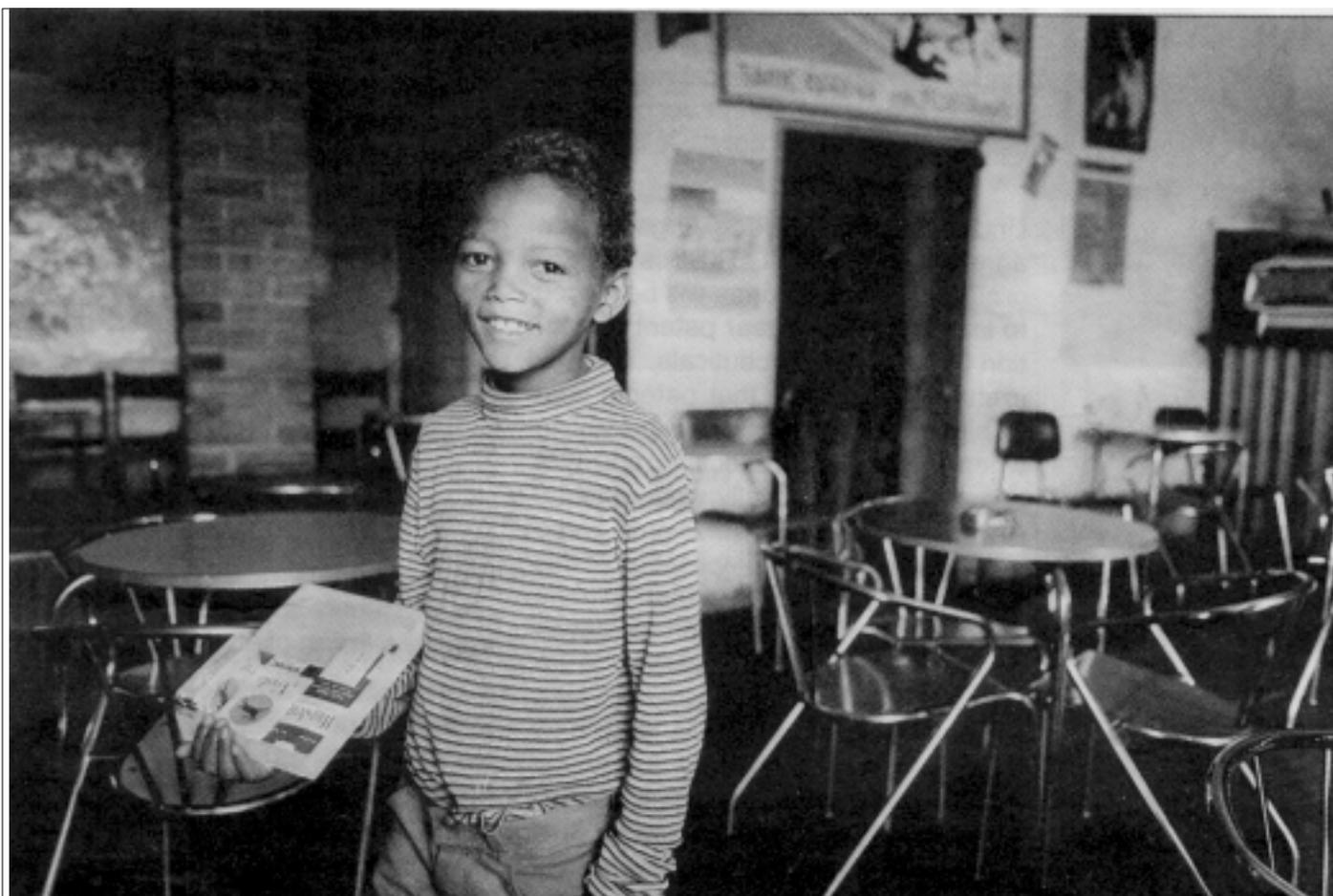

contact

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TRADE OR HEALTH?



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TRADE OR HEALTH?

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With respect to pharmaceuticals, the aims of the TRIPS Agreement are expressed as encouraging innovations, ensuring affordability and access to medicines, and reducing barriers to trade. No one would argue that these are anything but worthy aims. It is, however, these very aims that present a dilemma: while commercial interest can complement public health goals, it can also be in direct conflict! This issue of *Contact* looks at the areas of conflict and the possible social effects of the TRIPS Agreement, and particularly their impact on the poor. The issue also provides some suggestions on actions that can be taken to ensure public health interests in pharmaceutical and health policies are given priority over commercial interests when conflicts between the two occur.

*While commercial
interest can
complement public
health goals, it can also
be in direct conflict!*

Under the World Trade Organization agreement (to which TRIPS is an integral part), all signatories will be forced to implement a 20-year patent protection on new pharmaceuticals. There is irrefutable evidence that patents lead to higher prices than those prevailing when there is no protection, and that prices drop dramatically when patents expire and generic equivalents come onto the market. The implication of this agreement is therefore that generic equivalents of any new drugs developed – for example for AIDS or drug-resistant TB and malaria – will take longer to become available. Such new drugs are therefore likely to remain expensive for longer periods than they would be without the Agreement. This is well illustrated by the example of rifampicin which was produced in India within six years of its emergence on the market. Had rifampicin been subjected to a 20-year product patent, it would have remained very expensive and unavailable to many for an extended period.

Other possible effects are foreseen. These include price increases, a fall in consumption, local innovation, foreign direct investment and transfer of technology to developing countries. Research on diseases prevalent in

poorer countries and decreased access to drug information as a consequence of greater commercial secrecy are also predicted. All these need to be assessed and appropriate steps taken to minimize their impact on public health.

The need to find an appropriate balance between the interest of the patent (rights) holder and users was noted and considered in the TRIPS Agreement. This is particularly reflected in the limitations and exceptions to rights that are permitted within the Agreement. However, there seems to be a lack of, or very little, understanding that countries do have alternatives – and the right to pursue these alternatives in their best interests. Pressure needs to be brought to bear on WHO, WTO and other international and regional organizations to ensure that countries are given technical assistance, information, and advice on how best to address the implications of the trade policies, legislation, regulation and agreements in order to protect and promote health for all.

Examples of what NGOs can do to reverse the worst effects are highlighted in the article by Darlena David of the Christian Medical Association of India. In the interview with Dr Hans-Martin Hirt, an alternative to reliance on western pharmaceuticals is presented. We also include a listing of strategizing options.

Many of us who are interested in health for all do not consider it appropriate to treat health care as a matter of commerce only. In the late 1970s and 1980s, the popular saying was “think globally and act locally”. Today, the World Council of Churches believes that we must not only think globally and act locally, but that we must also strategize globally to be effective locally and globally. We hope this issue will help you think about how to do this with respect to TRIPS.

Eva Ombaka
WCC/CISS Pharmaceutical
Programme
Nairobi, Kenya

Captions

Trade or health? A street child selling cigarettes and chewing gum in the bars of Addis Ababa, Ethiopia.

Martin Adler/Panos Pictures

IS WTO A THREAT TO PUBLIC HEALTH?

Dr James Love, a consumer activist and director of the Consumer Project on Technology, is concerned about the effect of TRIPS (Trade-related aspects of Intellectual Property, see box on page 4) on health. He attended the World Health Assembly in April 1998 where many countries were lobbying for public health to be put before commercial considerations in trade negotiations and agreements.



James Love

Contact: What effect does the World Trade Organization (WTO) have on health?

James Love: WTO has to do with intellectual property, and there are several parts of the new TRIPS Agreement, which are very important for the health sector. For example, many poor countries that do not have patents on pharmaceutical drugs at the moment will in future be required to have them. As new drugs come onto the market, the effect of having a patent law will grow. Drug prices will be much higher. In the United States, for example, once a patent expires on a drug and there is competition from generics, prices fall very rapidly. The twenty-year patents stipulated in the TRIPS Agreement instead of the maximum ten or fifteen-year patents in the past will push up drug prices.

WTO has awesome power. It is much more powerful than UN bodies because it has enforcement mechanisms. It is going to be a supra government but it is run by people with very narrow interests

– representatives of ministries of trade or departments of commerce. Within any community, these diplomats do not represent all interests.

Contact: The justification for patents is to protect the profits of inventions and stimulate research. Are patents the correct way to stimulate R&D?

Love: Policies which enhance the public's access to new pharmaceuticals – and to other health care inventions – are a good thing for public health. Increased profits to drug companies are not an end, but rather one of the several mechanisms, which may or may not contribute to the size and efficacy of the R&D effort. National governments can increase research and development by funding research directly from their own budgets or by requiring drug companies to re-invest in health care research. Patents create financial incentives for firms to develop new drugs. This is the focus of the TRIPS accord and much US lobbying. The obvious shortcoming is that these patents create monopolies on important

As new drugs come onto the market, ... drug prices will be much higher



health care discoveries. Monopolies tend to seek high prices and high prices prevent many consumers from obtaining access to new technologies.

One's stand on patents must be based on the questions of "who benefits the most?" and "what are the alternatives?" and "is there a different way of doing it which may yield benefits to a maximum number of people?". The argument is not about "having patents" or "not having patents". We are not trying to get rid of pharmaceutical patents. The way to think about it is: "What sort of a patent system are you going to have?" The very winnable fights are those based on defining the type of patent system, which creates most benefit and who benefits the most. Is there a different way of doing this which accomplishes the same goals but spreads the benefits differently?"

Box: Understanding TRIPS

The aim of the TRIPS agreement is to strengthen intellectual property rights in the global economy. Intellectual property is an intangible asset (that is, something of value which cannot be physically touched), such as a patent or a copyright. Patents provide inventors with intellectual property rights. To be patentable an invention needs to have novelty (previously unknown to the public), non-obviousness (containing sufficient degree of innovation to merit protection), and industrial applicability. When a product is patented, it tends to earn a higher price. All countries which signed the "Final Act" ending the Uruguay Round in 1994 automatically became members of the World Trade Organization, and thus subject to the condition of the TRIPS Agreement. Compliance with TRIPS means that instead of an individual country being able to decide for itself on patent legislation, all WTO members have to accept 20-year patents on new pharmaceutical inventions.

What will be the effect of TRIPS? Drugs currently available as generics (that is, not protected by a trademark) will not be affected. However, as soon as TRIPS is in full force worldwide, any new drug coming on to the market will be under patent for 20 years. This presents a fundamental change. In the past, India developed its own means of producing rifampicin and made it available within six years of

its emergence on the market. Had rifampicin been protected by a 20-year patent in India, it would have been either very expensive or not available at all for a long period.

Poorer countries are allowed a breathing space or "transition period" in which to adapt to the new situation. Developing countries have until 1 January 2000 to fulfil their obligations to the treaty, and least developed countries have until 1 January 2006. Developed countries had only a one-year transition period following the introduction of the TRIPS Agreement on 1 January 1995.

How should these countries be responding to TRIPS? According to Dr Eva Ombaka, WCC's Pharmaceutical Adviser who attended a WHO/NGO meeting in October 1998 on the issue: "Countries should make themselves aware of the provisions of TRIPS (especially Article 8) such as opportunities for compulsory licensing and parallel importing which allow members to adopt necessary measures to protect public health. To help them take advantage of these provisions, a technical body, such as the World Health Organization, should advise them on how to revise their legislation in the interests of public health. WHO's technical support should also provide ongoing monitoring of the impact of TRIPS, especially in developing countries."

Contact: How should readers of *Contact* respond to TRIPS?

Love: The first thing they have to do is to start adopting policy statements or positions. We circulated a petition on the Internet on health care and intellectual property to be presented in the "Free Trade Area for the Americas" negotiations earlier this year. The only groups that signed on were Health Action International and our group. That looked pretty bad in my opinion when we went down to Costa Rica. We should have had 150 groups signed on.

Part of the problem is that many non-governmental organizations (NGOs) have not thought enough about it even to take positions. It was such a new topic for them they did not have any board resolutions to sign on to the document. So the first step is to find out what is going on. The best way is through the Internet. We have a Web page that covers health care issues and intellectual property with links to other groups that are active in this area, such as Health Action International, or other resources that are available. The World Health Organization issued a publication which is very helpful for people in health groups called "Globalization and access to drugs: the implications of the WTO/TRIPS Agreement" in November 1987 (see Resources page 15). Health Action International (HAI) has held meetings and taken positions.

There are many things that can be done within the context of the TRIPS to protect the public health interest. It is a complicated agreement but the exceptions that are given with regards to patents are as important as the rights themselves. Many of the controversies will have to do with how those exceptions are treated under the TRIPS.

One important thing to remember is that WTO is a political body, and that tribunals will be influenced by "international norms" or the opinions of experts on these topics. Various industry groups are already "manufacturing" norms. They actually pay people to write articles and hold conferences to establish the right way to protect health legislation

data or treat trademarks and patent. It is important for people who represent consumer interests not to rely entirely on that process. They need to have a proactive way of developing their own standards.

Contact: What are some of the specific issues that should be addressed?

Love: Patents may make it more difficult to get generics on the market. That essentially means prices would be higher for drugs in poor countries. However, we also know that countries have authority under the WTO to mitigate those problems through things like compulsory licensing.

Suppose a new AIDS drug comes on the market but that the price is so high that poor people in sub-Saharan Africa cannot buy the drug. Suppose further that the drug company refuses to go along with price control – saying, "If you make me sell the drug for this price, I will not import it into your country." In this situation, the government could issue a compulsory licence that would permit anyone who wants to sell the drug in the country to do so. A royalty has to be given to the company holding the patent, but it does not give the company the power to determine whether that drug is made available to the population and on what terms. Compulsory licensing is a power that governments have and sometimes, though rarely, exercise.

There has been very little compulsory licensing in most countries because historically countries that were poor did not have patents at all. They may have had patents on the process of manu-

The exceptions that are given with regards to patents are as important as the rights themselves.

Selling drugs in Angola



Peter Williams/WCC

Today, the legislation that South Africa has introduced provides an important model.

facture but they did not have patents on the products themselves. As a result there were few cases of compulsory licence. Compulsory licensing has probably been done more in the United States than it has in developing countries. Although it is allowed under TRIPS, another international agreement currently being discussed, the Multilateral Agreement on Trade (MAI), aims to abolish it.

Compulsory licensing is particularly important because medicine is changing radically. Think about biotechnology and gene therapy, for example. In Europe right now a company is trying to get the patent on a bacteria. People working on a new vaccine for meningitis are concerned that royalties might have to be paid to the holder of the meningitis patent every time someone takes a vaccine.

Contact: What is the pioneering action South Africa has taken?

Love: What South Africa wanted to do was two main things. One, they wanted to promote the use of generic drugs. They wanted doctors who work for the public health services to prescribe drugs by generic name - a proposal that faced opposition from the industry. The other thing they wanted to do was parallel

importing. The reason they wanted to do this was to be able to go out and get the best world price for any particular drug.

South Africa's "parallel importing" legislation allows it to import patented drugs from any country where it is available cheaply. Typically, when a patent owner holds patents in more than one country, the same pharmaceutical is sold at different prices in different countries. The patent owner is able to charge higher prices in smaller markets where there is less competition. For example, competition in the large US pharmaceutical market keep prices relatively low compared with prices in smaller markets of many African countries. The pharmaceutical industry has lobbied against the South Africa legislation is arguing that it goes against the TRIPS Agreement. The South African government has responded that the legislation is in the interest of public health - a provision which is allowed for in TRIPS. Today, the legislation that South Africa has introduced provides an important model for other countries to follow.

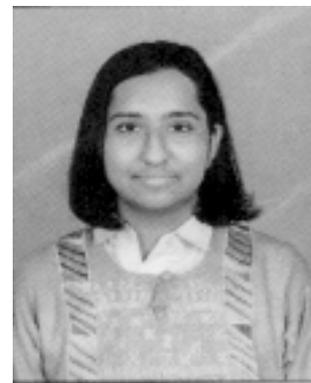
Dr James Love, Consumer Project on Technology, PO Box 19367, Washington DC 20036, USA. Tel: 1 202 387 8030. Fax: 1 202 234 5176. E-mail: love@tap.org More information about the Consumer Project on Technology is available on website: <http://www.cptech.org>

Where is the World Health Organization?

A resolution at the 51st World Health Assembly in May this year urged Member States "to ensure that public health rather than commercial interest have primacy in pharmaceutical and health policies, and to review their options under the Agreement on Trade Related Aspects of Intellectual Property Rights to safeguard access to essential drugs". This proved highly controversial and was referred back to the WHO Executive Board. It may, however, be brought back to the Assembly next year. According to Beryl Leach of Health Action International: "If WHO is not given the right to speak on health aspects of trade then we have lost a key voice at the international level. The international community relies on WHO to speak on public health concerns. If it is to show its commitment to Health for All, it needs to be able to speak out on all issues, including trade."

TRIPPING UP HEALTH IN INDIA

Darlana David, Communications Consultant with the Christian Medical Association of India (and editor of Contact from September 1998) outlines the fears associated with TRIPS, and describes some of the principles and actions taken by community groups in India.



Darlana David

Will essential medicines and affordable and nutritious food for all people become a utopian dream? The conditions imposed by the World Trade Organization's trade-related aspects of intellectual property rights are likely to seriously affect people's access to medicines and food, particularly in Asia. Transnational companies involved in pharmaceuticals and agriculture-based industries will be able to monopolise new varieties of medicines, seeds, genes, fertilisers and chemicals for up to 20 years with drastic consequences for food self-sufficiency in the Third World. In the area of medicines, prices will rise and the potential for domestic industry to produce new drugs will be much reduced.

Pharmaceuticals

India will be particularly badly affected because it has a highly developed pharmaceutical industry. India's pharmaceutical industry ranks number four in the world after USA, Western Europe and Japan. In 1970, the Indian Patent Act introduced process patents leading to a rapid growth of the domestic pharmaceutical industry, and a dramatic fall in the price of pharmaceuticals. Now, Indian companies produce 75% of the drugs consumed within the country, and also export in quantity.

India has started to manufacture and export a number of drugs while they were still protected by patents. Some

examples are acyclovir, albendazole, cefotaxime, ciprofloxacin, enalapril, fluconazole, ketoconazole, ketorolac, norfloxacin, and ranitidine. Drugs are often available at much lower prices in India than they are elsewhere (see chart with example of prices in India for ranitidine) because foreign pharmaceutical giants face competition from local manufacturers. Under TRIPS, India will be prevented from producing its own versions of drugs that are under product patent.

Traditional medicine

Products and processes derived from plants and based on the knowledge of local communities are also being patented under TRIPS. This has become a major area of conflict and concern because community groups believe that patenting will lead to a loss of control over the knowledge that is an ancient heritage of indigenous traditions.

Much is at stake. More than two-thirds of the world's plant species – at least

Farmers from Bhardoni Village, Patiala District, Punjab protest against the World Trade Organization In September 1998.



35,000 of which have medicinal value - come from developing countries. The value of germ plasm (part of the cell containing hereditary material) to the pharmaceutical industry was estimated in the early 1990s at US\$32,000 million per year. In India, over 50% of health care needs are being met by traditional systems of medicines. Practitioners use over 7,500 varieties of plants as part of their healing work.

Food

How does all this affect food? Poor people in Asia will find it more difficult to obtain essential food items as a result of the implementation of TRIPS. Take the example of the effect on rice. Patents will increasingly be applied to paddy varieties, bio-pesticides and bio-fertilisers. The monopoly power created by these patents will push up prices creating higher food prices. Food production will tend to concentrate on a small number of profitable cash crops endangering the security of food supply. At the same time, cropping patterns based on just a few varieties of seeds will be vulnerable to large-scale loss through disease.

Dr Vandana Shiva, Director of the Research Foundation for Science, Technology and Ecology (RFSTE) predicts a gloomy scenario. Seventy-five per cent of the total population of India is dependent on agriculture for their livelihood, and 90% of farmers are small and marginal with less than two acres of land. If farmers are no longer able to buy seeds from each other and are forced to buy patented products from multinational companies, many will not be able to make ends meet and will

have no option but to sell their land. Landlessness is bound to lead to large-scale urban migration bringing its own chain of hardships and unprecedented impoverishment. An agrarian people, deprived of their livelihood, may turn to violence to seek justice.

What to do?

Many groups of traditional healers, farmers' groups, social movements for alternative development, and scientists are discovering that in the age of monopolies, there is strength in communities who stand together to articulate the principle that people's health and well-being matters far more than trade and profits.

One important assertion of these groups is that of the **collective rights of local communities over community resources**. In India, a legislation on local self-government, named the "Panchayats (Extension to the Scheduled Areas) Act, 1996" has provisions which recognise the villagers' right to have control over their common resources. Community groups resist what they consider to be the privatising of people's knowledge.

Groups like the RFSTE work on several fronts. They lobby on legal and policy issues, and work with the media to ensure that their perspective is heard. They also educate the endangered communities of farmers and practitioners of indigenous systems of medicine arguing that **knowledge in the public domain cannot be patented**.

Experts in the indigenous systems of medicine at a workshop convened in April 1998 in Delhi declared **all**

Poor people in Asia will find it more difficult to obtain essential food items as a result of the implementation of TRIPS.

Price Comparisons of Medicines, 1996 (Indian Rupees)

Drugs/Brand	Company	India	Pakistan	UK	USA
Ranitidine (Zantac) 300 mg x 10s	Glaxo	18.53	260.40	484.42	1050.70
Times Costlier			14.05	26.14	56.70
Diclofenac sodium (Voveran)	Novartis (Ciba-Geigy)	4.95	55.80	96.46	334.95
Times Costlier			11.27	19.49	67.67

Reference: *New Patent Regime: Implications for Domestic Industry, Research & Development and Consumers*, B K Keayla January 1996

biological resources and the heritage of indigenous knowledge to be the national asset of the Indian people. They said that the State was not the owner but a mere trustee of this rich heritage. They demanded effective legislative measures be introduced to pronounce traditional indigenous knowledge and the medicinal plants of the Indian systems of medicine as the common and collective property of the people.

Community groups also argue that **since indigenous knowledge is not “novel”, it is not patentable.** Novelty comprises one of the grounds for establishing a patent on a plant use. Neem has long been used in agriculture as a bio-pesticide and fungicide. But since 1985, US, European and Japanese firms have taken out 65 patents on various formulas for stable, neem-based solutions and emulsions, and even on neem-based toothpaste.

Patenting the Indian Neem tree

‘Azarichdita Indica is a tree native to India and widely known as Neem’. For centuries, it has been used as a bio-pesticide and medicine. The Neem is worshipped as sacred. People in rural communities start their day by using the neem datun (toothbrush) to protect their teeth with its medicinal properties. Communities have invested centuries of care, respect and knowledge in propagating, protecting and using neem in fields and common lands. For millennia, many complex processes were developed for using it in specific purposes, though the active ingredients were not given Latinised names. An IPR claim on Neem is absurd because it claims nature’s creativity and creativity of other cultures as its own. Moreover, there is a false claim that the medicinal property is created by the patentee.’

Courtesy: Shiva, Vandana, *Biopiracy – The plunder of nature and knowledge*, South End Press, Boston (1997)

The “Neem Campaign” was launched in India to challenge the patenting of characteristics of the neem tree. Over a million people gave their signature to the petition, including small industrialists who have been producing neem-



Happiness is a plate of rice.

based products for the local market in India for decades. At the same time, RFSTE working with the International Federation of Organic Agriculture Movements and 200 other associates, filed two claims challenging Neem patent applications. One was successful. The European Patent Office agreed with the campaign claim that there is nothing novel or original about the process or products for which patents were being sought.

Seed Satyagraha

According to Gandhi no tyranny can enslave a people who consider it immoral to obey laws that are unjust. A massive movement – the Seed Satyagraha – has emerged over the past few years in response to the threats of intellectual property right clauses on agricultural products. Seed Satyagraha proclaims the common intellectual rights of Third World Communities. It has created an alternative to patented seeds by building community seed banks, strengthening farmers’ seed supply, and searching for sustainable agricultural options suitable for different regions.

But the real battle is beginning on another front. A number of well-known activist groups and NGOs have filed a petition to restrain the government from signing Article 27.5(3b) of TRIPS. The article allows patents on life forms. The Court has ruled that it could not “go into

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WCC



Drawing of Neem leaf

the wisdom of the economic policies” of the government.” However, activists are banking on the fact that only Parliament has the right to make laws for the country. If sufficient pressure is created against seed, plant and animal patents the Parliament will block laws that threaten the health and well being of the people. The people will decide what is good for them and they will let the government know, perhaps through the ballot box, whether they approve of the government’s policies or not.

Changing patent law

India is under tremendous pressure to

change its Patent Laws. Like other developing countries, India has until 1 January 2001 to fulfil her obligations under the Agreement. (Forty-eight “least developed countries have an additional five years.) Some key elements need to be kept in mind in developing patent laws, which would respect indigenous knowledge, cultural values and socio-economic context.

Patent laws should make it very clear that life forms cannot be considered an invention (and therefore cannot be patented). In particular, the following must not be considered inventions.

- a) The whole or part of natural living beings and biological materials found in nature, even if isolated from it or purified, including the genome (or germ plasm) of any natural living being.
- b) Essentially biological processes.
- c) New uses of a known product or process, including the second use of a medicine.
- d) Patents on life should be excluded because they are contrary to morality*, or injurious to human, animal or plant life, or health, or to the environment.
- e) Diagnostic, therapeutic and surgical methods for the treatment of humans or animals.
- f) Plants and animals in whole or any part, including DNA, cells, seeds, varieties and species.
- g) The human body and all its elements in whole or in part.
- h) Biological processes and products derived from them.

Community groups say that Shalom requires diversity, and that we all need Shalom to survive!

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* *Indian philosophy considers life forms as kin, not as resources.*

ARE NATURAL MEDICINES THE ANSWER?

Even without TRIPS, most people in the Democratic Republic of the Congo cannot afford imported pharmaceuticals. Dr Hans-Martin Hirt, medical adviser in what was then Zaire from 1985 to 1991, believes that some imported pharmaceuticals are nothing more than expensive, neatly-packaged replacements for something already growing in many people's back gardens. Unfortunately, today most local people have lost the skills their ancestors had for producing and using natural medicines. Interview by Keith Lindsey.



Credit: Anamed

Doctors in Kisantu, Democratic Republic of Congo, learn to make medicines themselves.

Keith Lindsey: Hans-Martin, how did you become an expert in tropical medicinal plants?

Hans-Martin Hirt: I am not an expert. Nobody is. Out of 10,000 medicinal plants I know virtually nothing. But I developed a great commitment to natural medicines when I was responsible for the importation of European medicines into one particular region in Zaire. The longer I was there, the more medicines I found that could be made from locally grown plants. Of course, not all medicines could be made, but in some cases locally produced medicines were equally or even more effective and had fewer side effects than imported drugs.

Lindsey: I believe that you had to leave Zaire in 1991. What did you do then?

Hirt: Together with a colleague in Zaire, Bindanda M'Pia, I had written a practical handbook, "Natural Medicines in the Tropics". We found that our work was appreciated throughout the tropical world, and so we translated this book into English and German. We

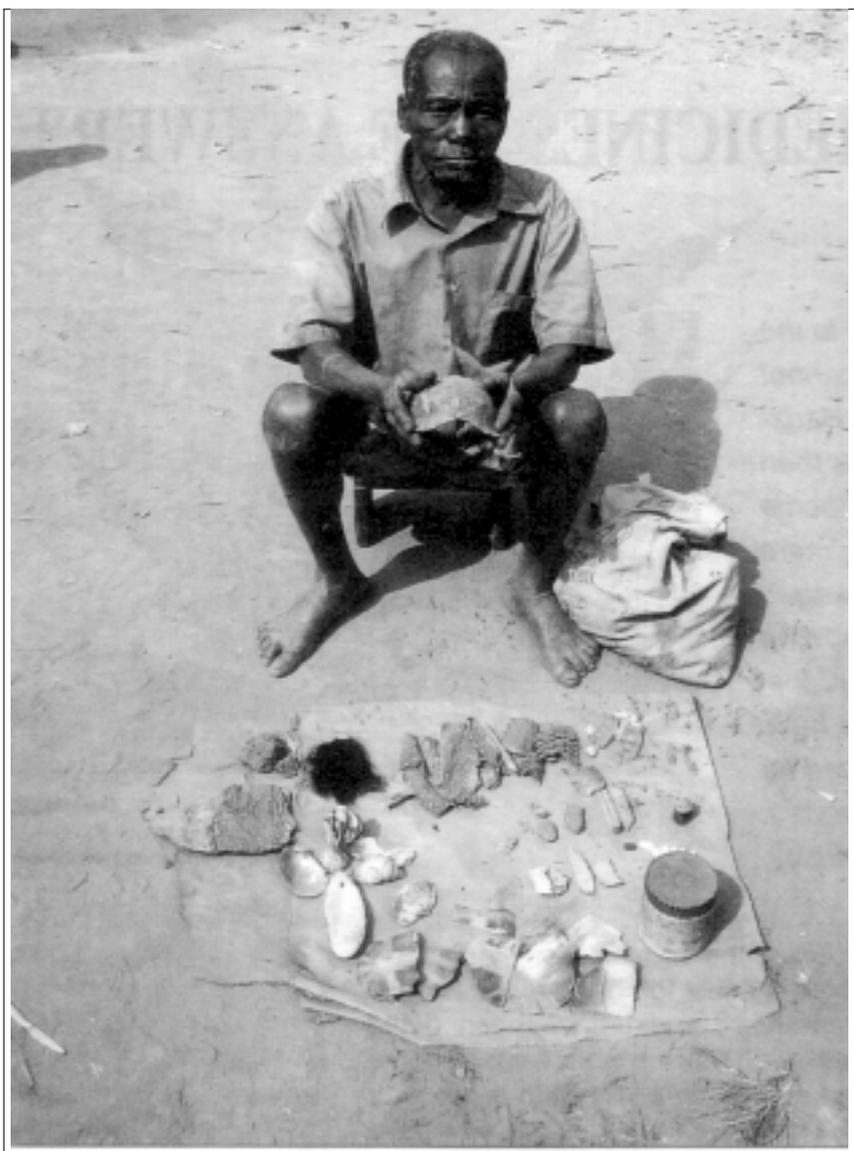
founded the organization "Anamed", which stands for "Action for Natural Medicines", and I have been doing week-long training workshops at home and abroad, in which, with a range of health workers and doctors, we make medicines out of medicinal plants.

Lindsey: Are you encouraged by the developments you see in health provision in the so-called developing countries?

Hirt: Not very much. There is a lack of working together. In some countries, the church is divided into many groups. And too often pharmacies that belong to the churches are empty – many bishops seem to see them as a means of making money. I would like to see the churches and the pharmacies working together to demand lower prices from European pharmaceutical companies.

The very survival of many people today depends entirely on their rediscovering their traditional skills of growing healing plants, and using the leaves, flowers, stems or roots in appropriate ways as natural medicines. Pharmacies

*And too often
pharmacies that
belong to the
churches are empty*



Credit: Anamed

Traditional pharmacy in former Zaire: the source of many patent medicines in Europe?

attached to hospitals need to develop their own gardens of healing plants, in order to produce their own medicines. I have been told that, in these troubled times in what is now the Democratic Republic of the Congo, the only medical

resource available to many hospitals is a copy of my book. Even when better times come, they will have a much greater degree of self-reliance if they successfully relearn their traditional skills.

Another important reason for the churches and medical organizations to work together is to bring political pressure to bear in the fight against patents on natural medicines. This may become even more urgent with the introduction of TRIPS. Like others, we believe that people should have rights under international law to use their traditional remedies. They should decide who has ownership of any patents.

Lindsey: What is the particular problem of patents?

Hirt: Once a particular process is patented, no local manufacturer can make that drug, and the country is dependent upon imports. Then 95% of money given for health care in developing countries ends up in the pockets of the pharmaceutical companies. The table giving details of the treatments for different forms of sleeping sickness gives an idea of the extent of the problem. Also, we are always anxious that what has been common knowledge to so-called unsophisticated people for centuries might be usurped by modern pharmaceutical concerns and patented as a new discovery.

Lindsey: What sort of role could the World Health Organization (WHO) play?

Hirt: The WHO could do far more to

Pharmaceutical companies profit while patients are forgotten Example: Sleeping sickness

The changing price of medicines for trypanosomiasis from the manufacturers (prices in Deutschmark)

<i>Medicine</i>	1960	1998
Lampit, 100 tablets, Bayer Argentina (nifurtimox)	6.40	15.40
Lomidine, 37 ampoules per treatment, Rhone-Poulenc (later May & Baker) (pentamidine)	5.60	33.00
Arsobal, 10 ampoules per treatment, Rhone-Poulenc (melarsoprol)	3.50	92.50

Ornidyl, (DFMO), Merrel-Dow, Those people who require Ornidyl or Arsobal will certainly die. There is no possibility that people can afford to pay the price. For purposes of comparison, the monthly wages of a teacher in Zaire/Democratic Republic of the Congo in 1960 were the equivalent of 300 DM. At that time, three hours' work would pay for treatment with Arsobal. This year, a teacher's wage is equivalent to 5 DM. A teacher must work for about 18 months to pay for a treatment with Arsobal.

protect developing countries from the scourge of patents. The needs of ill people must surely be more important than the legal rights of patents. In Anamed, we are also disappointed that the WHO is not prepared to confront the legislation that permits European companies to manufacture soaps and cosmetics that contain mercury. These products are then distributed in tropical countries where they are used to lighten the skin. Mercury is very toxic and causes massive health problems. According to the World Health Organization, mercury poisoning can provoke psychotic reactions such as delirium, hallucination and suicidal tendencies. Mercury can also enter the brain of the unborn child via the mother's placenta.

Lindsey: And what are you doing in Anamed to tackle the problem of patents?

Hirt: First of all, we continue to gather recipes from all over the world for producing medicines out of medicinal plants. Also we encourage governments to give us an invitation and sponsorship to run national seminars, and to take our book and present it to the population of their country as their property. We know that this approach offers a protection against the power of patents in that country.

Lindsey: Do you have any examples?

Hirt: Yes, in Uganda. On 3 November 1995 our book was publicly handed over to the population by Hon. Bagnma Isoke, Minister of State, in a ceremony at the conclusion of a seminar. Everybody could see it on the television and in the newspapers.

Lindsey: I understand that two million people die each year from malaria. Has Anamed any ideas about how countries can avoid being dependent on imported medicine?

Hirt: We recommend teas made from the leaves of different medicinal plants, for example, the neem and bitterleaf trees and the paw paw plant. Our current research is with *artemisia annua*. Hospitals in tropical countries are monitoring the effectiveness and the side effects of a particular *artemisia annua*, and the results are very encouraging. We will be keeping *Contact* informed as the research progresses.

Lindsey: You seem to have found a means whereby health workers and doctors can achieve a significant measure of self-reliance with regard to the treatment of malaria. Self-reliance is the key to the development of a degree of economic independence and stability in the face of overwhelming international commercial pressures.

Action for Natural Medicines (Anamed)

Being committed to the relationship between people and their environment, Anamed runs seminars and develops new projects that enable people in the tropics to become more self-reliant with regard to their health and social and economic well-being.

Objectives:

1. To promote the protection and cultivation of healing plants, and the skilled preparation of and treatment with natural medicines.
2. To support people in becoming more active in the care of the environment.
3. To support people in becoming more self-reliant with regard to their health and material needs, and at the same time to oppose any commercial



anamed logo from letterhead

initiative that continues their dependency on the North.

4. To promote local and international cooperation in pursuing these principles.

Anamed, Schafweide 77, 71364 Winnenden, Germany. Tel: 49 7195 910225. Fax: 49 7195 65367. E-mail: Keith_lindsey@hotmail.com

10-POINT PLAN OF ACTION

The suggestions listed here have been developed from the material contained in this issue as well as the recommendations of group discussions which took place at the Pharmaceutical Advisory Group (PAG) meeting held at the Ecumenical Centre, World Council of Churches, Geneva, Switzerland on 30th October 1997.

1. Get informed by finding out what is going on.

Read this issue of *Contact*, write to the World Health Organization for a copy of "Globalization and access to drugs: the implications of the WTO/TRIPS Agreement". If possible, use the Internet – website: <http://www.cptech.org> covers health care issues and intellectual property with links to other groups that are active in this area, such as Health Action International (HAI), and resources that are available.

2. Organize a meeting about public health versus trade.

The aim of the discussion would be to develop a policy statement or position paper. Once your board has signed a resolution on the issue, your organization will be ready to join in the action of groups such as HAI and the Consumer Project on Technology.

3. Join a network, such as HAI, providing information on TRIPS.
4. Organize a workshop on the use of natural and herbal medicines. Encourage the sharing of information and make sure that the process includes education on how to minimize the risks, such as intoxication. Seek help from Anamed (see page 13).
5. Document your national experience and share them with others.

6. Lobby your Ministry of Health and other relevant government departments

- Ensure promotion of the Essential Drug concept
- Urge your Minister of Health to read the WHO paper written specifically for health ministers, namely "Health Economics, The Uruguay Round and Drugs".
- Ensure that policy makers know how best to implement TRIPS in the interest of promoting public health. Tell them about the CPT website which provides information on different country experiences.
- "The TRIPS Agreement - A guide for the South" is written specifically for policy makers.

7. Provide information to others, and encourage them to lobby your government

- As well as sharing information with other health workers, try to be in contact with as many health and consumer NGOs, networks and associations, including medical associations, as possible. They need to know about TRIPS. Sympathetic journalists will also welcome information.

8. Send a message to World Health Organization's Action Programme on Essential Drugs or to your regional or national WHO office. Send a copy of the letter to the NGO Forum for Health. Your support will strengthen the voice for Health for All and against commercial and trade interests at the 52nd WHA in May 1999.

9. Ask HAI how you can participate in lobbying on behalf of public health at regional trade negotiation meetings.

10. Create a data-base of who is doing what and who could do what.

For more details of groups and publications mentioned here, please turn to page 15.

This list includes names and addresses of some useful contacts and publications to help you campaign for people's health to be put before trade and commercial interests.

CONTACTS

WCC Pharmaceutical Advisory Group (PAG)

holds annual meetings which address various issues concerning pharmaceuticals and health. Contact: Dr Eva Ombaka, Pharmaceutical Adviser for World Council of Churches, based in Nairobi, Kenya.

Consumer Project on Technology was created in 1995 to investigate a wide range of issues concerning technology and consumer interest. CPT is involved in issues relating to intellectual property, information technologies, medical technologies, and electronic commerce and privacy. Contact: Dr James Love,

Director, CPT (address on page 6).

Health Action International is a global network of health, development, consumer and other public interest groups in more than 70 countries working for a more rational use of medicinal drugs. HAI is currently involved in efforts to evaluate the impact of the World Trade Organization and the TRIPS Agreement on public health. It has regional offices in Peru and Malaysia. <http://www.haiweb.org>

NGO Forum for Health brings together non-governmental organizations involved in the promotion of health. The group meets

immediately prior to the World Health Assembly each year. Contact: Dr Eric Ram, Secretary NGO Forum for Health

Address box The Pharmaceutical Programme

CISS International
PO Box 73860
Nairobi, Kenya
Tel: 254 2 445160/445020
Fax: 254 2 440306

Health Action International (HAI) HAI-Europe
Jacob van Lennepkade,
334-T
1053 NJ Amsterdam
The Netherlands.
Tel: 31 20 683 3684.
Fax: 31 20 685 5002.
E-mail:
hai@hai.antenna.nl

NGO Forum for Health

Dr Eric Ram, Secretary
NGO Forum for Health
World Vision
6 Chemin de la Tourelle
1209 Geneva
Switzerland.
Tel: 41 22 798 4183
Fax: 41 22 798 6547

WHO reference materials
Globalization and access to drugs - Implications of the WTO/TRIPS Agreement, Health Economics and Drugs DAP Series No. 7, World Health Organization, Action Programme on Essential Drugs, WHO/DAP/98.9. Free of charge.
Health Economics, The Uruguay Round and drugs, WHO Task Force on Health

Economics, WHO/TFHE/97.1. Free of charge.

Health Economics, Drugs and health sector reform, WHO Task Force on Health Economics, WHO/TFHE/96.2. Free of charge.

Health economics: The effects of international trade liberalization on the health of poorest population groups: annotated bibliography, WHO/TFHE/98.1.

Papers in several languages are listed. Free of charge.

"The implications of the TRIPS Agreement for the protection of pharmaceutical inventions" is an article by Adrian Otten, *World Trade Organization*, Geneva, published in *World Drug Information*, Vol. 11, No. 1, 1997.

World Health Organization

Action Programme on Essential Drugs
1211 Geneva 27
Switzerland.
Fax: 41 22 791 4167.
E-mail: dapmail@who.ch

Pharmaceutical as Commodities in Public Health: The implication of the TRIPS agreement from the perspectives of the Developing Countries is a report of WCC's PAG annual meeting in 1997. It is available from WCC bookshop.

The TRIPS Agreement and Developing Countries a report prepared by the UNCTAD Secretariat. It

assesses the costs and benefits stemming from the TRIPS Agreement. Unctad/ITE/1/96.II.D.10 Cost: US\$22.00, 65pp. Address: UNCTAD, Marketing and Sales, UN Geneva, Palais des Nations, 1201 Geneva, Switzerland
Tel: 41 22 917 4872

Power, patients and pills: an examination of GATT/WTO and Essential Drugs Policies, the report of a

seminar organized by HAI-Europe.

The TRIPS Agreement - A guide for the South draws attention to the aspects of the agreement to which policy makers and technical personnel should pay special attention when formulating policy and legislation in this field.

WCC Bookshop

150, route de Ferney
PO Box 2100
1202 Geneva, Switzerland

South Centre

Chemin du Champ-d'Anier 17
Case Postale 228
1211 Geneva 19
Switzerland
Tel: 41 22 798 34 33
Fax: 41 22 798 85 31
E-mail: south@southcentre.org

WHO PUBLICATIONS

OTHER PUBLICATIONS

BABY BATANDWA IS CRYING! WHAT CAN I DO?

Batandwa is born with a very good way to tell you he needs you. He cries. When he cries, he is trying to tell you that he needs your help to make him comfortable again. Below, Gabriel Uργοiti, a doctor working with the National Progressive Primary Health Care Network in South Africa, writes more about why babies cry, and what parents can do about it.

As you become more familiar with Batandwa, you will discover that his cries sound different depending on what he needs. Learning the meaning of his cries helps you to know how to answer them. And when you do you are building a relationship with him, based on confidence and trust.

All babies have their own way of crying, but all have three clear cries to tell you that they are hungry, upset or have pain.



“I’m hurting”

When Batandwa has pain he cries in an unmistakable way. You will definitely know that something is wrong. Of course you will go to him when you hear this cry and do whatever is needed to make him comfortable.

This is a time when your gentle attention and warmth are very important. If he is not well and crying you must take him to the community health worker or clinic so that they can find out what is wrong with him. Don't wait.

“I’m hungry”

Usually Batandwa's "hunger cries" starts slowly and builds up to a loud, demanding cry. This means "I want to eat". Many babies do not get hungry at regular times during their first few months. So whenever you hear the hunger cry, think of feeding him.

Food is not the only thing for which he hungers. Every baby also needs attention and stimulation. Maybe when he cries, and does not want to eat, he tries to say "I want to be with you".



“I’m upset”

Batandwa may cry in a mild, fussy way when he is tired or in a bad mood. Or maybe he needs company or a change of scenery. The longer the crying is ignored, the louder it becomes. Crying is one way of trying to discover what he needs. You can also look for other clues, for example the way he moves. If you see him repeatedly throwing his legs up and straightening them again while crying he is probably telling you that his tummy hurts.



Try to always go to him when he cries

Because crying is Batandwa's clearest way of saying he needs you, you should go to him when he cries. Some people feel that answering all the time when a baby cries will spoil him. They say that he will become more and more demanding if you go to him every time he cries.

This is not the case. When you answer Batandwa's cries promptly, he learns to trust you. But more than that, he learns that you will react when he expresses himself in a less urgent way. As time goes on, he will start to use his facial expressions, movements and sounds to tell you what he needs.

If you cannot always answer his cries

Many times you are going to be delayed. Batandwa's trust in you is based on consistency, and consistency does not mean immediately responding to each and every cry.

Sometimes you will not understand why Batandwa cries. You will feel upset if he cries a lot. Many parents feel this way. You are not a bad parent. It is normal.

If this happens to you, it is important not to blame yourself or your baby.

Babies who cry all the time

Some babies suffer from tummy pains. Some people call this colic. These babies cry for hours at a time and are very difficult to calm. If you have this problem with your baby it is important to relax as much as you can and try your best to comfort him. At about 3-4 months many of these babies are well.

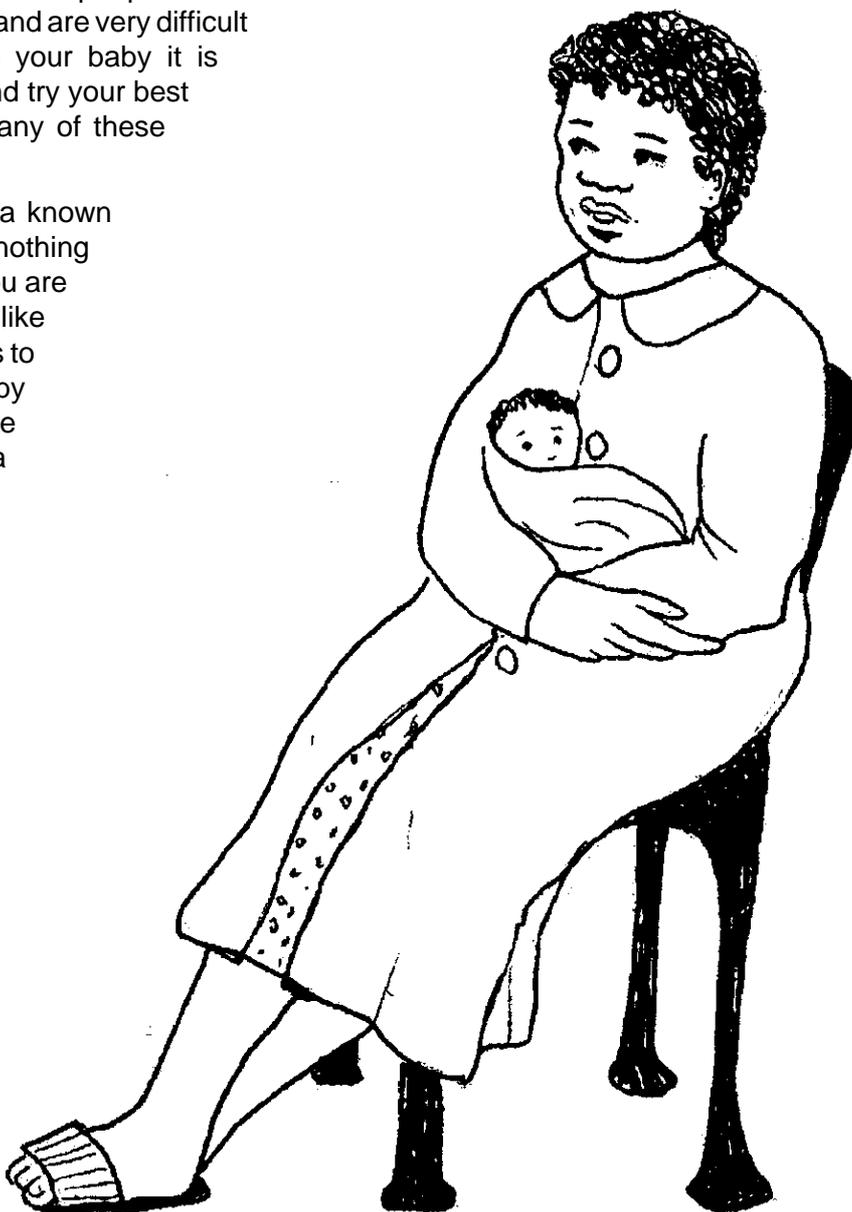
Other babies seem to cry more without a known reason. There will be some times when nothing you do seems to help calm your baby. You are likely to become tense and upset and feel like you failed. This too is natural and happens to all parents. When you are tense, your baby senses it by the way you hold him and he may even cry harder. If there is a grandparent or neighbour or other friend handy, let them take your baby so you can get a few moments to yourself.

If all else fails, put the baby to bed for a while. Being apart briefly, helps both of you to calm down and gives you a better chance to figure out what he needs.

When you have done your best to comfort Batandwa and he is still crying remember this:

You will both survive the experience. And maintaining a sense of humour can do wonders at these times.

Article taken from The NETWORKER, the official magazine of the National Progressive Primary Health Care Network (NPPHCN), Western Cape, South Africa. Address: PO Box 34572, Grootte Schuur, 7937, South Africa. Tel: 27 21 472482. Fax: 27 21 479483. E-mail: pphcmctc@wn.apc.org



USEFUL PUBLICATIONS

Tuberculosis – an Interdisciplinary Perspective

A book that looks at the social, economic and political dimensions of treatment-seeking and intervention edited by John D H Porter and John M Grange covers many issues of relevance to readers of *Contact*. The first section, "Introduction to tuberculosis and its control", includes chapters on the global burden of tuberculosis, determinants of the tuberculosis burden in populations, a critique of the global effort, the politics of tuberculosis, public health and human rights: the ethics of international public health interventions for tuberculosis, and tuberculosis in high prevalence countries.

The second section, "Tuberculosis from a patient's perspective", comprises the economics of tuberculosis diagnosis and treatment, socio-cultural dimensions in tuberculosis control, tuberculosis and HIV, tuberculosis in ethnic minority populations in industrialised countries and gender issues in detection and treatment of tuberculosis.

The final section points the way forward with the help of several case studies and by describing alternative approaches. Details: John M Grange, Imperial College School of Medicine, Dovehouse Street, London SW3 6LY, UK. Tel 44 171 351 8456, E-mail:j.grange@ic.ac.uk

LETTERS

LAP Programme in Cameroon

Thank you for the "The 'bottom-up' approach to health planning" (Contact 160) describing the LAP Programme in Cameroon. Such developments are excellent but the description does not tell how they are integrated into secondary biomedical health care provision.

How does the community see the possibility of referring individuals and community health problems on to this level? What should be the relationship between the administration of the two levels of health care? The programme starts where the people are but how does it lead on to health education?

At a time when evidence-based medicine is being promoted, the other extreme of a subjective approach to health needs is being taught. It must be better in planning to include the perceptions of the community and not just those of the health care professionals, but are we in danger of ignoring the findings of scientific research and measurement over the centuries? If health professionals' clinical impressions can be misleading, how reliable are the impressions of communities in which the diseases of poverty are common?

David Clegg

*Christian Medical Fellowship and Medical Missionary Association
London, UK*

Ruby Eliason responds:

Thank you for your questions about how Community-Determined Health Care (CDHC), using the conscientization approach, is integrated into secondary biomedical care provision. The first question about referrals ties in with the second question about the relationship between the administration of the two levels of health care.

Before the CDHC approach to planning is implemented, there has been considerable interaction between the community and project staff. The process begins when the community, after hearing about the Life Abundant Programme (LAP) from individuals or satisfied communities, makes application for LAP ministries. The area Field Supervisor then visits the community to learn about the people and their expressed needs, to explain LAP's philosophy of community self-reliance and also LAP organization, and to answer villagers' questions about LAP. The community appoints a Village Health Committee, which becomes the liaison body between the community and project. The Committee selects candidates for Village Health Worker (VHW) training, and collects village-wide donations for training the VHW, and for purchase of the basic medicines to be used by the VHW in simple symptomatic treatment. The Supervisor and Committee plan together for two events, a quantitative health survey of the community, and conscientization activities leading to CDHC.

There are education sessions for the VHW and the Committee before the VHW is

installed. VHW training includes the integration of health promotion, disease prevention, treatment of common disorders with about 20 drugs, and rehabilitation. The VHW learns the importance of making referrals to an Integrated Health Centre or Hospital for patients beyond his/her scope of treatment. The committee Seminar is about management of the village Primary Health Centre and the general activities of the VHW (the Field Supervisor supervises clinical work).

How does the CDHC approach lead to health teaching? Before introducing CDHC, the writer found there was little interest in health promotion teaching in villages with LAP ministries. However, this has dramatically changed with the introduction of CDHC. Communities have not only named health promotion activities as their priorities for how to get health, but they have been motivated to implement their health promotion goals. For example, treatment for sickness was 7th on Ngang's prescription for health. The people gave more importance to health promotion by the following priorities: community participation in health activities, spiritual care, general development, care of children, adequate food, and the practice of cleanliness. The Makoup community placed treatment after seven health promotion activities. In the five communities researched in 1998, treatment ranged from 5th to 9th, giving place to health promotion activities. In one of these communities, there was immediate village-wide participation in the cleaning of water sources. Furthermore, the main work of the VHW is teaching of individuals, families and groups on all aspects of health. He/she is assisted in this by the Committee.

In CDHC planning within the framework of LAP ministries, community values become integrated with the practice of biomedical care. The process is dynamic as dialogue continues, and praxis, the core of conscientization, occurs; praxis is movement from action to reflection, and again from reflection upon action taken to a new action. The result is better health for communities and families.

Our efforts continue to rehabilitate the CHAL library, which was scattered during the war. Health/development workers and health promoters in Liberia are starved of health and development information. Any suggestions/assistance you may be able to offer CHAL in this effort will be highly appreciated.

Can you help?

*Deanna K Isaacson
Christian Health Association of Liberia (CHAL)
PO Box 10-9056
1000 Monrovia 10, Liberia*

We are glad to be able to resume sending bulk copies of *Contact* to CHAL. We have also asked Healthlink Worldwide (formerly AHRTAG) to send a copy of "List of free international newsletters" to CHAL, and forwarded details of TALC's health library for district health workers. The books included in this small library include *Where there is no Doctor*, *A Book for Midwives* and *Helping Health Workers Learn*. The library costs 90 pounds sterling including postage and packing by surface mail worldwide. TALC, PO Box 49, St. Albans, Herts AL1 5TX, UK. Tel 44 1727 853869. Fax 44 1727 846852.

ANNOUNCEMENTS

Sustainability of church hospitals in developing countries

The report of CMC-Churches' Action for Health study on the determinants of success in sustaining church hospitals by Dr Kofi Asante is now available. A limited number are available free of charge, at present in English only. A directory of Christian health and medical associations will be available in the very near future. Write to Dr Kofi Asante, Executive Secretary, CMC - Churches' Action for Health, PO Box 2100, 1211 Geneva 2, Switzerland.

Departure of Dr Kofi Asante

In January of 1999, Dr Kofi Asante, our Executive Secretary for Health, will leave the WCC. Kofi has focused on resourcing and networking with Christian health coordinating agencies, and has developed significant new contacts. Currently, he has recently completed an analytical study of Christian health care institutions, addressing the question of their sustainability. We thank him for his dedicated service and bid him Godspeed as he returns to Ghana.

Contact's new editor

Darlana David who takes over as editor of *Contact* after this issue is currently consultant in the Communication Department at the Christian Medical Association of India. She is ideally suited to her new task having edited several newsletters and magazines, including most recently the Christian Medical Journal of India. Darlana has a Masters in English, a Diploma in Hospital Administration, and gained a distinction in her Masters degree at Manchester University (Mass Media and Education) in 1990. During the 1980s, she worked with ACHAN (Asian Community Health Action Network) in Madras and the Voluntary Health Association of India (VHAI) in New Delhi. Her interests include gender and justice; community health; pharmaceuticals and baby foods; alterna-

tive media, and development journalism.

New editor - new address

From 1 January 1999, *Contact* will operate from India. All correspondence and requests for back copies should be sent to the following address from that date onwards:

Ms Darlana M David, Editor *Contact*, c/o Christian Medical Association of India, 2, A-3 Local Shopping Centre, Janakpuri, New Delhi 110 058, India. Tel: 91 11 559991/2/3, 5521502. Fax: 91 11 5598150. E-mail: ccd.cmai@gems.vsnl.net.in

Contact will continue to be published in French and Spanish. However, the Portuguese version of *Contact* has been temporarily discontinued. Those interested in helping to restore it are invited to write to the editor.

REMEMBERING DR JONATHAN MANN



Jonathan Mann

In the 1980s when the world was gripped by apprehension over the realisation of what the HIV virus might mean to humanity if left unchecked, the figure of Dr Jonathan Mann appeared on the world stage. With quiet determination he set about creating the global programme on AIDS – commonly known as "GPA" at World Health Organization headquarters in Geneva.

I remember, when working as a consultant to GPA in 1989, Jonathan called for a lunchtime meeting of the expanding GPA. Ranged around the room were close to a hundred people. It was typical of Jonathan that he encouraged everyone to publicly introduce themselves. At last, his turn came, and very simply he said "Jon Mann, GPA". During the meeting he had reached out to all present, and created the basis for what came to be called the "GPA family". Life in GPA was tough, because the challenge of a rapid response to the needs of countries to strengthen their defences

against HIV required good organization in constantly changing scenarios.

Jonathan was a brilliant and outstanding leader who had the capacity to listen, to be humble, and to inspire those who worked with him. Although GPA underwent various changes, including absorption finally into the new UNAIDS programme, the legacy of Jonathan is clear. It was he who, at a certain point in time, had the courage to take the reins of leadership in an apprehensive world. He did that with great sensitivity, style, and compassion.

Today, Jonathan Mann's legacy is found in various corners of the world. It is evident when people get a chance to understand about HIV and AIDS – and to protect themselves, and others – and when people living with HIV and AIDS get compassionate care. Let us be determined to ensure that his legacy is continued and expanded. May he, and his wife, rest in peace, and may their family be comforted.

Marie Thérèse Feuerstein

Contact is the health and community development magazine of the World Council of Churches. The publication deals with various aspects of the churches' and community's involvement in health, and seeks to report topical, innovative and courageous approaches to the promotion of health and healing.

Contact is published by a partnership of the World Council of Churches (WCC); Christian Medical Association of India (CMAI); German Institute for Medical Missions in Tübingen (DIFÄM), and Medical Coordination Secretariat of the Netherlands (MCS). It is published four times a year in English, French and Spanish. Present circulation is approximately 15,000.

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Mailing list: **Christian Medical Association of India, 2, A-3 Local Shopping Centre, Janakpuri, New Delhi 110 058, India. Tel: 91 11 559991/2/3, 5521502. Fax: 91 11 5598150. E-mail: ccd.cmai@gems.vsnl.net.in** *Contact* is also available on the World Council of Churches website: <http://www.wcc-coe.org>