

**Authors:** M. Felicity Daly and Lesley Lawson

# Writing off a generation?

Why the G8 must prioritise AIDS treatment and commit to universal access.

## Summary

Leaders in the UK and other G8 countries have repeatedly stated that they consider HIV and AIDS to be the single most serious threat to the survival of poor countries. However, they continue to commit inadequate resources to the fight against this development crisis. ActionAid calls on the 2005 G8 summit to take urgent action to scale up access to treatment and commit to achieving universal access to life-saving medicines. To do otherwise would be writing off generations and ensuring that the Millennium Development Goals are unachievable.

### Executive summary

The devastating impact of the HIV and AIDS crisis is reversing development gains in worst-affected countries. Current trade, debt and aid policies present obstacles to the ability of developing countries to confront the HIV and AIDS crisis. A commitment to fight AIDS must prioritise the rapid scale up of access to treatment for all people living with HIV and AIDS with clinical need for these medicines. A failure to provide the necessary funding for treatment now will condemn a generation of people to death.

ActionAid calls on G8 countries to ensure that debt relief, trade rules and aid quantity and quality work to support developing country efforts to strengthen health systems, including the delivery of antiretroviral drug therapy. Treatment must be part of a comprehensive healthcare system encompassing HIV prevention, counselling and testing and AIDS care. The availability of treatment has been shown to have a significant positive effect on prevention, testing and reducing stigma associated with this communicable disease. The hope provided by the availability of treatment, creates greater incentive to people living in high prevalence areas to change behaviours that can stem the spread of HIV.

This pandemic is one of the most compelling arguments for breakthroughs that will **MAKEPOVERTYHISTORY**, the campaign calling for real change from Britain's stewardship of the G8 and EU in 2005. **DEBT** cancellation would allow the world's poorest countries to divert resources to national priorities ensuring predictable resources for HIV

and AIDS treatment. A quarter of the funding released by full debt cancellation would fill the funding gap for HIV in 2005.

G8 countries must ensure that their official development **AID** programmes for HIV and AIDS are dramatically increased and free of inappropriate conditions restricting investment in health systems, use of generic drugs or local capacity development. ActionAid urges G8 countries to end IMF conditions, which discourage national health systems able to provide comprehensive health services free to all at the point of use.

ActionAid argues that G8 countries must reform **TRADE** rules to ensure the right to public health takes precedence over pharmaceutical patents, and that conditions preventing the availability of cheaper generic drugs in developing countries are removed. We call on the G8 to support the growth of regional and national generics' manufacturing capacity in countries worst affected by HIV and AIDS as a long-term solution to the lack of affordable medicines.

ActionAid stresses that the G8 has a major role in ensuring universal access to treatment as a human right. The international drive to get three million people on antiretroviral drugs by the end of 2005 is showing promising results, but could be jeopardised because donor governments are not giving this initiative, nor the Global Fund to Fight AIDS, Tuberculosis and Malaria, sufficient support. The 2005 G8 summit must save this treatment initiative and set an ambitious target, accompanied by a realistic timetable, for providing universal access to antiretroviral therapy, which can **MAKEAIDSHISTORY**.

*“For African governments, the cost of writing off HIV-infected people will be too high to contemplate... The very future of our societies is tied to keeping these people alive.”*

Pascoal Mocumbi, former Prime Minister of Mozambique, Patron of the Commission on HIV and AIDS and Governance for Africa.<sup>1</sup>

## Introduction

In 2004 an estimated 3.1 million people died from AIDS-related diseases and there were 4.9 million new infections, leaving a projected total number of people living with HIV and AIDS at 39.4 million<sup>2</sup>. As the epidemic matures, there is a growing realisation that HIV and AIDS is creating a state of permanent emergency in many countries. The reach of the virus is neither average nor even. Sub-Saharan Africa is home to nearly two-thirds of all infections, with prevalence reaching a peak in southern Africa.

The impact is hardest on poor and marginalised people. Recent reports point to the long-term, macro impacts on food security, human resources, national security and economies. High death tolls threaten stability and governance, and in turn undermine the efforts to fight HIV and AIDS<sup>3</sup>. Women, at greater risk of infection, largely bear the impact of care provision within the home, the extended family and the community.

<sup>1</sup> Speech to the Commission on HIV and AIDS and Government for Africa in Addis Ababa, Ethiopia, October 14, 2004.

<sup>2</sup> UNAIDS AIDS Epidemic Update, Geneva, November 2004

<sup>3</sup> These impacts are well summarised in ‘Averting Catastrophe. AIDS in 21<sup>st</sup> century Africa’ The Africa All Party Parliamentary Group report, 2004.

Within the last two years unprecedented financial resources, growing political will and dramatic improvements in the affordability of medicines and diagnostics have contributed new hope. Provision of antiretroviral treatment, which has been shown to transform AIDS from a death sentence into a manageable condition, was considered unrealistic and unaffordable when the Millennium Development Goals (MDGs) were launched in 2000. Now it is seen as economically imperative as it keeps people alive and productive, protects livelihoods and prevents orphanhood. Without a massive scale up of treatment it will be impossible to achieve the MDGs in highly affected countries.

The World Health Organisation (WHO) and UNAIDS’ ambitious initiative to enrol three million people on antiretroviral drug therapy by the end of 2005 (hereafter ‘3 by 5’) may succeed in achieving the most important advance towards universal access to treatment for AIDS. If ‘3 by 5’ fails it will reveal a lack of willingness on behalf of donors to reform aid policy in order to support poor countries in their efforts to mount multi-sectoral responses to HIV and AIDS. The G8 must demonstrate its commitment to support promising initiatives that can turn the tide of the epidemic now. Otherwise empty promises, and relying on the hope of a long search for a vaccine, will have life threatening consequences for people living with HIV and AIDS.

**Access to treatment: a human right**

*The provision of universal access to treatment ensures the future of Africa. If we ensure access then we know the next generation of leaders will be there. Otherwise we are wasting our time. If you focus on vaccines you are looking at three generations that won't be saved.*' - Professor Babatunde Osotimehin, Chairman of National Action Committee on AIDS, Nigeria

Since the current generation of antiretroviral (ARV) drugs were introduced in the late '90s, people living with HIV and AIDS around the world have called for universal access as a human right. In the UK and Western Europe 100% of those in need have access to ARV drugs. The '3 by 5' initiative, seen as the most important development in the fight for treatment access, has the potential to demonstrate that scaling up towards the goal of universal access is possible, even in the poorest countries. A recent study in *The Lancet* estimates the current figure of people living with HIV and AIDS and in need of treatment to be closer to nine million.<sup>4</sup> In setting their target, WHO calculated three million as roughly half the people in urgent clinical need of ARV therapy in the developing world. The second interim '3 by 5' progress report, published 26 January 2005, shows some considerable achievements:

- 700,000 people are on ARV therapy meeting the second interim target.
- 78 countries have appealed for technical assistance for scale up (the target was 50).
- 3,000 outlets providing ARV therapy are operational (the target was 1,000).

<sup>4</sup> Anema K, K Chan, A McGuire et al. Is "3 by 5" enough? Recalculating the global need for antiretroviral treatment. *Lancet* 2004, 364 (9439) 18 September.

ActionAid is pleased that considerable progress has been made to meet targets since the first '3 by 5' interim report but cautions that the subsequent targets cannot be met without a concerted, collaborative effort to speed up disbursement of committed funds.

The subsequent treatment targets for 2005 are:

- July 2005: 1.6 million people on ARV
- December 2005: 3 million people on ARV.

**Constraints on access to treatment**

Global progress towards the '3 by 5' target can only be made if countries with the greatest unmet need for treatment are supported to change domestic policy and practice. Twenty countries have at least 50,000 people each who still need treatment in addition to the people who are already on treatment. South Africa, India and Nigeria account for 41% of the need. Political will at national level can make a significant difference in a successful response to the epidemic, but often national objectives are obstructed by neo-liberal economic agendas.

Recent reports by ActionAid International USA and others<sup>5</sup> as well as the Millennium Project Report<sup>6</sup>, suggests that International Monetary Fund (IMF) policies that set low inflation targets impose fiscal constraints on developing country spending on the public health sector thus restricting national responses to HIV and AIDS

<sup>5</sup> Rowden R, P Zeitz, A Taylor et al. *Blocking Progress: How the fight against HIV and AIDS is being undermined by the World Bank and the IMF*. September 2004.

<sup>6</sup> Investing in Development: A Practical Plan to Achieving the Millennium Development Goals  
<http://www.unmillenniumproject.org/html/about.shtml>

by preventing expansion of health services along with decent wages for health workers. Rather than the IMF calling the shots, low-income countries should be able to make their own decisions about relative short-term and long-term costs versus benefits of higher public spending to fight HIV and AIDS which ravages not only societies but economies.

G7 finance ministers must use their role on the IMF Executive Board to allow greater flexibility of macroeconomic policies such as inflation levels, money supply, interest rates and budgetary ceilings in future IMF arrangements. Developing countries must be free to allow for significant increases in multisectoral spending to pursue best practice recommendations on the fight against HIV and AIDS.

### **Constraint 1: the AIDS aid gap**

One of the most immediate obstacles to achieving the '3 by 5' target is the alarming funding shortfall. \$ 3.55 billion to \$ 3.80 billion is needed, but only \$1.55 billion is available for 2005, leaving a shortfall of more than \$2 billion. The level of international commitment to the '3 by 5' target must be matched by action on the ground. \$40 million is still required to fund WHO technical support to provide partners in national government support with their scale up. The absence of a relatively small amount of funding has delayed the deployment of WHO staff at country level.

The implementation of treatment programmes needs funding from other sources, notably donor governments. Canada underwrote much of the recent expansion of WHO assistance at country level with a \$100 million contribution,

the largest single donation to WHO in its history. The UK contribution has been more vocal than financial having provided £5 million only at the start of the initiative. If '3 by 5', with WHO's expertise, clarity of goals and country-level support, does fail, it will be an indictment of the richest nations of the world. In the words of Stephen Lewis, the UN Secretary-General's Special Envoy for HIV and AIDS in Africa, there will be "no excuses left. Only the mass graves of the betrayed."<sup>7</sup>

The Global Fund to Fight AIDS, TB and Malaria has a key role in scaling up treatment provision as part of its comprehensive response to the AIDS epidemic. The G8 launched the Fund at its 2001 summit but has since then consistently failed to adequately support it. The cash starved fund has had to delay disbursement of a new round of funds to developing country AIDS programmes during the same period wherein the '3 by 5' initiative requires country level engagement more than ever.

Donor pledges for the Global Fund for 2005 have fallen short of the estimated contributions needed. By end of 2004, only \$1.18 billion was pledged towards the \$2.5 billion needed for 2005 including renewals of earlier rounds (1-4) and the full funding for a new round 5. The G8 must ensure sustainable financing for the Fund to enable comprehensive responses for a significant leap in 2006. At the 2003 G8 summit it was proposed that financial commitments to the Global Fund should total \$3 billion annually from 2007 onward with the G8 countries taking

<sup>7</sup> Press briefing, March 3, 2004. Quoted in Mukherjee, J. Basing treatment on rights rather than ability to pay: 3 by 5. *Lancet* 2004; 363, March 27, 1071-1072.

a lead in putting together this package.<sup>8</sup> Rounds 1–4 of the Global Fund have committed money to pay for 1.6 million people to receive ARV over the next five years.

Advocates have been calling for the Fund to re-examine its Comprehensive Funding Policy, which requires that the entire cost of a grant agreement be placed in the bank before the Fund signs an agreement. It is recommended that instead, when grant agreements are signed, they can be paid in part using money promised for the subsequent years, rather than insisting that money must be held in the bank from the beginning of the grant. G8 donors, including Japan, oppose any softening of the Comprehensive Funding Policy and thus options available for a robust round 5 are limited.

There is clearly a problem with capacity at country level through the Country Coordinating Mechanisms (CCM). The CCMs have been unable to keep up with the pace of the rapid scale up of treatment provision required by '3 by 5' due in part to lack of funding for technical capacity, including outsourced experts assisting the CCMs during these initial years. The delay of round 5 until October 2005 severely limits the Fund's ability to contribute to the '3 by 5' target.

The Fund's replenishment conference in the UK in September 2005 is an opportunity to

---

<sup>8</sup> President Chirac proposed that the Global Fund's needs of US\$3 billion annually should be provided in this way: one third by the USA, one third by European countries and one third by other countries (foundations, organisations, corporate donors).  
See [www.theglobalfund.org/cn/about/fighting/history](http://www.theglobalfund.org/cn/about/fighting/history)

significantly increase multiyear pledges to the Global Fund. The struggle to secure annual donations is essential for long term financing of the Fund's stakeholders including WHO and their partners in developing countries.

Statements made during the UK Chancellor's recent trip to Africa estimated that US\$10 billion per annum is needed for a comprehensive response to HIV and AIDS in low and middle-income countries<sup>9</sup>. These funds would be made available by predictable, long term, front-loaded funding through the proposed International Finance Facility (IFF). A commitment of this size would be welcomed for providing a predictable flow of aid to develop health systems and treatment plans.

### **Constraint 2: donor priorities**

Donor priorities change and threaten moves towards increased aid. Of the \$15 billion President's Emergency Plan for AIDS Relief (PEPFAR), US Congress has only approved the release of a small percentage over the first two years' money. It is thus not clear how this five-year commitment will fulfil its total pledge by 2007. There are limited reliable resources with which WHO and its partners can pursue current treatment scale up towards the goal of universal access to ARV.

Over recent months, ActionAid has become concerned that there is greater attention in the UK to fund research for a vaccine than other priorities in the fight against HIV. Whilst a

---

<sup>9</sup> Remarks by the Right Hon Gordon Brown MP, Chancellor of the Exchequer: A comprehensive plan for HIV/AIDS 13.1.05

vaccine would be an essential long-term solution, we believe that treatments should be a priority for the G8 this year. An HIV vaccine could be up to 15 or 20 years away.<sup>10</sup> It is not guaranteed that one will be developed nor that it can target the strains of HIV most prevalent in Africa. G8 countries must prioritise treatments urgently in order to meet the MDGs and ensure African countries can bring themselves out of a downward spiral of AIDS and poverty.

In the pursuit of treatment the US is among the most important partners that WHO and UNAIDS cite for its considerable contribution to meeting the interim '3 by 5' targets. But PEPFAR's insistence on using patented ARVs, rather than the cheaper generic versions, inflates their costs and significantly reduces the numbers reached. Democratic US Senators have calculated that PEPFAR's use of branded pharmaceuticals, among other conditions on the use of this aid, costs twice the amount than purchasing generics from India, for instance<sup>11</sup>.

### **Constraint 3: drug prices**

The high cost of ARV drugs is one of the biggest problems hampering efforts to achieve '3 by 5'. The price of ARV drugs has fallen thanks to the entry of generics to African health markets, but they remain out of reach for many of the worst affected countries' public health systems. An estimated 35% of the cost of implementing '3 by 5' lies in the purchase of ARVs.<sup>12</sup> The current lowest cost available to countries for first line treatments is about US

\$168 per person per year but the average price is still around US\$400.<sup>13</sup> Prices are not expected to drop much further in 2005, partly because of the high costs of ingredients and manufacture. Costs will certainly not come down to the target of \$50-\$100 that WHO originally identified in order to achieve '3 by 5'. But the ARV-producing companies – branded and generic – do have the capacity to manufacture enough drugs by the end of the year. It is now up to the international community to ensure that the high cost of these drugs will not pose a barrier to continued improvement in the uptake of and adherence to ARVs now and in the years to come. As well as providing the necessary financial assistance, the G8 must recognise that drug prices will be driven down further if competition continues between and within the generics industry and the research-based pharmaceutical companies. Therefore the G8 must support the development of generic competition, and the ability of developing countries to manufacture their own generic copies of ARVs, at national or regional level.

### **Constraint 4: trade restrictions**

Another impediment to efforts to roll out treatment is intellectual property protection on manufactured drugs. WTO's member states are obliged to follow the Trade Related Aspects of Intellectual Property Rights (TRIPS) agreement which came into force for all but the least developed countries on 1 January 2005. There are concerns that, as the major producers of generic ARVs such as India, become TRIPS

<sup>10</sup> ibid

<sup>11</sup> Kaiser Daily Report, October 29, 2004

<sup>12</sup> Avert, The WHO 3 by 5 strategy, 2004

<sup>13</sup> Personal communication, Dr. Joseph Perriens, Director AIDS Medicine and Diagnostics Service, Department of HIV/AIDS

compliant. This could result in reduced access to these cheaper drugs, providing a treatment regimen of just two pills a day, which practitioners working in the worst-affected and poorest countries have found enhances compliance<sup>14</sup>.

African countries, led by Nigeria, have called for the upcoming WTO ministerial in December 2005 to revisit the August 2003 compromise agreement. WTO members agreed then to a mechanism to allow continued export of generic medicines to worst affected and poorest countries. Concerns remain that, in practice, access to generic drugs will be restricted by the complexities and red tape of the agreed TRIPS flexibilities.

Perhaps of even greater concern is the impact that TRIPS implementation will have on access to medicines in the future. It is likely to restrict the ability of generic manufacturers to make cheap copies of any new, more effective AIDS drugs as they come on to the market, thus keeping them priced out of reach of most of the world. Furthermore it is likely to prevent developing countries from being able to develop their own domestic or regional generics' manufacturing capacity, which would help drive prices down and give them a stable long-term supply of cheap ARVs.

Existing protection in many least developed and developing countries is often already stronger than the minimum required by TRIPS. The United States has continued to pursue bilateral agreements with trading partners that tie developing countries to much more stringent

<sup>14</sup> MSF press release.

patent protection than the WTO requires.<sup>15</sup> Major generics producers such as India, Brazil and China must be protected from the impact of the WTO rules in the future. G8 countries must act on their commitment made at the World Health Assembly to make affordable drugs available to those who need them. In the long-term, a more progressive approach to patents and pricing will be necessary, including the support of regional and national generics' manufacturing in areas with serious AIDS epidemics.

### **Constraint 5: health service inequity**

Poor and marginalised people must be the first focus for expanding ARV access. Gender equity is essential to the design and implementation of health systems being scaled up. Fewer women than men are able to take up health services in developing countries due to a variety of factors including: favouring men's needs in allocation of household resources; lack of transport links to health centres; domestic responsibilities including childcare, water collection and subsistence farming and a lack of health professionals sensitised to women's concerns. WHO recognise it must step up gender disaggregated monitoring and evaluation of access to and utilization of ARV programmes. It acknowledges that treatment for children is a neglected issue: in fact paediatric formulations of ARV do not yet exist.<sup>16</sup>

<sup>15</sup> Fleck, F. Bush accused of pressuring countries to stop producing generic drugs. *British Medical Journal* 2004; 329:192 (24 July).

<sup>16</sup> Notes for Press Briefing by Stephen Lewis, on his recent trips to Malawi and Tanzania 18 1 05.

Delivery of treatment to rural areas far from major cities must also be addressed. Typically, remote rural areas have the weakest health delivery services. Treatment will only be universally available when the poorest people in the poorest countries have equal access. The world's wealthiest nations have the power to determine if this will be achieved.

Successful treatment for people living with HIV and AIDS depends on a comprehensive approach, which integrates a broad range of services including: prevention, voluntary counselling and testing, nutritional care, counselling and psychosocial support. This should take place in a 'continuum of care' in the health sector, community and the home<sup>17</sup>. Prevention requires sustained focus to avoid tens of millions requiring treatment in future. There is a danger that new ARV programmes may drain existing health services by diverting funding and skilled personnel.

### **Constraint 6: weak health systems**

Donor countries, including the G8, must allow developing countries to commit resources to strengthen national health systems to prepare for universal access and to provide better service overall. The WHO Commission on Macroeconomics and Health has recommended that a large injection of additional public funds into health services, infrastructure and research was required to address the health needs of developing countries. The Commission proposed that donors should increase assistance for health from the current levels of

<sup>17</sup> Stop AIDS Campaign 2004 describes this approach more fully.

about \$6 billion per year to \$27 billion by 2007<sup>18</sup>.

G8 countries must take action on the 'brain drain' of skilled health personnel from developing countries to rich countries. A recent report<sup>19</sup> has shown that 38 sub-Saharan African countries fall short of the WHO minimum guidelines of 20 physicians per 100,000 of the population. About 13 countries in the region have five or fewer physicians per 100,000 and 17 countries have 50 or fewer nurses per 100,000.

The UK recently indicated that it is considering raising the salaries of healthcare workers in Malawi by 50% to reduce their migration to work in the UK<sup>20</sup>. G8 countries should commit to investment in the training of health personnel in highly affected countries and ensure that all developing countries can provide adequate wages and working conditions which may allow them to retain skilled personnel and discourage migration by increasing health sector support through removing fiscal constraints on public sector spending.

Worldwide, poor and marginalised communities experience the greatest obstacles to accessing healthcare and medicines, especially under systems that require payment of user fees.

<sup>18</sup> Investing in Health: A summary of the findings of the Commission on Macroeconomics and Health <http://www.who.int/macrohealth/infocentre/advocacy/en/investinginhealth02052003.pdf>

<sup>19</sup> Physicians for Human Rights (2004) *An action plan to prevent brain drain: building equitable systems in Africa*. PHR, Boston, June 2004.

<sup>20</sup> Notes for Press Briefing by Stephen Lewis, on his recent trips to Malawi and Tanzania 18 1 05.

Previous World Bank and International Monetary Fund policies pressured developing countries to introduce user fees for primary healthcare and education. It is now acknowledged that these policies led to a reduction in use of services<sup>21</sup>, but they continue to be applied in many low income countries.

There is widespread evidence that user-fees in health systems encourage self-treatment, deter treatment compliance and act as a barrier to full, if any, use of facilities.<sup>22</sup> User-fees are particularly burdensome to people living with HIV and AIDS, who may be impoverished by long periods of illness. Additionally the high costs of AIDS-related drugs and diagnostics, even when largely borne by the state, carry prohibitive payments for users. In Nigeria patients pay \$318 annually for tests, drugs and care – an amount greater than the average per capita income.<sup>23</sup>

## Conclusion

The campaign for increased and equitable access to ARVs has achieved a measure of success with WHO providing a clear road map to expanded access. Bilateral and multilateral donors have indicated their willingness to support these efforts. But it is not enough. Political will and funding are lagging behind promises made. Even the short-term goal of enrolling three million people on treatment by 2005 does not have the support it requires to succeed.

Current trade, debt and aid policies present obstacles to the ability of developing countries to fight AIDS and to scale up access to treatment towards universal access. Failure to provide the necessary funding for treatment now will write off generations of people living with HIV and AIDS.

The G8 2005 summit at Gleneagles will directly affect the future of nearly 40 million people and the economic viability of their countries. The richest nations of the world must stand by the commitments they have made at: Okinawa in 2000; Genoa in 2001; Kananaskis in 2002 and Evian in 2003 and act immediately to give life and hope to people living with HIV and AIDS.

---

<sup>21</sup> ActionAid. *Low credit. A report on the World Bank's response to HIV AND AIDS in developing countries. 2004.*

<sup>22</sup> Gilson L and D McIntyre, Removing user fees for primary care: necessary, but not enough by itself. *EQUINET Newsletter*, August 2004. Available at [www.equinet africa.org](http://www.equinet africa.org)

<sup>23</sup> 'Abt associates to highlight true cost of antiretroviral therapy at AIDS conference'. Available at [www.abtassociates.com](http://www.abtassociates.com)

### Summary of recommendations

ActionAid calls on the G8 countries to commit to a multilateral timetable for universal access to antiretrovirals for people living with HIV and AIDS in developing countries and ensure that their actions on aid, debt and trade contribute to making this achievable. As a first step, we need a clear and unequivocal commitment to the achievement of '3 by 5'.

ActionAid calls on G8 countries to allow developing country governments to utilise debt relief and unconditional aid flows to support national health systems to deliver antiretroviral therapy as part of a comprehensive approach, which includes both prevention and care. G8 countries working in concert with the International Financial Institutions should abolish user-fees in public health systems and support healthcare free to all at the point of use.

### TRADE

Trade rules must be reformed to ensure that public health rights take precedence over pharmaceutical patents and remove conditions that prevent use of generic medicines. The 2005 WTO ministerial must ensure its members can overcome restrictions on exporting generic medicines to developing countries.

### AID

As part of action for **more aid**, G8 countries should urgently provide a package of funding for WHO to enable it to carry out its technical assistance for '3 by 5'. The G8 should agree on a package of funds to continue and maintain treatment scale up until universal access is achieved.

The G8 should commit full funding for the Global Fund to Fight AIDS, TB and Malaria for 2005 and commit to sufficient annual national contributions. The G8 should support the growth of regional and national generics' industries in worst-affected countries as a long-term solution to lack of affordable medicines.

As part of action for **better aid**, G8 countries must ensure that their own aid programmes for HIV and AIDS are free of inappropriate conditions which restrict the ability to invest in health system strengthening, use generic medicines or build local capacity.

International Monetary Fund (IMF) policies must cease to impose fiscal ceilings on developing countries that restrict spending on the public health sector. Low income countries must be able to make their own decisions about relative short-term and long-term costs versus benefits of higher public spending to fight HIV and AIDS which ravages not only societies but economies.

### DEBT

ActionAid calls on G8 countries to cancel the debts of the world's poorest countries in full, by fair and transparent means, allowing countries to divert resources to national priorities ensuring predictable resources for HIV and AIDS treatment.

For further information contact:  
M. Felicity Daly, UK HIV/AIDS Policy Officer  
[felicity.daly@actionaid.org](mailto:felicity.daly@actionaid.org)  
Simon Wright, UK HIV/AIDS Team Leader  
[simon.wright@actionaid.org](mailto:simon.wright@actionaid.org)