

# HAI News

NUMBER 126 THE NEWSLETTER OF HEALTH ACTION INTERNATIONAL JULY-SEPT 2003

**HAI News** reports on developments in national and international campaigns on health for all. This newsletter highlights activities of network contacts involved in improving access to medicines, rational drug use and poverty eradication.

HAI News is produced by  
HAI Asia-Pacific  
Coordinating Office

#### Editors

K.Bala, Passanna Gunasekera

Health Action International (HAI) is a network of individuals and NGOs involved in health and pharmaceutical issues.

HAI Coordinating Offices

#### HAI Asia-Pacific

5, Frankfurt Place,  
Colombo 4,  
Sri Lanka  
Tel: (94 11) 2554 353  
Fax: (94 11) 2554 570  
Email: [hai@haiap.org](mailto:hai@haiap.org)  
Website: [www.haiap.org](http://www.haiap.org)

#### HAI Europe

Jacob van Lennepkade 334 – T  
1053 NJ Amsterdam,  
The Netherlands  
Email: [info@haiweb.org](mailto:info@haiweb.org)  
Website: [www.haiweb.org](http://www.haiweb.org)

#### AIS Latin America

Aptdo 41 – 128,  
Lima,  
Peru  
Tel / Fax: (51 1) 346 1502  
Email: [ais@amauta.rcp.net.pe](mailto:ais@amauta.rcp.net.pe)  
Website: [www.aislac.org](http://www.aislac.org)

#### HAI Africa

P.O.Box 78360  
Nairobi  
Kenya  
Tel: (254 2) 444 835  
Fax: (254 2) 440 306  
Email:  
[haiafrica@africaonline.co.ke](mailto:haiafrica@africaonline.co.ke)  
Website: [www.haiafrica.org](http://www.haiafrica.org)

Articles in HAI News may be reproduced for non-profit use. Please clearly credit HAI News as the source and send us a copy of the article.

## In This Issue...

### • Lead Article

\*The People's Health Movement: A People's Campaign for HEALTH FOR ALL - NOW

### • Network News

- \*Access to Essential Medicines in the Western Pacific Region in Penang
- \*US seeks further restrictions on Generic Medicines for Developing Countries
- \*Dr Samlee Plianbangchang, the next Regional Director of SEARO
- \* Assured Quality and Lowest Prices: What the Global Fund requires for buying medicines
- \* Patents at any price or drugs for all?
- \*Life-sized board game for on Access to ARVs
- \* People's tribunal on access to ARVs

### • Journal Scan

- \*New Research and Campaign news from physicians for a National Health Program
- \*Doctors call for National Health Insurance Journal of the American Medical Association
- \*New hope for WTO talks
- \*Zoellick vows to work for TRIPS deal, lays out US conditions
- \*Mozambique to get AIDS drug plant
- \*Hand in hand with industry?
- \*CERS exposes misleading claims of healthcare product company
- \*New TB superbug discovered in South Africa

### • Resources

- \*Good Practices in public-health-sensitive policy measures and patent laws
- \*Health opportunities in development
- \*Poverty, health and development –health cooperation papers

### • Other

- \*HAI Africa's official website launched
- \*WHO-SEARO publication notice

# **The Peoples Health Movement: A People's campaign for HEALTH FOR ALL – NOW!**

## **By Dr Ravi Narayan\***

### **Background**

In 1978, in Alma – Ata, the universal slogan *Health for All by the year 2000* was coined. Simultaneously, the famous *Alma Ata Declaration* was overwhelmingly approved, putting people and communities at the center of health planning and health care strategies and emphasizing the role of community participation, appropriate technology and inter-sectoral coordination. The Declaration was endorsed by most of the governments of the world and symbolized a significant paradigm shift in the global understanding of Health and Health care. (WHO – UNICEF, 1978).

Twenty five years later, after much policy rhetoric

- some concerted but mostly ad-hoc action
- quite a bit of misplaced euphoria
- distortions brought about by the growing role of the market economy that affected health
- a fair dose of governmental and international health agencies' amnesia and,
- this Declaration remains unfulfilled and mostly forgotten, as the world comes to terms with the new economic forces of globalization, liberalization and privatization which have made Health for All a receding dream.

The People's Health Assembly in Savar, Bangladesh in December 2000, and the People's Health Movement that evolved from it were both a civil society's effort to counter this global *laissez faire* and to challenge health policy makers around the world with a *Peoples Health Campaign for Health for All-Now!*

### **The People's Health Assembly**

The Global People's Health Assembly brought together 1450 people from 75 countries, and resulted in an unusual five-day event in which people shared concerns about the unfulfilled Health for All challenge. The Assembly program included a variety of interactive dialogue opportunities for all the health professionals and activists who gathered for this significant event. These events included:

- ⇒ a rally for Health;
- ⇒ meetings in which the testimonies on the health situation from many parts of the world and struggles of people were shared and commented upon by multidisciplinary resource persons; (People's Health Movement 2002)
- ⇒ parallel workshops to discuss a range of health and health related challenges;
- ⇒ cultural programmes to symbolize the multi-cultural and multiethnic diversity of the people of the world;
- ⇒ exhibitions and video/film shows; and
- ⇒ an abundance of dialogue, in small and big groups, using formal and informal opportunities.

The People's Health Assembly was preceded by a series of pre-assembly events all over the world. The mobilization in India was a significant example among many such initiatives. For nearly nine months preceding the Assembly, there were grassroots, local and regional initiatives of people's health enquiries and audits all over India; health songs and popular theater; sub-districts and district level seminars; policy dialogues and translations of national consensus booklets on health into regional languages and campaigns to challenge medical professionals and the health system to become more Health for All oriented. Finally, over 2500 delegates converged on Kolkata (Calcutta), mostly coming by five people's health trains, and brought ideas and perspectives from seventeen state conventions and 250 district conventions. In Kolkata, the assembly endorsed the Indian People's Health Charter after the

two days of conferences, parallel workshops, exhibitions, two public rallies for health and cultural programmes. About 300 delegates from this Assembly then traveled to Bangladesh, to attend the global Assembly. Similar preparatory initiatives, though less intense, took place in Bangladesh, Nepal, Sri Lanka, Cambodia, Philippines, Japan, in Asia and other parts of the world, including Latin America, Europe, Africa and Australia. The Latin American region was another hotspot of intense mobilization building on the long history of people's health campaigns and community health programmes in that region.

### **The People's Charter for Health**

Finally, at the end of a full year of mobilization and five days of very intense and interactive work in Savar, a *Global People's Charter for Health* emerged which was endorsed by all the participants (People's Health Assembly 2000a). This Charter has now become:

- ⇒ an expression of our common concerns;
- ⇒ a vision for a better and healthier world;
- ⇒ a call for more radical action;
- ⇒ a tool for advocacy for people's health; and
- ⇒ a worldwide rallying manifesto for global health movements, as well as for networking and coalition building.

The significance of this Global People's Charter is multiple:

- ⇒ it endorses Health as a social/economic and political issue and as a fundamental human right;
- ⇒ it identifies inequality, poverty, illiteracy, exploitation, violence and injustice as the roots of ill-health;
- ⇒ it underlines the imperative that Health for All means challenging powerful economic interests, opposing globalization and drastically changing political and economic priorities;
- ⇒ it tries to bring in new perspective and voices from the poor and the marginalized (the rarely heard) encouraging people to develop their own local solutions; and
- ⇒ it encourages people to hold accountable their own local authorities, national governments, international organizations and national and transnational corporations.

The vision and the principles of the Charter, more than any other document preceding it, extricates Health from the myopic biomedical-techno-managerialist approach it has fostered in the last two decades --with its vertical, selective magic-bullets-approach to health-- and centers it squarely in the more comprehensive context of today's global socioeconomic-political-cultural-environmental realities. However, the most significant gain of the People's Health Assembly and the Charter is that, for the first time since Alma Ata, a Health For All action-plan unambiguously endorses a call for action that tackles the broader determinants of health. These include:

- ***Health as human right;***
- ***Economic challenges for health;***
- ***Social and political challenges in health;***
- ***Environmental challenges for health;***
- ***Tackling war, violence, conflict and natural disasters;***
- ***Evolving a people-centered health sector;***
- ***Encouraging people's participation for a healthy world.***

In a nutshell, the People's Health Movement promotes a wide range of approaches and initiatives to combat the ill-effects of the triple assault by the forces of globalization, liberalization and privatization on health, health systems and health care initiatives. In more detail, these include calls for a wide range of action to tackle the determinants of health and build health systems that are primary health care focused and Health For All oriented.

### **Box 1**

#### **Action Initiatives in the People's Charter for Health**

- combating the negative impacts of Globalization as a worldwide economic and political ideology and process;
- significantly reforming the International Financial Institutions and the WTO to make them more responsive to poverty alleviation and the Health for All Now Movement;
- a forgiveness of the foreign debt of least developed countries and use of its equivalent for poverty reduction, health and education activities;
- greater checks and restraints of the freewheeling powers of transitional corporations, especially pharmaceutical houses (and mechanisms to ensure their compliance);
- greater and more equitable household food security.
- some type of a Tobin tax that taxes runaway international financial transfers;
- unconditionally supporting the emancipation of women and the respect of their full rights;
- putting health higher in the development agenda of governments;
- promoting the health (and other) rights of displaced people;
- halting the process of privatization of public health facilities and working towards greater controls of the already installed private health sector;
- more equitable, just and empowered people's participation in health and development matters;
- a greater focus on poverty alleviation in national and international development plans;
- greater and unconditional access of the poor to the health services and treatment regardless of their ability to pay;
- strengthening public institutions, political parties and trade unions involved, as we are, in the struggle of the poor;
- opposing restricted and dogmatic fundamentalist views of the development process;
- greater vigilance and activism in matters of water and air pollution, the dumping of toxics, waste disposal, climate changes and CO2 emissions, soil erosion and other attacks on the environment;

**Box 1**  
**Action Initiatives in the People's Charter for Health (Contd.)**

- militant opposition to the unsustainable exploitation of natural resources and the destruction of forests;
- protecting biodiversity and opposing biopiracy and the indiscriminate use of genetically modified seeds;
- holding violators of environmental crimes accountable;
- systematically applying environmental assessments of development projects and people centered environmental audits;
- opposing war and the current USA – led, blind ‘anti-terrorist’ campaigns;
- categorically opposing the Israeli invasion of Palestinian towns (having, among other, a sizeable negative impact on the health of the Palestinian people);
- the democratization of the UN bodies and especially of the Security Council;
- getting more actively involved in actions addressing the silent epidemic of violence against women;
- more prompt responses and preventive/rehabilitative measures in cases of natural disasters;
- making a renewed call for a comprehensive, a more democratic People's Health Care that is given the resources needed and holding governments accountable in this task;
- vehemently opposing the commoditization and privatization of health care (and the sale of public facilities);
- independent national drug policies focused around essential, generic drugs;
- the transformation of WHO, making sure it remains accountable to civil society;
- assuring WHO stays staunchly independent from corporate interests;
- sustaining and promoting the defense of effective patient's rights;
- an expansion and incorporation into People's Health Care of traditional systems of medicine;
- changes in the training of health personnel to assure it covers the great issues of our time as depicted in our People's Charter for Health;
- public health-oriented (and not for-profit) health research worldwide;
- strong people's organizations and a global movement working on health issues;
- more proactive countering of the media that are at the service of the globalization process;
- people's empowerment leading to their greater control of the health services they need and get;
- creating the bases for a better analysis and better concerted actions by its members through greater involvement of them in the PHM's website and list-server (pha-exchange);
- fostering a global solidarity network that can support and reach out to fellow members when facing disasters, emergencies or acute repressive situations.

- People's Charter for Health, 2000

As we enter the new millennium, this comprehensive view of actions for Health, is probably the most significant contribution of the People's Health Assembly and the evolving People's Health Movement. (Schuftan, 2002).

### **Significant Gains made by the People's Health Assembly and the Movement:**

Noteworthy are the ongoing and growing mobilization process at global level, the Assembly as a historic first gathering and the movement that is evolving. In more detail, the gains include the following:

- ◆ For the first time in decades, health and non-health networks have come together to work on global solidarity in health. These networks include the International People's Health Council (IPHC); Health Action International (HAI); Consumers International (CI); the Asian Community Health Action Network (ACHAN); the Third World Network (TWN); the Women's Global Network for Reproductive Rights (WGNRR); Gonoshasthya Kendra (GK) and the Dag Hammarskjöld Foundation (DHF). In the last couple of years, new networks like the Global Equity Gauge Alliance (GEGA) and the Social Forum Network have linked with us.
- ◆ Even at country level, in some regions, this is beginning to happen. In India, for instance, this national collective now includes the science movements; the women's movements; the alliance of people's movements; the health networks and associations; some research and policy networks and even some trade unions. In Latin America, the pre PHA networking has been further strengthened. In Bangladesh and Italy new networks are growing.
- ◆ Another significant development has been the evolving solidarity PHM has found for its various collective documents at the global level (People's Health Assembly 2000b & c). These have included themes such as:
  - *Health in the era of globalization: from victims to protagonists;*
  - *The political economy of the assault on health;*
  - *Equity and Inequity Today: some contributing social factors;*
  - *The medicalization of Health Care and the challenge of Health for All;*
  - *The environmental crisis : threats to health and ways forward;*
  - *Communication as if people mattered: adapting health promotion and social action to the global imbalances of the 21<sup>st</sup> century.*

Taken together, these documents represent an unprecedented, emerging, global consensus.

- ◆ At country level also, such consensus documents to support public education and policy advocacy have been upcoming. In India, for instance, five little booklets, now translated into most Indian languages, are available on the following five themes:
  - What globalization means to people's health;
  - Whatever happened to Health for All by the year 2000;
  - Making life worth living by meeting the basic needs of all;
  - A world where we matter: focus on health care issues of women, children, street kids, the disabled and the aged; and,
  - Confronting the commercialization of health care.
- ◆ These booklets have been published by 18 national networks which form the national coordination committee in India and represent unprecedented consensus, the first of its kind in five decades!
- ◆ The People's Health Assembly itself was an unusual international health meeting expressing and symbolizing an alternative health and development culture of dialogue and celebration. An extract from the report of two participants in the adjacent box describes this alternative dialogue.

## **Box 2**

### **The People's Health Assembly – An Alternative Culture of Dialogue**

“  
‘TO GIVE THE VOICELESS A VOICE’ was a foremost goal of the People’s Health Assembly. And indeed, the PHA had strong representation from a wide spectrum of marginalized and underprivileged groups, many of whom had never before had a chance to speak at a local council, much less at an international forum. Speakers from all corners of the earth represented everyone: from community health workers to traditional birth attendants, from mother’s clubs to a collective of unemployed alcoholics (from Scotland), from tribals to ethnic minorities, from migrant workers to refugees, and from commercial sex workers to activists with AIDS.....

“The PHA was a marvelous forum for sharing experiences and exchanging ideas. Events were enlivened by role plays, music, dancing and poster sessions. Dramatic ‘testimonials’ of personal hardships – many of which brought tears to the eyes – portrayed the setbacks that people were suffering due to social injustice, unfair laws, and globalization. To give more people a chance to speak out, literally hundreds of relatively small concurrent sessions were held, ranging from women’s rights to genetic engineering and everything else under the sun”.

(Werner and Sanders, 2000)

- ◆ Another significant gain has been the translation of the People's Charter for Health into nearly forty languages worldwide. These include Arabic, Bangla, Chinese, Danish, English, Farsi, Finnish, Flemish, French, German, Greek, Hindi, Indonesian, Italian, Japanese, Kannada, Malayalam, Ndebele, Nepalese, Philippine, Portuguese, Russian, Shona, Sinhala, Spanish, Swahili, Swedish, Tamil, Urdu, Ukrainian and now in the process of being translated to Tonga, Lithuanian, Norwegian, Welsh ,Thai, Cambodian, Vietnamese, Pastun, Dhari and Creole. An audio tape in English with Braille titles is also available. All these have been translated by volunteers, committed to the People's Health Movement. Audio Visual aids including videos for public education, exhibitions, slides, and other forms of communication are coming up. The BBC Life Series video on the Health Protesters was a good example.
- ◆ The movement itself has evolved a communications strategy which includes a website ([www.phmovement.org](http://www.phmovement.org) ); the e-list server group for exchange and discussion ([pha-exchange@kabissa.org](mailto:pha-exchange@kabissa.org)); news briefs (nine since January 2001) and a host of press releases on a wide variety of themes and on special events and crises.
- ◆ Presentations of the Peoples Health Charter, are constantly taking place in national, regional and international fora which have included the World Health Organization, the Global Forum for Health Research (GFHR – Forum 5 & 6) and the World Health Assembly.
  - The development of the evolving dialogue between the PHM and WHO is particularly interesting.
  - In April 2001, the very effective and assertive in-house lobbying by a visiting PHM Activist to a WHO research seminar resulted in the formation of the WHO Civil Society Initiative announced at the World Health Assembly, in May 2001. Six PHM leaders were invited to meet and dialogue with the Director General.
  - By May 2002, WHO CSI invited PHM to present the People's Charter for Health as a Technical Briefing in the World Health Assembly. 35 PHM members participated.
  - In May 2003, over 80 PHM delegates from 30 countries attended the Assembly; made statements on Primary Health Care, TRIPS and other issues and were invited to meet the DG designate, who welcomed a greater dialogue with PHM members at all levels so that WHO could be in touch with the realities of the lives of the poor and the marginalized. The Assembly was preceded by a PHM Geneva meeting for the 25<sup>th</sup> Alma Ata Anniversary, which was attended by some WHO staff, including the PAHO Regional Director.
  - In July 2003, the new WHO-DG Dr. Lee, who had met 6 PHM activists at the WHA 2003 wrote to the coordinator suggesting further dialogue and critical collaboration. This has been followed up through a series of informal meetings.
  - In January 2004, team of WHO staff will be attending the PHM facilitated International Health Forum in Mumbai, January 2004 to listen to the voices of Civil Society.  
These are all small, but incremental movements towards a critical dialogue of PHM with WHO and efforts to bring WHO that was derailed by the 'Investing in health campaign' of the mid 1990s to its original commitment to Health for All, Now.
- ◆ In many countries of the world, emerging country level PHM circles are beginning to organize public meetings and campaigns which include taking health to the streets as a Rights issue. Discussions on the charter by professional associations and public health schools; and articles and editorials in medical/health journals are also beginning to increase.
- ◆ Policy dialogues and action research circles on WHO/WHA; poverty and AIDS; women's access to health; health research; access to essential drugs; macroeconomics and health; public-private partnerships; food and nutrition security issues are beginning their work.
- ◆ In 2003, PHM decided to focus on the Alma Ata Anniversary as a theme for action initiatives. A million signatures for Health for All campaign was launched on the internet; an Alma Ata Anniversary packet of reflections, press releases and other documents were released and published; Alma Ata Anniversary reflections were held all over the world at national and state levels and also facilitated in NGO / civil society meetings and conferences.
- ◆ In January 2004, PHM is facilitating an International Health Forum in Defense of People's Health in Mumbai, which will take stock of all the initiatives, campaigns and action towards

Health for All Now, all over the world since the people's health movement evolved in Bangladesh in December 2003. This forum will just precede the World Social Forum 2004 an alternative annual global gathering of activists who wish to emphasize and celebrate that Another World is possible. It will be an important milestone to take stock of the road travelled.

## Conclusion

To conclude, the People's Health Assembly and the People's Health Movement that has emerged from it has been an unprecedented development in the journey towards the "Health for All" goal. The movement:

- ⇒ is a multi-regional, multi-cultural, and multi-disciplinary mobilization effort;
- ⇒ is bringing together the largest gathering of activists and professionals, civil society representatives and the peoples representatives themselves,
- ⇒ is evolving global instruments of concern and action, and
- ⇒ is involved in solidarity with the health struggles of people, especially the poor and the marginalized affected by the current global economic order.

***Recognizing that we need a continuous, sustained, collective effort, the People's Health Movement process must remind us, through the People's Health Charter that a' long march' lies ahead in the campaign for Health for All, Now.***

## References:

1. **WHO – UNICEF (1978),**  
*Primary Health Care, Report of the International Conference on Primary Health Care, 6-12 September, 1978, Alma Ata – USSR.*
2. **People's Health Movement (2002),**  
*Voices of the Unheard – Testimonies from the People's Health Assembly, December 2000, GK Savar – Bangladesh.*
3. **People's Health Assembly (2000a),**  
*People's Charter for Health, People's Health Assembly, 8 December 2000, GK Savar – Bangladesh.*
4. **Schuftan, Claudio (2002),**  
*The People's Health Movement (PHM) in 2002: Still at the fore front of the Struggle for "Health for All Now"; issue paper -2 for World Health Assembly, May 2002, People's Health Movement*
5. **People's Health Assembly (2000b)**  
*Discussion papers prepared by PHA Drafting group, PHA Secretariat, GK Savar, Dhaka –Bangladesh*
6. **People's Health Assembly (2000c),**  
*Health in the era of Globalization, From victims to protagonists – A discussion paper by PGA Drafting group, PHA Secretariat, GK Savar, Dhaka – angladesh.*
7. **Narayan, Ravi (2000)**  
*The People's Health Assembly – A People's Campaign for Health for All Now, Asian Exchange Vol. 16, NO. 2., P- 6-17, 2000*
8. **Werner, David and Sanders, David (2000)**  
*Liberation from What? A Critical reflection on the People's Health Assembly 2000, Asian Exchange, Vol. 16, No. 2., p 18-30, 2000*

***\*The writer is the Coordinator of the People's Health Movement Secretariat (Global). For further information, please visit : [www.phmovement.org](http://www.phmovement.org), [www.wsfindia.org](http://www.wsfindia.org), [www.sochara.org](http://www.sochara.org)***

# - Network News -

## **Consultation on "Access to Essential Medicines in the Western Pacific" in Penang**

WHO statistics reveal that one third of the world's population lacks access to essential medicines with almost fifty percent of the population in the developing countries in Africa and Asia not having access to the most basic and essential drugs. This issue has been spoken about in the recent past, international and local organizations have organized world conferences and seminars to address access to essential drugs, however what is needed is still gigantic.

The World Health Organization in collaboration with the National Poison Centre, University of Sains (Science), Malaysia organized a consultation titled, "Consultation Meeting on Improving Access to Essential Medicines in the Western Pacific Region" in Penang, Malaysia in July 2003. The consultation which was attended by seventeen individuals from 12 member states and WHO consultants was an attempt at addressing the irregular access to good quality essential medicines in the Western Pacific Region. A pragmatic strategy to improve member state's access to essential medicines is required. The possible impacts of trade globalization on access to essential medicines in the Western Pacific Region need to be anticipated and systematically addressed. With the implementation of patent protection for pharmaceutical products as a result of the TRIPS Agreement in 2005, essential medicines under patent such as anti-retroviral drugs for HIV/AIDS will not be accessible to many countries due to high prices. Feasible options to improve access to good quality essential medicines need to be identified taking into account trade globalization and the implementation of the TRIPS Agreement. It is in this view that the consultation was organized.

Among many topics which were discussed at the consultation some important topics were Access to Essential Medicines: measuring access to medicines and current problems, needs and experiences; improving access through rational selection and use: selection of Essential Medicines, rational use: consumers, providers and system perspectives; improving access through affordable pricing, sustainable financing and the supply system; assuring quality: combating counterfeit and substandard products and improving access to HIV/AIDS medicines, trade globalization and the TRIPS Agreement: options for improving access, legal perspectives and current international initiatives.

Analysing current problems affecting access to essential medicines in the Western Pacific Region, reviewing the draft that operational regional strategy for improving access to good quality essential medicines as guide for collaboration efforts between WHO and Member states and developing recommendations for WHO and Member States to improve access and to reduce prices of essential medicines were outlined as the objectives of the consultation.

## **US seeks further restrictions on generic medicines for developing countries**

Medecins Sans Frontieres (MSF), Oxfam, Health Action International (HAI), Third World Network (TWN) and the Consumer Project on Technology (CPTech), NGOs long involved in the process over "Paragraph 6" have acquired new information indicating that the US seeks further restrictions on exports of generic medicines to developing countries. They fear that the recent talks at the WTO TRIPS Council may result in further threats to access to medicines in poor countries.

The NGOs have learnt that, in a small group of five negotiating countries, the US has been seeking further provisions on a deal nearly agreed to in 2002, known as the "December 16" or "Motta text."

Since 2001, the WTO TRIPS Council has been trying to find a solution to what is known as the

Paragraph 6 problem: countries without drug production capacity will not be able to make meaningful use of compulsory licensing because of TRIPS restrictions on exports of generics.

According to Ellen 't Hoen, spokesperson for Medecins Sans Frontieres (MSF), "The proposed deal poses so many hurdles and hoops to jump through, that we are really worried it may not work at all. By continually demanding more restrictions, the US seems to be pushing for a watertight system so that no generic drugs ever get through to the patients in developing countries who desperately need them."

On top of the Motta text, US demands apparently include:

- Restricting the solution to "humanitarian use," a vague clause that may disqualify normal generic production;
- An "opt-out" clause, that will further hinder the economic viability of the solution;
- Heavier burdens on suppliers to change the packaging of products made under this system; and
- A "review mechanism," to monitor usage of the system and diversion of generics back into wealthy markets; this is a redundant layer of bureaucracy that can easily be manipulated to pressure countries out of the system.

Taken together, the effects of these provisions would be to discourage countries from using the system at all, and to heavily restrict generic production. The Motta text is already extremely cumbersome and does not provide an economic incentive to export generics. It seems that the US is pushing for additional limitations to the Motta text, which would be included in an accompanying "Chairman's Text".

Both the WHO and intellectual property experts have recommended a much simpler, workable and economically viable solution: allowing generic production for export as a limited exception to a patent right. This is the solution the NGOs also favour.

"We recommend the WTO start with a clean slate," said Michael Bailey of Oxfam. "WTO Members should take the time to find a real solution. Surely it is more important to get medicines to the most vulnerable populations, than simply to have a deal cut by Cancun."

*Source: Posted on e-drug, August 2003*

### **Dr Samlee Plianbangchang, next Regional Director of WHO/SEARO**

The 56<sup>th</sup> Session of the WHO Regional Committee for South-East Asia Region held in September 2003 in New Delhi, India, nominated Dr Samlee Plianbangchang as the next Regional Director. The nomination will be ratified by the 113<sup>th</sup> Executive Board of WHO in its January 2004 session. He would take office on 1 March 2004 on the completion of the term of office of the current Regional Director, Dr Uton Muchtar Rafei.

Dr Samlee Plianbangchang began working in WHO from 1984 as consultant in primary health care, and then moved up to become the Director of the Integrated Control of Diseases Programme. In 1996 Dr Samlee took over as the Deputy Regional Director- a post he held till his retirement in 2000. Earlier, Dr Samlee worked at several key positions in the Royal Thai Government Ministry of Public health. He was Director, Technical Division, Department of Medical Services from 1974 to 1981 and was Secretary, National Advisory Board for Disease Prevention and Control and Director of its Office from 1981 to 1985 and Acting Director, Division of International Health, Ministry of Public Health (1981-1982).

Dr Samlee graduated with a MD degree from Chulalongkorn Hospital Medical School, University of Medical Sciences, Bangkok, Thailand. He did his Master of Public Health and Tropical Medicine and Doctorate of Public Health from Tulane University, School of Public Health and Tropical Medicine, Louisiana, USA., with emphasis on International Health Administration and National Health Planning.

His interest and expertise lie in international health planning and administration, including programme and project development, coordination and management; epidemiology and human ecology, and public health education and practice.

He has received the Jacob C. Geiger Gold Medal Award for the Best Doctoral Thesis from Tulane University USA and the Physician's Recognition Award from American Medical Association (1970-1973). He is a member of Delta Omega (ETA Chapter) which is a highly prestigious professional society in U.S.A. He was certified by American Board of Preventive Medicine to be a specialist in international public health in 1971.

Dr Samlee has published a number of papers on health planning and administration, and medical education in both Thai and English.

*For further information please contact Mrs Harsaran Bir Kaur Pandey, Information Officer, WHO SEARO at 23370971 or 23370804, extn. 26424/26401*

### **Assured quality and lowest prices: what the global fund requires for buying medicines**

Health Action International (HAI) has produced a fact sheet, "Assured Quality and Lowest Prices: What the Global Fund Requires for Buying Medicines," to give guidance to countries and organisations that are involved in the process of applying for and receiving funds to procure medicines from the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund).

Explicit guidelines and readily accessible information about board decisions and requirements are not yet finalised, giving rise to insufficient understandings on how to procure medicines affordably to meet the needs of the greatest number of people.

The fact sheet pulls together key citations and other important decisions in one concise document. Each section contains pointers to internationally accepted best practice documents, some of which are explicitly referenced by the Fund. Access to this information will help to ensure that national efforts comply with Global Fund principles and requirements.

In the near future, the Global Fund will publish comprehensive procurement guidelines. The Global Fund and World Health Organisation are in the process of developing further guidance and tools. WHO will publish technical guidance and prequalification information on procurement and quality issues and services in early 2004.

The fact sheet summarises the following information:

- \*Key Global Fund citations about medicines procurement and supply management
- \*Fund principles and requirements on procurement and supply management capacity
- \*Fund requirements about cost and price
- \*Fund requirements on quality
- \*Advantages of generics
- \*Fund requirements about conforming to national and international legal agreements

HAI will continue to monitor Global Fund publications and decisions and update this fact sheet as needed.

*The fact sheet is available for free from the HAI Africa website ([www.haiafrica.org/globalfund](http://www.haiafrica.org/globalfund)). It can be downloaded in PDF. It is also available on CD-ROM, which includes full copies of all of the documents*

*referenced in the fact sheet. Copies of the CD-ROM are available for free by writing to the HAI Africa coordinating office, PO Box 73860, Nairobi, Kenya or info@haiafrica.org.*

### **Patents at any price or drugs for all?**

Germany's largest pharmaceutical industry association VFA (Verband forschender Arzneimittelunternehmen, German association of research based pharmaceutical companies) attempts to promote the concept of patents for drugs in developing countries by launching a new booklet. The NGOs view this effort as a strategy to mask industries' failure to supply affordable medicines to the world's poor.

The VFA-booklet contains some accurate information, simultaneously it carries several wrong figures and bizarre arguments. With a detailed critique BUKO Pharma-Kampagne counteracts the industry's misleading PR. The VFA further harms the Third World countries by branding the authorities of those countries as incompetent and corrupt. People are described as not being educated enough to take AIDS-drugs.

However, studies in Brazil and Africa show that compliance with antiretroviral therapy is as good or even better than in rich countries. Although manufacturers in poor countries are considered incapable of producing quality drugs the WHO has quite a different stand and has qualified a large number of drugs by such manufacturers and plans to treat half of all AIDS patients by 2005. Today less than one percent of AIDS infected patients are treated.

The critique that patents make drugs more expensive in developing countries is according to VFA a "misunderstanding". If one compares the prices for the treatment of a single AIDS patient in industrialised countries (10,000 US\$ per year) with the prices of generic producers in countries without patent protection (less than 300 US\$) then this argument seems futile.

The price reductions of multinational companies - forced by public pressure - are not a sustainable solution. The drugs are still too expensive for the poor and reach only a few patients. Therefore, the production and export of cheap generics must be protected. This would save the lives of millions of patients in need. The WTO should be well advised to support the access to cheap essential drugs.

**Source: Buko Pharma , 4. August 2003**

### **Life-sized Board Game on Access to ARVs**

Last April, one of the members of the Kenya Coalition for Access to Essential Medicines (of which HAI Africa is an active member), Malini Morzaria, wanted to come up with a different and more interactive way to bring home the message about access to antiretrovirals (ARVs). One night, in thinking about how the coalition was going to fill a large exhibition space at the National Museum of Kenya during a month-long exhibition on the face of HIV/AIDS in Kenya, the inspiration for a life-sized board game hit her. It is called HIVYO, which is Kiswahili for "that's how it is."

Her main goal was to find ways for people of all ages to understand at a personal level, what HIV+ people face, including in trying to access the treatment they need. According to Malini, "When you can make the problem real to people themselves, it is easier for them to open up to learn more about it." As soon as she explained the game to staff at the HAI Africa office, they immediately agreed to support the development and production of the game.

The board is printed on a large (10x10ft), PVC banner material that is easy to transport and lay out on any ground surface. The die is a sponge square, approximately the size of a football, that has been easily adapted to have the typical numbering found on dice. Standing at the start, players face the following path of squares on which they might find themselves:

1. Your nearest health facility is 15 miles away, walk. Play again.
2. You are too afraid to seek treatment because you are ashamed of being HIV positive. Play again.
3. Your employer has just fired you because you are HIV positive. Play again.

4. The nearest pharmacy is out of stock. Play again.
5. Your family is not ready to accept your plight and help. Play again.
6. Sorry, no doctor available at the nearest health centre. Play again
7. The hospital staff are on strike. Play again.
8. Your medical insurance has been cancelled because you are HIV positive. Play again.
9. You do not have enough money for a consultation. Play again.
10. There is a shortage of the medication you are on, and you cannot afford another course. Play again.
11. You have no "matatu" fare and are too sick to walk. Play again.
12. Lucky: your family agrees to pay for the treatment. Go to the end (Square 17).
13. The medicine is only available at a private hospital at up to 20,000 Kenya shillings per month, too expensive for you. Play again.
14. You have a new job, but fail the medical because you are HIV positive and so they do not hire you. Play again.
15. The stock has expired in the pharmacy. Play again.
16. You are at the end of the game , 500 people die daily due to AIDS. Walk on to the next square, See what you can do to help.
17. THE END: Nearly 50 per cent of Kenyans don't have access to medicines essential for their well being. There are many barriers that keep these medicines from people who need them including poor infrastructure, inefficient supply systems, high costs and a lack of political action. The Kenya Coalition for Access to Essential Medicines works to improve access to affordable medicines for all Kenyans, whether you are HIV positive or not. Please sign the petition to make treatment affordable to all of us.

During the month the game was at the museum, the coalition had a volunteer present in order to answer the many questions that the steps and information raised in players' minds as they stepped in the shoes of an HIV positive person. More than 7,000, mostly young people from local schools, played HIVYO during the exhibition.

The feedback was so positive that HAI Africa arranged for the game to be exhibited throughout the ICASA conference in Nairobi in September, where a further 900-1,000 people played it with great enthusiasm and interest. Requests to use the game came from a school in the United States, Médecins sans Frontières in South Africa and AIDS NGOs in Nigeria and Zimbabwe. Consequently, HAI Africa is working with Malini on ways that interested non-profit groups can make copies of the game, adapting it to their local situation. Malini is currently working on developing two more similar games, one on stigma and one on prevention.

***Further information about how groups can use HIVYO will be available soon on the HAI Africa website ([www.hiafrica.org](http://www.hiafrica.org)).***



## **People's Tribunal on Access to ARVs**

The Kenya Coalition for Access to Essential Medicines, with help from HAI Africa, which is a coalition member, organised a successful open-air tribunal at the start of the ICASA conference that was held in Nairobi in late September.

Hundreds of people gathered around the steps of City Hall, near the ICASA meeting site, at lunchtime to hear the testimonies of Kenyans, young and old, female and male, explain the diverse problems they face because of stigma, poverty and lack of access to treatment. At the end of their testimonies, the audience, which had been given placards that read guilty on one side and not guilty on the other voted on the key issues raised by the speakers. They voted the Kenyan government guilty of not doing enough to provide adequate and affordable treatment to those coping with HIV and AIDS. And they voted foreign pharmaceutical companies guilty of blocking attempts by developing countries to use legal means to access cheaper quality medicines. They voted Kenyan society guilty of perpetuating stigma and discrimination against HIV positive people.

## **Public-Private Partnership in health and shift in Public Policy**

An international conference organised by BUKO Pharma-Kampagne brought together thirty experts from different organisations, groups and countries for a critical reflection on the dynamics, determinants and consequences on public health and access to health care and the major shift in public policy towards public private partnerships (PPPs) in November 2003.

The introduction was followed by a satirical play on the marriage between the pharmaceutical industry and BUKO Pharma-Kampagne. It was blessed by the Almighty market and set the tone for discussions, using an analytical approach in a relaxed atmosphere. The strategic promotion of corporate interests by UN and governmental agencies was seen as problematic from the point of view of public health and access to health care of the poor.

While partnerships are based on the rationale of increasing resources for health problems of the poor, there was little evidence that coverage, quality or efficiency of health care actually improved through these partnerships. Corporates and big foundations gained image promotion as being socially conscious and responsible and literally entered into decision making positions in global and national health policy processes. The trend of corporate PPPs was increasing rapidly with 90 global public private initiatives (GPPIs), developed over the past three to five years. GPPIs had a strong biomedical techno-centric approach with product promotion of drugs, diagnostics and vaccines. The impact of PPIs on health systems or access to health care from a human rights perspective was being studied by civil society organisations and academics.

The concept of partnerships was discussed along with involvement of the public and communities in these processes. Partnerships are based on trust and shared goals. In that context the use of the word can be misleading and the term public-private interaction or initiative was suggested as being preferable. The term private or private sector covers a wide range of sectors, from the private non profit or voluntary sector to traditional healers, family and general practitioners, civil society and community based organisations, small nursing homes and mission hospitals and the corporate sector. The interests of these groups are different and there is need for clarity in usage of terms. In PPIs it is often the corporate sector that participates. The size or reach of corporates often exceed that of national states.

Involvement of the voluntary or private not-for-profit sector in "partnerships" could also be problematic and could possibly distort the role of this sector. The neo-liberal broader context in which PPIs in health were developing also had an impact on the basic determinants of health. Trade policies through which prices of primary commodities including agricultural prices were crashing, cancelling of subsidies under pressure in some countries affected livelihoods and purchasing capacity of large sections of people – the social majority with adverse health affects. Worsening of infant and child mortality rates were evidence of this.

Decreasing public sector health budgets in proportion to total budgets and to GDP in Pakistan, India and other developing countries weakened already stretched public health systems. Enhanced global trade in products like alcohol, unhealthy foods and lifestyle products were also part of this overall trend.

On the other side broad based social movements like the Peoples' Health Movement, the World Social Forum, movements at national and local level and research advocacy and lobby groups were more actually getting engaged in the policy process along with governments. The importance of participatory, democratic transparent methods were underlined and also the need to share information and strengthen each other.

**Source: Buko Pharma press release translated by Dr. Thelma Narajan, Community Health Cell, Bangalore/India**

## **- Journal Scan -**

### **New Research and Campaign News from Physicians for a National Health Program**

Studies conducted by researchers at Harvard Medical School and the Canadian Institute for Health Information illustrate the failure of the private, fragmented and business oriented US health care system to control administrative costs, as compared to Canada's single-payer system. One of the studies, in seeking to answer whether the ascendancy of computerization, managed care and more businesslike approaches to health care have decreased administrative costs, answers the question with a resounding "no".

The second study provides a state-by-state breakdown of savings each state could achieve if the United States adopted a national health insurance program. "Hundreds of billions are squandered each year on health care bureaucracy, more than enough to cover all of the uninsured, pay for full drug coverage for seniors and upgrade coverage for the tens of millions who are under-insured," said Dr. Steffie Woolhandler, co-founder of Physicians for a National Health Program and lead author of the studies. "Americans spend almost twice as much per capita on health care as Canadians, who have universal coverage and live two years longer. The administrative savings of national health insurance make universal coverage affordable."

The first study finds that health care bureaucracy cost US residents \$294.3 billion in 1999. The \$1,059 per capita spent on health care administration was more than three times the \$307 per capita in paperwork costs under Canada's national health insurance system. Cutting US health bureaucracy costs to the Canadian level would have saved \$209 billion in 1999, researches found.

The authors found that bureaucracy accounted for at least 31 percent of total US health spending in 1999 compared to 16.7 percent in Canada. They also found that administration has grown far faster in the United States than in Canada. Between 1969 and 1999, administrative and clerical personnel in the US grew from 18.2 percent to 27.3 percent of the health work force. In Canada, those personnel grew from 16 percent in 1971 to 19.1 percent in 1996.

The researchers also released a second report basing on data adjusted to reflect estimates of 2003 spending, found that health bureaucracy now consumes at least \$399.4 billion annually and that national health insurance could save about \$286 billion in administrative costs. The researchers found wide variation among states in the potential administrative savings available per uninsured resident.

For instance Texas, with 4.96 million uninsured could make available \$3,925 per uninsured resident if a national health plan were implemented.

The high US administrative costs can be attributed to three factors: private insurers have high overhead in both nations but play a much bigger role in the United States than in Canada, doctors and hospitals in the US must deal with hundreds of different insurance plans, each with different coverage and payment rules and referral networks that must be tracked. In Canada, doctors bill a single insurance plan, using a single simple form and hospitals receive a lump sum budget.

*Source: Medical Reform, Volume 23, Fall 2003, originally by Drs. Woolhandler and Himmelstein, co-founders of Physicians for a National Health Program – a 10,000 member organization that advocates for Canadian-style national health insurance in the United States. Public Citizen is a non-profit member-supported, consumer advocacy organization*

### **Doctors Call for National Health Insurance Journal of the American Medical Association**

In an unprecedented show of physician support for National Health Insurance (NHI), 7,782 US physicians propose single payer NHI in an article in the August issue of the Journal of the American Medical Association.

The Physicians proposal for “National Health Insurance” was drafted by a blue ribbon panel of leading physicians. The signers include two former US Surgeons General, the former Editor-in-Chief of the New England Journal of medicine, hundreds of medical school professors and deans, and thousands of practicing doctors throughout the nation.

“This is an historic moment. Today, thousands of physicians are taking a stand on the side of patients and repudiating the powerful insurance and drug lobbies that block wholesome reform,” said Dr Quentin Young, a leading Chicago physician who chaired the Department of Medicine at Chicago’s Cook County Hospital. The doctor’s article also critiques the health reform plans that have been offered by President Bush and the major Democratic presidential contenders. “Proposals that would retain the role of private insurers – such as calls for tax credits, Medicaid/CHIP expansions and pushing more seniors into private HMO’s – are prescriptions for failure.

*Source: Medical Reform, Volume 23, Fall 2003, originally from Journal of the American Medical Association, 13 August 2003*

### **New hope for WTO talks**

One of the two key barriers to reaching agreement in the current round of World Trade Organisation (WTO) talks could soon be removed, states the South African Trade and Industry Minister Alec Erwin.

In what appears to be a complete turnaround, the US has indicated to trade negotiators that it could be willing to withdraw its objections to a December proposal that would have given poor countries with no manufacturing capacity the right to import essential generic drugs under a compulsory licence.

Erwin has previously slated these objections - that the proposal would lead to profiteering and would be abused by unscrupulous manufacturers wanting to trade in lucrative first world markets - as nonsense. In line with its fears, the US had previously said that it wanted the types of drugs, and the diseases they were meant to fight, to be tightly circumscribed. This would have limited the rights of developing countries to determine their own public health agendas.

In an interview with Business Report, Erwin accused the US pharmaceutical industry of acting in "pure blind self-interest" and called for pressure to be kept on the world's biggest economy to pass the proposal. But he later stated the US administration now "understood the problems" faced by developing countries, which needed access to cheap medicines to combat dread diseases such as HIV/AIDs and malaria.

South Africa's chief trade negotiator, Xavier Carim, said that all US wanted was clear assurance that drugs meant for poor countries would not be diverted to rich markets. He said this assurance was already contained in the text of the proposal but that further political declarations could be forthcoming from countries if this was needed. Under current WTO rules, compulsory licences are limited to domestic suppliers for local consumption.

The US is the epicentre of the global pharmaceutical industry and was the only country in the WTO that did not sign the agreement. In terms of WTO rules, all 146 member countries have to agree on everything before a deal can be struck. The US turnaround means that there is now the prospect that there could be agreement in the negotiations on the trade-related aspects of intellectual property rights (TRIPS) within the WTO.

The TRIPS negotiations are vital because it is in these that developing countries' rights to override pharmaceutical patents and import generic medicines to fight health crises will be won. And unless there is movement on both of these issues, it is unlikely that there will be progress on other aspects of the talks, such as investment and competition rules, that will be of benefit to developed countries.

Erwin denied that developing countries would back off from their stance on TRIPS in return for the US throwing its weight behind them against the EU and Japan in Canada.

**Source: IP Health listserve originally written by Quentin Wray**

### **Zoellick vows to work for TRIPS deal, lays out U.S. conditions**

U.S. Trade Representative Robert Zoellick stated that he identified for a group of selected Trade Ministers the key issues that must be addressed in order for the U.S. to sign on to a deal that will give developing countries new flexibility to secure cheap generic copies of patented drugs under the Agreement on Trade Related Aspects of Intellectual Property Rights.

At a press conference held after a two-day session with Trade Ministers from twenty five countries, Zoellick said a deal on TRIPS and health should include a anti-diversion language to ensure that drugs

meant for poor countries were not diverted to rich countries. He said this would include making pills a different colour or changing the packaging of drugs.

Zoellick described this as a reasonable effort since some African leaders had told him drugs never get to poor people because they are instead sold on the marketplace because of their value.

He also said the U.S. wants to make sure that the new system is used for humanitarian purposes and does not become a loophole for creating a commercial export industry. U.S. drug companies have charged that the system could be abused by generic drug industries in India and Brazil, and have pushed for legally binding language that would prevent developing countries that have sufficient manufacturing capacity from using the new flexibility.

Zoellick said since the negotiations on the compulsory licensing system, covered by paragraph 6 of the Doha ministerial declaration on TRIPS, would involve an amendment to the TRIPS Agreement, the U.S. needed reassurances on this point. Finally, he said a mechanism was needed to review the new system to ensure that it is really being used by the countries that need it, suggesting that the U.S. wants to avoid a situation where the system becomes available to every country regardless of need.

He mentioned Singapore, Hong Kong and Korea as some countries that made statements indicating they would not use the compulsory licensing system except under emergency circumstances.

He said the U.S. was working with other countries in trying to find a solution, and suggested any new proposals would flow through the TRIPS Council. He said a solution to the TRIPS dispute was one of the core issues for the World Trade Organization ministerial in Cancun in addition to agriculture and industrial market access.

At issue is paragraph 6 of the Doha ministerial declaration on TRIPS and Public Health, in which ministers said they would seek agreement on a compulsory licensing system to allow developing countries that have insufficient or no pharmaceutical manufacturing capacity to issue compulsory licenses and import generic copies of patented drugs. The U.S. was the lone holdout to a proposed compromise text floated by the chairman of the TRIPS Council in December.

Pharmaceutical companies have shifted their strategy from pushing for the scope of an agreement to be limited to a specific number of diseases, to pushing for diversion safeguards and a limiting of the agreement's scope to countries that truly lack or have no manufacturing capacity. This would not include most developing countries. Pharmaceutical companies have insisted that they want legally binding language on these points, but developing countries are resisting any changes to the December 16 chairman's text. They have said they could accept a chairman's statement clarifying some of its provisions, provided it was not legally binding.

*Source: IP-health, 1 August, 2003*

### **Mozambique to get AIDS drug plant**

Brazil has pledged to build a plant in Mozambique to produce anti-retroviral drugs for HIV/AIDS sufferers. President Luiz Inacio Lula da Silva gave his support to the project on a visit to the southern African state. "We intend to produce anti-retroviral drugs here... in the shortest possible time," said the leader who is best known by his nickname Lula. He was speaking on a five-nation tour of the continent.

Brazil has emerged as something of a model for the developing world in the fight against the HIV/AIDS epidemic, having developed cheap copycat generic drugs to the anger of global pharmaceutical companies. An aggressive and highly effective campaign to promote safe sex in the media has also helped the Latin American giant keep the infection rate to less than 1% of its population. This contrasts sharply with infection rates in southern Africa where they are known to reach 30 percent in parts and about 16 percent in Mozambique specifically.

Brazil was earlier said to be planning to construct three factories in Africa as a whole but Lula would not be drawn on the exact timetable for construction, saying it would be "in the near future".

*Source : E-drug, November 2003*

### **Hand in hand with industry?**

Governments and UN bodies such as the World Health Organization (WHO) are engaging in a growing number of global partnerships in health. By working with companies and private foundations, they hope to solve health problems in developing countries. Wemos in collaboration with local organizations has started to conduct case studies in order to find out whether such partnerships are a suitable way to do this and whether they serve the interests of the general population. The following are taken from their studies.

“As a result of globalization, the influence of the multinational corporations at the global level has increased enormously. This influence has stretched out into the social sphere and also in the international political ambit, such as the UN-system. In 1999 Kofi Annan said at the World Economic Forum that the UN once only dealt with governments, but that now he knows peace and prosperity cannot be achieved without partnerships involving the business community. Also the former Director of the WHO has affirmed several times that today’s health problems are so vast and complex therefore tackling these problems requires the participation of all sectors, including the business sector.

These statements reflect the recent trend of mushrooming of initiatives, especially in health, whereby UN institutions like WHO and UNICEF collaborate with pharmaceutical companies and foundations such as the Bill and Melinda Gates Foundation. They tackle health problems like the vaccination of children, the distribution of drugs, the development of new medicines and drugs for tropical diseases, etc. These so-called global public private initiatives allow the UN institutions to access financial resources they could not access before. But it also provides the business sector with opportunities to influence health policies as they never could before.

From our perspective as civil society organizations working on the right to health, this new phenomenon raises many questions. The most fundamental question is whether public interests and values like equity and universality can ever be compatible with private interests and values of free entrepreneurship, raising profits and rewarding shareholders. Therefore it is of critical importance to know –apart from the goals- how decisions are taken, how accountability is arranged for, how the operative systems are organized and how sustainability is assured.

So far little information is available about the real benefits these initiatives have delivered for especially vulnerable and excluded populations, and for the strengthening of public health systems”.

To find out more about this issue, Wemos has started to conduct research at the local level in a number of countries, including Kenya, Uganda, India and South Africa. This is done in co-operation with local organisations. The central question which this research needs to answer is whether these global partnerships in health are suitable to provide an equitable and sustainable health improvement which contributes to the right to health for all people, especially for those most in need.

Partner organizations of Wemos in Asia, Africa and Latin America will carry out these case-studies, observing the effect that partnerships in health have on the national health system and the fulfillment of the right to health in their countries. They will choose an initiative that is relevant for the activities of their organization. An analysis of global partnerships at the European level has just been finished, providing insight in the main activities of global partnerships, identifying their main participants, trends in organisational structure and pointing out areas for further research.

Wemos continues: “At the present time we face a situation whereby some transnational corporations are financially bigger than many small Southern countries. At the international level they lobby for rules and regulations that protect their patents, their investments and their market access. We see that due to the increasing gaps between rich and poor countries and between social groups within countries, several communicable diseases related to poverty and the lack of fulfillment of basic needs have taken astonishing proportions (AIDS, Malaria, TBC and others). Global partnerships in health are expected

to play a role attacking these problems. But the proposed approaches seem emergency actions (top down, non-integral approach, without strengthening local structures, magic bullets, etc) that do involve risks. Partnerships should address the local need for care, they should be sustainable, the decision making should be transparent and they should be developed and implemented with the participation of the people they are meant to serve”.

The highest attainable standard of health is a fundamental Human Right. Wemos Foundation has been working since 1981 to improve people’s health in developing countries through influencing international policy.

***To find out more about Wemos’ project Health and the Role of the Private Sector, please contact [ppi@wemos.nl](mailto:ppi@wemos.nl) or call +31-20-4352050.***

### **CERS exposes misleading claims of healthcare product company**

In response to a complaint made by Consumer Education and Research Society (CERS), Ahmedabad, the Food and Drugs Control Commissioner, Gujarat State, has ordered Conybio Healthcare (India) Private Limited, Chennai, to stop publication and distribution of its pamphlets claiming that its products cure diabetes, blood pressure, parkinsonism, spondylitis, paralysis, piles and cancer through Far Infrared Rays. The Commissioner in his jurisdiction has also ordered raids on the company, issuing of prohibitory orders and seizure of goods manufactured by it. One team of the firm visited the office of the commissioner and was advised to stay away and abstain from issuing misleading advertisement in violation of statutory provisions.

The company distributed sun shades to cure one from migraine and sun stroke, socks for acidity, pillow covers for spondylitis, palm guards for Parkinson's disease, eye-shade for sinusitis, T-shirts for high, low blood pressure, short pants that cure gas, acidity, prostate, piles, urinary system problems, ladies briefs for menstrual problems, bed sheets for paralysis strokes and brassieres for breast cancer in the market.

The Assistant Commissioner, Food and Drug Control Administration, Valsad had come across more than 30 such products of the company. He prohibited the sale of these products. CERS had drawn notice of the Commissioner that the claims made by the company go against Schedule J of the Drugs and Cosmetics Rules, 1945, as well as Section 3 (d) of the Drugs and Magic Remedies (Objectionable Advertisements) Act, 1954.

Based on a complaint from a reputed orthopaedic surgeon at Valsad, CERS wrote to Conybio Healthcare, on 19 April 2003, to send copies of efficacy studies done and results obtained with each of the product shown in its brochure. Subsequently it sent a complaint to the Commissioner, Food and Drug Control Administration, Gandhinagar on 22 April 2003.

The Commissioner has asked Conybio Healthcare to produce evidence to substantiate medical claims for its products and to provide scientific proof in support of the effect of Infrared Rays which it claims is present in its products. The company, through its representatives, has informed the commissioner that it had never undertaken such studies by any recognised Indian institute.

CERS had also sent a complaint to the Secretary General, the Advertising Standards Council of India, New Delhi. The matter is being vigorously pursued by CERS with the authorities concerned.

***Source: INSIGHT -- The Consumer Magazine, Ahmedabad, 21.11.03***

## **New TB superbug discovered in South Africa**

Scientists have sounded the alarm over Tuberculosis "superbugs" stalking communities across the Western Cape that could wreak health havoc throughout South Africa.

One variant, called DRF150, is resistant to almost all the front-line antibiotics used to treat drug-resistant TB, which means hundreds of thousands of rands may be needed to bring the mini-epidemic under control.

The new strain has its epicentre in George, where sixty patients are affected, but another twenty cases or so have also been found in Worcester, Villiersdorp and the northern areas of Cape Town. A few cases have been isolated in Mpumalanga and in Nairobi, Kenya.

The emerging mutant strain, which has not been identified anywhere else in the world, brings a formidable new enemy into the Western Cape's battle with tuberculosis prevalence that is already at record levels.

It poses a serious threat for both local and national health authorities, according to Professor Tommie Victor, the specialist who identified it.

Victor, Professor of Medical Biochemistry in Stellenbosch University's Faculty of Health Sciences, said the new TB threat had been identified by a committed group of health-care workers, scientists, clinicians and nurses.

According to the study findings, which analysed data from 72 clinics in the Boland, Overberg and Karoo regions, more than 60 percent of drug-resistant TB is being transmitted from person to person.

Until now, usually drug-resistant TB occurred in people who did not take their TB medication regularly.

Previously, the drug-resistant TB that has most worried health authorities has been the Beijing/W strain, which emerged in New York in 1995 and cost millions of dollars to bring under control.

The Stellenbosch study also found the Beijing/W drug-resistant strain of TB in patients attending most of the clinics they examined.

Pointing to the astronomical expense of treating drug-resistant TB, Victor said treating ordinary TB cost about R200 per patient for a six-month course. In the case of drug-resistant TB, that spiralled to between R25,000 and R30,000, and the treatment period required was tripled to 18 months.

The Stellenbosch group has come up with a new method of identifying drug-resistant TB in 12 days, much shorter than the usual two months of testing required - a delay which Victor said could be partly to blame for its spread.

"The problem traditionally is that the bacterium grows very slowly, so people were only getting a diagnosis on drug resistance about two months after being tested.

"In that time, they (those infected) were out there in communities spreading the disease," he said.

**Source: This article by Di Caelers was originally published on page 1 of The Cape Argus on November 12, 2003**

# Resources

## **Good Practices In Public-Health -Sensitive Policy Measures And Patent Laws**

**Publisher: TWN (ISBN: 983 2729 06 8)**

**Year:2003; No. of pp:111**

The Third World Network is an independent non-profit international network of organizations and individuals involved in issues relating to development, the Third World and North- South issues. Its objectives are to conduct research on economic, social and environmental issues pertaining to the South; to publish books and magazines; to organize and participate in seminars; and to provide a platform representing broadly Southern interests and perspectives at international fora such as the UN conferences and processes.

Its publication Manual on Good Practices In Public-Health -Sensitive Policy Measures And Patent Laws has now been released. The international intellectual property standards enshrined in the World Trade Organization's Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) have priced many essential drugs out of reach of poor patients by awarding patent holders monopoly rights over these products. Nevertheless, nestled within the folds of the Agreement itself are provisions which do enable governments to override exclusive patent rights in order to secure access to affordable medicines.

This Manual examines the TRIPS-consistent policy measures to which states may have recourse for the purpose of producing, importing and exporting lower-priced versions of the patented drugs they need. Detailed suggestions are advanced, by way of model legal provisions, as to how governments may give effect to each of these measures - compulsory licensing, parallel importation, government use and exceptions to patent rights - in their national patent laws. In addition, the Manual discusses the domestic administrative and institutional framework required for the equitable and effective implementation of these provisions.

The outcome of a series of expert workshops and consultations organized by the Third World Network, this Manual will serve as a practical guide for policymakers and citizen groups in efforts to formulate intellectual property disciplines which meet not only the legal obligations of the TRIPS Agreement but also the moral imperative of safeguarding public health.

This manual was first presented at the "Regional Consultation on WTO/TRIPS Agreement and Access to Medicines: Appropriate Policy Responses" held in Colombo from 17-19 April 2003. It was hosted by the Ministry of Health, Sri Lanka and organized by Third World Network (TWN) in collaboration with Health Action International Asia Pacific (HAIAP). While the Department of Essential Drugs and Medicines Policy, Drug Action Programme, (EDM/DAP), World Health Organization (WHO), Geneva and the South-East Asian Regional office of WHO, New Delhi co-sponsored the Consultation. Among the 70 participants were senior health and trade officials and representatives of health-related NGOs and social movements from eighteen Asian and Pacific countries, as well as international experts and resource persons.

Contents ~ Preface ~ Acknowledgements ~ Introduction  
PART I: TRIPS-consistent options for affordable medicines: Measures for import, domestic production and export ~ Chapter 1 - Import ~ Chapter 2 - Local production ~ Chapter 3 - Export  
PART II: Model Legal Provisions for Public-Health-Sensitive Patent Laws ~ Chapter 4 - Parallel import ~ Chapter 5 - Public Non- Commercial Use (Government Use) ~ Chapter 6 - Exception to Patent Rights ~ Chapter 7 - Compulsory Licence  
PART III: Proposals for an appropriate Institutional And Administrative Framework for Public-Health-Sensitive Patent Laws ~ Chapter 8 - The Competent Authority ~ Chapter 9- Adequate Remuneration or Compensation  
Bibliography ~ Annex 1 ~ Annex 2

**Price**

**US \$12 for First World Countries. Add US\$3.50 for postage**

**US \$9 for Third World Countries. Add US\$2.50 for postage**

**RM15 for Malaysia. Add RM1.00 for postage**

**How to Order the Book**

**Order your copy from our online bookstore:**

<http://www.panasia.org.sg/ecom/mos/user/webdriver?Mlval=MOS&START=41&WINSIZE=5&orgid=12&catid=4>

**Contact Third World Network at 121S Jalan Utama, 10450 Penang, Malaysia, Tel: 604-2266159; Fax: 604-2264505; Email: [twnet@po.jaring.my](mailto:twnet@po.jaring.my)**

**Poverty, Health and Development – Health Cooperation Papers Volume 17**

**Published by Associazione Italiana Amici di Raoul Follereau (AIFO)**

**158 pages**

Poverty has become the primary concern of developing countries during the last decade. AIFO, an international organization working towards Primary Health Care, community based rehabilitation programmes and leprosy control launched a publication on poverty, health and development during the NGO forum at the World Health Assembly in Geneva, 2003. This 158 page publication contains a foreword, introduction, three sections and an annex on the People's Health Assembly and People's Charter of health.

In keeping with AIFO's mission which is "...supporting leprosy affected persons and persons with disabilities through integrated development projects in a spirit of partnership, with particular attention towards the poorest and vulnerable groups of persons...AIFO promotes activities of development education in Europe, for a better understanding of causes underlying poverty and under-development and for a just North-South relationship" it has carried out numerous projects in developing countries over the past years to support the poorest and the most marginalized population. The results of these projects reveal that it has been no easy task to reach these people in need. Therefore, an international workshop was held in Bologna, Italy 2001 to address the issue of barriers organizations envisage when reaching out for the most vulnerable, marginalized and the poorest population and to discuss the different dimensions of poverty. The sixty four participants from sixteen countries and the resource persons discussed and shared their own experiences, had group discussions, made presentations and delivered speeches on the general themes. The proceedings are thus, compiled into a book.

The first part of this publication evaluates the main presentations and discussions that were presented during the international workshop. While the second part presents a report on a pilot project carried out jointly by the Disability and Rehabilitation team of the World Health Organization and AIFO with the aim of promoting community based rehabilitation in urban and suburban slum and low income communities. This was considered one of the best means of reaching out to the marginalized and disabled population. The third and final part of the publication consists of articles and papers on poverty, health and development written by several contributors from around the world, (many of

whom are members of the People's Health Movement), and presented during national conferences organized by AIFO.

The style adopted is heterogenous, the diction simple with facts being laid down in a rather easy-to-understand manner. Hence the above factors make these personal experiences and academic papers quite stimulating to read. This publication would be of immense interest to anyone who is involved in poverty and development studies or work.

*The publication is available on the AIFO webpage : <http://www.aifo.it/english/homeenglish.htm>*

*Copies are available free-of-charge at:*

*AIFO, Via Borsilli 4-6, 40135 Bologna, Italy*

*Fax: + 390-51-43.40.46*

*Email: [info@aifo.it](mailto:info@aifo.it)*

## **Health Opportunities in Development: A course manual on developing Intersectoral Decision-making Skills in Support of Health Impact Assessment**

**Published by: The World Health Organization, Liverpool School of Tropical Medicines, Danish Bilharziasis Laboratory, Institute of Education, University of London**

**Part I: Course Basics**

**Part II: Course Implementation**

**Part III: Course Materials**

**69 + 131 pages and CD ROM**

Health Opportunities in Development, a course manual on developing Intersectoral Decision-making skills in support of the Health Impact Assessment (HIA) is published jointly by The World Health Organization, Liverpool School of Tropical Medicines, Danish Bilharziasis Laboratory and the Institute of Education, University of London. Part I of the manual examines the course basics. The chapters focus on basic principles in a generic way, rationale and structure of the course and also presents the concept of problem-based learning.

Part II is on course implementation and it covers the preparations and the actual conducting of the course, Health Opportunities in development comprehensively. Part III, the final part contains the course materials in a separate volume including six Task Guides for the HIA course, guidelines for tutors and resource persons, a genuine field trip and a recommended list of publications.

The purpose of this manual is outlined as to guide one through design, implementation and evaluation of a course that aims to build capacity in the essential intersectoral functions that support a sound HIA; under the context of socio-economic development in a very broad sense.

The publication is intended for a diverse readership. It would typically suit mid-level managers from Ministries, local agencies and departments. However, it could be of an asset to institutions and agencies that run short term courses and students.

Robert Goodland, World Bank's former Senior Environment Adviser talks of the manual as, "...this is the reality of today: the demand for intersectoral decision-making skills is increasing. International bodies such as the EU, bilateral development banks and multilateral development banks and national governments themselves are adopting healthy public policy as part of sustainable development.

They have recognized that health is not the responsibility of the health sector alone. They are searching for appropriate instruments and suitably skilled staff. This manual contains one approach in response to this demand."

***Please contact:***

***WHO, Marketing & Dissemination, 1211 Geneva 27, Switzerland***

***Tel: +41 22 791 24 76, Fax: +41 22 791 48 57, Email: [publications@who.int](mailto:publications@who.int)***

***Price: Swiss francs 75/US\$ 67.50***

***Developing countries: Sw fr. 52.50***

### **HAI Africa launches its website**

HAI Africa is pleased to announce the launch of their own regional website, [www.haiafrica.org](http://www.haiafrica.org). While still under construction, the regional office has high hopes that in the coming year it will become fully functional and the source of information that will be very useful to all of our partners."

The TRIPS Agreement and Pharmaceuticals, A Report of an ASEAN Workshop on the TRIPS Agreement and Its Impact on Pharmaceuticals, Jakarta 2-4 May 2000 was published by The South East Regional Office of the World Health Organization. The report has been compiled on the basis of input from the resource persons and major stakeholders at the ASEAN Workshop on the TRIPS Agreement and its Impact on Pharmaceuticals along with some background information on WTO and IPR. The aim of the report is to give an overview of the TRIPS Agreement and its possible implications on the pharmaceutical sector in developing countries. To get your copy, contact:

***Dr K. Weerasuriya, Regional Adviser - Essential Drugs and Medicines Policy, WHO South East Asia Regional Office, New Delhi, India. Please e-mail to him at [weerasuriyak@whosea.org](mailto:weerasuriyak@whosea.org) with your full postal address and phone number".***