

The LATCA Community Advisory Board (CAB) is an advisory board composed of representatives from the treatment advocate community from the LATCA region who meet, as needed, with representatives of pharmaceutical companies, research institutes and public health institutions to ensure that relevant information is being shared with communities and a positive dialogue is established to improve access to medicines for those in need.

The main objective of the LATCA-CAB is to ensure dialogue at a regional level among people living with HIV and/or hepatitis C, treatment advocates, and representatives of the pharmaceutical industry and policymakers, in order to improve access to treatment, care, and support for patients.

Specific objectives of the LATCA-CAB include:

- Ensuring equal dialogue between community of patients, pharmaceutical industry, regulatory and public health agencies on a regional level to achieve universal access to treatment in the region
- Increasing the role of patients' community in price regulation, procurement mechanisms and clinical trials being conducted in the region
- Establishing a regional hub for communities of patients in order to build capacity in the area of treatment access the LATCA region
- Representing the interests of LATCA patients' community at a global level.

The LATCA-CAB is managed by a steering committee composed with 5 selected members to reflect geographical representation, sexual orientation and gender identity, knowledge, community credibility, and honesty to the extent possible. The committee develops the program and chooses the participants and activities for the meeting while the administrative and financial controls are provided by ITPC-LATCA.

The role of the Steering Committee is to:

- Decide the work plan, in consultation with members
- Agree on the program of CAB meetings
- Approve participants for the meeting
- Seek for funds, in consultation with the secretariat
- Update the administrative and governance procedures for the CAB, in consultation with ITPC-LATCA secretariat
- Select a Chair and Deputy Chair (or co-Chairs) for CAB from among steering committee members
- Appoint other voluntary officers as needed from among its number or the members.

LATCA-CAB Meeting October 22-23



On October 22-23 the LATCA-CAB organized a meeting in Panama City, Panama; bringing together 14 treatment advocates, representing 13 countries in the Latin America and Caribbean region and advocates working at the regional and international levels. The LATCA-CAB invited representatives and experts from civil society, PAHO, ONUSIDA, the MPP and ViiV pharmaceuticals.

The goal of this meeting was to ensure dialogue at the regional level among people living with HIV and/or hepatitis C, treatment advocates, and representatives of the pharmaceutical industry and policymakers in order to improve access to treatment, care, and support for patients. Specifically to ensure equal dialogue between community of patients, pharmaceutical industry, regulatory and public health agencies on a regional level to achieve universal access to treatment in the region. As well as to increase the role of patients' community in price regulation, procurement mechanisms improving and clinical trials being conducted in the region

Expected results of the meeting are to strengthen HIV treatment literacy and gain

more knowledge in human rights, intellectual property and the use of TRIPS flexibilities among other topics related to the technical expertise of the epidemic. An additional result is to establish priorities to contribute to improving access to treatment for HIV and co-infections and to update the LATCA-CAB's action plan.

Topics to be addressed in the meeting

- Update information from the community
- Intellectual Property and safeguards of TRIPS
- Epidemiological updated in LATCA countries
- Update of the continuum of care and 90-90-90 Goals
- New guidelines from WHO on HIV
- Coinfections TB/HIV and HIV/HEP C
- Update about PrEP
- Purchase Mechanism PAHO
- Voluntary Licenses in the region and expectations in the next three years
- DTG, Abacavir and other ARV medicines/ Innovation drugs

Meeting with ViiV Healthcare



Background

ViiV Healthcare is a joint venture of GSK, Pfizer and Shionogi created to focus on HIV treatments. There are currently 202 clinical trials completed or underway including dolutegravir/lamivudine, cabotegravir/rilpivirine long-acting (treatment), cabotegravir long-acting (Pre-exposure prophylaxis) and fostemsavir (treatment for highly experienced patients) which are in phase 3. ViiV's access strategy is based on research and development, patents and licensing, product donation and expanded access programs, capacity building. The pricing policy for middle-income countries is based on GNI and the impact of the epidemic in each country, on a case-by-case basis. ViiV currently supports over 300 programs to address the needs of people living with HIV, including education, care and treatment projects.

ViiV released dolutegravir in 2013, when it was launched in the United States. Currently ViiV has registered the drug in 100 countries, with 17 generic manufacturers producing the drug. In Latin America and the Caribbean, countries are covered by the voluntary licenses (Bolivia, El Salvador, Guatemala, Guyana, Haiti, Honduras, and Nicaragua). More countries in the region are covered by the royalty-free pediatric license, with large exceptions including Brazil and Mexico.

ViiV is working with CHAI and Unitaïd to expedite the development, registration and

market entry of pediatric formulations of DTG in developing countries.

Question: What is ViiV's plan to handle countries that are not in the voluntary license?

ViiV Healthcare: We are committed to improving the accessibility of our medicines and are ready to grant voluntary licenses to developing countries, as well as low- and middle-income countries. Our main concern is that people get their medicines. DTG is registered in more than 100 countries, and we have voluntary licensing agreements in place (either direct or via the MPP) with 18 generic manufacturers. We collaborate with the MPP to provide access to other countries; African countries, and low- and middle-income countries can benefit from the voluntary license. For the other countries, we have a flexible pricing policy, and we try to take into consideration both affordability and the burden of the epidemic. We speak with governments, and of course the negotiated agreement must be sustainable for ViiV. We have 121 countries that are in the VL. Just because a country is not in the license does not mean that DTG will not be available. In regards to pediatrics, we are working with partners to such as PADO, IMPAACT and PENTA to develop age-appropriate formulations. Building on a successful partnership with the Clinton Health Access Initiative (CHAI) and Mylan to develop and introduce a dispersible formulation

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of ABC/3TC for children, ViiV, CHAI and Unitaid have together established an innovative new partnership. This partnership aims to expedite the development and introduction of optimized pediatric formulations of dolutegravir (DTG), providing generic partners with financial and technical incentives to develop and manufacture generic DTG for the treatment of HIV in children and infants across resource-limited settings providing incentives for them to do begin production. Our voluntary licenses cover 99% of children living with HIV in developing countries.

Question: Beyond the World Bank criteria, what other criteria do you consider when determining the geographic scope of your voluntary licenses?

ViiV Healthcare: Our Voluntary License territory covers all Lower Middle Income Countries, Low Income Countries, Least Developed Countries as defined by the World Bank, and all of Sub-Saharan Africa. We use World Bank Criteria because these are independent, objective and verifiable. Where a country is not part of our voluntary licensing territory, we have a flexible pricing policy takes into consideration in burden of disease and affordability amongst other factors.

Question: We see that countries with similar incomes have very divergent prices. In your slide you presented your pricing policy and you mention middle-income countries. How do you practically apply your pricing policies in Latin America?

ViiV Healthcare: We want our price to reflect our objective of leaving no person living with HIV behind. We work closely with the government that is purchasing a drug to come to an agreement on a price that is comfortable for them and sustainable for ViiV Healthcare. Brazil wanted to expand use of DTG, so we agreed

on a price that made that possible. We try to factor in how the government is purchasing medicine and where DTG fits in their HIV program, then we look at income and disease burden to determine a good price. We many not always find the perfect answer, but of my jobs is to figure out how to drive access and ensure the balance is right. In Latin America there are only a handful of countries that have patents, so generic manufacturers should be trying to work in these countries. It is not a perfect answer, the business is complicated.

Comment: There are few LATCA countries in the license. We have these criteria which are punishing Latin America. Colombia, Argentina and Panama have high incomes, but the reality does not reflect this classification, and so countries are not buying these medicines. Mexico is paying four times what Bolivia is paying for the same drugs. Please involve civil society because governments are not going to give you the full story. Work more with civil society to analyze the capacity to purchase the medications.

ViiV Healthcare: We have an agreement with the MPP which includes all LMICs, LICs, and LDCs. It does not show where we actually have patents. Brazil, Colombia, Mexico have them. In many other countries, like Argentina, generic manufacturers are free to supply generics if they want to. At the moment, generic manufacturers are not supplying them, so ViiV is supplying them. Therefore, the price might not be what you want, but reflects what is sustainable for our business. It is the government's job to ask for generics. There are different categories of countries. For High Income and Upper-Middle Income countries, which are not part of the voluntary licensing territory, we will work with governments to ensure prices are affordable on prices. There are upper-income countries with no patents. So a generic company could supply

these countries tomorrow if they wanted (i.e. Argentina). For lower-income countries and below they benefit from the VL, and if a country moves from upper-middle to lower middle income, it can be added to the license. ITPC-MENA brought to our attention the case of Tunisia and Mongolia and we added them to the VL. So we do listen to civil society and respond. I am open to listening to you. I am new, I've been here for 1 year, and I am 100% available to listen, to hear your concerns and take them back to the business. I see this as the beginning of the conversation and not the end. I commit to you that that is why I am here and that is what I want to do. What is exciting about this job is that I get to be the person that interacts with the company and civil society and bring them together and you have my commitment to play that role.

Question: Generally, there are not good clinical studies on women. What reactions are there for menopausal women and Trans women on hormones.

ViiV Healthcare: We are looking at quality of life issues, when thinking about women and Trans women. First, you need to identify the medications that women are receiving that may not require a prescription but may interact with their treatment. DTG has minimum interactions; there are no important interactions with hormones therapies. Pre-menopause and post-menopause studies are similar. DTG has a study of drug drug interaction with hormones and there was no specific interaction with these medicines. Biochemically and from real-life studies

Question: Do you know when Cabotegravir will be available for MSM and women?

ViiV Healthcare: Cabotegravir, like every drug must follow certain steps. We are on step three,

which means we are reaching the end. But we need to wait. We will have approval in 2020/21. The most important thing is to evaluate and ensure safety and efficacy. We are not reaching for a cure, but for long acting therapies as a complete treatment for PLHIV, with similar efficacy to current oral therapies. Long-acting cabotegravir/rilpivirine will be coming soon as a complete treatment for PLHIV. And for use as PrEP, cabotegravir will come later on. Clinical trials on the use of cabotegravir for PrEP are currently ongoing in MSM, transgender and women subgroups.

Question: What is ViiV's policy to achieve equality in treatment access?

ViiV Healthcare: We try to make sure that in all countries where people have the most difficulty in accessing our medicines we have VLs. This allows generic companies to provide and sell drugs in low-income countries. For wealthier countries we try to make sure our pricing matches what the countries can afford. We allow generic drugs for 94% PLHIV. Can we do more? Probably. We are looking at pricing for upper-middle income countries, by trying to figure out pricing based on the wealth of the country and the disease burden. For many countries we are not providing the drugs at all, we allow generic manufacturers to sell and we do not collect royalties.

Question: Is there a policy to support countries who are receiving migrant from Venezuela, who are living with HIV?

ViiV Healthcare: The global crisis of refugees is an issue that ITPC-MENA raised with us. We are looking to see what we can do with these migrant populations. It is early, so I do not have an answer yet. The answer could be working with NGO partners, or UNAIDS. This work has to be collaborative. We could take a unilateral

decision, but this work also involves working with governments. This question comes up often. This is a multifactorial issue, not just a Venezuela issue, but with all refugees around the world.

Question: We know that you have been working with the FDA on the 5mg dosage for infants. Was it approved or not?

ViiV Healthcare: We have approval for 10mg and 25mg doses with the FDA and the EMA. We are working on 5mg trials with PENTA and IMPAACT and we hope that we will have enough efficacy data to apply for approval by the end of 2019. We are working with WHO to speed up the approval process. Verification by weight varies, the impact studies are not specific to DTG. We are looking for the approval of 5mg for usage for kids below 6 years.

Question: We would like a promise in regard to the 5mg dosage. What is the timeline?

ViiV Healthcare: It is important to have pediatric formulations and we are committed to a 5mg dose. The clinical trials are currently under way. Our timelines are governed by the regulatory authorities, and they want to see longer term data. We must take this into account, as it relates to pediatrics, as this is a very specific group of patients.

Question: I would like to take advantage of this opportunity to mention the news about stem cells used to treat HIV. What are your thoughts on this?

ViiV Healthcare: There were two transplants that happened to five people. If you read the article these people are still under treatment. It is a possibility that the treatment might result in remission, but not a cure. Sterilized is the term

we use when we mean cured. ViiV Healthcare is engaged in research for HIV remission or cure. In addition, we are committed to exploring new treatment delivery technologies and formulations that can help to prevent HIV infection in the future, e.g. in using a long-acting treatment regimen. We are working towards prevention, remission, and cure.

Question: You were talking about the new molecules that are being created. Can you talk about co-infections with HCV?

ViiV Healthcare: We focus specifically on HIV. DTG was analyzed for its interaction with new treatments for HCV. There are no known issues with drug-drug interactions.

Question: We heard a lot of noise about DTG during AIDS 2018. Can you please tell us your thoughts on pregnant women using DTG?

ViiV Healthcare: Preliminary findings from a birth outcomes surveillance study conducted in Botswana show a higher than expected number of certain birth defects, called neural tube defects (NTDs), among newborns whose mothers were exposed to dolutegravir-based anti-retroviral therapy (ART) at conception. The findings are part of the Tsepamo study, an NIH/NICHD-funded birth outcomes surveillance study conducted by the Botswana-Harvard AIDS Institute Partnership in Botswana. There is no known mechanism linking dolutegravir with these types of birth defects, and there are no relevant findings in pre-clinical studies. The signal reported from the Tsepamo surveillance study does not prove causality but provides a hypothesis for exploration. We have notified the required regulatory authorities and are working in close collaboration with external stakeholders, including the WHO and study investigators, and a full assessment to better understand these

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cases and the potential risk is being conducted. We have informed HCPs and investigators and made specific recommendations for the use of DTG in women of child-bearing potential based on the data currently available and WHO current guidance. ViiV Healthcare has taken and will continue to take immediate and comprehensive actions in patients' best interest. New data on the use of dolutegravir in periconception during pregnancy will soon be released and this new data will certainly better inform authorities, researchers, communities, and clinicians on the use of dolutegravir in early pregnancy.



Background

The Medicines Patent Pool was founded in 2010 by Unitaid to increase access to new treatments for HIV through licensing of patented medicines and facilitate innovation in fixed-dose combinations and pediatric formulations. In 2015 the MPP expanded to hepatitis C and tuberculosis drugs and in 2018 to other patented medicines included or to be included in the WHO Essential Medicines List. The MPP currently licensed 13 HIV medicines, 2 HCV direct-acting antivirals, and has one TB candidate. The MPP has negotiated licenses with 12 originator companies and research centers, as well as 24 generic manufacturers. The MPP also created the database MedsPaL which provides information on patents, data exclusivity and license agreements of selected HIV, hepatitis C, tuberculosis and other patented essential medicines in lower- and middle-income countries. For HIV treatment bicitgravir and cabotegravir were priority drugs to be licensed, of which bicitgravir has already been licensed. Doravirine, fostemsavir and rilpivirine are on the watch list. For HCV treatment glecaprevir/pibrentasvir, daclatasvir and ravidasvir were on the priority list, of which daclatasvir and ravidasvir have already been licensed.

Question: Last Tuesday in Honduras there was a stock-out of emtricitabine/

tenofovir (TRUVADA), every product that you have negotiated with VLs, do all of them have a producer?

Medicines Patent Pool: For every license there is at least one producer. For the particular drugs you are referring to I do not know exactly who. I will take note of this. We are not in charge of procurement, but we can look into it. The patent pool does not purchase, but we belong to working groups and we discuss stock outs. I represent MPP within this group.

Question: What are the indicators of success for MPP? The amount of licenses, or the quality?

MPP: The indicators are the amount of patients that receive medications from generics produced through the licenses. The amount of product that reaches the patient. When a generic producer has an agreement with South Africa, for instance, the impact can be huge, as they have a large number of patients. The MPP tries to include the maximum number of countries, but this depends on negotiations with the companies. The negotiations are long (can take up to two years).

Questions: We understand that

the work of the MPP is to negotiate voluntary licenses. Bolivia did not have a patent on dolutegravir, and they are now in the license. This way of working is confusing to us. What is the rationale behind fighting to include countries in the licenses when they are not patents in the country?

MPP: The product may be patented in a country of manufacture, like India. In addition, ViiV can file for patent protection in the country. The point of the license is to give countries additional choices and to provide legal certainty to the manufacturers. If, for example, Bolivia decided to produce generic DTG, through the license they could purchase the API from a sub-licensee.

Questions: Bolivia has a strong policy against multi-national corporations, especially based in the United States, and does not sign free trade agreements (FTAs) which are why Bolivia has such lower prices. Perhaps without being in the license Bolivia is free to find the lowest prices. So again, why put Bolivia in the license?

MPP: I cannot fully answer this because I am not a part of the negotiation with the companies. But I can bring this up with those who are involved, to see if it is possible from legal/confidentiality stand-point to speak with civil society and countries to know if they even want to be in the license. However, the license does not oblige a country to buy from licensees and they can always look around for better prices when there is no patent. This is the case of Bolivia, so if they wanted to buy the product from a company outside the license they can. Moreover, there may be patents in the key countries of manufacture, so being in the license may be important for that.

Question: What I understand is that there is a reference price, and only certain generic sub-licenses you can purchase from. Is that accurate?

MPP: If a country is in the territory it can buy from licensees. If a country is not in the territory but there are no patents protecting the concerned product, it can also purchase from the sub-licensees. There is nothing in the license that says you cannot purchase from another producer (not in the license) when there are no patents. In this case, a country can also purchase the raw material (API) for local production.

Question: We are interested in knowing the metrics of success. How many licenses, how many countries? But also the quality of the license. Bolivia did not need a license. Morocco went through something similar.

MPP: Licenses are not linked to indicators. We measure success by the number of patients on treatment thanks to our licenses.

Question: Have you ever rejected a license because it was not good enough, what is not acceptable for you?

MPP: Negotiations continue until we get terms that will significantly improve the situation in as many countries as possible. Our Expert Advisory Group (EAG) reviews the license and provides its assessment and the MPP Board has to approve the conditions negotiated before a new license is signed. One license took a long time, because the terms at first were not as good as we wanted them to be. Instead of a few months, it took two years, until better terms were agreed upon, and it was only then that we presented it to the EAG and the Board. We worked until we saw that there was real public health impact to the

license. At the point at which it is better to have a license than to not have it. So, negotiations can last longer, until we know we have achieved the best agreement possible from the public health perspective.

Question: Who are the stakeholders who sit down and negotiate whether or not a VL is necessary or not?

MPP: Together with a group of experts in their field and CSOs we go through a priority setting exercise to define the drugs we should focus on (an update priority setting report gets published regularly). Then, the business development team from the MPP sits down to discuss the license. Then the legal team of the patent pool negotiates the terms with the company. And the Expert Advisory Group, composed of independent experts that include people from the communities of PLHIV assess the license before it goes to the Board for approval.

Question: What happens if the company applies for a patent and we are not in the license, how do we prevent the patent from being issued?

I would prefer Panama to be in the VL. Then the issue would not come up. If a country is excluded and there is no patent, and then a patent comes into effect, this is outside our power. There may be other options that are outside the field of expertise and the scope of action of the MPP, like the use of flexibilities included in the Trade-Related Aspects of Intellectual Property Rights Agreement (TRIPS) agreement. All MPP licenses are compatible with the use of flexibilities in TRIPS.

Comment: It seems that certain countries are being punished with these licenses. 40% of our budgets are being used on ARVs.

MPP: Nobody is being punished and there are opportunities for switching to more affordable treatments in an attempt to optimize treatments. For example, in principle DTG is less expensive than LPV/r for several countries, and can be used as first or second line treatment. Therefore, a switch to DTG may have a positive impact on prices. The WHO will recommend DTG for first line. The patents will be expiring in 10 years.

Comment: Guatemala has 20 years of patent protection (for LPV/r?). Other countries in the region are in similar circumstances.

MPP: Guatemala is part of the territory included in our license for DTG (both adult and pediatric). Transition to DTG may be then a good idea, and in line with WHO recommendations. Each country has different circumstances, but there are generic producers out there, and most of the countries in the region are part of the territory and/or have no patent on DTG and therefore can access more affordable options through generic production.

Question: For countries where there are no patents how does pricing work?

MPP: The prices are set by companies and are initially similar, but vary hugely after negotiation with countries and depend on volume negotiations usually. They may change if a country has to pay royalties, but the royalties are very low. For many drugs, even when the agreement allows for royalties, in practice, they have not been collected. Thus, the impact of royalties is small.

Question: What do you think of the case of Venezuela? Or the case of Colombia? What emergency actions are you planning?

MPP: If the supply of drugs has been impeded or halted, this is an issue that goes beyond the issue of patents. We do not do procurement. We can speak to manufacturers to speed up registration. But these political issues can be difficult to manage. We can make suggestions, but we do not have power to compel manufacturers to act. We can try to make the generic producers understand the issues and encourage and support them to registry locally but at the end it's a decision only they can take.

Question: Which products are you negotiating right now for our region?

MPP: We do not negotiate for regions; we negotiate products, and try to make the license as wide as possible. We are in the process of creating a new product priority list that will be publicly available; new candidates for the WHO Essential Medicines List may be included.

Question: Can you clarify who is involved in the negotiation process and how does it work?

MPP: I am not a part of the negotiation team. We prioritize products and publish a priority list that gets presented to the board for approval. Then we start working on these priorities by reaching out to the companies and by trying to convince them to work with the MPP. Once there is an agreement, the list of countries starts to take shape. Not all countries proposed by MPP are accepted. The final license agreement and terms, including the geographical scope, is presented first to the Expert Advisory Group of independent experts and then to the board that approves it on basis of its potential public health impact. The MPP reaches out to civil society to explain the license. If possible from a legal/confidentiality standpoint, we could internally see if it is possible to start contacts with civil society earlier.

Comment: The MPP should be using us for support. We should meet more often to push the companies to negotiate better terms. There are countries that have similar income levels and some are included, or managed to get included, and others are not (i.e. Mexico and Colombia). Why is this?

MPP: We would like and work hard to find new ways to enlarge geographical scope. And in some licenses there are a large number of middle-income countries that are able to benefit. Of course, we would like to include Mexico as well as other upper middle income countries in the licenses, but it is not always possible, because at the end of the day it requires convincing the patent holder.

Comment: Civil society groups will continue to invite the MPP to their meetings, but we would like to be invited during your negotiations. Please take this message to Esteban. We want benefits for the population, either through VLs or CLs. But we need to walk hand in hand to achieve these things.

MPP: Everything we said about the countries without patents was sent to the different Ministries of Health to make them aware of their options when doing the procurement. If you know other parties that need to be contacted please let us know. Because many officials in these countries did not know there were no patents in their countries. MPP is committed to continue and strengthen coordination with civil society

The LATCA-CAB held in Panama City, Panama in October 2018 was an opportunity for treatment advocates from across the region to come together and build their capacity on a variety of topics related to access, including: pricing mechanisms, intellectual property, voluntary licensing, research and development and clinical trials. It was also an opportunity for the participants to discuss the issues that are unique to their countries as well as those common to the region. Due to the income status of many countries in Latin America and the Caribbean as designated by the World Bank, many countries are not eligible for inclusion into voluntary licenses territory. However, participants were consistent in their message that the income status of countries does not paint a complete picture of the issues they are struggling with at country level, such as corruption, internal conflict, right-wing governments, low health budgets, refugee flows and extreme wealth inequality.

A common theme throughout the CAB was the belief that voluntary licenses punish Latin American countries and are potentially doing harm in terms of access. The advocates present insisted that both the MPP and ViiV include civil society groups in their negotiations and deliberations. That even more so than national governments, civil society is best placed to know the needs of communities and people living with HIV and the limitations and constraints that are present on the ground. ViiV and the MPP both promised to do more outreach and coordination with civil society groups.

The income classification of many countries in the region has a limiting effect on the scope of action of advocates. Although ViiV spoke proudly of their access programs, the representatives spoke very little of region and mentioned very few of the countries present in the room. During the MPP presentation it was clear that originator companies have seemingly drawn a redline when it comes to middle-income countries and their voluntary licenses and that the MPP has very little room to negotiate on this point.

The participants did however leave the CAB cautiously optimistic about new entry points for collaboration with the MPP and ViiV to include consulting on negotiations of future licensing, the opportunity to propose pilot projects for access in the region and generally increased cooperation to improve access to treatment for all in the LATCA region.

List of Community Participants

Participant	Country
Marcela Romero	Argentina
Violeta Ross	Bolivia
William Patricio Morales	Chile
Fabián Betancourt	Colombia
Sergio Montealegre	Costa Rica
Felix Reyes	Dominican Republic
Odir Miranda	El Salvador
Alma de León	Guatemala
Rita Jiz	Guatemala
Rosa González	Honduras
Raúl Caporal	Mexico
Detrich Peeler	Morocco
Jaime Luna	Panamá
Guiselly Flores	Perú
Walter Trejo	Venezuela

List of Representatives of Companies and Institution



ViiV Healthcare

Anjali Radcliffe

International Government Affairs, Policy
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Rafael Camero

Regional Medical Scientist

Medicines Patent Pool

Fernando Pascual Martinez Consultant

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Mary Ann Seday

Regional Evaluator