed to achieve the goal of providing universal access to prevention, treatment, care and support services for HIV/AIDS by 2010.

The last few years have seen a significant increase in the resources available for HIV/AIDS. The total international spending on AIDS mitigation has risen from US$1.7 billion in 2001 to an estimated US$8.9 billion in 2006. At the same time there has been a marked increase in the availability of prevention, treatment, care and support services in the global South, with the number of persons receiving anti-retroviral therapy (ART) more than tripling from just under 400,000 in 2003 to over 1.6 million by mid 2006.2

Yet despite this progress, people continue to die, in tragic numbers. Even with recent funding increases, the amount of resources available for HIV/AIDS in 2006 was still far short of the $14.9 billion that the Joint United Nations Program on HIV/AIDS (UNAIDS) had estimated was required to meet the Millennium Development Goal (MDG) of slowing and reversing the pandemic.3 Over 80 per cent of those at risk of infection lack access to prevention or testing services, while over 5 million still lack access to ART.4 The number of children who have lost at least one parent due to HIV/AIDS has reached 15.2 million and continues to expand, threatening the survival and well being of the next generation in affected countries.5 Without multiplied interventions, millions of persons in the South will continue to fall ill and die of the disease, causing devastating impacts on individuals, families, communities and countries.

In 2005 the international community decided that this shortfall in the struggle against HIV/AIDS could not be allowed to continue. This view was made clear by the G8 and the United Nations General Assembly which committed these organizations to the goal of reaching universal access to prevention, treatment, care and support for HIV/AIDS by 2010.

This is a bold and courageous target and will not be easily achieved. Financial, human and physical resources must be dramatically increased, and all members of the international community will need to take dedicated and concerted action to make this target a reality. In particular, there is a need to improve a) the funding available for HIV/AIDS interventions; and b) the capacity of Southern governments to use the human resources available for treatment and care programs.

The Government of Canada has increased its funding for global HIV/AIDS interventions over the past few years and has altered its legal framework to support improved treatment access. However, its failure to announce new commitments at the XVI International AIDS Conference in Toronto in August 2006 led to unnecessary and disturbing ambiguity about its continued rule. The December 1, 2006 World AIDS Day announcements by the Hon. Josée Verner did reconfirm previous commitments to the Global Fund, new money for vaccine and microbicide research and announced new funding for the Canadian International Development Agency’s AIDS-related projects.6

Yet if Canada is to do all it can to help reach the 2010 goal, the government should not only reconfirm its commitment but also examine its response to the global HIV/AIDS pandemic to see where it has succeeded and where it can significantly expand. Failure to do so may cost Canada its ability to claim leadership in the global battle against HIV/AIDS and in international development assistance more generally.

This paper will evaluate Canada’s stated policy framework to determine the extent to which it supports the goal of providing universal access to prevention, treatment, care and support by 2010.
2. Context of the epidemic

The HIV/AIDS epidemic is the most destructive force of our time. It is estimated that there have been over 25 million deaths from the disease, including 2.9 million in 2006 alone (more than 10 times the number killed in the devastating Indian Ocean tsunami of 2005). More disturbing is the fact that the pandemic continues to spread, with an additional 4.3 million becoming infected in 2006. Roughly 40.3 million persons are now living with HIV/AIDS.

HIV/AIDS is truly a global epidemic, with 54 countries having adult infection rates over one per cent. However, almost all of the 27 countries with infection rates over four per cent are located in the South. Sub-Saharan Africa alone holds 63 per cent of the world’s HIV/AIDS case load, despite making up just 10 per cent of the world’s population. This concentration reflects the South’s general lack of resources for prevention and treatment as well as the fact that their citizens are more likely to be placed in situations conducive to HIV transmission.

Despite these staggering infection rates and 25 years of experience, the majority of those at risk of infection lack access to prevention services or lack the ability to use them. UNAIDS reports that “at best” one half of children currently attending school around the world will receive HIV education. As of 2005, fewer than one in five injection drug users and fewer than one in ten men who have sex with men had any access to prevention services. Intervention services to prevent mother to child transmission were offered to nine per cent of pregnant women, with less than six per cent coverage in sub-Saharan Africa.

In terms of impact, HIV/AIDS has drastically reduced the life expectancy in several high-prevalence countries. The seven countries with prevalence rates over seven per cent now have an average of just 49 years – 13 years lower than would be expected in the absence of AIDS. Increased sickness caused by HIV/AIDS also places a heavy burden on the health care system. It is estimated that 70 per cent of all hospital occupancy in Malawi and 50 per cent of that in Lesotho is the result of HIV/AIDS. Rising illness and death among the rural workforce has also undermined food security in a number of areas, leading to increased hunger and malnutrition.

The pandemic has undermined progress on other social indicators as well. Efforts to improve access to education in several Southern countries have been blocked by rising absenteeism, illness and death among teachers and also by families’ need to redirect money from school fees to immediate survival costs. Overall, the effects of the pandemic have added an extra US$1 billion per year to the cost of achieving the MDG of universal access to education by 2015.

Notably women bear the brunt of coping with the pandemic. Women are usually the primary caregivers for those with the disease, which increases the economic and familial duties they already perform. In some areas women are also more likely to be infected with the disease, such as sub-Saharan Africa where they compose 59 per cent of infected adults. This asymmetrical infection rate reflects the fact that women in the region tend to have less control over the terms of their sexual encounters, lower education rates, fewer legal rights, and less control over household resources.

In terms of prosperity, HIV/AIDS affects a country’s short-term economic performance by increasing the number of workers absent due to illness or due to the need to care for the sick and attend funerals. Studies from East Africa have shown that AIDS-related absenteeism can account for between 25-54 per cent of a company’s costs. AIDS also raises training and recruitment costs due to the need to replace workers who become too ill to work. It is estimated that HIV/AIDS is reducing annual rates of GDP growth by up to 2.5 per cent in the worst affected countries. Moreover, the pandemic reduces the potential for long-term economic growth by forcing households and governments to shift their spending from longer-term investments in education or infrastructure towards immediate health care expenses.

More disturbing than the pandemic’s current impact is the fact that its effects will only worsen over the coming years. At present it is estimated that only 6.5 million of persons living with HIV/AIDS in the South are in immediate need of treatment, meaning that they will die of illness sometime in the next two years without ART. This reality, which reflects the long time delay between HIV infection and the onset of symptomatic AIDS, means that the current social and economic impacts being experienced in the
South are being caused by just a fraction of the existing number of infections. Therefore, the impact of the AIDS epidemic will continue to worsen for sometime even after the number of new infections begins to fall.

While there are signs that the epidemic is slowing in countries like Uganda and Thailand, it is also beginning to take off in several countries in Asia and Eastern Europe. Uzbekistan saw a 7,200 per cent increase in the number of new infections from 1999 to 2004, while India now has over 5.7 million persons infected with HIV/AIDS – the highest number of infections of any country on the globe. Although the infection rate in Asia and Central and Eastern Europe is low as a percentage of the population, the failure to fight the disease now could lead to a massive epidemic in just a few years time.

3. Reaching for the goal of universal access

Achieving universal access to prevention, treatment, care and support services for HIV/AIDS by 2010 is imperative in order to save millions of lives. Without further improvements, projections show there will be 62.3 million new AIDS infections between 2005 and 2015. However, the implementation of a comprehensive prevention program could prevent 31.1 million of these infections. Furthermore, repeated studies have shown that scaling up access to ART and prevention simultaneously will not only decrease the mortality of those infected, but also will increase the effectiveness of prevention interventions, further lowering the number of new infections. Treatment programs facilitate prevention by raising awareness about the disease, providing opportunities for education, and changing the perception that AIDS is a death sentence. Together these benefits help to reduce stigma, which creates more space for prevention and a greater willingness for testing. Evidence also shows that those receiving treatment are less likely to transmit the disease.

In addition to saving lives, the scaling up of prevention, treatment, and care services for HIV/AIDS can also save money. Estimates show that each infection prevented averts an average of US$4,700 in subsequent health care costs, meaning that the comprehensive prevention program could potentially avert more than $140 billion in health costs by 2015. Long-term evidence from Brazil also demonstrates that universal treatment programs can save governments billions of dollars by reducing hospitalization and medical costs for AIDS patients. Furthermore, both prevention and treatment programs generate significant additional benefits for individuals and society, such as reduced absenteeism and skill loss, reduced disruption to family units, and improved human security.

It is clear that achieving the 2010 goal makes both moral and financial sense. However, the most basic rationale for reaching the goal of universal access is that the international community has already pledged to meet this commitment; that the most powerful and richest developed countries have stated their support for it; and that obligations generally originating in international human rights treaties, together with more specific references in the Millennium Declaration and MDGs, the UNGASS Declaration and the recent UNGA review provide an extensive mandate for action. The goal of universal access has also long been supported by groups of present and potential beneficiaries and by a growing international non-governmental campaign.

The implications of this commitment to universal access include:

- A global action plan that includes detailed national plans with targets and time-lines, including the involvement of people living with HIV/AIDS and other affected communities in their development, implementation, monitoring and evaluation
- Global targets that can be reviewed in planned UN evaluations of progress in 2008 and 2010
- A comprehensive approach to access HIV/AIDS services provision guided by human rights.

HIV/AIDS AND DEVELOPMENT
4. The policy environment for universal access

4.1 The international context

The MDGs: a very modest if challenging objective
In 2000 the international community established eight Millennium Development Goals, the sixth of which was “to halt and begin to reverse” the pandemic by 2015. While perhaps looking good on paper, this goal is now seen as “scandalously modest...Goal 6 takes inadequate note of the far-reaching impact of the disease on development” and did not really take into account “the lifesaving potential of new treatments”.34

The UN Declaration of Commitment
The Declaration of Commitment on HIV/AIDS produced at the UNGASS on HIV/AIDS in 2001 took the objectives further. And the comprehensive review just completed makes an important admission:
“We heads of State and Government and representatives of States and Governments...recognize...that we now have the means to reverse the global pandemic and to avert millions of needless deaths”.35

“3 by 5”: Overall failure, significant success
In 2003, the World Health Organization (WHO) and UNAIDS launched the “3 by 5” Initiative, with the objective of bringing the number of persons in treatment to 3 million by the end of 2005. While this objective was not met, an estimated 1.3 million people were accessing ART at the end of the Initiative, a three-fold increase from when it started. However, there are still 5 million who need treatment to prevent illness and death. Some 85 per cent of these persons live in poor countries and 600,000 of them are children.

Lifting the bar
At the Gleneagles Summit in July 2005, the G8 pledged to “implement a package for HIV prevention, treatment and care, with the aim of as close as possible universal access to treatment for all those who need it by 2010.” The commitment was reiterated at the Millennium Plus 5 session of the General Assembly in September 2005.

The comprehensive review by the UN General Assembly of progress achieved since the 2001 Special Session on HIV/AIDS, which concluded June 2, 2006 reaffirmed this objective in its Political Declaration, with the commitment:
“...to pursuing all necessary efforts to scale up nationally driven, sustainable and comprehensive responses to achieve broad multisectoral coverage for prevention, treatment, care and support, with full and active participation of people living with HIV, vulnerable groups, most affected communities, civil society and the private sector, towards the goal of universal access to comprehensive prevention programs, treatment, care and support by 2010.”36

The Declaration places this objective squarely in the framework of the achievement of human rights, reaffirming:
“...that access to medication in the context of pandemics, such as HIV/AIDS, is one of the fundamental elements to achieve progressively the full realization of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.”37

The Canadian government has been part of the negotiation and agreement to each of these accords. It is one of the governments with greatest access to the “means” necessary to achieve the objectives set, and bears a special responsibility in that light.

4.2 Policy-making in Canada

There are nine departments and agencies within the Canadian government that have either explicit or implicit influence over Canada’s policy response to the global HIV/AIDS pandemic. The exact relationship and division of responsibilities among these agencies is difficult to determine and at times they pursue somewhat contradictory goals. However, an understanding of this policy-making context is required if opportunities for improving Canada’s policy response are to be found.
Three main departments manage Canada’s policy response to the global HIV/AIDS pandemic:

- **Foreign Affairs Canada (DFAIT)** has the main responsibility for developing the government’s foreign policy on HIV/AIDS and is the lead agency for Canada’s representation at the United Nations and other international forums.

- **The Canadian International Development Agency (CIDA)** manages Canada’s development assistance and has limited policy responsibility for a number of related issues, such as gender equality, health promotion and good governance.

- **Health Canada** is the primary agency representing Canada at the WHO and other international health forums. It also handles the approval of medications and manages the international component **Federal Initiative to Address HIV/AIDS**.

In addition to these, there are a number of other government agencies that influence Canada’s policy response to HIV/AIDS:

- **The Public Health Agency of Canada (PHAC)** is responsible for coordinating the **Federal Initiative to Address HIV/AIDS** and for working with civil society groups to develop an “all-Canada” response to HIV/AIDS.

- **Industry Canada** shapes Canada’s foreign policy on HIV/AIDS through its responsibility for managing patent laws, including those permitting the export of generic pharmaceuticals.

- **International Trade Canada** is responsible for negotiating all of Canada’s international trade agreements, giving it considerable influence over Canada’s position on issues such as trade-related intellectual property rights, which in turn can influence the availability of medications for AIDS treatments.

- **The Department of Finance** can strongly influence Canada’s policy on HIV/AIDS through its role as Canada’s lead representative at the International Monetary Fund (IMF) and World Bank; two organizations that have a large impact on efforts for universal access through their control over debt servicing levels and the conditions they impose on Southern governments.

- **Citizenship and Immigration Canada (CIC)** can influence Canada’s foreign policy on HIV/AIDS by facilitating the immigration of skilled health workers from Southern countries, thereby undermining efforts to achieve universal access.

- **The Department of National Defence (DND)** affects Canada’s response to HIV/AIDS through its role in situations of conflict where HIV/AIDS is more likely to spread.

**Key policy documents and initiatives**

- **The Federal Initiative to Address HIV/AIDS in Canada** is the government’s main response to HIV/AIDS in Canada, although it also contains one element that is focused on improving Canada’s international networking around the disease.

- **Leading Together: Canada Takes Action on HIV/AIDS (2005-2010)** is a pan-Canadian strategy on HIV/AIDS involving government, civil society, persons with AIDS and the private sector. While it too has a largely domestic focus, the strategy also includes an international component.

- **Commitment and Action: Foreign Affairs Canada HIV/AIDS Strategy** lays out how DFAIT interprets the disease, its areas of focus, and how it plans to relate to other government departments.

**Policy coordination and consultation mechanisms**

There are a number of bodies that have been established to coordinate the HIV/AIDS programming of different government agencies and to gain input from civil society. These include:

- **The Assistant Deputy Ministers Committee on HIV/AIDS** – Composed of ADMs from 13 departments and agencies, this body works to ensure that Canada’s policies and programming on HIV/AIDS are coordinated at both the domestic and international levels. It is currently working to develop a comprehensive Government of Canada position statement on HIV/AIDS. The group is chaired by PHAC.

- **The Interdepartmental Forum on Global HIV/AIDS Issues** – Consisting of representatives from PHAC, DFAIT, CIDA, Health Canada, and the Canadian Institutes of Health Research, this group meets quarterly to discuss global HIV/AIDS issues and
strive for coherence in the federal government’s programming. Other government departments are invited to attend on an as-needed basis.

- The Consultative Group on HIV/AIDS Global Issues – A group of representatives from both government and civil society that meets each quarter to discuss Canada’s response to the global AIDS pandemic.19

- The Ministerial Council on HIV/AIDS – A body made up of knowledgeable Canadians (including several persons living with HIV/AIDS) that advises the Minister of Health on matters relating to HIV/AIDS. Although the Council is primarily focused on the domestic aspects of the disease, it has also created an International Issues Committee.

Additional consultations are also held regarding certain issues, such as Foreign Affairs Canada’s 2003 workshop on HIV/AIDS, Human Security, and Canadian Foreign Policy.

5. Improving the financial resources available for HIV/AIDS interventions

The need for financial resources

Achieving the 2010 goal of universal access will require a massive scaling up in the resources available for HIV/AIDS programming. UNAIDS estimates that the cost of implementing a comprehensive set of interventions for HIV/AIDS in the global South was US$14.9 billion in 2006 and will rise to US$18.1 billion in 2007.40 However, based on current commitments, the amount of funding available from all sources (e.g. international donors, Southern governments, charitable organizations, private citizens) was only US$8.9 billion in 2006 and will reach just US$10 billion in 2007, leaving a shortfall of more than US$14 billion in the 2006-2007 period.41 Moreover, the gap is only likely to widen in 2008, when it is projected that US$22.1 billion will be required for AIDS programming.

Canadian NGOs, working together in the Global Treatment Action Group, have cited an initial target for Canadian contributions of five per cent of the global objective. This would suggest a target share of global needs of US $745 million for 2006 and US$ 905 billion for 2007. Within this, our current pledges to the Global Fund – only one element in the total need – are not yet equal to five per cent of current requirements. To reach five per cent, we would need to increase from its contribution of C$250 million for two years (2006-7) to a level of C$350 million for each of 2008 and 2009.42

There are a number of reasons why the cost of HIV/AIDS interventions will rise so dramatically over the coming years. Previous programs, such as the “3 by 5” Initiative, have focused on the use of existing health resources in order to scale up care and treatment services as rapidly as possible. This approach has successfully engaged almost all of the available capacity in the affected countries. As a result, future spending must include the longer-term costs of new infrastructure (hospitals, clinics, laboratories), new health workers (doctors, nurses, pharmacists social workers, lab technicians, nutritionists) and new support workers (educators, counsellors, procurement and supply chain managers).43 Funding is also required to top-up the salaries of these new health workers to prevent their migration to industrialized countries.44 For more information of the need for health workers, please see Section 6.

The price of interventions is also rising in response to repeated experience that shows HIV/AIDS programs require more than a bare minimum of funding if they are to be successful. For example, studies have shown that the imposition of user fees inhibits the uptake of treatment and prevention services, particularly among the poor.45 To be successful, funding levels must be sufficient to allow these services and any associated supports to be provided freely without any user fees.

In addition to increasing the funds available, achieving universal access by 2010 also requires an increase in the duration and certainty of funding provided.46 The benefits of programs for prevention, health worker training, and orphan care will only be realized over the long-term and cannot be abandoned if results are not immediately available. Likewise the benefits of treatment programs will only occur if they receive continual funding. In fact, unexpected interruptions in support for treatment programs can actually worsen the pandemic by causing people to stop taking their medication, which raises the spectre
of increased viral resistance. Funding for HIV/AIDS must be protected from short-term fluctuations in political priorities if the pandemic is to be stopped.

Achieving the goal of universal access by 2010 requires investment in research. The spectre of drug resistance requires continued investment in the development of new therapies. Research on female-friendly prevention techniques such as microbicides is also needed to ensure that prevention options are available to women with less control over the terms of their sexual experiences. Research may also reduce the cost of AIDS interventions through the development of simplified treatment regimes (e.g. fixed dose combination tablets) or drugs that do not require refrigeration. In addition, long-term research may lead to a vaccine for the disease, if not a cure.

There is a clear need for the immediate and massive expansion of funding for HIV/AIDS programs in the South. However, people living with HIV/AIDS cannot be expected to make up this shortfall since they already account for up to 45 per cent of national spending on the disease, spending that is often diverted from other needs, such as food and education.47 The governments of Southern countries can (and should) spend more on health care, and we encourage African leaders to devote 15 per cent of their budgets to health care as was promised in the Abuja declaration.48 Nevertheless, even significant increases in AIDS spending by Southern countries will not provide the amounts required. Southern countries also have limited freedom to increase their health spending given the large number of social needs they face and the debt repayments they are forced to make. As a result, the vast majority of the required increase in funding must come from the international community, and particularly from Northern donor states.

5.1 Evaluating Canada’s funding for global HIV/AIDS interventions

There are three ways that Canada can do its part to ensure there is sufficient funding available to reach the goal of universal access by 2010: providing international assistance, working to increase debt relief, and supporting innovative financing mechanisms.

<table>
<thead>
<tr>
<th>Table I</th>
<th>Canadian assistance commitments for HIV/AIDS, 2005</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Value (US$)</td>
</tr>
<tr>
<td>Bilateral HIV/AIDS programming</td>
<td>108.2</td>
</tr>
<tr>
<td>Assistance via GFAT*</td>
<td>128.4</td>
</tr>
<tr>
<td>Total HIV/AIDS assistance</td>
<td>236.6</td>
</tr>
</tbody>
</table>

\* This figure reflects 57% of Canada’s GFAT\* contribution, which is the proportion of the GFAT\* resources spent on HIV/AIDS.

From: Kates and Lief, International Assistance, p. 10.

5.2 Official Development Assistance (ODA)

Over the past few years, the government of Canada has come to see itself as a leading donor for HIV/AIDS programs. It made the single largest contribution to the “3 by 5” Initiative (C$100 million) and is providing significant support to the International Partnership for Microbicides ($15 million over 2004-2007) and the International AIDS Vaccine Initiative ($62 million over 2002-2007). Table I outlines Canada’s total support for HIV/AIDS interventions in the South in 2005. Particularly notable is the fact that Canada has 5.5 per cent of total donor commitment for HIV/AIDS and 15.8 per cent of all donor contributions to the Global Fund Against AIDS, Tuberculosis and Malaria (GFATM).49

However, while Canada’s level of support for AIDS for programs may appear impressive as a percentage of total donor funding, the story is quite different if funding levels are examined relative to economic output. As shown in Table II, in proportion to its gross national income, Canada has committed more than five times as much support for AIDS as Italy and more than four times as much as France.50

Yet Table II also shows that Canada’s AIDS funding commitment per $1 million Gross National Income (GNI) is substantially below that provided by the UK, Ireland, Sweden and the Netherlands, with the later giving twice as much.
Table II
HIV/AIDS funding in proportion to economic output, 2005

<table>
<thead>
<tr>
<th>Country</th>
<th>Total HIV/AIDS Funding per $1 million GNI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Canada</td>
<td>224.9</td>
</tr>
<tr>
<td>France</td>
<td>62.8</td>
</tr>
<tr>
<td>Ireland</td>
<td>358.5</td>
</tr>
<tr>
<td>Italy</td>
<td>39.9</td>
</tr>
<tr>
<td>Netherlands</td>
<td>442.9</td>
</tr>
<tr>
<td>Sweden</td>
<td>376.2</td>
</tr>
<tr>
<td>UK</td>
<td>303.9</td>
</tr>
</tbody>
</table>

From: Kates and Lief, International Assistance, p. 15.

Canada must raise its support for HIV/AIDS if it is to help close the gap in the funding required for universal access. As discussed above, the total funding available for HIV/AIDS in 2006 was projected to be US$6 billion short of the amount required to stop the disease. Assuming that Canada continues to provide 5.5 per cent (2005) of the global resources available for HIV/AIDS, it would have needed to give an additional US$168 million in 2006 to cover its share of the gap.

Applying the UNAIDS estimates of need for coming years, Canada’s actuals look a bit limited compared to what might really meet the challenge.

Table III
Canada’s share of global UNAIDS targets:

<table>
<thead>
<tr>
<th>Year</th>
<th>UNAIDS targets</th>
<th>Canada’s share, based on 5%</th>
<th>Canada’s actuals</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005</td>
<td>US$12.0 billion</td>
<td>US$600 million</td>
<td>US$236.6 million</td>
</tr>
<tr>
<td>2006</td>
<td>US$14.6 billion</td>
<td>US$745 million</td>
<td>TBA</td>
</tr>
<tr>
<td>2007</td>
<td>US$18.1 billion</td>
<td>US$905 million</td>
<td>TBA</td>
</tr>
</tbody>
</table>

These shortcomings have been highlighted by Canadian civil society organizations active in this field. In the Leading Together strategy document, developed by civil society, these groups argued that:

Canada’s contribution to HIV/AIDS has not kept pace with the scope of the emergency. As a high-income country, Canada should be contributing an equitable amount in proportion to our Gross National Product.

They also argued that the government of Canada should raise official development assistance to 0.7 per cent of GDP.

Unfortunately, Canada’s commitment to the goal of universal access by 2010 has yet to be matched by a pledge to provide the needed increases in HIV/AIDS funding. This lack of commitment is not surprising since Canada has refused to match other G7 members in setting a timeline for increasing aid to 0.7 per cent of GDP. Notably the new Conservative government has promised to honour the previous administration’s commitment to raise Canada’s ODA by eight per cent per year in order to reach the donor average of 0.42 per cent. However, these increases will not be large enough to permit the expansion of AIDS assistance that is required to make Canada’s commitment to universal access a reality. In fact, there is no guarantee that any portion of the aid increases promised by the government will be devoted to HIV/AIDS. Canada must strengthen its funding commitments for HIV/AIDS if it still desires to be recognized as a leader in the global response to the disease. [For a further examination of Canada’s potential contribution, see the section on Innovative Sources.]

Evaluating our part in the response

Discussions of Canada’s share of the material elements in stopping and reversing the pandemic and in guaranteeing universal access by 2010 have many dimensions. As some assessors have noted, “no one measure alone can answer the question”.

Michael O’Connor of the Interagency Coalition on AIDS and Development (ICAD) points out that, while Canada’s share of the global economy may be estimated at 3.1 per cent, the government does contribute more than this share to such international efforts as the International Fund for Agricultural Development and the Global Environment Facility, and seven per cent of the support offered UNICEF by governments and international agencies.
Beyond the mathematical questions are broader issues of the responsibility of a wealthy country and a government that enjoys repeated budgetary surpluses. On the one hand Canada and the UK are remarkable among G7 members for allocating a much greater share of overall G7 resources to HIV/AIDS than their share of GDP would suggest. On the other hand the estimated gap in providing the resources needed for an expanded response to AIDS in low and middle income countries continues to grow.

There are also issues of an ethical as well as human security dimension which emerge when one compares overall investment in combating a pandemic that is killing people by the minute and the escalating commitment to military expenditure by Canada. The current National Defence estimates for 2006-07 are $14.789 billion, up from $13.425 billion in 2005-06. Canada’s foreign aid estimates for 2006-07 are $2.974 billion (up from a 2005-06 figure of $2.776 billion), with funding for the HIV/AIDS only a small portion thereof. The 2005 Canadian Federal Budget pledged significant further funding, including both budgetary increases and capital spending mounting to a 34 per cent increase by 2009-10, to spending of $19.7 billion. In late June 2006, the Department of National Defence announced capital spending on aircraft, helicopters, trucks and ship support totaling $17.1 billion over coming years. A country capable of this sort of military investment should be capable of much more in life-saving investments in global health and combating HIV/AIDS. Reaching 0.7 per cent of GDP in ODA should be only an initial step.

Recommendaitions:

1. In order to increase the coherence between Canada’s objectives on HIV/AIDS mitigation, its policy in multilateral institutions and its funding commitments, Finance Canada should be added to the Assistant Deputy Ministers Committee on HIV/AIDS, the Interdepartmental Forum on HIV/AIDS Global Issues and the Consultative Group on HIV/AIDS Global Issues.

2. The Government of Canada should immediately set a timeline and targets for increasing its ODA disbursements to 0.7 per cent of GDP.

3. Canada must provide its fair share of the resources that UNAIDS estimates are required to reach the goal of universal access to prevention, treatment, care and support by 2010.

4. Canada must create a long-term, stable, and predictable framework for its support for HIV/AIDS.

5. Canada must continue to support HIV/AIDS research, both through the Canadian Institutes of Health Research and through multilateral efforts such as the International Partnership for Microbicides and the International AIDS Vaccine Initiative (IAVI).

5.3 Debt Relief

Despite much attention in recent years to the need for debt relief in the Global South, many developing countries are still paying large amounts of debt service. The flow to debt-holders in developed countries exceeds by far the shortfall in funds from donor countries for adequate HIV/AIDS response. Sub-Saharan Africa, as pointed out in a recent KAIROS study, “annually pays two to three times as much as this shortfall to service external debts. African countries forfeited US$23.4 billion to interest and principal payments in 2005, up from an average of US$13.2 billion over each of the previous seven years.” Clearly, the elimination of debt servicing payments would greatly increase the amount of resources that Southern countries could devote to combating the HIV/AIDS pandemic.

Efforts to reduce the debt owed by developing countries have been ongoing since the late 1970s. These initiatives generally involve the provision of financial support and debt rescheduling to countries unable to meet their debt obligations. In order to obtain this support, recipient countries must typically agree to implement a Structural Adjustment Program (SAP) aimed at restoring the country’s long-term fiscal solvency.
The largest multilateral debt relief initiative currently underway is the Enhanced Heavily Indebted Poor Country (HIPC) program operated by the IMF and World Bank. Before they can receive any relief, countries in the program must follow an IMF approved SAP for three years and must develop a Poverty Reduction Strategy Paper (PRSP) that outlines how they will reduce poverty with the debt savings they receive. If at the end of three years the IMF and World Bank find that the country has satisfactorily adhered to its SAP, then the country is said to have reached its “Decision Point” and will begin receiving interim debt relief. However, the country must then continue with the SAP for at least one more year until it reaches its “Completion Point” at which time the IMF and World Bank will decide if it can finally receive the full debt cancellation available under the program.

Canada’s contribution
Over the past decade, the Government of Canada has championed the cause of debt relief for Southern countries. In 2000 it introduced the Canadian Debt Initiative under which it stopped collecting interest payments from countries in the HIPC program. In February of 2005 it set a precedent by calling for 100 per cent debt relief for HIPC countries and 19 other potential recipients. This principle of 100 per cent debt relief was ultimately adopted by the G8, and is embodied in the Multilateral Debt Relief Initiative (MDRI) the Group launched at its Gleneagles Summit in 2005. The MDRI expands existing programs by providing 100 per cent forgiveness for the debts that HIPC countries owe to the IMF, the International Development Association (the concessional lending arm of the World Bank) and the African Development Fund (the concessional lending arm of the African Development Bank). The program was fully launched in July 2006 and is now providing relief to 20 HIPC countries and two others. The total potential value of the MDRI is close to $60 billion in loans and interest.

Problems with the current system
While the HIPC and the MDRI programs are positive steps, they also have strong limitations. First, existing debt relief programs deal only with debt owed to certain creditors, such as with the MDRI which fails to address debts owed by Latin American countries to the Inter-American Development Bank. In addition, 20 HIPC countries are excluded from the programs because they have yet to reach their completion points, meaning that it may be several years before they receive relief under HIPC or the MDRI.

This situation is troubling since many of these countries require immediate debt forgiveness in order to respond to HIV/AIDS. In fact, complying with the SAPs required by debt relief programs has caused many countries to reduce their expenditures on health, social and nutrition programs, which aggravated the impacts of the pandemic. Furthermore, the need to respond to HIV/AIDS can reduce a country’s ability to follow a SAP, decreasing the chance that it will reach its completion point. Worse still is the fact that countries trying to reach their completion point must still make payments on their debt.

A further issue is that more countries need debt relief than are currently eligible for it. At present, the criteria for HIPC debt relief is based on estimates of debt sustainability, not the resources that countries require to meet the MDGs. Analyses have shown that there are up to 60 developing countries in addition to the HIPCs that require immediate 100 per cent debt relief if they are to achieve the MDGs. The Government of Canada has recognized this reality and in February 2005 it proposed the extension of 100 per cent debt relief to 19 non-HIPC countries. Now that the principle of 100 per cent debt relief has been accepted, it is imperative that this relief is immediately extended to all countries in need. The fact that there are several high prevalence countries that spend more on debt service than they do on health is truly shameful.

A final concern is that the Government of Canada currently structures its debt relief in order to make itself appear more generous than it really is. Under current policies, Canada finances its debt relief from planned increases in ODA. Therefore, if the government announces a $100 million increase in ODA and $100 million in new debt relief, Canada’s total international assistance goes up by only $100 million, not $200 million as it may appear.
**Recommendations:**

6. The Government of Canada should extend 100 per cent debt relief to all countries that require additional resources to achieve universal access by 2010 and the MDGs, and should encourage other countries and the International Financial Institutions (IFIs) to do the same.

7. A country’s need for resources to achieve the MDGs should be the primary criteria on which Canada and the international community base decisions for debt relief.

8. The need for countries to adhere to an IMF approved SAPs before they receive debt relief must be ended. A country should be provided with debt relief immediately if the relief is required for the country to achieve the MDGs. However, countries should be monitored to ensure that debt relief is used appropriately (see section 6 on conditionality).

9. Canada should finance its debt relief and forgiveness from new budget appropriations, not from planned ODA increases.

10. In order to ensure greater coherence, Canada’s policy at the World Bank and IMF as they affect health systems and HIV/AIDS should be agreed on an interdepartmental basis and representatives from departments other than Finance should be included in Canadian delegations to the IFIs.

**5.4 Multilateral conditionalities**

In addition to serving as the main criteria for debt relief, the conditions that the IMF and World Bank (IFIs) impose in their SAPs have profound effects on the ability of Southern countries to respond to HIV/AIDS. In addition to being a requirement for debt relief, most donors engage in a process known as “cross-conditionality” under which they will only provide assistance to countries that are in compliance with their SAPs. Furthermore, the provisions in SAPs also determine key elements of a country’s economic policies, including the size of its budget expenditures. As a result, SAPs have a tremendous impact on the resources available for combating the HIV/AIDS pandemic.

**An introduction to IFI conditionalities**

The conditionalities contained in SAPs are usually attached to loans that Southern countries receive from the IMF’s Poverty Reduction and Growth Facility (PRGF).63 Officially, PRGF loans are given to support the objectives of the PRSPs that Southern countries create to outline how they plan to reduce poverty using the funds they obtain from aid and debt relief.64 PRSPs are supposed to be public documents that are developed by the government in consultation with civil society. However, since the IMF believes that poverty reduction is best achieved through export-led growth supported by foreign capital, the conditions attached to PRGF loans usually force Southern countries to implement policies aimed at creating a stable environment for foreign investors.65

SAPs usually place particular emphasis on the need to achieve an inflation rate target in the low single digits.66 In order to help countries reach their inflation targets, the IMF determines the amount that governments can spend without raising the demand for goods and services to a level that would cause inflation. These governments must then cut their spending to fit within the amount identified, which is referred to as the government’s “fiscal space”.67 Since SAPs dictate that HIPCs cannot reduce their debt servicing payments, the required cuts must come from other areas, like health and education.68 Some conditionality programs also try to keep countries within their fiscal space by limiting the wage bill for the civil service (e.g. the Zambian PRGF has a wage ceiling of eight per cent of GDP).69

Of particular significance to HIV/AIDS programming is the fact that some inflation targeting regimes may also include restrictions on the amount of aid that a country can receive. These limits are justified on the grounds that unplanned donor funding could increase a country’s spending beyond its fiscal space. In addition, receipt of large sums of foreign currency could also cause a country’s currency to appreciate, which would make its exports less competitive (a phenomenon known as the “Dutch Disease”).70 In fact, the IMF’s concerns about the negative impact of unplanned donor funding are so large that it has called on HIPCs to turn down unplanned grants. As stated in an IMF sponsored discussion
paper: “Dutch Disease effects must be weighed against the long-term benefits of the associated spending, though these are not easy to measure in terms of the probability of successful outcome and social return.”71 Based on this analysis, the Fund advises HIPC countries only “to accommodate higher aid-financed poverty-reducing spending, where the macroeconomic impacts on competitiveness are manageable, if the increased aid flows are largely on concessional terms and do not endanger sustainability.”72

**Evaluating the impact of IFIs’ conditionalities on efforts to fight HIV/AIDS**

The IFIs’ policy of prioritizing debt repayment and low inflation rates over government spending is widely seen to have exacerbated the HIV/AIDS pandemic. The spending cuts imposed by SAPs forced many poor countries to reduce their health spending at the very time the epidemic was taking off.73 Without adequate funding, the health systems in these countries have been unable to respond effectively to the pandemic, allowing it to spread quickly. Moreover, the funding restrictions have forced many countries to impose user fees for health and social services, which caused many people who could not afford to pay to lose access to the health system.74 This reality was dramatically demonstrated in 2001 in Uganda when the removal of health care user fees led to a 50 to 100 per cent rise in clinic usage.75 User fees have also been shown to be a significant barrier to universal access to prevention, care and treatment services for HIV/AIDS since the poor do not have the resources to pay for treatment.76

IFI conditionalities have also undermined the fight against AIDS by increasing the volatility of donor funding. Since the IMF is the global “lender of last resort”, other donors and investors usually follow its decisions about the worthiness of recipient countries. Consequently the IMF has “signalling” power over HIPC countries, meaning its decision to suspend funding can cause dramatic drops in aid flows.77 Such a situation occurred when the IMF suspended aid to Zambia following the government’s decision to run a larger than planned deficit in order to raise salaries and benefits for civil servants.78 Other donors quickly followed the IMF’s lead, causing aid to Zambia to drop from over US$700 million in 2002 to about US$450 million in 2003.79 Debt relief was also suspended. As a result, Zambia was forced to borrow from domestic sources to meet the shortfall, causing its debt and interest payments to rise.

The IMF’s restrictions on the receipt of foreign aid have also hindered efforts to increase AIDS spending to the level needed to achieve universal access by 2010. For example, in 2004 Uganda was pushed to restrict its spending on AIDS despite receiving a new grant from the GFATM.80 Mozambique also experienced a similar situation when it was encouraged to turn down a grant from the Clinton Foundation.81 Oxfam has pointed out that these restrictions create a disincentive for increases in foreign aid, since donor countries are unlikely to give more if recipient countries are unable to receive it.82 While the IFIs insist that their conditionalities will put Southern countries on the path to development, these restrictions are hindering these countries’ efforts to provide the levels of prevention, care and treatment needed to stop the pandemic.

**Alternative models of conditionality**

Achieving universal access by 2010 will likely require large increases in spending by Southern governments, massive amounts of foreign aid, and a significant expansion of the public wage bill. All of these changes may raise inflation and as a result may run contrary to the policies currently endorsed by the IFIs. Therefore, responding effectively to the HIV/AIDS pandemic requires greater macroeconomic flexibility than is normally allowed by the IFIs.

Significantly, there are many economists who believe that the IFIs’ focus on achieving inflation in the low single digits is misplaced. While not denying that hyperinflation can be destructive, these economists argue that inflation can rise to between 10 to 20 per cent without harming long-term economic growth.83 In fact, they argue that the drastic measures required to push inflation below 10 per cent can actually harm economic growth rather than help it. As such, there may be significantly more fiscal space available in which to increase spending on HIV/AIDS than the IFIs currently admit. This argument is supported by a “late-breaking” paper presented at the Toronto conference which demonstrated that the
potential macroeconomic costs of rapidly scaling up access to ART are far less than the reduction in GDP growth that would occur if the epidemic were allowed to proceed unchecked. In fact, in several jurisdictions the benefits produced by treatment programs will become larger than the costs as early as 2010.

Based on these arguments, we believe that the SAPs currently being imposed are unnecessarily slowing the response to the HIV/AIDS pandemic. States should be allowed to increase their expenditures on HIV/AIDS so long as any negative impact from this spending is less harmful than the long-term destruction that will occur if the pandemic goes unchecked. This need for a new approach to macroeconomic policies has also been noted by UNAIDS, which has stated that:

Potential short-term inflationary effects of increased and additional resources applied to the HIV epidemic can be managed, and in any event, pale in comparison with what will be the long-term effects of half-hearted responses to AIDS on the economies of hard hit countries.

The Government of Canada has yet to change the macroeconomic conditions that it attaches to its assistance. However, DFAIT’s HIV/AIDS strategy calls for “the Department of Finance to ensure effective Canadian advocacy for appropriate approaches to health and HIV/AIDS within international financial institutions,” which indicates that a change in policy may be coming.

**Ensuring stable and predictable funding**

In addition to easing the macroeconomic conditionalities attached to international assistance, achieving universal access to services for HIV/AIDS requires stable and predictable donor funding. The UK has taken the lead in this regard and in March of 2005 adopted a new policy on aid conditionality which states that assistance will be suspended only if:

a) countries move significantly away from agreed poverty reduction objectives or outcomes or the agreed objectives of a particular aid commitment

b) countries are in significant violation of human rights or other international obligations
c) there is a significant breakdown in partner government financial management and accountability, leading to the risk of funds being misused through weak administration or corruption.

This policy change took place because of the British government’s desire to increase the predictability of its aid flows and because it felt that “it is inappropriate and...ineffective for donors to impose policies on developing countries.”

**Recommendations:**

11. The Department of Finance should work closely with CIDA and DFAIT to ensure that the conditions attached to Canadian aid provide Southern countries with the macroeconomic flexibility they need to scale up their response to HIV/AIDS.

12. Canada should use its bilateral and multilateral relations to encourage other donors to increase the macroeconomic flexibility that Southern countries have available to respond to the pandemic.

13. Canada should lobby the IMF and World Bank to adopt more flexible conditionality policies. In particular, Canada should encourage these institutions to remove conditionalities that restrict government spending on health, education and social programs, curtail the receipt of foreign aid, or prevent legitimate increases in a country’s public wage bill.

14. Canada should no longer engage in “cross-conditionality”, but should instead make its own decisions regarding the suspension of international assistance.

15. Canada should create a policy on aid conditionality along the lines of that established by the UK government (Department For International Development — DFID) that will suspend aid only in those circumstances where further assistance will not contribute to poverty reduction objectives.
6. Human resources: ensuring stable, able and sustained prevention, care and treatment

At the start of the HIV/AIDS epidemic, many Southern countries lacked the human resources necessary to respond to it effectively. Disturbingly this human resource gap has expanded significantly as the epidemic has spread with the result that both governments and aid agencies are now unable to implement a full range of HIV/AIDS interventions due to a shortage of health professionals. Consequently, the need to improve human resources is now seen by the WHO as one of the five “key challenges” to achieving universal access.

The extent of the problem
At the global level there is a total shortage of approximately 4 million health workers, including 2.4 million doctors. The shortage is most severe in sub-Saharan Africa, which requires 0.82 million new health workers to provide universal access to AIDS services and achieve the MDGs. Even South Africa, which has a comparatively large number of health workers, estimated that it will need to recruit 975 medical officers, 6,822 nurses, 661 pharmacists, and 526 nutritionists between 2004 and 2008 in order to implement its program for universal treatment. However, this lack of health workers not only exists in regions with a high HIV prevalence like sub-Saharan Africa, but also in countries as diverse as Albania, Bangladesh and Guyana.

The shortage of health professionals in the South is caused by a number of factors including insufficient training, low salaries, illness and death, migration to industrialized countries, and burnout caused by poor working conditions. However, the cause of the shortage varies significantly from country to country, with death being the largest cause in Lesotho and Malawi, while migration is the primary cause in many other jurisdictions.

The migration of health workers from the South to the North has reached staggering proportions. For example, Canada is now home to up to 1,800 South African doctors who together represent roughly five per cent of doctors currently remaining in South Africa. Likewise, the number of Ugandan doctors in Canada is equal to about three per cent of Uganda’s current physician complement, while the number of doctors arriving in the country from Nigeria has tripled over the past 10 years. Notably the situation is similar in other Northern countries, such as the UK, which in 2003 issued work permits for health workers to 5,880 South Africans, 2,825 Zimbabweans, 1,510 Nigerians, and 850 Ghanaians. Health workers are also leaving the Caribbean at an alarming rate, with 458 nurses from the region migrating to Canada, the United States, and the UK in 2000 alone.

Health worker migration is particularly problematic from a policy perspective since it not only causes a loss of capacity in Southern countries but also provides a subsidy to much wealthier Northern states. Poor countries like Ghana, which has just one doctor for 17,489 persons, should not be supplying health workers to the UK, where the ratio is one to 300. Zambia, which has one of the world’s highest AIDS prevalence rates, has seen all but 50 of the 600 doctors trained in the country since independence migrate to the North. The migration of African health workers, where the cost of training a specialist doctor is US$100,000, is believed to provide the North with subsidy of $500 million per year, while the migration of Caribbean nurses to Northern countries represents a subsidy of up to $16.7 million.

Needed responses
The human resources available for health interventions will need to be dramatically increased if universal access to prevention, treatment, care and support is to be achieved. However, any interventions to develop the human resources available must employ a holistic approach that simultaneously expands the number of health workers available while also reducing the number who are lost to illness and migration.

UNAIDS has recognized the critical impact of the human resource shortage and has factored in the cost of training 5,700 new doctors and 3,070 new nurses per year. However, these training initiatives will be slow to bear fruit since Africa only has the capacity to train 10 per cent of that number.

Although some argue that the migration of health workers is not a significant problem, most now accept that the phenomenon must be reduced if universal access is to be achieved. However, stopping
migration is difficult since health workers must have the same freedom of movement enjoyed by other citizens. In the short term, one of the simplest methods to reduce the extent of migration is for Northern countries to ban the active recruitment of health personnel from countries with severe health worker shortages. This ban is supported by the Commonwealth Code of Practice for the International Recruitment of Health Workers, which recognizes the freedom to migrate but calls for an end to systematic recruitment. The Commonwealth Health Ministers passed the Code in 2003, although the group’s Northern members including Canada, New Zealand, Australia, and the UK failed to sign the document. However, the UK has introduced a Code of Practice for the International Recruitment of Healthcare Professionals that bans the active recruitment of health workers from approximately 150 Southern countries. South Africa has also taken steps to end its reliance on health workers from lesser-developed countries, even though it remains a target of health worker recruitment itself.

Longer-term initiatives to slow the rate of migration will need to address both the “push” factors that make health workers want to leave the South and the “pull” factors that attract them to the North. The key push factors that lead to migration are low pay, poor working conditions, and lack of advancement opportunities. Evidence has shown that the probability that a health worker will choose to migrate is inversely proportional to his or her salary. This reality is clearly demonstrated by the case of Barbados, which pays its nurses up to twice as much as other Caribbean states and experiences roughly half their level of nurse migration. Since salaries in the North can be up to 24 times higher than those in the South, health workers often have a substantial incentive to migrate. In addition, Southern health workers often face poor working conditions in facilities that are overcrowded and under equipped. Regrettably the HIV/AIDS epidemic has worsened these working conditions by increasing patient load and reducing the number of available staff.

The North can help to reduce the push to migrate by working with Southern countries to develop retention programs that improve the salaries, working conditions, and training opportunities available to Southern health workers. UNAIDS has stressed the need for these retention programs and now includes funds to top-up health worker salaries in its estimates of the cost of stopping the pandemic. Perhaps the most comprehensive initiative to build the human resource capacity of a health system is Malawi’s Emergency Human Resources Program. Malawi has one of the lowest number of health workers in the world, with just 1.6 doctors and 28.6 nurses per 100,000 people, compared with nine doctors and 64 nurses per 100,000 in Ghana. Moreover, the number of vacancies for physicians in the country (294) is more than double the number of physicians actually working (139). In 2004, the Government of Malawi declared a human resource crisis in the health sector. This declaration was supported by Peter Piot, the Director of UNAIDS, and by Sir Suma Chakrabarti, the Permanent Secretary of DFID who stated that lack of human resources for health in Malawi was an emergency “requiring exceptional measures that might otherwise be dismissed as unsustainable”.

In response to the crisis, the Government of Malawi, DFID and the GFATM launched the Emergency Human Resources Program, which seeks to address the health worker shortage holistically by:

- raising Malawi’s capacity to train health workers by 50 per cent
- topping-up the salaries of 11 key types of health workers by 52 per cent
- providing housing for medical staff
- developing incentives for health workers working in rural areas
- re-recruiting up to 75 nurses and 60 clinical officers each year from those who are no longer active but have remained in Malawi
- supporting the recruitment of 50 volunteer doctors and nurse tutors each year from Northern countries to take key “stop-gap” positions in training and service delivery.

The program will be funded by US$273 million from 2004-2011. So far, it is topping-up the salaries of 6,050 health workers, has re-recruited 705 Malawians and is on pace to exceed targets for volunteer doctors and nurses from the North. At the same time, the number of persons receiving ART in Malawi has risen to 35,000.
Building on the Malawian experience, at the 2006 International AIDS Conference in Toronto, the WHO launched a new initiative to build the human resource capacity of health systems throughout the South. Known as Treat, Train, Retain (TTR), the initiative seeks to:

- **Treat**: Reduce illness and death among health workers and provide support services to reduce burnout.
- **Train**: Increase the number of health workers entering the workforce in the South and facilitate the adoption of simplified treatment protocols among existing workers.
- **Retain**: Improve working conditions and provide salary top-ups and other incentives in order to reduce the push factors that cause health workers to leave rural areas or migrate to the North.119

The WHO estimates that it will cost between US$7.2 and US$14 billion over the next five years to implement the TTR in the 60 countries with the highest AIDS burden.120 The lower estimate assumes a two-fold increase in health worker salary while the higher estimate assumes a five-fold increase. Regrettably some health ministers do not believe that they will be able to implement the program due to concerns over fiscal space and macroeconomic stability.121 In response, the WHO has pointed out that the lower cost estimate corresponds to an annual expenditure of just $0.60 per person or between two to five per cent of the usual health care spending in low-income countries. As such, the funds required for TTR should not cause a large disruption to national economies.

The “pull” factors that attract migrants to the North could also be greatly reduced if Northern countries became self-sufficient in the production of health care professionals.122 This view is strongly supported by the World Association of Rural Physicians in their Melbourne Manifesto, which stresses that all countries must take responsibility to train their own health workers and that the international recruitment of health workers should take place in the context of a memorandum of understanding (MOU) that lays out the terms of the exchange and the benefits to both parties.123 The need for self-sufficiency was also stressed in the April 2005 London Declaration of a conference organized by the British Medical Association and attended by associations of medical professionals from Australia, Britain, Canada, South Africa, the United States, and the Commonwealth.124

Regrettably the North’s aging population and the long period of time required to train health workers means that the region is unlikely to eliminate its demand for Southern health workers in the foreseeable future.125 As a result, the North should put in place programs to reduce the impact of health worker migration when it does occur. The development of these policies is supported by World Health Assembly resolution 57.19, which calls for states to manage the migration of health professionals from developing countries and minimize its impacts.126 The UK is the leader in this area and has signed MOUs on the managed migration of health workers with both South Africa and the Philippines. The UK-South Africa agreement allows South African health workers to spend a specified period studying and practicing in the UK and encourages British health workers to work in South Africa, particularly in the rural areas.127 The MOU also contains provisions for mutual access to training, hospital twinning programs and the exchange of health care techniques.128

Unfortunately no matter how quickly interventions to increase training and reduce migration are introduced, the supply of trained health workers in the South is not likely to meet the level of demand for some time. Consequently it is generally acknowledged that attaining universal access to treatment by 2010 will require a new approach that shifts the delivery of the lowest level health worker possible. The WHO pioneered this “public health” model for AIDS care in the “3 by 5” Initiative by creating a simple, standardized protocol for ART treatment that reduced the need for doctors and laboratory monitoring.129 This approach was much better suited to the resource-limited setting found in most Southern countries and led to a rapid increase in the number of persons receiving therapy.

**Canada’s response**

It is difficult for the Government of Canada to respond to the migration of health workers from lesser-developed countries since health care and the licensing of health workers are provincial responsibilities, while immigration is a federal jurisdiction.130 Consequently, effective federal-provincial cooperation is required to ensure that Canada is self-sufficient in its human resources for health care.
Canada has yet to formally sign any code governing international recruitment of health workers, nor has it taken any steps to ban the recruitment of health workers from jurisdictions with severe shortages. However, the negative impact of health worker migration is mentioned in DFAIT's recent strategy on HIV/AIDS. The strategy's “expected results” appendix also calls for DFAIT to “Work with Citizenship Immigration Canada, Health Canada and provinces to develop an approach on migration of health care workers”.131

However, while DFAIT's pledge is encouraging, it appears to directly contradict the policies contained in the government’s Internationally Trained Workers Initiative (ITWI), one element of which is specifically aimed at increasing the number of foreign trained health care professionals practicing in Canada. The ITWI's health worker program was first conceived of in fall 2004 when the Prime Minister and Premiers agreed to reduce health care wait times by speeding the integration of internationally trained health care professionals. It was then launched in April 2005 with $75 million over five years to speed the recognition of the credentials held by foreign health workers. The government estimates that these interventions could lead to the integration of up to 1,000 doctors, 800 nurses and 500 other health professionals into Canada's workforce.134

Regrettably no effort has been made to reconcile the ITWI with international ethical recruitment guidelines or to mitigate the program’s potentially negative impact on developing countries. Clearly the Government of Canada must take immediate action to ensure coherence between its support for universal access by 2010 and the ITWI. To do otherwise is not only inconsistent, but also morally reprehensible. As the Lancet editorial team argues: “To poach and rely on high skilled foreign workers from poor countries in the public sector is akin to the crime of theft.”135

Notably Canada has also lagged behind its peers in developing agreements for the managed migration of health professionals. In 2005 Canada took steps towards developing a MOU on managed migration with South Africa, but no further progress has yet been made. Canada has also failed to respond to suggestions from the Commonwealth and the Caribbean community (CARICOM) that a managed migration program for nurses should be established between Canada and the Caribbean. Canada could, for example refuse to give permission for employers to hire workers under the Temporary Foreign Workers Program unless employers comply with the Commonwealth Code of Practice for International Recruitment of Health Workers.138

The issue is of sufficient import that it should be broached with G8 partners which include most of the significant “pull” countries.

**Recommendations:**

16. Canada must immediately end the practice of deliberately relying on internationally trained health care professionals to fill domestic shortages. The Government of Canada and the provinces should develop and implement a plan for Canada to achieve self-sufficiency in the production of health care workers in the shortest possible time.

17. Recognizing that health workers from countries may continue to decide to seek careers in Canada, Citizenship and Immigration Canada should work with the provinces to develop a strategy to offset its negative impact on health systems in the countries of origin, including compensation for training costs and encouragement of “circular” migration (returning to country of origin after having completed a period of work, experience and training in Canada).

18. Canada should develop managed migration agreements with countries that are the source for large numbers of migrant health workers. Agreements with CARICOM and South Africa would be excellent starting points.

19. The health care component of the ITWI should be changed to a program that seeks to maximize the mutual benefits of existing migration by providing training and by assisting migrants to return to their original country.

20. Canada should provide its fair share of support to the Treat, Train and Retain initiative.

21. Canada should sign the Commonwealth Code of Practice for the International Recruitment of Health Workers and, in order to ensure pan-Canadian conformity, use its principles as the basis for a “Canadian Code for the International Recruitment of Health Care Professionals” which would be developed in cooperation with the provinces and with relevant CSOs and professional/union bodies.
7. Saving lives: the crunch

“The lives of [applause] hundreds of millions depend on full funding for needed HIV prevention. The lives of the 40 million people living with HIV today depend on maintaining full and unbroken funding for universal access to HIV treatment.”

— Dr Peter Piot, Executive Director, UNAIDS to the opening session, Toronto International AIDS Conference, August 13th, 2006

The objective of universal access to treatment by 2010 presents perhaps the most ambitious humanitarian commitment in recent history. It is only one side of a coin in which prevention, care and support must form complementary elements.

UNAIDS states that 80 per cent of those in urgent need of treatment is the equivalent of “universal” coverage, based on experience to date in a variety of settings, where treatment seldom exceeds 80 per cent for reasons “including adverse reactions to drugs and personal choice”. Based on this modified objective and experience in the significant “ramp-up” of treatment through the UNAIDS/WHO “3 by 5” Initiative, it estimates total needs in middle- and low-income countries at US$12.4 during 2006-2008, for treatment and care activities (including palliative care, opportunistic infections, anti-retroviral therapy, testing, etc.). This represents a growth from $3.043 billion in 2006 to over $5.3 billion in 2008 and rising. Africa would require 55 per cent of this expenditure, Latin America and the Caribbean 17 per cent, East Asia/Pacific 16 per cent, etc. Estimates for funding for prevention rise to US$ 29.8 million per annum by 2008 with a distribution which emphasizes South/Southeast Asia and Eastern Europe to a greater degree. Cost estimates for building human resource capacity, infrastructure and program support for strengthening health systems and support for orphans and vulnerable children add a further US $12 billion over 2006-2008.

The objective of access to treatment cannot be achieved without a similar emphasis on prevention. As Microsoft head Bill Gates noted in his keynote address to the Toronto International AIDS Conference:

Between 2003 and 2005 with the infusion of funds from the President’s Emergency Plan for AIDS Relief (PEPFAR) and the Global Fund, the number of people in low- and middle-income countries receiving anti-retroviral drugs increased by an average of 450,000 each year. Yet over the same period, the number of people who became infected with HIV average over 4 million a year. In other words, for each new person who got treatment for HIV, about 10 people became infected.

In short, treatment without prevention is like stepping up slowly on a rapidly descending escalator. Prevention without treatment is a death sentence for millions.

7.1 Focus on treatment

Gates outlined his own sketch of the challenge regarding universal access to treatment:

Even during our greatest advance, we are falling behind. Let’s consider what this means for universal treatment. Right now, nearly 40 million people are living with HIV. The lowest price for first-line treatment drugs is about $130 per person per year. In many cases, the cost is much higher. The cost for personnel, lab work and other expenses easily exceeds another $200 per person per year. That means that even when you assume the best possible prices today, the annual cost of getting treatment to everyone in the world who is HIV positive will be more than $13 billion a year every year.

A vivid and still positive picture of the challenge at country level emerges in the current case of Brazil where access to treatment is guaranteed by law and free, currently serving more than 170,000 people. The prospects for Latin America as a whole are equally challenging, as are those for countries, like Brazil, with universal treatment access programs such as Thailand.

► The rate of growth of new patients (up 450 per cent since 2002) vastly exceeds the cost savings through negotiated price reductions on anti-retrovirals (ARV) (down $61 in the same period).

► The transition of patients from first line to second line treatments can double the budgetary draw in two years.

► Second and third line pharmaceuticals are high priced.

► ARV costs were limited by use of nationally produced products (older drugs) in the early 2000s, but given Brazil’s implementation of the Trade Related Aspects of Intellectual Property Rights (TRIPS) agreement, and the increased use of second line
treatments, the proportion of multinational-produced drugs has increased from 52.6 per cent in 2002 to 74.3 per cent in 2005.

- Per patient/year costs for ARV therapy dropped from over US$6,240 in 1997 to US$1336 in 2004 but are rising to US $2500 in 2005.\textsuperscript{142}

The Brazilian case is in many dimensions a “best” case. Related obstacles and high costs challenge developing countries with much more restricted resources.\textsuperscript{143}

In order to facilitate and sustain universal access – together with strengthened health systems – two simultaneous and related approaches are essential:

- A significant scale up in funding available
- A concerted effort to reduce prices through negotiation and competition, full use of existing TRIPS “flexibilities”, including compulsory licensing and setting aside TRIPS in health-related emergencies.

7.2 Breaking the barriers: putting health first

“The world is beginning to realize that the patenting and monopolistic manufacture and marketing of essential medicines creates gross social injustices and forms a key barrier to universal access to treatment. Essential medicines should be available to all who need them at the lowest possible cost. They should be the property of mankind, not private property.”

— Senator Jon Ungphakorn (Thailand) at the UNGASS Review Session, New York June 1, 2006\textsuperscript{144}

Universal access, and the radical scale up of treatment necessary, will only be achieved if medicine costs can be kept as low as possible. Achieving market leverage through collective purchasing may contribute to lower costs as, given public pressure, does corporate-initiated reduction for specific drugs or countries, essentially for public relations purposes. Nevertheless huge price differentials for the same product remain, and where single suppliers dominate a particular market, leverage is reduced or impossible. The best way to reduce medicine prices to their lowest levels is through the use of generic competition, which removes patent fees and introduces competition to push prices lower.

7.3 The intellectual property regime

A primary impediment to generic production of appropriate medicines is intellectual property protection giving the developer of a medication the exclusive right to produce it for a fixed period after its invention. This period is needed, it is argued, in order for the developer to recuperate the research and development expenditures that went into the discovery of the medication.

A further impediment is the direct use of corporate influence to discourage use of compulsory licensing and other TRIPS-compatible instruments and/or its embodiment in trade agreements which go beyond the basic World Trade Organization TRIPS provisions.

The main instrument of international intellectual property protection is the TRIPS agreement, which is part of the WTO. After an intense period of debate and protest, in 2001 the WTO issued the Declaration on the TRIPS agreement and public health, which recognizes that the TRIPS agreement “should not prevent members from taking measures to protect public health” and “can and should be interpreted and implemented in a manner supportive of WTO members’ right to protect public health and, in particular, to promote access to medicines for all”.\textsuperscript{145} The declaration meant that countries that could produce and would declare a compulsory license could do so for domestic needs, but left countries lacking domestic manufacturing capacity in a difficult situation. It took almost two years of further negotiation to secure the August 30th, 2003 decision of the WTO General Council, which provided that a member country could export quantities of a drug produced under compulsory license, limited by a number of criteria. In December 2005 this provision was made permanent through an amendment.

These steps, taken in large part due to internationally organized civil society pressure, have led to several national legislative measures to facilitate export, but the waiver created in August 2003 was not used in the two years following. In the view of CSOs that had pressed for change, the WTO formula is “overly cumbersome and inefficient”. It requires too many steps on the part of both potential exporting and importing countries. As Médecins Sans Frontières (MSF) commented, the provision as defined in
December 2005 “has made permanent a burdensome drug-by-drug, country-by-country, decision-making process, which does not take into account the fact that economies of scale are needed to attract interest from manufacturers of medicines”. The provision is likely to fail to accomplish its objective.¹⁴⁶

7.4 Building roadblocks

While Canada and several other producer countries have developed export facilitating legislation, obstacles presented by the application of the international patent regime have, if anything, increased. India and Brazil, able to license some first line antiretrovirals until 2005, are now subject to the full provision of TRIPS.

The significance is considerable. India has the third largest drug research and development workforce in the world and is the fourth-largest producer of medicines by volume, becoming the largest exporter of generic drugs in the world. MSF indicates that about half of the patients receiving ARVS in developing countries are dependent on Indian producers. The effect of the new regime is still in question, but it could have catastrophic consequences on price and availability of AIDS medicines. As Robert Radtke of the Asia Society points out: “If India is no longer allowed to produce key low-cost generics, patients in many countries will be unable to afford treatment. Competition that drives down generic drug prices would disappear. While prices will rise, accessibility will decrease and many will die.”¹⁴⁷ The Indian regime contains a number of provisions aimed to carry on some of the flexibilities of the previous period. These are currently under attack by Novartis, among others, in a case before the Chennai High Court.¹⁴⁸

In the case of Brazil, where a successful treatment program has extended tens of thousands of lives, conflict emerged with Abbott Laboratories when Brazil was refused a voluntary license to produce Kaletra. As positions on both sides stiffened, Brazil threatened the use of a compulsory license as was its right under TRIPS. Abbott gave in with a cheaper price. Brazil is a large country and market, with experience and expertise in responding to HIV/AIDS. Few smaller and less developed countries have the clout or resource to take on a major pharmaceutical.¹⁴⁸

In a third case, Thailand, the negotiation of a bilateral trade agreement with the US has led to a vivid debate over the impact of associated intellectual property provisions. A pioneer in generic production, Thailand has reduced AIDS-related deaths by 79 per cent. When a WHO official argued publicly that the stricter intellectual property provisions of the bilateral agreement would lead inevitably to higher drug prices and jeopardize lives, the US pressured WHO and the official was transferred to India. WHO has been asked by Thai officials for an explanation. Thailand has recently granted compulsory licenses, among others, for efavirenz, a key element in fixed dose combination tablets in the treatment of HIV/AIDS, permitting the Government Pharmaceutical Organization to import generic efavirenz from India, where the drug is not patented. The government cited “public use” as its rationale. “Thailand and other countries could use a similar rationale to license additional HIV drugs; drugs for other infectious diseases with public health consequences such as malaria, tuberculosis or influenza; or drugs for cancer or other chronic diseases.”¹⁵⁰

The Thai case is one window on the relentless pressure to undertake TRIPS-plus provisions in trade agreements with the United States. As KAIROS has documented, each bilateral agreement includes some advance in intellectual property protection and privilege. These may include limitations on the powers of national drug regulatory authorities, further limitations on the availability of test data useful for innovation, extensions in patent life beyond 20 years, limitations on the ability to issue compulsory licenses, etc. These negotiations are almost always carried on in great secrecy, marginalizing non-trade related government departments, parliamentarians and the public.¹⁵¹

Legal provisions, even where they exist, may not be adequate to offset political pressure by powerful governments or corporate power. Further, as MSF points out, patent status is not always clear, many products are not registered in many countries, and in some cases “patent barriers may in fact only be perceived, and not real”.¹⁵²

Time is vital. The more complicated the regime, the more clearances necessary (apart from quality assurance), the more permissions sought, the fewer
lives extended and saved. After the Doha Declaration it took negotiators almost two more years to come to the August 30th resolution, and that decision was sufficiently complicated in its implications that it has not yielded any “takers” as yet, almost two years later. At current rates those 44 months represent a death toll of at least 11 million souls.

Clearly, one of the most important ways to deal with roadblocks is to stop creating them. Many civil society delegates at the Toronto conference advocated a moratorium on further “free” trade agreements and TRIPS-plus extensions of intellectual property protection. The head of Brazil’s national AIDS program recommends a review of all trade agreements to prevent intellectual property “abuse” regarding health.

7.5 Breaking barriers

The UK-sponsored Commission on Intellectual Property Rights in its 2002 report examined the implications of IP protections for development policy. It was clear in its conclusion:

“There are no circumstances in which the most fundamental human rights should be subordinated to the requirements of IP protection.”

The WHO Commission report in 2006 provides greater detail and quite comprehensive recommendations. It recommends a variety of steps to facilitate research, development and delivery of quality medicines including advance purchase commitments, domestic price regulation in the interests of public health, encouragement of competition.

To get around patent-related obstacles to development of affordable fixed-dose combination, second-line and third-line regimens, the institution of patent pools is suggested. “A patent pool is created when a number of patents rights, held by different owners are brought together (pooled) and collectively managed.” Such an arrangement can reduce licensing transaction costs, eliminating blocking patents and the facilitation of down-stream innovation. The WHO Commission refers to findings in a report in 2000 by the United States Patent and Trademark Office on patent pools and biotechnology patents which concluded that: “The use of patent pools in the biotechnology field could serve the interests of both the public and private industry, a win–win situation.” The WHO Commission suggests pooling is worthy of consideration particularly with relevance to developing country needs. “Patent pools, therefore, could be most useful for technologies particularly relevant to developing countries, because the lack of strong market incentives may enable agreements that would otherwise be more difficult to engineer. Low-margin research directed towards problems of poor people might be promoted. Patent pools have also been proposed for the development of vaccines, given the large number of products owned by different entities and, consequently, the complexity of identifying, tracking and obtaining licences for patented technologies.”

A number of the Commission’s recommendations suggest change in corporate behaviour, including transparent and consistent pricing policies, restraint in patent registration and more fulsome sharing of data. Corporate donation programs have made headlines and saved lives, but as the Commission points out, they are no replacement for more structured and sustainable public sector action.

Attempts to use combined public leverage based in several jurisdictions have been undertaken by Latin American countries with the assistance of the Pan-American Health Organization (PAHO). As James Fitzgerald, Coordinator of PAHO’s Strategic Fund informed the Toronto conference: “Pooled procurement of ARVs and HIV/AIDS commodities is feasible, especially when multiple qualified suppliers are available...It requires strong political commitment from Member States, supported by an organizational and technical framework in procurement planning and supply management.”

Private initiatives like that of the Clinton Foundation have also entered the game. The new UNITAID pilot may offer the opportunity to bring combined consortium pressure to accomplish some of the changes required to facilitate access and achieve the greatest efficiency through lower prices. Non-governmental organizations addressing the organizers have argued forcefully that the associated governments should act not merely to increase resources for purchase, but for changes in the system that protect high prices and patent protections which injure public health.
7.6 The Jean Chrétien Promise to Africa Act — JCPA (Now the Canadian Access to Medicines Regime — CAMR) 159

Canada was the first country to develop legislation following the August 30th, 2003 decision embodied in the JCPA which became law on May 14th, 2004. The JCPA has a number of positive as well as negative aspects, and at the time of writing has not resulted in the export of a single generic drug to serve treatment needs in developing countries.160 Advocate and critic Richard Elliott of the Canadian HIV/AIDS Legal Network argues that the Act is important “as part of an overall global effort to improve access to medicines. But it can and must be improved”.161 The flaws and cumbersome compromises that hobble the legislation are detailed by Elliott and by MSF, in a recent publication Neither Expeditious, Nor a Solution.162 A parliamentary review of the legislation is due in 2007.

The Toronto conference was the occasion for marking the lack of progress — not a single pill has been produced and exported after two years — and examining the reasons why. While Health Canada is undertaking new measures to encourage implementation,163 and the Federal Health Minister reiterated the commitment to review the legislation, NGOs including the Global Treatment Action Group and MSF urged more immediate action. UN Special Envoy Stephen Lewis was clear, stating the problem lies not with WTO regulations, which offer some windows of “flexibility.”

“The problem is the big pharmaceutical companies. They are negotiating with the generic companies forever, always stalling, and because governments — both Liberal and Conservative — don’t seem to have the backbone to stand up to these pharmaceutical companies, this never gets resolved. What you have to do here is issue a compulsory license. That’s what it’s called. That’s the procedure. If the big pharma companies will not grant to the generic companies…a voluntary license, then the government steps in and amends the regulations and delivers a compulsory license, which the legislation allows them to do and provides for. The fact that they [the government] haven’t done this is what is stalling this process. And this [current government] review is just another delay. So we’ll be 3.5 to 4 years before a pill ever leaves Canada which, in the context of the pandemic, is outrageous.”164

Thus, while the review of the legislation is useful, particularly in order to learn how to facilitate rather than complicate generic export in future, it should not be used as an excuse to delay a compulsory license for export immediately.

While Canadian produced generics may not, at this time, be particularly cost competitive, the continuing extension of the TRIPS regime and its impact on availability and price of second line and further treatments may make them more attractive within a year or two. Thus revision of the legislation to facilitate manufacture and export is essential.

The Canadian case, MSF argues, indicates that if the WTO August 30th decision was to be useful, it would have been in the Canadian legislation, among others. But the WTO framework, as indicated above, is simply too cumbersome and time consuming. The WTO (and members like Canada) “should explore automatic solutions that do not necessitate complex time-consuming procedural steps”.165 Meanwhile the public health amendment to TRIPS which makes the August 30th decision permanent, moves slowly into ratification. In October, Switzerland and El Salvador announced they had ratified it, joining the US. Kenya announced it was in process of doing so and is seeking technical assistance.166 Seven countries, including Canada, have integrated it into national legislation.

The Canadian legislation is currently being reviewed, in accordance with a provision in the original act. Canadian non-governmental organizations as well as expert and corporate advocates have submitted opinions, and Industry Canada must report its assessment by May 14th, 2007.

The Canadian HIV/AIDS Legal Network has stressed that “the challenge currently facing the Government and the Parliament of Canada is to ensure that Canada’s legislative regime is drafted in such a way that it is as simple, straightforward and streamlined as possible”. The present act has not functioned because it is “burdensome, cumbersome and complicated”. It should be replaced with something much simpler and straightforward, facilitating access to those who need it.167 The Legal Network provides detailed recommendations for a retooling of the legislation.
Recommendation:

22. We recommend that the Government and Parliament of Canada fundamentally redesign the basic process for granting legal authorization to produce generic pharmaceuticals for export to eligible countries.

7.7 Beyond leverage: building local productive capacity

“To improve access to essential drugs in Africa, the stimulation of local manufacturing of essential drugs provide a win-win solution to all involved parties and most importantly it represents a viable and sustainable means of tackling the problem at its source.”

— Krsana Kraisintu, Thailand.

The most direct way of ensuring supply and appropriate “fit” is the creation of productive capacity for affordable quality generics on site in the countries that need them or where individual domestic markets are too limited, on a regional basis.

One of the suggestive models is the Government Pharmaceutical Organization a state enterprise established under the Ministry of Health in Thailand. The GPO manufactures and a Research and Development Institute contributes to the development of new products. The initiative not only improved availability but also led to reductions in prices from five to 20 times. The leader in this effort, Krsana Kraisintu moved to establish collaborative projects in several African countries — among them the DRC, Eritrea and Tanzania — to produce anti-retrovirals and anti-malaria drugs on site notes: Creation of local goods manufacturing site capable of receiving the technology transfer represents the best viable and long-term sustainable option for greater access to medicines in African countries.

The commitment “of developed country members [of the WTO] to provide incentives to their enterprises and institutions to promote and encourage technology transfer to least-developed country members” was reaffirmed in the Doha Declaration (Para.7). It is explored more thoroughly in the report of the WHO Commission:

“In the longer term, the development of innovative capacity for health research in developing countries will be the most important determinant of their ability to address their own need for appropriate health care technologies.”

WHO Health Organization on Pharmaceutical Futures

The Commission recommends investment in education and human resource development to aid the development of capacity, with support from donors. It also calls on donor governments to undertake other steps which would build productive capacity:

Recommendation 5.2 “The formation of effective networks, nationally and internationally, between institutions in developing countries and developed countries, both formal and informal, are an important element in building innovative capacity. Developed and developing countries should seek to intensify collaborations which will help build capacity in developing countries.”

Recommendation 5.4 “Developed countries, and pharmaceutical companies (including generic producers), should take measures to promote the transfer of technology and local production of pharmaceuticals in developing countries, wherever this makes economic sense and promotes the availability, accessibility, affordability and security of supply of needed products.”

Recommendation 5.5 “Developed countries should comply with their obligations under article 66.2 of the TRIPS Agreement and paragraph 7 of the Doha Declaration.”

8. Innovative sources: securing sustained and predictable funding for treatment

8.1 The Solidarity Levy and UNITAID

“Global tasks demand global financing. If we are to achieve the Millennium Development Goals, we have no option but to introduce innovative financing instruments.”

— German Development Minister, Heidemarie Wieczorek-Zeul, at the Paris Conference, March 1, 2006.173

At the initiative of Brazilian President Lula da Silva and French President Jacques Chirac, a renewed international initiative on innovative financing for development has developed in the last three years.174 Further, as Chirac has also pointed out, several of the innovative financing instruments lend themselves to funding health needs among other development urgencies. A “Leading Group” involving chief executive offices, foreign ministries, finance ministries and/or development ministries of more than 40 countries is currently advancing research and implementation of a menu of innovative proposals.

Of initiatives now in play, the most concrete is the “solidarity levy” on airlines tickets initiated by the French, the International Drug Purchase Facility, now known as UNITAID175 which will receive and invest most of the revenue from the levy in the purchase of pharmaceuticals, diagnostics, etc. The solidarity levy on airlines tickets, approved by the French National Assembly in December 2005, was implemented on July 1, 2006. Chile announced a similar levy, the UK will contribute revenues from its existing levies, and Brazil and Norway have joined in implementing the financing plan. It is rooted in a concept of international taxation levied nationally and coordinated through cooperation agreement among governments. Its rationale is based on global health needs and the urgency of securing sustainable and predictable resource flows.

The French legislation sets caps (€1 economy, €10 for first and business classes for domestic and intra-EEC flights) on all flights departing from French territory, and from €4 to 40 on other flights, depending on class. The rates are expected to generate revenue of up to €200 million per year. French officials cite an expectation of five per cent annual growth in airline traffic despite temporary set-backs like 9/11 and the more recent alleged threat to London Heathrow. The levy funds the UNITAID.

UNITAID proposes:

► To expand available resources and ensure it is based on recurrent and sustainable income
► To make demand secure and solvent over the medium term
► To pursue a pro-active policy to reduce prices and diversify available products, including second-line ARVs or Assertive Community Treatments (ACTs) for the treatment of malaria, attracting new suppliers
► To ensure the quality of drugs and diagnostic kits.

The sponsors have focused on objectives for each of AIDS, malaria and tuberculosis, including: increased availability of pediatric ARVs and infant diagnosis capacity, stimulation of the production of fixed-dose combination products for infants; diagnostics and ARVs for preventing mother-to-child transmission; and reducing the price differential and increasing generic supplies of second line ARVs. Similar focus for work on malaria and TB has also been defined.176

It is also suggested that strengthening the WHO pre-qualification program on drugs and the support of buffer stocks be included in the facilities objectives.

The UNITAID could invite tenders, negotiate competitive prices and or group purchases. (The PAHO Strategic Fund is a model).

The UNITAID would seek to combat interruptions in supply by devoting part of its budget to establishing and managing buffer stocks.

The five core countries launched the initiative at the 2006 General Assembly of the UN and put it in operation October 1, 2006. An interim board has met and a broader consultative group of stakeholders will be appointed. Civil society representatives on the board have voice and vote. Initially the administration is based in the WHO. Consultation and collaboration with a wide variety of other actors including the Clinton Foundation, UNICEF, UNAIDS and the Global Fund have characterized the initiative as it seeks to define its particular niche and role.
CSOs have stressed the importance of UNITAID acting as an advocate and agent for access. If UNITAID only supplements the funds available through such agencies as the Global Fund and the Clinton Foundation, it is really not adding much new nor exploiting its full potential. Reinforcing the WHO’s pre-qualification process can speed approval and delivery. Group purchasing leverage can gain lower prices, but this alone is insufficient. The current patent system still holds many lives hostage. Countries do not make full use of the “flexibilities”, including compulsory licensing, available to them under TRIPS, and initiatives like patent pooling remain under utilized. In short, the CSOs have argued that a consortium of countries like those engaged with the UNITAID could break “patent blockage”. Attempts to amend the initial constitution of UNITAID by CSO participants have as yet been parried by official procedural delays.

8.2 Canadian solidarity

Canada is a significant participant in the global air traffic enterprise, with over 63 million passengers in 2005 and annual growth exceeding four per cent domestic and seven per cent for transborder and international flights, recovering from a serious dip related to 9/11. Even applying a simple Chilean-style $2 levy on each passenger ticket could yield and estimated $120 million per annum. A graduated levy on the French model would yield much more.

The Canadian government states that it “does not intend to apply an airline tax”, arguing that dedicated taxes are “inefficient” and that the airline industry is “somewhat fragile”. The French government position in contrast is that the airlines levy is efficient and low-cost to administer, although Air France may be arguably less “fragile” than Air Canada, if not high-flying Westjet.

The government claims an “open mind” about innovative sources, and “is carefully studying the merits of participating in UNITAID”, evaluating its comparative advantage with regard to other channels for aid. Meanwhile Canada is prioritizing advanced market commitments to encourage corporations to invest in vaccine research, not only for AIDS but also for meningitis and pneumonia. Worthwhile as the objective may be, it does nothing toward saving lives today.

The government’s position, restricting expenditure to ongoing budget revenue, ignores the urgency of the AIDS challenge and leaves the level of response girdled by the slowly increasing official development assistance budget. It ignores the commitment not only of developed countries like France and Norway but also of a large number of developing countries in the Francophonie and the Commonwealth. It also ignores the potential of the UNITAID’s usefulness as a mechanism of collective pressure to modify the restrictive operation of intellectual property regimes. The Leading Group, chaired by the Republic of Korea from March 2007 for six months, meets again in Seoul in July to advance the airlines levy, UNITAID and other initiatives. Canada should join now.

Recommendations:

23. The solidarity levy and UNITAID are positive initiatives and have considerable potential for significant contribution to the goal of universal treatment. We recommend that the Canadian government join the Leading Group.

24. That the Canadian government engage relevant CSOs, airlines firms and trade unions in developing a plan for the implementation of a solidarity levy on airlines tickets in Canada.

Beyond UNITAID: beefing up revenue

While the levy will raise several hundred million dollars, the contribution toward universal treatment is material but modest. A sustained source of much greater revenue is required to support a long-term response for care, treatment and support. Revenues from a relatively incidental tax on international financial transactions would meet the challenge.

While Canada was one of the first countries to consider the idea of a Tobin tax or tax on international currency transactions, and the Canadian Parliament late in the 1990s passed a resolution encouraging implementation in concert with others, Canada has not yet taken up the issue. Canada with Norway supported the idea of further study of innovative sources of development financing at the Geneva 2000 UN review conference, but Canadian governments in the current decade have been virtually silent on the issue.
Such a Currency Transaction Tax (CTT) is feasible, has been well-researched and only needs a country to take leadership in a pilot project. Brazil has noted that it already has a domestically applied equivalent to the tax. An international leader on this theme is needed and, given previous interest, Canada would be well placed to join the Leading Group and contribute in this area.\(^{179}\)

**Recommendation:**

25. As a member of the Leading Group, Canada should undertake a creative role by developing an alliance with a limited number of other governments in pursuit of a currency transaction tax, to be devoted to global and multilateral purposes, such as support of the UN, a portion of which would be directed to health objectives, in particular, achieving universal access by 2010.

---

**9. Strategy and implementation**

If the objective of universal access is to be met by 2010, an energetic and multi-dimensional strategy to clear barriers and facilitate availability of sustained accessible supply of affordable quality medicines will have to be developed and implemented.

Three years ago *Meeting the Challenge* recommended that Canada undertake a whole-of-government approach led by Foreign Affairs:

- Support and, where necessary, initiate international cooperation to ensure the provision of affordable quality supplies of medicines by encouraging regional generic production facilities
- Encourage the formation of an international consortium of generic-producing countries to scale-up production, distribution and sustainable supply
- Secure public commitments by the World Trade Organization...that will facilitate and support this strategy
- Work with developing countries to implement ways to significantly lower the prices of anti-retroviral therapies and other HIV-related drugs, including the establishment of workable laws that give full effect to compulsory licensing
- That [the] current policy of encouraging further implementation of intellectual property obligations by developing countries be suspended pending the human rights assessment of trade negotiations; and that the policy be amended, if appropriate, in the light of the findings of that assessment

- Oppose provision such as TRIPS-plus proposals in the Free Trade Areas of the Americas negotiations, and similar provisions in any bilateral trade negotiations, that would extend intellectual property rights and limit states’ policy options in balancing intellectual property protections against other policy objectives, such as protecting and promoting human rights.\(^{180}\)

These are all valuable components of a strategy for the next four or five years. Similar recommendations have been recently made by international bodies.

The recent WHO-mandated Commission on Intellectual Property Rights, Innovation and Public Health clearly reaffirmed the rights of governments pursuing public health in the face of pressures like those outlined above, including legislation on compulsory licensing:

Recommendation 4.10: “Governments need to prioritize health care in their national agendas and, given the leverage to determine prices that patents confer, should adopt measures to promote competition and ensure that pricing of medicines is consistent with their public health policies. Access to drugs cannot depend on the decisions of private companies but is also a government responsibility.”\(^{181}\)

Recommendation 4.13: “The Doha Declaration clarifies the right of governments to use compulsory licensing as a means of resolving tensions that may arise between public health and intellectual property, and to determine the grounds for using it. Developing countries should provide in their legislation for the use of compulsory licensing provisions, consistent with the TRIPS agreement, as one means to facilitate access to cheaper medicines through import or local production.”\(^{182}\)

The Commission recommended steps to facilitate countries in using their full rights under existing TRIPS provisions. It has also advised countries, to ensure participation of health officials and not to negotiate away their rights to facilitate treatment and protect public health:

Recommendation 4.21: “In bilateral trade negotiations, it is important that governments ensure that ministries of health be properly represented in the...
negotiation, and that the provisions in the texts respect the principles of the Doha Declaration. Partners should consider carefully any trade-offs they may make in negotiation. Bilateral trade agreements should not seek to incorporate TRIPS-plus protection in ways that may reduce access to medicines in developing countries.”

The Commission’s recommendations in these and a number of other areas merit careful review and in many cases support and implementation by the Canadian government.183

The Program Coordinating Board of UNAIDS in June 2006 undertook action to “help enable developing countries to employ the flexibilities outlined in the World Trade Organization’s agreement on Trade-Related Aspects of Intellectual Property Rights and to strengthen their capacities for this purpose”.184

RECOMMENDATION:


9.1 Toward a renewed Canadian strategy for universal access: making medicine affordable and available.

In addition to the still valid approaches drawn from Meeting the Challenge (above), we would recommend the following:

27. That with regard to the CAMR (JCPA) legislation, an arms-length evaluation be undertaken prior to the proposed review of the legislation in 2007, with particular attention to the reasons why potential beneficiaries of the provisions, including African governments and non-governmental agencies have not yet utilized the facility, and with recommendations for its revision and improvement.

28. That the Canadian government, utilizing the advice NGOs and ASOs develop a strategy for offsetting current patent-regime-related and political barriers to the full exercise by developing country governments of flexibilities under TRIPS, including compulsory licensing, governmental use as well as the development of positive means (such as patent pools) to encourage relevant development and production of key generic medicines, supporting such initiatives as the UNAIDS enabling initiative.

29. That in pursuit of this strategy Canadian participation in the UNITAID initiative be utilized to effect collective leverage to offset barriers and ensure the lowest possible prices, assured quality and sustained and reliable availability of essential medicines.

30. That the Canadian government encourage and support the establishment of publicly-owned generic production facilities for essential medicines in seriously affected developing countries and/or on a regional basis where appropriate in terms of need and potential market.

31. That the findings and recommendations of the WHO Commission on Intellectual Property, Innovation and Public Health be given interdepartmental and parliamentary review with the participation of NGOs and ASOs.

10. Political leadership

The literature on the global HIV/AIDS pandemic emphasizes the impact that strong political leadership can have on efforts to stop the disease. This reality was made very clear in the case of Uganda, where early action by President Yoweri Museveni’s government is credited with slowing the epidemic. Leadership has been decisive in bringing life-saving action for treatment in Brazil and Thailand. In contrast, the South African government’s resistance to enlightened policy for HIV/AIDS is one of the primary reasons why the epidemic has spread so quickly in that country.

However, while strong political leadership within affected countries is essential for an effective response to HIV/AIDS, it is by no means sufficient. The vast majority of these countries are unable to fund or implement the interventions needed to meet the 2010 goal of universal access. Northern countries must therefore take an active leadership role in ensuring that the South has the resources it requires to stop the pandemic. Moreover, Southern leaders who are reluctant to address HIV/AIDS are more likely to respond to the problem if they face sincere but strong encouragement on the subject from Northern leaders.
Most of the Government of Canada’s publications on the global HIV/AIDS pandemic refer to Canada as a leader in the response to the disease. For example, DFAIT’s HIV/AIDS strategy argues that Canada had demonstrated leadership by:

- Consistent support for international programs to respond to HIV/AIDS such as UNAIDS and the GFATM
- Participating in the drafting of the UN Declaration of Commitment on HIV/AIDS, and particularly its efforts to ensure the declaration emphasized human rights, gender equality, and support for vulnerable groups and persons living with HIV/AIDS
- Using of Canada’s term as G8 President to draw attention to the development challenges faced by Africa, including HIV/AIDS
- Continuously pushing for the inclusion of civil society groups in the international response to HIV/AIDS
- Working to draw attention to the needs of at risk groups like injection drug users, men who have sex with men, prisoners, sex workers, orphans, and displaced persons
- The contribution of $100 million to the WHO’s “3 by 5” Initiative
- The passage of the Jean Chrétien Pledge to Africa Act (Bill C-9) which made Canada the first country in the world to make the legislative changes needed to implement the WTO decision on TRIPS and public health
- Supporting the International AIDS Vaccine Initiative and International Partnership for Microbicides.

As the WHO Commission reviewing new developments in combating AIDS puts it: “All these initiatives reflect a new awareness: relying on purely economic mechanisms cannot solve the problem. A worldwide mobilization of resources, both public and private, and political commitments at all levels, is necessary to address the issue.”

Canada can and must be a leader in this next decisive phase of the combat of HIV/AIDS, the achievement of universal access by 2010.

**Developing coherence in policy and implementation**

In Meeting the Challenge (2003) we called on the Canadian government to “ensure effective interdepartmental collaboration on Canada’s global response to HIV/AIDS, involving all federal departments and agencies that are significantly involved in the global response”.

Significant progress has been made, both in policy and with regard to operations.

- There is reference to the importance of comprehensive and coordinated policy in government statements.
- Interdepartmental consultation is more common at various levels and an interdepartmental committee of deputy ministers, has begun to meet.

These initiatives are encouraging. Nevertheless the processes could move with greater agility and at least one significant gap remains.

To date a key player in establishing the resources available and the policies developed and applied by such key intergovernmental agencies as the World Bank and the International Monetary Fund, the Department of Finance, has not been integrated into interdepartmental coordinating mechanisms regarding global HIV/AIDS policy, apart from the Privy Council Office.

Given the absolute importance of the availability of funding, the urgency to develop innovative sources and the far-reaching effects of Bank/Fund policies as discussed above, it is essential that Finance Canada be
integrated in interdepartmental working bodies from the deputy minister level down, and be engaged, as well in substantive dialogue with the CSO advisory groups concerned with Canada’s global role. Similarly, it is important that those representing Canada in trade and intellectual property negotiations are mandated with policies driven by the priority of the right to health and the objective of universal access by 2010.

However, in order for Canada to truly be a leader, the Canadian government must ensure that these policy changes are accompanied by a clear commitment of political resources. Prior to their 2002 Summit, G8 leaders each appointed a Personal Representative for Africa in order to demonstrate their commitment to the issue of African development and to provide a single point of contact for negotiations regarding the G8 Africa Action Plan. The importance of focused leadership in the combat of AIDS has been demonstrated at a global level by the role of Canadian Stephen Lewis as the Secretary-General’s Special Representative. Former US President Bill Clinton and business tycoon Bill Gates have also demonstrated the usefulness of personal leadership. To this end, the Canadian government should take up the long-standing proposal of appointing a high-profile AIDS ambassador for Canada. Such an ambassador could facilitate interdepartmental collaboration and coordination, reduce the likelihood of interdepartmental competition, contribute to forward momentum in implementation of commitments and assist ministers and others in focusing public attention and support.

Finally, in Meeting the Challenge, we outlined a number of steps Canada should undertake in its bilateral relations, particularly with the United States, and in leadership in regional and multilateral organizations. Some of these recommendations have been taken on by Foreign Affairs and other parts of government, but several remain to be implemented.186

**Recommendations:**

32. The Prime Minister and other cabinet Ministers must make a serious and public commitment to halting the HIV/AIDS pandemic and achieving the goal of universal access to prevention, treatment, care, and support services by 2010.

33. That the Canadian government appoint an AIDS ambassador for Canada to be a central focal point for policy development and coordination. This approach has already been implemented in a number of other countries.187 The ambassador should chair the meetings of all interdepartmental working groups and consultative mechanisms dealing with Canada’s international HIV/AIDS policy and practice.

34. The government must be prepared to honour the commitments that it makes. For example, the DFAIT strategy calls for the government to pressure other countries to adopt progressive policies. This is particularly important in halting negative aspects of the TRIPS regime and pressure for TRIPS-plus provisions. Seeing concrete evidence of this, particularly against more intransigent governments like that in the US is required.

35. Canada should take the lead in increasing its funding to reach a level proportionate to its share of developed country GDP.

36. Utilizing such relevant forums as the “Leading Group on Innovative Financing”, the Commonwealth, and the UN and its agencies, Canada should network with like-minded countries to achieve common ends in pursuit of goals like those outlined above.
11. Conclusion

The objective of universal access to prevention, care, treatment and support on a sustained basis is feasible. To achieve it will require the sort of resources and political attention currently given to much more questionable enterprises, like the growth of militarism and military responses to global problems. However, to bring about universal access will also mean the achievement of rebuilt and newly capable health systems, the creation of jobs, the combat of related illnesses, the sustaining of nutritional adequacy along with other basic human needs, along with other essential components of the Millennium Development Goals.

As well as positive investment, the removal of barriers in international agreements and practice — including countering persistent corporate pressure — and the encouragement of committed international and domestic political leadership will be necessary. Canada and Canadians have already demonstrated remarkable creativity and courage in the face of the pandemic. However, in a number of areas our policies are ambiguous and our role has contributed to rather than removed barriers. We have invested significant sums in efforts against the disease, but our wealth and our benefits from globalization are such that we could and should do much more. There is thus ample scope for a fresh engagement guided by reformed policies and focused on the achievement of universal access by 2010.
Endnotes


2 Estimated range of 1.4 – 1.9 million. UNAIDS/WHO, Progress in scaling up access to HIV treatment in low- and middle-income countries, (Geneva, UNAIDS/WHO, 2006), p. 3.

3 UNAIDS, Resource needs for an expanded response, pp. 11-12.


7 new money for various CIDA projects ($120 M) either already approved or in negotiation.

8 reiteration of $250 million for the Global Fund (over two years), following through the previous governments commitment.

9 the Prime Minister has promised at the St. Petersburg G8 a commitment of $450 million to strengthen health systems.


11 Estimated range 3.6 – 6.6 million. Ibid.

12 Estimated range 39.5 – 41.1 million. Ibid.


15 Ibid., pp. 4-5.

16 UNAIDS, 2006 Report, pp. 60, 133.


21 UNDP and OHRLLS, Hoping and Coping, p. 33.

22 Ibid., p. 23.


25 Ibid.


28 Ibid.


37 Ibid. para. 12.

38 The 13 departments and agencies are: Canadian Heritage, Canadian Institutes of Health Research, Canadian International Development Agency, Citizenship and Immigration Canada, Correctional Service Canada, Department of National Defence, Foreign Affairs and International Trade Canada, Health Canada, Human Resources and Social Development, Indian and Northern Affairs Canada, Industry Canada, Justice Canada, Public Health Agency of Canada.

39 Organizations that are currently represented in the group are: Health Canada, PHAC, CIHR, CIDA, DFAT, the Canadian AIDS Society (CAS), the Canadian HIV/AIDS Legal Network, the Canadian Public Health Association (CPHA), the Interagency Coalition on AIDS and Development (ICAD), the International Council of AIDS Service Organizations and the Canadian Association for HIV Research (CAHR).

40 UNAIDS, Resource needs for an expanded, p. 23. The authors recognize that cost estimates are being revised and are increasingly sophisticated in terms of depth and accuracy. The Global Fund, for example, is in the middle of strategic planning which will include setting a nominal size for the fund for the coming 3-4 years.

41 Ibid., p. 24.


44 UNAIDS, Resource needs for an expanded, p. 22.


Ibid., p. 15.


Note from Michael O’Connor, February 8, 2007.


IMF, *Factsheet - The Multilateral Debt.*


ActionAid, *Square Pegs, Round Holes and Why You Can’t Fight HIV/AIDS with Monetarism.*


Rowden, *Changing Course,* p. 7.


Ibid.


Rowden, *Changing Course,* pp. 29-32.


Ibid., p. 9.

Godfrey Musauka, “Where are the Human Resources to Rollout ART?”


Secretary General of the United Nations, *Scaling up HIV,* p. 11.

Ibid., p. 11.


UNDP and OHCHR, *Hoping and Coping,* p. 58.


106 Those who argue against taking action to stop health worker migration generally claim that Southern countries are already compensated for the loss of health workers by the remittances they receive from those who migrate. However, remittances do not replace the capacity that was lost and tend to benefit only the migrants’ immediate family, providing little support to other members of society. Dawson, A Managed Temporary Movement, p. 30.


111 Eastwood, A Managed Temporary Movement, pp. 10-11.


114 UNAIDS, Resource needs for an expanded, p. 22.


117 DFID, Improving Health in Malawi, p. 14; Schouten, “The Malawian Government’s.”

118 Schouten, “The Malawian Government’s Emergency Human Resources Program.”

119 WHO, Treat, Train, Retain, pp. 7-15.


121 WHO, Treat, Train, Retain, p. 17.


125 Dawson, A Managed Temporary Movement, p. 30.

126 World Health Assembly, 57th Session, International migration of health personnel: a challenge for health systems in developing countries, Resolution 57.19, May 24, 2004


131 Department of Foreign Affairs and International Trade, Commitment and Action, p. 20.

132 Ibid., p. 30.


135 Labonté et al., “Managing health professional.”


138 Address to the opening session of the Toronto International AIDS Conference, August 13th, transcript as presented by KaiserNetwork.org: http://www.kaisernetwork.org/health/fast/uploaded_files/081306_ias_opening_transcript.pdf Opening Session XVI International AIDS Conference 08/13/2006 1 kaiserconference.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.


141 Mariangela Simao. Director, National STD/AIDS Program. Ministry of Health, Brazil. Overcoming barriers to access to care. Cutting the cost: prices and access. Local manufacturing in developing countries. Presentation XVI International AIDS Conference.

142 The implications of the interplay of patents, prices and the availability of key drugs for provision of sustained universal treatment are illustrated by several current instances:

• The impact of providing the most effective first line treatment combination with the inclusion of tenofovir disoproxil fumarate (TDF), following WHO guidelines, would increase annual treatment for an adult in a developing country from US$132 to US$321 - US$708, in one combination, or from US$541 to US$553 in another, increases of 2.5 to 5.5 times in cost. These estimates assume that the producer’s advertised price can be obtained. As MSF comments: “The impact of these prices on national AIDS programs, and their potential to scale-up treatment would be catastrophic.”

• The provision of the key elements for cheap and accessible fixed dose combinations (FDCs)

• The provision of key elements for the production of second-line treatments. Estimates of the cost increase implications of providing second line treatments range from ten-fold in Least Developed Countries to 40 times in middle-income countries.

• Prices vary extensively from country to country and source to source. The WHO reported in March 2006, that low-income countries were paying higher prices than middle-income countries for nevirapine 200mg, and paying one drug company an average price of US$445 per patient year, while others were paying an average price of US$64 per patient-year for a generic alternative.

• Availability is a further factor retarding access to treatment. For example, new heat-stable tablet formulations particularly useful in tropical settings and those lacking refrigeration have been developed, but remain unregistered for use in any developing country except for South Africa.


143 Jon Unphakorn, Overcoming Health System and Social Sector Constraints to the Movement Towards “Universal Access to Treatment – The Need for a Global Response” Notes for an address to the United Nations General Assembly High Level meeting to Review UNGASS (2001), June 1, 2006. Senator Unphakorn is Vice-Chairman of the Senate Committee on Social Development and Human Security, Thailand Parliament.


KAIROS, Global Justice Report. The WHO Commission on Intellectual Property Rights, Innovation and Public Health, documents the importance of Brazil’s domestic production capacity for life-saving access to treatment. “The ability to manufacture locally, and to estimate the likely cost of local production, adds to the credibility and strength of Brazil’s negotiating position with companies. As a result, even as the number of patients needing more expensive and complex treatment has increased, the average cost per patient per year has decreased by two thirds in the past few years, although the few patented drugs, not manufactured locally, still account for a substantial proportion of the overall drug procurement cost.” WHO, Public Health, Innovation and Intellectual Property Rights: Report of the Commission on Intellectual Property Rights, Innovation and Public Health. (Geneva, WHO, April 2006) p. 128.


KAIROS, Global Justice Report.


Marianella Simao, Director, National STD/AIDS Program. Ministry of Health, Brazil. Overcoming barriers on access to care. Cutting the cost: prices and access. Local manufacturing in developing countries. Presentation XVI International AIDS Conference.


Commission, P. 68.

4.11 Corporate donation programs can be of great value in a number of fields in collaboration with the actions of governments and nongovernmental organizations. However, addressing health needs in developing countries requires more structured and sustainable actions by governments and other parties that stimulate accessibility to products, while generating new treatments and products adapted to the needs of developing countries.


Now renamed the Canadian Access to Medicines Regime (CAMR).

The advantages and drawbacks of the legislation are examined in detail in Richard Elliott, Pledges and pitfalls: Canada’s legislation on compulsory licensing of pharmaceuticals for export. International Journal of Intellectual Property Management. Pre-publication copy.

Ibid.

MF Canada and Campaign for Access to Essential Medicines, Neither Expediencia, Nor a Solution: The WTO August 30th Decision is Unworkable. An Illustration through Canada’s Jean Chrétien Pledge to Africa. Toronto, Montreal and Geneva, MSF Canada and Campaign for Access to Essential Medicines, August 2006.

Health Canada has produced a CD-ROM to elucidate procedures for accessing the Canadian Access to Medicines Regime (CAMR).


MF Canada and Campaign for Access to Essential Medicines, Neither Expediencia, Nor a Solution: The WTO August 30th Decision is Unworkable. An Illustration through Canada’s Jean Chrétien Pledge to Africa. Toronto, Montreal and Geneva, MSF Canada and Campaign for Access to Essential Medicines, August 2006 p. 7.


http://www.wto.org/english/tratop_e/minist_e/min01_e/min01_electric.html

Declaration on the TRIPS Agreement and Public Health – www.wto.org

For a recent overview of a number of these initiatives, see Frank Schroeder, Innovative Sources of Finance after the Paris Conference – the concept is gaining currency but major challenges remain. Friedrich Ebert Stiftung. Berlin. 2006; and Peter Wahl, From Concept to Reality. Briefing Paper. Dialogue on Globalization. Friedrich Ebert Stiftung. Berlin. 2006 www.fes.de/globalisation.org

[reference to action against hunger and poverty].

The sponsoring governments decided to adopt a single word/brand UNITAID to provide an easily-referenced identity for the initiative, instead of lengthy translations of International Drug Purchase Facility. John W. Foster was a participant in the Paris Conference which launched the Leading Group.

Ibid.


Hon. Peter C. MacKay, Minister of Foreign Relations to Bill Stixey, M.P. October 6, 2006.

The North-South Institute has a history of detailed research on the feasibility and potential revenue from such an initiative.

Meeting the Challenge p. 7-8.

Ibid.

P. 134.

P. 139.

Among the most relevant recommendations are the following:

4.14 Developed countries, and other countries, with manufacturing and export capacity should take the necessary legislative steps to allow compulsory licensing for export consistent with the TRIPS agreement.

4.15 The WTO decision agreed on 30 August 2003, for countries with inadequate manufacturing capacity, has not yet been used by any importing country. Its effectiveness needs to be kept under review and appropriate changes considered to achieve a workable solution, if necessary.

4.18 Developed countries and the WTO should take action to ensure compliance with the provisions of Article 66.2 of the TRIPS agreement, and to operationalize the transfer of technology for pharmaceutical production in accordance with paragraph 7 of the Doha Declaration on the TRIPS Agreement.


Commission. p. 196.

Meeting the Challenge. p. 4-12.

Countries as diverse as China and the United States have made such appointments for several years.
List of persons interviewed

**Academic**

Ted Shrecker, Associate Professor, Epidemiology and Community Medicine, University of Ottawa.

Dr. Laura Ritchie Dawson, Senior Associate, Centre for Trade Policy and Law, Carleton University.

**Civil Society**

Michael O’Connor, Executive Director, Interagency Coalition on AIDS and Development (ICAD).

**Government**

Christopher Armstrong, Acting Team Leader - HIV/AIDS, Policy Branch, Canadian International Development Agency.


Mathew Sajkunovic, International Economist, Department of Finance Canada.

Nilima Gulrajani, International Economist, Department of Finance Canada.

Valerie Percival, Senior Advisor, Health, Department of Foreign Affairs and International Trade.

**Commonwealth**

Dr. Dula de Silva, Head, Health Section, Commonwealth Secretariat, Dr. Joseph Kwadwo Amuzu, Advisor, and colleagues in the Health Section, Commonwealth Secretariat.
# Annex I

## Abbreviations and acronyms

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACT</td>
<td>Assertive Community Treatment</td>
</tr>
<tr>
<td>ADM</td>
<td>Assistant Deputy Minister</td>
</tr>
<tr>
<td>ART</td>
<td>Anti-retroviral therapy</td>
</tr>
<tr>
<td>ARV</td>
<td>Anti-retroviral</td>
</tr>
<tr>
<td>C-9</td>
<td>Bill C-9: The Jean Chrétien Pledge to Africa Act - Now named the Canadian Access to Medicines Regime (CMAR)</td>
</tr>
<tr>
<td>CAFTA</td>
<td>Central American Free Trade Agreement</td>
</tr>
<tr>
<td>CARICOM</td>
<td>Caribbean Community</td>
</tr>
<tr>
<td>CG</td>
<td>Consultative Group on HIV/AIDS Global Issues</td>
</tr>
<tr>
<td>CIDA</td>
<td>Canadian International Development Agency</td>
</tr>
<tr>
<td>DAC</td>
<td>Development Assistance Committee of the OECD</td>
</tr>
<tr>
<td>DFAIT</td>
<td>Department of Foreign Affairs and International Trade Canada (formerly Foreign Affairs Canada)</td>
</tr>
<tr>
<td>DFID</td>
<td>United Kingdom Department for International Development</td>
</tr>
<tr>
<td>DND</td>
<td>Canadian Department of National Defence</td>
</tr>
<tr>
<td>EC</td>
<td>European Commission</td>
</tr>
<tr>
<td>FDC</td>
<td>Fixed Dose Combination ART medications</td>
</tr>
<tr>
<td>FI</td>
<td>Federal Initiative to Address HIV/AIDS</td>
</tr>
<tr>
<td>FTAA</td>
<td>Free Trade Agreement of the Americas</td>
</tr>
<tr>
<td>G7</td>
<td>Group of Seven Industrialized Countries</td>
</tr>
<tr>
<td>GFATM</td>
<td>Global Fund Against AIDS, Tuberculosis and Malaria</td>
</tr>
<tr>
<td>GNI</td>
<td>Gross National Income</td>
</tr>
<tr>
<td>GTAG</td>
<td>Global Treatment Access Group</td>
</tr>
<tr>
<td>HIPC</td>
<td>Heavily Indebted Poor Country</td>
</tr>
<tr>
<td>HIV/AIDS</td>
<td>Human Immunodeficiency virus / Acquired Immune Deficiency Syndrome</td>
</tr>
<tr>
<td>IAD</td>
<td>International Affairs Directorate of Health Canada</td>
</tr>
<tr>
<td>ICAD</td>
<td>Interagency Coalition on AIDS and Development</td>
</tr>
<tr>
<td>IFF</td>
<td>International Finance Facility</td>
</tr>
<tr>
<td>IFI</td>
<td>International Financial Institution</td>
</tr>
<tr>
<td>IMF</td>
<td>International Monetary Fund</td>
</tr>
<tr>
<td>IPS</td>
<td>Government of Canada International Policy Statement</td>
</tr>
<tr>
<td>ITWI</td>
<td>Internationally Trained Worker Initiative</td>
</tr>
<tr>
<td>JCPA</td>
<td>Jean Chrétien Promise to Africa Act</td>
</tr>
<tr>
<td>MDRI</td>
<td>Multilateral Debt Relief Initiative</td>
</tr>
<tr>
<td>MOU</td>
<td>Memorandum of Understanding</td>
</tr>
<tr>
<td>MSF</td>
<td>Médecins Sans Frontières</td>
</tr>
<tr>
<td>OECD</td>
<td>Organization for Economic Cooperation and Development</td>
</tr>
<tr>
<td>PAHO</td>
<td>Pan-American Health Organization</td>
</tr>
<tr>
<td>PEPFAR</td>
<td>President’s Emergency Plan for AIDS Relief</td>
</tr>
<tr>
<td>PHAC</td>
<td>Public Health Agency of Canada</td>
</tr>
<tr>
<td>PRSP</td>
<td>Poverty Reduction Strategy Papers</td>
</tr>
<tr>
<td>SAP</td>
<td>Structural Adjustment Program</td>
</tr>
<tr>
<td>TRIPS</td>
<td>Agreement on the Trade Related Aspects of Intellectual Property Rights</td>
</tr>
<tr>
<td>TRIPS-Plus</td>
<td>Intellectual property provisions contained in trade agreements that are more stringent than those in the original WTO TRIPS agreement</td>
</tr>
<tr>
<td>TTR</td>
<td>Treat, Train, Retain</td>
</tr>
<tr>
<td>UNAIDS</td>
<td>Joint United Nations Program on HIV/AIDS</td>
</tr>
<tr>
<td>UNGASS</td>
<td>United Nations General Assembly Special Session on HIV/AIDS</td>
</tr>
<tr>
<td>UNITAID</td>
<td>International Drug Purchasing Facility</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
<tr>
<td>WTO</td>
<td>World Trade Organization</td>
</tr>
</tbody>
</table>
The North-South Institute with a 30-year record of excellence in research in many dimensions of the challenge of sustainable human development is making a significant contribution in health-related issues in collaboration with the World Health Organization, the Canadian Centre for Policy Alternatives, the Institute of Population Health of the University of Ottawa, and others. The North-South Institute’s Canadian Development Report 2006 highlights health as a human right.

Specific work on HIV/AIDS and development has been a recurrent focus since the turn of the century.


The Institute contributed expertise and testimony in the Parliamentary consideration of the Jean Chrétien Promise to Africa Act regarding intellectual property and access to medicines. We have also collaborated in the preparation of the Global Health Platform by the Global Treatment Action Group, and in the 2006 Civil Society Platform for Action. The Institute also collaborated in the panel on HIV/AIDS and Canadian policy at the 2006 CIDA International Cooperation Days.

For other health-related publications, see: www.nsi-ins.ca