Recent Seminal Articles on the Global AIDS Crisis

The following articles, drawn from mainstream sources, represent a growing awareness throughout all quarters that the current status quo on AIDS drugs for have and have-not countries can no longer stand. That the African AIDS holocaust can be prevented and is not, has come to represent one of the greatest crimes against humanity, and the tide is turning against the big drug companies and their insatiable greed at the expense of human life.

"I want someone to explain to me why it isn't called murder."

J'accuse

The West is willfully turning its back on the greatest human tragedy of our age, says the former deputy head of Unicef

STEPHEN LEWIS

Friday, January 26,

Last October, I sat in on a Grade 5 "life skills" class at the David Livingstone Elementary School in Harare, Zimbabwe. There were 41 of the most eager, verbal, bright, downright adorable 10-year-olds I had seen in a very long time. Life skills classes, held once a week, give teachers the opportunity to deal with the HIV/AIDS pandemic raging through the country, indicative, as it is, of what's happening throughout Southern Africa.

"I want to know what you worry about," said the teacher. "I want each of you to write down your greatest worry on a piece of paper, and then I'll gather them all up, put them in this box, and draw them out one by one to talk about what you've said." I'm not going to go into the details of each fascinating, lively and intense discussion that accompanied every hand-written note. I'm simply going to observe that in seven of every 10 instances, the words on the paper had something to do with death. Death of a parent, death of a sibling, death of an uncle or aunt, death of a friend's father, death of a friend.

"You see, Mr. Lewis, when everyone is dying all around you, the children don't know what to do but pray. We pray after school, we pray at lunch-breaks, we pray on Saturdays, we pray all the time. For the children, since nothing else seems to work, the intervention of God is the only hope left."

When the teacher asked the kids what they would do about this pervasive chant of death, they answered, in the majority, "prayer." When the teacher pressed them to be more specific, they said "We'd call on God."

As we left the classroom, I awkwardly told the teacher that I didn't really understand the responses. And she said that I was right: I didn't understand. "You see, Mr. Lewis, when everyone is dying all around you, the children don't know what to do but pray. We pray after school, we pray at lunch-breaks, we pray on Saturdays, we pray all the time. For the children, since nothing else seems to work, the intervention of God is the only hope left."

That afternoon, I toured the adult wards of the Harare General Hospital. It is no hyperbole to say that virtually every bed was filled with the dead and the dying. There were almost no drugs to treat the most painful opportunistic infections, let alone drugs to treat the virus itself. And right in the midst of our walkabout, orderlies would wheel in grisly aluminum caskets to cart away those who had just died. There were moments when I felt I was standing in a graveyard.

Let me fastforward, as they say, to last Friday. I was in New York to sit in on a Security Council debate dealing with HIV/AIDS and peacekeeping forces. The day was oddly discordant, because in the midst of so serious a subject, it was also the last hurrah of the outgoing American Ambassador, Richard Holbrooke, and the air was filled with mocking jibes, grovelling farewells and other clubby rhetorical appurtenances. Nonetheless, two speeches broke the pattern of forced camaraderie and stale interventions.

The French Ambassador unleashed a verbal broadside against the pharmaceutical companies, and their hideous refusal to provide drugs at cost or, even better, no cost at all. The Indian Ambassador abandoned all the customary proprieties to make the point that millions of people in the South were dying while the North refused to provide the dollars, or to amend intellectual property rights so that drugs would be available and death forestalled.

As I sift these disparate episodes through my mind, one question keeps intruding: I want someone to explain to me why it isn't called murder.

Last year there were 3.8 million new infections in sub-Saharan Africa. Last year 2.4 million people died of AIDS in sub-Saharan Africa. By the end of last year, 25.3 million Africans were living with

the disease, 55 per cent of whom are women. The most vulnerable target group lies between the ages of 15 and 24. More than 16 million Africans have died since the pandemic began in the late 1970s/ early 1980s.

A significant change has recently occurred in the way the disease is viewed in Africa. Up until the middle of the year 2000, the focus was overwhelmingly on prevention and care. Then, abruptly, at the international conference on AIDS in Durban in July, and again at the African Development Forum in Addis Ababa last December, the ground shifted. Suddenly, "People Living With Aids" began to make their voices heard, and their voices cried out for treatment.

It brings back another recollection. I remember chatting with three pregnant HIV-positive women at a little prenatal counselling clinic in Kigali, Rwanda, in the summer of 1999. They had all voluntarily accepted testing, and they were all voluntarily on drugs to reduce mother-to-child transmission, and they were all thinking about whether or not to breast-feed their babies, because breast-feeding increases the risk of transmission, although bottle-feeding is obviously very difficult to afford and to arrange in Africa. After we discussed, almost triumphantly, the choices they now felt open to them, the conversation took a dramatic turn. I'll never forget it: "Okay," they said, "we'll do anything to save our babies, but what about us?"

I had no answer.

And that's the crux of the issue. Here in the wealthy West, we have antiretroviral drug cocktails which prolong life, improve the quality of life, and serve, as it were, to save life. We have the drugs. We use them. In the developing world, where 95 per cent of the new infections occur, virtually everyone HIV-positive is doomed to a gruesome and painful death. The numbers of people who can afford the drug cocktails are so infinitesimal as be invisible.

But it's worse, much worse. Neither the pharmaceutical companies who have the drugs, nor the governments who have the money, nor the governments who could amend their laws to make cheap generic drugs available, are prepared to prolong or to rescue African lives.

Some six months ago, there was an international flurry of self-congratulation as five multinational pharmaceutical companies promised to reduce or remove the cost of HIV/AIDS drugs for Africa. Intense private negotiations between the United Nations and the companies have followed. The negotiations are a farce; they redefine the meaning of bad faith. Nothing of consequence has been agreed. It's really the monumental scandal of our times.

Admittedly, it would be no easy matter to monitor and treat large populations of infected people through health delivery systems that are often in tatters. But you could still reach a significant number. The fact that we're not even prepared to try is a miserable commentary on the human condition. Let me put it as simply and bluntly as possible. The drugs exist and the money is available to prolong and improve the lives of millions. Some would live a full life-span.

Jeffrey Sachs, the noted Harvard economist, says that there are generic drugs which could be imported from India to treat the majority of HIV-positive Africans for $350 per person per year. If we had the political will, there is no question that we have the money.

Then why isn't it being done? And because it's not being done, why doesn't it amount to murder? Mass murder.

Stephen Lewis is a former Canadian ambassador to the UN. He has served as deputy executive director of Unicef, and as a member of the International Panel of Eminent Persons, which was set up by the UN to review the 1994 genocide in Rwanda.

Fortunately, his diagnosis was made in 1997, only months after Brazil started a controversial policy to manufacture and produce its own generic AIDS medicines and distribute them free to patients. It meant affordable treatment, a shot at a healthier life and, for Carmona, even the financial freedom to help others as an AIDS volunteer.

"It is why I am here today," Carmona said recently...

Brazil's free AIDS-drug program slashes cases, earns global interest

Chicago Tribune - December 24, 2000
Patrice M. Jones, Tribune Foreign Correspondent

RIO DE JANEIRO -- For Antonio Carmona, finding out he had AIDS was just the start of an uphill physical, emotional and financial battle to survive.

The physical and emotional battle he expected, but it was the financial toll that in some ways was immediately the most devastating. Only months after finding out he had the disease, the veteran journalist was fighting not only sickness and weight loss but also escalating medical bills that drained his savings and later his family's.

Fortunately, his diagnosis was made in 1997, only months after Brazil started a controversial policy to manufacture and produce its own generic AIDS medicines and distribute them free to patients. It meant affordable treatment, a shot at a healthier life and, for Carmona, even the financial freedom to help others as an AIDS volunteer.

"It is why I am here today," Carmona said recently, as he took at break from volunteering as a community representative for an AIDS treatment and support group based near Rio de Janeiro.

His story is just one part of a broader fight against AIDS in Brazil, an initiative that at first brought controversy and now praise to Latin America's most populous country.

Brazil has inched into the spotlight as a model for other developing nations with its multifaceted approach to stabilizing the spread of a disease that was expected to ravage its working-age population only a few years ago. When AIDS first burst onto the world health scene in the 1980s, Brazil was one of the countries hardest hit.

Now, while 20 percent of adults in South Africa are infected with HIV, less than 1 percent of Brazilians are infected, and many countries, including South Africa, are trying to determine how Brazil made it work.

"We have tried to be very aggressive at mobilizing our resources," Paulo Teixeira, head of the Brazilian Health Ministry's AIDS program, said at a recent Rio de Janeiro international AIDS conference.

"For the last two decades, we have tried to make it easy to talk about condoms, to talk about sex, to talk about sick people publicly," Teixeira said. "And we have always worked with non-profit organizations that go out into the field and provide the personal support and help that we cannot provide."

Even before data began to show the country's success in fighting AIDS, Brazilian officials were unusually frank in pushing prevention and treatment programs.

This year, despite the Roman Catholic Church's anti-condom stance, some 10 million condoms were distributed during Carnival festivities. One recent ad campaign warned men that promiscuity could lead to their transmitting the disease to their wives or girlfriends.

Brazilians say the frank talk, which has attacked traditional prejudices about the disease, along with free medicines and community support, has worked.

According to United Nations figures, 600 people in Latin America and the Caribbean are infected each day by the virus that causes AIDS--about one every two minutes. The Caribbean suffers from the world's second-highest rate of infection after sub-Saharan Africa. Regionally, the nation most devastated is Haiti, where more than 5 percent of the population are infected. Bahamas reports a 4 percent rate of infection.

In Brazil, some 540,000 adults, only 0.6 percent of the population, are registered as HIV-positive, a figure researchers say would have skyrocketed if the rate of new infections had continued unabated since the first cases began to be detected two decades ago.

From the beginning, the mobilization of the gay community and non-profit organizations was critical to Brazil's fight. Their influence is still strong, particularly as the economic profile of those contracting the disease has changed; now the hardest hit are the poor.

Brazil's success has brought international delegations from many countries, including several in Africa. South Africa, particularly, has been interested in finding out the key to Brazil's success in manufacturing generic drugs that stabilize--but not cure--the condition of many people who have AIDS.

"The Brazilian response is kind of a flagship not only in Latin America and the Caribbean but also at the global level," said Luiz Loures, chief for Latin America and the Caribbean for UNAIDS.

"The Brazilian response is transferable," he added, noting that while Brazil is wealthier than some other developing nations, political will and community support have made the difference in a variety of countries. "We are also looking at other countries, such as Senegal and Uganda, that have taken the lead in Africa or other regions to provide symbols in this fight."

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The government spends about $4,500 per patient each year for typical drug treatment. In the U.S., similar treatment cost between $12,000 and $15,000.

In 1994, Brazil's government urged domestic pharmaceutical firms to start manufacturing AIDS drugs. Now Brazil makes eight of the 12 anti-retroviral drugs used in the so-called AIDS cocktail. Because of Brazil's production, prices for AIDS drugs exclusively produced abroad have dipped 9 percent but more than 70 percent for those that compete with Brazilian generic brands. The plummeting prices and Brazil's firm intention of pushing ahead with manufacturing new drugs has put the nation at odds with pharmaceutical manufacturers.

The overall effort also has been controversial among researchers who have questioned whether Brazil has the technology and infrastructure to produce proper generic equivalents.

"I was against it at first," said Mauro Schechter, one of the world's foremost AIDS researchers, of Brazil's program. "I thought it would be very expensive and difficult to establish the necessary lab infrastructure.

"But the program has been very effective," said Schechter, who nonetheless says there is anecdotal evidence that some of Brazil's generic drugs may not be equivalent to top pharmaceutical brands.

Despite criticism, Brazilian officials have pushed forward, saying they produce quality drugs and arguing that they can produce the drugs because of a provision in World Trade Organization rules for countries to take measures to protect the population in case of a national emergency.

Others disagree.

"We believe Brazilian officials have had some good efforts putting resources toward this major problem, but they are still part of the world order and need to work things out with our companies," said Mark Grayson, spokesman for the Pharmaceutical Research and Manufacturers of America in Washington.

A lot of very greedy people

John le Carre
Monday February 12, 2001
The Guardian

I had not been exploring Big Pharma for more than a couple of days before I was hearing of the frantic recruitment of third world "volunteers" as cheap guinea pigs. Their role, though they may not ever know this, is to test drugs, not yet approved for testing

in the US, which they themselves will never be able to afford even if the tests turn out reasonably safe. And then to disappear.

In the US it costs on average $10,000 per patient to conduct a clinical trial, in Russia $3,000, and in the poorest parts of the world, still less.

I learned also of how Big Pharma in the US had persuaded the state department to threaten poor countries with trade sanctions to prevent them making their own cheap forms of the patented lifesaving drugs that could ease the agony of 35m men, women and children in the third world who are HIV-positive, 80% of them in sub-Saharan Africa. In pharma jargon, these patent-free copycat drugs are called generic. Big Pharma likes to trash them, insisting they are unsafe and carelessly administered. Practice shows they are neither. They simply save the same lives that Big Pharma could, but at a fraction of the cost.

Big Pharma did not invent these lifesaving drugs that they have patented and arbitrarily overpriced. Antiretrovirals were for the most part discovered by publicly-funded US research projects into other diseases, and only later entrusted to pharmaceutical companies for marketing and exploitation. Once the pharmas had the patent, they charged whatever they thought an Aids-desperate western market would stand: $12,000 to $15,000 a year for compounds that cost a few hundred to run up. Thus a price tag was attached and the western world, by and large, fell for it. Nobody said it was a massive confidence trick. Nobody remarked that, while Africa has 80% of the world's Aids patients, it comprises 1% of Big Pharma's market.

Do I hear you offering the drug companies' time-worn excuse that they need to make huge profits on one drug to finance the research and development of others? Then kindly tell me, please, how come they spend twice as much on marketing as they do on research and development?

An 11-month Washington Post investigation last year into the malpractices of US and multinational pharmas in poor countries culminated in a series of devastating articles that should earn the writers a Pulitzer prize, the thanks of all decent people and the naked loathing of the industry. One immediate consequence has been the establishment of a national committee to monitor the activities of US and multinational pharmas overseas.

A recent, equally splendid article by Tina Rosenberg in the New York Times Magazine rightly held up Brazil as the way forward, and showed us the limitations, in law, of the pharmaceutical companies' grip on their own patents. Brazil, in a word, has put the survival of its own people above the huffing and puffing of Big Pharma. It has produced its own generic anti-retrovirals at $700 for a year's supply as against at least $10,000 for the patented versions. And it is dishing them out to every Brazilian who needs them, whether or not he can pay for them. And Big Pharma, instead of rushing screaming to its lawyers and lobbyists and the US state department, has bitten the bullet and dropped its prices in order to compete. Maybe, after all, the pharmas are not as powerful as they think they are. Unfortunately, under George Bush we're unlikely to find out.

Bush came to power on the back of a lot of very greedy people, not least Big Pharma, which poured millions into his campaign, more than twice the sums it gave the Democrats. Several of the godfathers and grandfathers who packaged and promoted Bush have more-than-close connections with the pharma industry. Clinton, by the end of his second term, had learned to resist Big Pharma's $75m-a-year US lobby and was advocating the release of generic Aids drugs to people in the third world who were dying by the million for want of them, and still are. But all the signs are that George is pledged to put the clock back to day zero.

Tina Rosenberg offers one of those very rare, simple solutions that are, of course, too obvious and clear-headed to be acceptable to the health bureaucrats of the world community: let the World Health Organisation treat global Aids in the same way that Unicef has treated global vaccination, which saves 3m lives a year and prevents crippling diseases in tens of millions more. She calculates the cost at around $3bn, which she suggests isn't too bad a number if you're heading off the collapse of a continent.

She might have added - and perhaps in her mind she did - that the market capitalisation of just one of the pharma giants is counted in hundreds of billions of US dollars.

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A Harsh Campaign to Prevent Affordable AIDS Treatment

Kevin Watkins
Monday, February 12, 2001
The International Herald Tribune

OXFORD, England - Welcome to the new drug war. Not the one being fought against cocaine barons in the jungles of Latin America but the one being waged by the American government and the global pharmaceutical industry against the world's poor.

The question at the heart of the conflict is whether world trade rules should be used to defend at all costs the drug patents and associated exclusive marketing rights of powerful companies, or whether governments should retain the right to put affordable medicine before corporate profit.

Next month a new front in the war will be opened in a South African court. Some 40 drug companies, including corporate giants such as GlaxoSmithKline and Bayer, are contesting a 1997 law which allows the government to import cheap drugs, thereby bypassing the monopoly granted to patent holders.

The principal defendant, and architect of the law in question, is Nelson Mandela. His crime: insisting on his country's right to purchase anti-AIDS drugs at the lowest possible price in order to maximize treatment for the country's 4 million sufferers.

South Africa is not alone. Four years ago Brazil waived patent rights on HIV/AIDS drugs, allowing local companies to produce cheap versions. Prices fell by more than 80 percent. Today almost every Brazilian AIDS patient gets free of charge the same triple therapy cocktail that has improved survival prospects in the United States. The HIV/AIDS death rate has been halved, and the savings to the health budget are estimated at $400 million.

Good news for public health? Maybe, but Brazil has just been put in the dock at the World Trade Organization, courtesy of the United States.

At stake is a public health law that allows the Brazilian government to insist that patent holders either produce drugs locally at a controlled price or allow a local manufacturer to do the same. To U.S. trade negotiators, this represents a violation of intellectual property rights. In the eyes of Brazilian public health groups, the U.S. actions amount to a gross violation of the right to health.

So far, recourse to the WTO has been the exception rather than the rule. This is partly because the United States has a far more potent weapon in its arsenal: namely, the threat of trade sanctions under the "Special 301" trade law provision. Sixteen countries - including India, Egypt, the Dominican Republic and Thailand - have been invited to strengthen patent protection. The poor in those countries will face the consequences. In the case of the Dominican Republic, these will include withdrawal of trade preferences for textile exports, an outcome that could cost 200,000 jobs.

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The legal issues vary, but there are three common themes in these Special 301 cases. First, they have all been initiated by the U.S. trade representative after complaints from Pharmaceutical Research and Manufacturers of America.

Second, they have been directed at countries with strong generic drugs industries, capable of producing low-cost copies of patented drugs.

Third, the aim is to overturn national legislation allowing governments to give priority to affordable medicine for the poor over the patent rights of drugs companies.

All of which raises some disturbing questions about world trade rules and public health.

Ultimately, patents are a contract between inventors and the rest of society. Inventors are rewarded for the commercial risk they take with a temporary monopoly, lasting 20 years under WTO rules, during which they have the right to sell their inventions at whatever price they choose. Governments have to balance potential conflicts between the public good and private monopoly.

The wrong balance is being struck. This year 11 million people in developing countries will die from preventable infectious diseases, many of them because they are unable to afford basic medicines. More stringent patent protection threatens to make such medicines even less affordable.

The facts speak for themselves. Companies in Brazil and Thailand are able to market a version of the drug fluconazole, used in the treatment of meningitis, at annual treatment prices of $100, compared to $3,000 for the patented product price. In India, companies market ciprofloxacin, an anti-infective drug used in the treatment of bloody diarrhea, at one eighth of the price charged in Pakistan, where only the patented version is available.

In theory, the WTO agreement allows for public health safeguards, but these are being progressively eroded through the combined efforts of Washington and the pharmaceutical industry. It is bad enough that the world's most powerful industrial lobby has adopted such harsh standards. Far worse is the willingness of the U.S. government to back such demands with gunboat trade diplomacy recalling 19th century Britain.

Pharmaceutical companies maintain that the way to deal with the public health threat posed by patents is through philanthropic price discounts, negotiated on a product-by product and country-by-country basis. But while philanthropy has a positive role to play, this is too limited a response.

What is needed is a fundamental reform of the WTO intellectual property rules, starting with a reduction in the period of patent protection, reinforced health safeguards and a comprehensive ban on the threatened use of trade sanctions.

Evil triumphs in a sick society

Larry Elliott
Monday February 12, 2001
The Guardian

Let me tell you a story about life, death and profit. It involves some of the poorest countries in the world and some of the richest companies. It goes to the heart of how the modern world is to be run and whether the institutions set up to police the global economy are up to the job.

Eleven million people in poor countries will die from infectious diseases this year. Put a different way, it means that by the time you finish reading this column 100 people will have died. Half of them will be children aged under five. Just over a quarter - 2.6m - will die from HIV/Aids.

It is easy to work out why the death toll is so high. Poverty breeds ill-health and encourages the spread of infection, and the world is

awash with poor countries. Just as a starving man knows there is food at the Ritz, governments in Africa, Asia and Latin America know there are medicines to treat these illnesses if only they could afford them.

But the bigger developing countries have found a way round this problem by making cheap copies of western drugs. India, for example, makes 70% of its own drugs, while Egypt, Thailand, Argentina and Brazil have also taken steps to become more self-reliant in pharmaceuticals. Poorer developing countries also benefit because they can import cheap generic drugs even if they cannot manufacture them.

This should mean our story has a happy ending. It means more people get treated because the health budgets of poor countries go further. It means that developing countries have a chance to move into industries that have a higher technological component. And it means increased competition, putting downward pressure on prices. This final point - that the freer markets are the better - is usually the clincher when it comes to the economics of globalisation. But not this time.

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Enter the two other characters in our story - the world's largest pharmaceutical companies and the World Trade Organisation. Four companies dominate the pharmaceutical industry - Merck, Pfizer, Glaxo SmithKline, and Eli Lilly, and they wield enormous financial clout.

The Big Four operate like a cartel, and like all cartels seek to wield monopoly power. It is basic economics that monopolies lead to higher prices, which is why many governments use anti-trust legislation to break them up. To say that the Big Four do not like the idea of cheap drugs coming onto the market from developing countries is something of an understatement. More competition equals lower share price.

But the financial muscle of the pharmaceutical companies also gives them enormous political leverage. So, during the Uruguay round of trade talks they lobbied hard for tougher rules protecting intellectual property, which provided patent protection for a minimum of 20 years for "new and inventive" products.

Where previously around 50 developing countries and several developed countries had excluded medicines from being patented, the Trade Related Intellectual Property Rights (Trips) deal made both pharmaceuticals and biotechnology part of the global regime. Infringements of the Trips agreement are heard by a WTO disputes panel, and unlike in a criminal trial, the burden of proof put on the defendant country.

In itself, the Trips - a protectionist clause in what was supposed a free trade agreement roused suspicions about the way in which the rules were being skewed to suit powerful interest groups in rich countries. However, some safeguards were included. Countries could cite a national emergency as a reason to infringe the Trips agreement.

Effectively, this provided two loopholes. Countries could either manufacture cheap drugs themselves using what are known as compulsory licences to override patents, which is what Brazil is trying to do, or they could import a patented drug from wherever it was sold cheapest, the method favoured by South Africa.

All quite simple, you might think. If the HIV/Aids pandemic does not constitute an emergency it is hard to know what would. The developing countries win, the drugs companies admit defeat, more people live happily ever after. If only. What is happening now is that the US is using every available means to close the WTO loopholes.

In part this has involved armies of lawyers crawling all over the 73 articles making up the Trips agreement, in part it has involved legal action. But it also involved 21st century gunboat diplomacy. For example, the US offers a special deal to the Dominican Republic for exports of textiles. It is now threatening to withdraw this privilege unless the country scraps plans for compulsory licensing and parallel importing. Brazil and India have been warned that they could face sanctions under America's bilateral Super 301 legislation.

The dirty work for the drugs' companies is being done by the US government, although there is little doubt who is really behind it all. But gunboat diplomacy is still a dangerous game, because there is a risk that public opinion will turn against Merck and Glaxo SmithKline in the way that they have turned against Phillip Morris and the other tobacco companies. Becoming an international pariah is not good for the share price either.

The Big Four have a defence. They say patent protection is vital if companies are to plough vast sums into developing new cures for the diseases affecting poor people. In addition, they argue that the incomes of the world's poor are so low that they would not be able to afford even generic copies of patented drugs, and that the answer is some form of public-private partnership. Several of the big companies back global initiatives either by donating drugs or by subsidising drugs provision.

But the arguments of the pharmaceutical industry do not really stack up. For a start, their profit margins were already fat even before the Trips deal came into force. Secondly, R&D costs are dwarfed by money spent on marketing drugs. Thirdly, only 10% of R&D goes on drugs that account for 90% of global disease, with the bulk spent on first-world afflictions such as obesity. Finally, the drugs made available at lower prices are limited in supply and are still more expensive than generic substitutes.

As Brazil has shown it is possible for a relatively poor country to treat HIV/Aids if they can manufacture the necessary drugs themselves. The price of triple therapy treatment is $4,000 in Rio, compared to $15,000 in New York. Almost 90,000 Brazilians who are HIV positive receive free treatment, four times as many as would receive the care if the country were paying full patent price.

The US has started proceedings at the WTO seeking to force Brazil

to amend its patent law. Brazil, to its great credit, is standing up to the US bully boys in what is clearly a test case for multilateralism. Ever since the riots in Seattle, the WTO and the other global institutions have been under relentless scrutiny and attack, the main charge being that they put profit before people. If the WTO backs the drugs companies, it will be case proved. What should happen is that the WTO should clarify its rules to give developing countries the right to produce or import medicines at affordable prices. If a country says that it is infringing a patent to cope with a national emergency, the burden of proof should be on the patent holder to prove that the country is wrong.

The WTO is not a law unto itself. Governments should write the rules, not multinational corporations. And if they fail to back Brazil, India and Egypt they will have blood on their hands. It was once said that all that is needed for evil needs to triumph is for good men to do nothing. And what is happening here is evil. I have tried to think of another word for it. But there isn't one.

At the mercy of drug giants

Millions struggle with disease as pharmaceutical firms go to court to protect profits

Sarah Boseley in Johannesburg
Guardian
Monday February 12, 2001

Refilwe is a spectral figure, so thin that the light from the huge hospital window at her back seems to pass through her. She sits as straight as a knife, all bone, white robe, and huge eyes gazing at nothing, breathing shallowly through an open mouth. She is 30 and has a son of seven. She has tuberculosis and her mouth is covered with the telltale white spots of a common infection she cannot fight off, because HIV is destroying her body's resistance.

Ask her how she is and she slowly turns her entire body towards you. "I'm feeling better," she whispers. It is a fiction maintained by the plump and jolly nurses at the Natalspruit hospital outside Johannesburg who have dozens more like her on drips in wards 13 and 16, where anybody with any strength resists going because if you have HIV, you have no future.

Refilwe, impossibly, gets to her feet and makes her way with pitiful steps and the arm of a nurse to the door, a walking wraith. She is going to the TB clinic. They will sort out the TB but then they will send her home to die. She is fatally weakened and there are no antiretroviral drugs to take on HIV here.

Nokuthula, 23, is also under a death sentence, for all that she appears robust with health. So is her 18-month-old son Sipho, whose name means a gift. The young mother has put herself and her child in the care of the traditional healer in the township outside Natalspruit hospital who gives them herb and bark infusions to make them strong. But traditional medicine could not save Nokuthula's husband, who died of Aids last September.

At an age when women in the west are embarking on families and careers, Refilwe and Nokuthula have begun the business of dying. They live in the East Rand suburbs of Johannesburg, South Africa, where one in five is estimated to be harbouring the virus that will kill them.

Across Africa and the developing world millions more will die of diseases that are treatable in the west, such as diarrhoea, meningitis, malaria, TB and Aids. The hospitals do what they can, but their best efforts are a sticking plaster on a haemorrhage. The western drugs they need are unaffordable. Life is priced too high.

Thirty-five miles away in Pretoria, a legal battle critical to the fate of many more women like Refilwe and Nokuthula, their men and their children, is about to begin. Case number 4183/98 in the South African high court is an action brought by 42 pharmaceutical companies, including the British giant GlaxoSmithKline, against the South African government.

The case is an attempt to block South Africa from importing cheap medicines. The drug companies have spent three years and millions of pounds preparing the case.

They have retained virtually every patent lawyer in South Africa. On March 5 their barristers will try to stop the South African government from buying the medicines its people so badly need from countries where the prices are lowest, on the grounds that it is infringing world trade agreements.

At an age when women in the west are embarking on families and careers, Refilwe and Nokuthula have begun the business of dying...

Across Africa and the developing world millions more will die of diseases that are treatable in the west, such as diarrhoea, meningitis, malaria, TB and Aids. The hospitals do what they can, but their best efforts are a sticking plaster on a haemorrhage. The western drugs they need are unaffordable. Life is priced too high.

The rest of Africa will be closely watching the outcome of the trial. So will developing countries on other continents. With the death toll from infectious diseases inexorably rising, especially in Africa, a tide of outrage is swelling among local activists and international aid organisations who see medicines denied to the sick in the name of commerce.

More than 2.5m people die every year from Aids-related illnesses. More than 13m children have lost one or both parents to the condition. There are more than 32m men, women and children infected by HIV in developing countries. AZT and 3TC, the basic antiretroviral drugs in the west, would keep them alive and well, but the price tag is $10,000 (7,000) to $15,000 per patient a year. The majority of employed people in South Africa, with whole families to support, earn less than $3,000 a year, and by comparison with most of the rest of the continent, they are rich.

But there are now alternatives - cheap copies of life-saving medicines called generics, made mainly in Brazil, India and Thailand whose national laws allow them to ignore drug patents in cases of dire human need. Thailand believes it could reduce the cost to $200 a year per patient. It is a price the South African government might be able to pay for the life of Refilwe and Nokuthula, but the drug companies, in Case 4183/98, afraid of the potential worldwide conse-

quences if their prices start to be undercut, say no.

Today in Cape Town at least 5,000 supporters of the successful grassroots Treatment Action Campaign will march on parliament to demand the medicines. At the same time in London, Oxfam is launching an international campaign demanding help for developing countries who want to use legitimate measures to buy or make their own cheap drugs, but who are bullied into submission by the lawyers working for drug companies and by the western governments who support them.

The pharmaceutical companies argue that they need 20 years of patent protection to recoup the vast sum it costs to research and develop drugs. They say it takes $1bn and at least 12 years to get a new medicine to market.

But, their accusers say, 90% of those new medicines are designed for 10% of the world's population in rich countries who can pay for them. The companies argue they already sell to developing countries at prices lower than in the west and that, with the approval of UNAids, the joint UN programme on HIV/Aids, five major companies have offered 85% discounts on drugs that are badly needed.

That could bring antiretrovirals down to $1,500 a patient, low enough for poor countries to hand them out to a chosen few but, say critics, millions would still have to die.

The Pharmaceutical Manufacturers Association of South Africa, which is bringing the case with the international companies, says it supports any country's right to buy supplies of drugs that are cheaper abroad "in exceptional circumstances". But it argues that section 15c of the Medicines Act, passed by the South African government in 1997 to allow it to import cheap copies of western medicines, would give the health minister "unfettered discretion to override patent rights for medicines in this country". And it was appalled when the South African delegation told a World Health Organisation meeting in January 1999 that the new legislation was a model which the rest of Africa should follow.

It is not just Africa that worries the big pharmaceuticals. On behalf of the industry the US government is taking the offensive to Brazil, which has had dramatic success in manufacturing its own cheap copies of patented drugs and now exports generics. Its price for an AZT equivalent is down from $15,000 a year to $4,000. There are now 60,000 people with HIV in Brazil who get free treatment.

At the heart of the growing legal battles directed against South Africa, Brazil and several other developing countries lies a little known international agreement called Trips - trade related intellectual property rights. It was agreed within the World Trade Organisation in order to ensure patent rights were respected around the world. The poorest countries have until 2006 to comply with Trips by passing their own patent laws. Under Trips, signatory states can pass clauses, as South Africa has tried to do, to bypass patents and make or buy cheaper drugs in cases of "dire emergency", and few could argue Aids is less than that.

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But the west's sharp legal minds, backed by vast drug company wealth, are willing and able to mount expensive challenges in the courts to uphold their patent rights - and thus the price of their drugs - as is about to happen in Pretoria.

For the first time, there is also about to be a challenge in the WTO itself. Last month the new US administration, which accepted substantial election funding from the pharmaceutical industry, asked for a WTO disputes hearing where it will claim Brazil is in breach of Trips. Oxfam and others fear the offensive against Brazil and South Africa marks a new determination by the drugs companies to resist the flouting of their patents by poor countries.

GlaxoSmithKline has recently threatened legal action against the Indian generics company Cipla, blocking its plans to bring a cheap version of Combivir - AZT and 3TC in one pill - into Uganda and Ghana. "The implementation of WTO patent rules is taking place against the backdrop of a sustained campaign led by the pharmaceutical industry which may well erode the public health protection provided by safeguard provisions," says an Oxfam report published today.

In Khayelitsha, a shanty town that sprawls over a vast plain near Cape Town's airport, the Nobel prize-winning volunteer doctors are raising the stakes. They pioneered the use of nevirapine, a drug that stops pregnant women transmitting HIV to their babies. Now the government is rolling out the programme to the entire country.

After the period of apostasy, when President Thabo Mbeki upset the medical world by doubting that HIV caused Aids, the government seems willing to seek out and use cheap drugs if it is allowed to.

Last year it opened an infectious diseases clinic - code for HIV - where people are offered counselling and treatment for the "opportunistic infections" that can kill. They use fluconazole, a strong antibiotic most hospitals lack because of its price, to treat cryptococcal meningitis and thrush.

In May, they will take the most radical step of all and start 150 adults and 30 children who are at death's door on antiretrovirals - the very medication that keeps people in the west with HIV alive. Dr Eric Goemaere, head of the South African mission of Medcins sans Frontires, sees it as a marker for the future. "We are here on the frontline to show that it is possible and it will change attitudes totally," he says.

South Africa could by now be in the relatively advantageous position of Brazil, he believes, making its own cheap drugs and importing others. Perhaps Nokuthula's husband need not have died and Refilwe might be strong. There was a political willingness to use generics in 1997, but Case 4183/98 put a stop to all that. "I have no hesitation in saying that I'm totally convinced that's exactly where it is," Dr Goemaere said. "The pharmaceutical companies blocked South Afric becoming like Brazil."

South Africa's director general of health, Ayunda Ntsaluba, says

something similar. "Three years down the road, access to medicines would have been completely different. We would be providing certainly for opportunistic infections, although it would be disingenuous to say we would have been providing triple therapy," he said.

It is hard to be a doctor in Africa. Herman Reuter, a young South African of German extraction who works for MSF in Khayelitsha, has more medicines at his disposal than most, but he is clearly under strain. Doctors go into the profession to cure the sick, not temporarily staunch their wounds before they die.

"We have our worse days and our better days," he says. "I saw one woman last Friday with a CD4 count of two [very low resistance to infection]. I said we hope to give antiretrovirals by May. She said, 'yes, but doctor, what happens until May?' I see many people die."

A very sick woman of about 41 had been brought to his clinic that morning by her 18-year-old daughter. She had cryptococcal meningitis. A week earlier, she had been to a government hospital and was turned away. There was nothing they could do for her, they said. They did not have the right medicine. But they mentioned the MSF clinic.

Dr Reuter was able to give her fluconazole, which costs around $4 for a 200mg capsule that will, for the moment, save her life. His last resort is to send the very sick to Somerset hospital in Cape Town, where pharmaceutical companies are running trials of drug combinations for HIV.

There is a bitter irony in it. The trials cannot be run in Britain or the US where the drugs will eventually be sold because everyone who needs antiretrovirals is on them. Refilwe and Nokuthula have no hope of a trial. Their best chance is to eat well, if they can afford to, to build up their strength and hang on.

Refilwe, like the rest of the patients in wards 13 and 16, refuses to accept she has HIV. What is the point when there is no treatment? "I don't know why I'm sick," she says, barely audibly.

Nokuthula places all her hope in the traditional healer, David Ngalana, even though he acknowledges he can give her only limited help. A large poster on the wall declares: "Traditional medicine can cure almost all sicknesses but currently we cannot cure HIV/Aids."

Nokuthula knows nothing about Aids drugs. There are no antiretrovirals for the people of her township, so they may as well not exist. She will drink her treebark infusions and convince herself they failed to save her husband only because he did not take them properly. In that way, maybe, hope can triumph for a while over despair.

Kenyan Aids orphanage declares war on the drugs company giants

By Declan Walsh in Nairobi
22 February 2001
The Independent

Dickson and Georgina lived last year on a fragile precipice between life and death. Georgina, aged four, shook with pneumonia and lacked the strength to stand up straight. Dickson's cracked face was so plastered with lesions and blisters that most people couldn't bear to look at him.

But six months have seen a miraculous transformation. Georgina springs from the arms of her nanny and bounds down the path. An irrepressible smile has replaced the festering viral infection on Dickson's face, which has almost completely cleared up.

It has never been clearer: the difference between life and death for millions depends on who puts the label on the bottle. But there is one massive obstacle. The Nairobi orphanage is spoiling for a fight with the drug companies that have thrown resources into making sure generics never see the light of day. One, the British company Glaxo SmithKline, yesterday announced record profits of $8.lbn.

The difference? A costly $9 daily cocktail of Western Aids drugs they have received since August. Nyumbani, the Nairobi Aids orphanage where they live, is now taking on the global drug titans in an effort to bring life-saving drugs to millions of other dying Africans.

Fr Angelo D'Agostino, its director, said: "I'm sick and tired of seeing funerals. So now we are going to try a different way." Nyumbani will defy international patent law and import a new Aids drug from India. The drug is the same, the difference is price: the Western drugs cost $3,000 a year, while the generic from Bombay's Cipla costs as little as $350.

The orphanage can only treat its 12 worst cases. With generics, the orphanage's 71 children could be transformed. Pneumonia would wane. Cracked skin would heal. And the ravages of Aids would be slowed down for up to 12 years.

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The impact in the outside world would be infinitely greater. Some 25 million Africans have HIV -- three-quarters of the world total -- but only 0.01 per cent of them can afford Western drugs. Generics made in India, Brazil or Thailand cost a fraction of that price and could revolutionise Aids treatment for many.

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Stinging from criticism, Glaxo and other big drug companies promised in May last year to slash their prices by 85 per cent. Yesterday, Glaxo said it would increase access to the HIV and Aids medicines in

developing countries by supplying its products at heavily discounted prices to a range of non-profit organisations.

But Aids workers say they can't wait any longer. Chris Ouma, an Aids doctor, said: "The truth is, we've just about had it. You can only watch people dying for so long. If we have to break laws to get drugs in, we'll do it." In 10 days' time, 42 drug companies will launch a court case in an attempt to force the South African government into overturning legislation allowing generics. The case has taken three years to come this far and cost millions of the dollars small change for companies that took in twice as much money as all of sub-Saharan Africa last year.

The drug giants shouldn't be too worried about Africa. The whole continent only accounts for one per cent of turnover, while 80 per cent comes from the US, Britain, Japan and four other Western countries. While Africans are often used in tests for drugs like Aids, they can seldom afford to buy them.

But the companies are worried that a bad example from Africa might give other impoverished countries the wrong idea. Or perhaps cheap African drugs could find their way into the West, where patients pay from $10,000 to $15,000 a year.

An attempt by Uganda and Ghana to import a generic version of Glaxo's Combivir drug resulted in a stiff letter from Glaxo reminding Cipla that the sale of generics represented "an infringement of our exclusive patent rights".

The Western companies are also trying to make sure Africa stick to Trips, a World Trade Organisation agreement that protects patent rights. And in the US, the pharmaceutical industry spent an unprecedented $17m in support George Bush's presidential campaign. Last month, the Bush administration applied to the World Trade Organisation to stop Brazil making generics.

The prices being proposed by Cipla -- $350 per patient for Medecins Sans Frontiers and $600 for national governments -- are still way beyond the reach of most Aids sufferers. In Kenya, for instance, it would cost $1.3bn a year to treat its estimated 2.1 million HIV sufferers -- the equivalent of 11 times the national health budget.

Dr Ouma said: "I know that 100 per cent coverage is impossible. But 40 per cent is. It seems to us that black people are the ones who are dying while the white people are the ones getting the profits."

Millions of lives could be saved. In a Nairobi MSF clinic Alice, a 27-year-old university secretary with HIV, came to ask for the prescription that would save her life. The drugs would cost $250 a month, far beyond the means of her $170 salary. But the Cipla price of about $50 is affordable.

At Nyumbani, nobody has been buried since the drugs cocktail programme got into full swing last August. One of the last to die was a nine-year-old called Samson. Twelve of Samson's friends in Nyumbani have since been saved. But time and money is running out. And if the drug companies keep the generics out of Kenya, the neat little graveyard will soon be filling up again.

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