

GlaxoSmithKline, under pressure, cuts price of AIDS treatment for poor countries

Under political pressure and pending lawsuits in the United States, British pharmaceuticals giant GlaxoSmithKline Plc announced on 28 April that it was cutting the price of its leading Combivir treatment for people with HIV/AIDS in poor countries by 47% to 90 US cents a day.

Richard Feacham, executive director of the Global Fund to Fight AIDS, TB and Malaria said it was “another step” towards improving access to life-saving antiretroviral drugs in Africa and other parts of the developing world that are worst affected by AIDS. “This must be matched by increased resources to finance the purchase of medications,” he said.

Glaxo, the world’s largest manufacturer of HIV/AIDS drugs, said it had also cut the price of Combivir’s two component drugs when sold separately: Efavir (3TC) by 45% to 35 cents a day and Zidovudine (AZT) by 38% to 75 cents a day. These are available to 63 of the world’s poorest countries, including all of sub-Saharan Africa. This is the second cut in the price of Combivir since it was reduced to US\$ 1.70 a day in September 2002, and the company says it is a result of reducing manufacturing costs.

The cut brings Glaxo’s pricing closer to that of generic drug companies, and will be a blow to those that stood to gain from a trade agreement to make cheap life-saving drugs available to poor countries — an agreement that was due to be finalized in December but has been stalled for months. The deal is now expected to be agreed at the next World Trade Organization ministerial meeting in the Mexican city of Cancun in September. It would allow poor countries facing a public health crisis, such as the HIV/AIDS pandemic, to issue a compulsory licence to generic drugs companies to produce affordable versions of a patented drug.

Companies such as Ranbaxy Laboratories Ltd of India have already dented Glaxo’s market. The Indian

company offers a WHO-approved version of Combivir, known as Zidovudine (AZT) and Lamivudine (3TC) for less, at 73 US cents a day.

Daniel Berman of Médecins Sans Frontières said cheaper Combivir would be particularly helpful for people with HIV/AIDS in countries where generic — or non-patented — products like Ranbaxy’s combination treatment were not available.

Glaxo’s move will doubtless help to improve its image and standing with investors. AIDS Healthcare Foundation welcomed the company’s “humanitarian action” and said it was withdrawing a Californian lawsuit — one of three pending legal actions it has brought against the drug giant over its business practices.

“It’s a specific discount on a specific product and it’s a product that’s needed,” said Jonathan Quick, Director of Essential Drugs and Medicines Policy at WHO, adding: “Glaxo leads the way for other companies”.

Dr Quick said, however, that the onus was on drug-producing countries to reach a deal on waiving patents to make medicines. He urged countries to agree to more voluntary licences, under which major drug companies also agree to transfer technology to generic firms in developing countries by showing them how to manufacture the life-saving drugs.

Combivir is a combination of AZT and 3TC and is vital to many triple-drug therapies. Since it was launched in the US in 1997, it has transformed HIV infection from a fatal condition to one with which it was possible to live if one could afford the treatment. Few people in the world’s poorest countries have been able to afford it, despite past price cuts.

Glaxo to date said it had increased shipments of Combivir, the WHO-recommended HIV/AIDS treatment, to the developing world from 2.2 million tablets in 2001 to nearly six million in 2002, the equivalent of 3 million daily doses. ■

Fiona Fleck, *Geneva*



Saul and Florence, both HIV-positive, both able to live if medication is affordable. Photo taken at Kibera Community Centre, Kenya.

UNAIDS/G. Prozzi

Nutritionists unimpressed by sugar lobby’s outcry

Threats by the US sugar industry to lobby Congress to cut off the American contribution to WHO have failed to make the organization withdraw a contentious expert report on nutrition and health. The report, entitled *Diet, nutrition and the prevention of chronic disease*, was formally launched in Rome on 23 April. It concluded that a diet low in saturated fat, sugar and salt and high in fruit and vegetables was required to tackle the epidemic rise in chronic diseases worldwide.

In a series of letters to WHO’s Director-General Dr Gro Harlem Brundtland, the sugar lobby attacked the report’s recommendation that sugar should represent at most 10% of the daily energy intake. They claimed that the report’s conclusions were scientifically flawed and reflect “the expert panel’s complete disregard of the preponderance of scientific evidence.”

At WHO, however, these reproaches made little impression. “We took into account all the comments we received from various stakeholders [upon publication of a draft version on the Internet]. But we felt no need to

reconsider the recommendations," said Dr Pekka Puska, Director of Noncommunicable Diseases and Health Promotion at WHO. "Denouncing a WHO report as unscientific," he adds, "is a standard procedure if big commercial interests are at stake. That's what the tobacco people used to say."

Though the situation is reminiscent of WHO's fight with big tobacco companies, which has been going on for years, Puska is quick to point out that "food is not tobacco. Tobacco is an unnecessary product that kills its consumers, whereas food is necessary for life. So it's a question of changing dietary patterns from unhealthy to healthy. Besides, there is already a lot of collaboration going on between WHO and vast parts of the food industry."

The nutrition and health report, which had been commissioned jointly by WHO and the UN Food and Agriculture Organization (FAO), is the result of a two-year expert consultation. Thirty independent experts from 20 countries analysed "the best currently available scientific evidence on the relationship of diet, nutrition and physical activity to chronic diseases," says Dr Ricardo Uauy from the London School of Hygiene and Tropical Medicine who chaired the expert group. "The strength of the report is that it is a real consensus document. At the end, 30 scientists were happy with every single word in it."

The 100-page report provides the scientific basis on which WHO can build its "global strategy on diet, physical activity and health" in accordance with a World Health Assembly resolution adopted in May 2002. The strategy aims at reducing the growing burden of chronic conditions such as cardiovascular disease, cancer, diabetes and obesity, which have reached epidemic proportions — not only in industrialized countries but in developing ones as well. Chronic diseases were the cause of some 60% of the 56 million deaths reported globally in 2001. "We have known for a long time that foods high in saturated fats, sugars and salt are unhealthy; that we are, globally, increasing our intake of energy-dense nutritionally poor food as our lives become increasingly sedentary," said Dr Brundtland at the launch of the report. The report began the work, she

said, of "laying the foundation for a global policy response."

That is probably why the sugar industry's reaction was "unusually strong," as Dr Puska put it. "Our recommendations are nothing new. They are in line with about 25 national expert reports, which all come up with a sugar limit of more or less 10%. What's different this time is that we don't want the report to be just another paper, we want action. And dietary changes are the most cost-effective way to prevent these chronic diseases. Maybe the sugar lobby was afraid WHO is serious this time."

That would explain their heavy-duty lobbying efforts. Besides trying to persuade Dr Brundtland to prevent publication of the report, the Sugar Association, a US trade organization, also wrote to US health secretary Tommy Thompson, asking him to use his influence to get the report withdrawn. "We will use every avenue available to us to expose the dubious nature of the ... report, including asking Congressional appropriators to challenge future funding ... to the WHO," one of the letters says. "Taxpayers' dollars should not be used to support misguided, non-science-based reports."

In support of their claims that the harm sugar does is vastly overstated by the WHO report and that up to a quarter of our energy intake can safely consist of sugar, the Sugar Association cited a report published last year by the prestigious US National Academy's Institute of Medicine (IOM). That report, however, did not spell out a specific sugar limit for achieving a healthy diet, as was made clear in a letter to Secretary Thompson by Harvey Fineberg, President of the IOM. "Interpretations suggesting that a sugar intake of 25% of total calories is endorsed by the Institute's report are incorrect," Dr Fineberg wrote.

Dr Uauy agrees, saying, "the available data simply do not support a 25% limit [for sugar] as a safe recommendation for populations that become more and more sedentary. We felt we should not be more liberal on sugar now that obesity is a much greater challenge than 15 years ago. That's why we decided to go with the 10% figure from the 1990 report; we were using a precautionary approach."

With the report's recommendations in hand WHO is currently consulting its Member States, nongovernmental organizations and the private sector about how best to turn the recommendations into a global strategy. In early May WHO officials led by Dr Brundtland, together with Dr Uauy, met with food company representatives in Geneva. According to Dr Uauy, the meeting went "quite well. They have no problem [with our recommendations]. On the contrary, they are mainly interested in producing healthier food." ■

Michael Hagmann, *Zurich*

Counselling reduces high blood pressure

Intensive counselling can get people to make a wide array of lifestyle and dietary changes that will reduce their risk of developing high blood pressure, according to a major US clinical trial. But duplicating the trial's methods in the context of everyday patient care would be difficult.

High blood pressure is one of the 10 leading health risks worldwide and causes 7 million deaths a year, according to WHO's *World health report 2002*. More than three-quarters of cardiovascular disease can be traced to high blood pressure, high cholesterol, tobacco use, or a combination of those factors, the WHO report said.

Previous clinical trials of lifestyle modification and hypertension have focused on one intervention at a time. The new study, conducted at four clinical centres and published in the 23/30 April issue of *JAMA*, demonstrated that patients can cope with a large number of lifestyle changes all at once.

"What made this [study] different was that we counselled them on so many fronts," says Eva Obarzanek of the US National Heart, Lung and Blood Institute in Bethesda (MD). "They had a lot of things to change."

In the study, 810 generally overweight adults with blood pressure in the above-optimal or stage one hypertensive range — that is, with systolic blood pressure (BP) ranging from 120–159 mm of mercury and diastolic BP of 80–95 mm — were divided into three groups for different regimens.

One group merely got advice — a 20–30-minute session with professional counsellors who handed out literature and discussed behavioural changes. Six months later, this group's mean

systolic BP had declined by 6.6 mm and its mean diastolic BP by 3.8 mm.

A second group was treated to four individual counselling sessions and 14 group meetings with counsellors over six months on such lifestyle modifications as exercise, weight loss, and reduced salt and alcohol intake. They decreased their mean systolic BP by 10.5 mm and their mean diastolic BP by 5.5 mm. Forty per cent knocked their blood pressure down to less than 120/80.

The third group got the same behavioural counselling plus a tough diet modelled on the DASH ("Dietary Approaches to Stop Hypertension") diet, which calls for nine or more servings of fruits and vegetables daily, two or more servings of dairy products and lower fat consumption. Their mean systolic BP dropped 11.1 mm and their mean diastolic BP 6.4 mm. Forty-eight percent reduced their BP to less than 120/80.

Only 39 of the 810 patients in the trial were smokers — too few to allow researchers to tease out any differences between smokers and non-smokers.

The study produced two surprises: the advice-only group did better than researchers expected, probably because of the counselling. But the combination of the behavioural and dietary modifications did not add up to as much improvement as the researchers had hoped.

Nevertheless, "I would still recommend a combination of these things," says Victor Stevens of the Kaiser Permanente Center for Health Research in Portland (OR), principal investigator at the study's coordinating centre. "I think the combination is more effective than each of these things individually."

Stevens also says adapting the trial's approach to real-world patient treatment is feasible. "Yes, there is a cost, and it's not trivial," he says, but points out that dealing with hypertension and the other ills that often accompany it is costly, too: "How many heart attacks would you have to prevent to make a major saving?" ■

Bruce Agnew, *Bethesda (MD)*

Farmers kill 23 million birds to stop influenza virus

European health officials are continuing to monitor an outbreak of a highly

pathogenic strain of avian influenza A (H7N7) that has claimed the life of a Dutch veterinarian and resulted in the slaughter of more than 23 million chickens and other fowl in the Netherlands and Belgium. Since its discovery at six poultry farms in central Holland on 28 February, the virus has also caused eye infections and mild flu-like symptoms in more than 80 people, most of them workers involved in the culling operations.

Experts worry that if the bird flu continues to infect people, it could exchange genes with a human influenza virus and create a strain that is either more contagious or more virulent — or both — toward humans. Known as "antigenic shift", gene swapping between animal and human influenza viruses occurs relatively rarely, but it has led to some of the deadliest flu epidemics in history.

So far, however, there is no evidence that the Dutch outbreak has unleashed a new and dangerous human-bird influenza hybrid. The virus that killed the 57-year old veterinarian on 17 April, days after he visited a contaminated poultry farm, was genetically identical to the virus killing chickens. "The virus was not at all mutated," says Jim van Steenbergen, coordinator of Communicable Disease Control for the Netherlands, in Utrecht. Why the veterinarian's illness progressed from mild flu-like symptoms to severe massive bilateral pneumonia remains a mystery which researchers are investigating.

It is known that the man who died and most of the people infected with the bird flu failed to follow the protective measures that Dutch authorities had listed to prevent humans from becoming infected. Initially, people involved in culling chickens were obliged to wear protective goggles and clothing and facemasks. But after the first cases of eye infections were reported, which included three family members who had never come in contact with infected birds, health officials ramped up the measures to include flu vaccinations and taking oseltamivir, a drug which stops viruses replicating. About 1500 people, including farmers and families on contaminated farms, have been vaccinated.

The Dutch authorities acted immediately to stop the virus circulating among chickens as well, imposing restrictions on the movement of poultry, poultry manure and eggs throughout the Netherlands and abroad. But the virus has spread to more than 240 farms



A container unloads chickens culled to stop the spread of avian influenza A.

and crossed the southern border into Belgium. Birds from more than 1000 farms have been sacrificed. And pigs, which can simultaneously harbour avian, swine and human influenza viruses, are being sent to slaughter early if they test positive to the avian virus.

Before the outbreak, the Netherlands was home to more than 100 million chickens. It is the world's largest egg exporter and the European Union's biggest poultry exporter. Despite the size and density of its poultry and egg industry, the country has had no outbreak of avian influenza in three decades. In recent years, however, researchers at Erasmus University in Rotterdam found bird flu within Dutch borders in migrating waterfowl, which are the natural reservoir for avian influenzas. Scientists suspect the current outbreak originated when domesticated birds came in contact with droppings of wild waterfowl.

The culling of flocks in the Netherlands and Belgium dwarfs the well-publicized 1997 slaughter of all chickens — some 1.4 million birds — in Hong Kong following an outbreak of avian flu A(H5N1) that killed 6 people. In February this year, WHO confirmed that the virus had resurfaced in two members of a Hong Kong family who had recently visited south-eastern China. The 9-year old boy recovered, but his father died. The boy's younger sister died in China of similar symptoms, but it is not known if she was infected with virus. ■

Charlene Crabb, *Paris*