A Petition To Bring Suit Against Defendants,
(including the Pharmaceutical Manufacturer's Association and members of the United States Government) on the Charge of Genocide Upon Individuals Living with HIV/AIDS

Working Document: July 29, 2000

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A Petition To Bring Suit Against Defendants,  
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on the Charge of Genocide Upon Individuals Living with HIV/AIDS

"Recently, there has been increasing mobilization around the idea of a right to essential and new drugs and growing resistance to the notion that intellectual property rights should trump other policy considerations."

Preface

This document is being distributed to various delegates to the United Nations as well as to leaders of nations at the greatest risk of losing a substantial proportion of their population to HIV/AIDS. It is also being publicly distributed.

Prevention of the spread of HIV remains a critically vital component of national and international health care efforts. However, this must not neglect the need to assure adequate treatment of infected individuals. When concerted and insidious efforts are made toward sustaining artificially high prices, the result is genocide by greed.

Introduction

Throughout history, humans have had to deal with the powerful emotions of anger and hate. Too often, these emotions, often fueled by greed, have led to one group obtaining a great deal of power over another group. When that power is wielded with an ability to kill, it has resulted in some of the most horrific episodes of human history. The murder of millions by leaders like Adolph Hitler, Pol Pot and Joseph Stalin are recent examples. These are unequivocal examples of expressions of the worst of our human heritage and nature.

Diseases, too, have taken their toll on humanity. The Black Plague, the Spanish Influenza outbreak, Ebola, tuberculosis, malaria--each have contributed untold suffering and death to human populations. In the latter part of the 20th century, a new scourge erupted that again has threatened global stability, the economies of nations and the lives of millions. Infection by the human immunodeficiency virus (HIV) is widespread and gaining ground. A great majority of infected individuals will go on to develop the Acquired Immune Deficiency Syndrome (AIDS)--and, without treatment, most will die.

Diseases, however, are acts of nature. They have no particular malevolent intent. Diseases, like floods, earthquakes, volcanoes, are merely manifestations of the remarkable pageantry of existence in its beauty and its terror.

Often, we respond to these disasters--and the remarkable side of humanity is that we often do so. When disaster strikes, thousands rally to help. Millions and sometimes billions of dollars are spent. Every effort is undertaken to ameliorate suffering. And this can be at great risk and against remarkable odds. Helping thousands to overcome the devastating floods in Mozambique is a recent example (March, 2000) of a remarkable effort, despite their limited medical infrastructure, destroyed roads and other significant challenges. While their previously slow growth has been set back and suffering continues, a concentrated effort has been brought to bear to help these people. Our nobler side is on display.

Yet how would we react if a group of companies decided that helping flood victims was not economically viable? If they declared that they would only provide relief supplies at an exorbitant price? And what if these companies were the only source of these supplies? And as a result of their vigorous efforts, no relief could be brought to the survivors of the flood and millions died? Would we not hold those companies responsible? Would they not, in effect, be committing genocide?

In this report, we review the activities of the Pharmaceutical Manufacturer's Association (PhRMA), the International Federation of Pharmaceutical Manufacturers Associations (IFPMA), the United States government, including Rodney Frelinghuysen, a congressman from New Jersey, Representative Hastert and Senators Trent Lott, Jessie Helms and William Roth for their role in developing sanctions against South Africa as well as contributing to the atrocity of untreated AIDS deaths globally1 (collectively, "Defendants"). We review Defendants' efforts to maintain egregiously high prices which prevent access to medications to treat people living with HIV/AIDS in developing nations. We believe that their actions deliberately inflict on the group conditions of life (inability to obtain medications) that result in their physical destruction. And that this callous disregard constitutes a form of genocide hitherto unrecognized but no less real than the more readily identified forms described above. It is genocide when the perpetrators are fully aware that the consequences of their actions are suffering and death. The scope of that suffering and death is stunning.

We believe that upon reviewing this material, you will see the compelling need to bring them to justice. To bring a suit against Defendants in the International Court of Justice for committing acts of genocide rooted in a greed no less
deadly, cruel and intentional than that driven by a motive of malevolent intent. We will show that Defendants' actions in threatening the sovereign rights of developing nations and the use of the threat of sanctions by the United States government extend significantly beyond the sometimes "unfortunate" consequences of business practices, and fall under the definition of genocide. We hope you will be convinced of the urgency and gravity of the situation and address it with vigor and alacrity.

The lives of millions are at stake.

The Target Population: People with HIV/AIDS

Traditionally, acts of genocide are viewed as affecting ethnic, religious or national groups. The millions of Jews murdered in the Holocaust, as well as gypsies, gays and lesbians, Poles, Hungarians and other groups. The hundreds of thousands of Tutsi's slaughtered by Hutus in Rwanda. The massacre of Armenians. The destruction of the culture and the murder of the people of Tibet by the Chinese government. The destruction of indigenous populations in the Americas over the past hundreds of years, up to and including the genocide carried out against Mayans by the authoritarian regime in Guatemala.

However, in the instant case, the population that is being oppressed most onerously is a group bound by a single, diminutive yet devastating agent: HIV. The Defendants' actions (as described below) are having a direct impact on this population more than any other. People with HIV do not fit into any one religious category: people with HIV/AIDS may have any of the faiths known to humans, as well as agnosticism and atheism. They are not simply Angolans or Thais. Not all Thais have HIV. People with HIV are represented in all the races of humankind.

The tie that binds is HIV. And bound, the majority will die without access to affordable treatment.

For those living in more affluent nations of the United States, the European Union, Australia, and other wealthier nations, a variety of treatments have been developed that substantially reduce the risk of developing AIDS and dying as a result of wasting or opportunistic infections. These include potent antiretroviral therapy (ART), treatments for opportunistic infections (OIs) as well as nutritional supplementation. Such treatments have their most substantial impact in the context of access to diverse foodstuffs and abundant, clean water.

In resource-poor nations, the situation is far more dire. Availability of ART is almost completely nonexistent except for a very wealthy minority. OI treatments remain scant. In many places, the very first issue that needs to be addressed is the availability of food and clean water. Many challenges to access exist that make it hard enough for people to survive and thrive despite HIV. Civil war eclipses concerns of AIDS when daily survival is uncertain. Natural disasters threaten stability further. Perhaps the most devastating component is poverty. The medical infrastructure may be in disarray. These problems collectively make life with HIV extremely problematic.

Addressing these issues in a global, comprehensive and culturally sensitive and appropriate fashion should be a priority of world governments. However, some forces are operating to pressure governments to simply write off these tens of millions of infected individuals by placing a first and wholly insurmountable barrier to treatment access: unconscionable and indefensible pricing policies.

HIV/AIDS: Global Scope

The spread of HIV does not appear to be slowing appreciably. Exact figures cannot be certain due to variability in reporting procedures. However, the numbers of deaths attributable to AIDS are more easily identified. And the history is grim and growing more alarming. Indeed, the following table reflects the extent of the horror to date:

Global summary of the HIV/AIDS epidemic, December 1999

<table>
<thead>
<tr>
<th>People newly infected with HIV in 1999</th>
<th>Total</th>
<th>5.6 million</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults</td>
<td>5.0 million</td>
<td></td>
</tr>
<tr>
<td>Women</td>
<td>2.3 million</td>
<td></td>
</tr>
<tr>
<td>Children &lt;15 years</td>
<td>570,000</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Number of people living with HIV/AIDS</th>
<th>Total</th>
<th>33.6 million</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults</td>
<td>32.4 million</td>
<td></td>
</tr>
<tr>
<td>Women</td>
<td>14.8 million</td>
<td></td>
</tr>
<tr>
<td>Children &lt;15 years</td>
<td>1.2 million</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>AIDS deaths in 1999</th>
<th>Total</th>
<th>2.6 million</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults</td>
<td>2.1 million</td>
<td></td>
</tr>
<tr>
<td>Women</td>
<td>1.1 million</td>
<td></td>
</tr>
</tbody>
</table>
The alarming spread of HIV infection throughout the world represents a threat to economic stability. Issues with regard to treating women, numbers of orphans; perinatal transmission prevention is important but cannot replace the need for a mother!

Availability of drugs, ARV and OI drugs

****

http://www.who.int/bulletin/news/vol.77no.1/africanaids.htm
Bulletin of the World Health Organization

The International Journal of Public Health
AIDS shortens life and dents economic growth across Africa

HIV infections continues to take a severe toll on life and health in sub-Saharan Africa, according to the latest figures released by the United Nations. The UN Population Division in New York in last autumn released figures suggesting that AIDS has taken fully seven years off the average life expectancy at birth of a baby born today in any of 29 affected African countries. In the absence of AIDS, life expectancy for these countries would average 54 years, but HIV has reduced that figure to 47 years.

In certain countries where more than 10% of the adult population is infected with HIV, including Botswana, Kenya, Malawi, Mozambique, Namibia, Rwanda, South Africa, Zambia and Zimbabwe, the UN says that the virus may have reduced life expectancy even more sharply, by 10 years. And, as the spread of the virus continues, its impact will worsen, with babies born between 2010 and 2015 facing lives that are on average 17 years shorter than they should have been — 43 years instead of 60 years in the absence of AIDS. But, because birth rates are generally high in the region, no African country, however hard-hit, is expected to see the overall growth in its population reversed.

A similarly disturbing picture for southern Africa was described by the Joint UN Programme on HIV/AIDS (UNAIDS) on the eve of World AIDS Day, 1 December 1998, based on the same epidemiological and demographic models. In 1998 two million people died of AIDS in sub-Saharan Africa, according to the agency. While these deaths reflect infections that happened several years ago, new infections continue to occur at "alarming" levels, says UNAIDS. In nine severely affected southern African countries, the agency estimates, a total of 1.4 million adults became infected in 1998, half of them in South Africa alone. By 2005, it is expected that South African companies will be paying out AIDS-related benefits equivalent to 19% of their salaries' bill. Studies from other African countries show that households whose breadwinner has AIDS lose most of their income, while their children's education is sharply reduced. Zimbabwe is expected to have 0.9 million "AIDS orphans" by the year 2005.

© World Health Organization / Organisation mondiale de la Santé, 1999

Further information from WHO Report:

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• Sub-Saharan Africa continues to bear the brunt of HIV and AIDS, with close to 70% of the global total of HIV-positive people. Most will die in the next 10 years, joining the 13.7 million Africans already claimed by the epidemic and leaving behind shattered families and crippled prospects for development.

• Because of AIDS, companies doing business in Africa are hurting and are bracing themselves for far worse as their workers sicken and die. According to a survey of commercial farms in Kenya, illness and death have already replaced old-age retirement as the leading reason why employees leave service. Retirement accounted for just 2% of employee drop-out by 1997.
Life expectancy at birth in southern Africa, which rose from 44 years in the early 1950s to 59 in the early 1990s, is set to drop to just 45 between 2005 and 2010 because of AIDS. In contrast, South Asians, who could barely reach their 40th birthday in 1950, can expect by 2005 to be living 22 years longer than their counterparts in AIDS-ravaged southern Africa.

New information suggests that between 12 and 13 African women are currently infected for every 10 African men. There are a number of reasons why female prevalence is higher than male in this region, including the greater efficiency of male-to-female HIV transmission through sex and the younger age at initial infection for women.

In 1999, an estimated 570 000 children aged 14 or younger became infected with HIV. Over 90% were babies born to HIV-positive women, who acquired the virus at birth or through their mother’s breastmilk. Of these, almost nine-tenths were in sub-Saharan Africa. Africa’s lead in mother-to-child transmission of HIV was firmer than ever despite new evidence that HIV ultimately impairs women’s fertility: once infected, a woman can be expected to bear 20% fewer children than she otherwise would.

In short, the huge gap in HIV infection rates and AIDS deaths between rich and poor countries, and more particularly between Africa and the rest of the world, is likely to grow even larger in the next century. Likely, but not certain. Massive national and international efforts may yet help to end the stifling silence that continues to surround HIV in many countries, to explode myths and misconceptions that translate into dangerous sexual practices, to expand prevention initiatives such as condom promotion that can reduce sexual transmission, to create conditions in which young children have the knowledge and the emotional and financial support to grow up free of HIV, and to devote real money to providing care for those infected with HIV and support to their families. A trail of successful responses has already been blazed by a small number of dedicated communities and governments. The challenge for the leaders of Africa and their partners in development is to adapt and massively expand successful approaches that make it harder for the virus to spread, and that make it easier for those affected to live full and rewarding lives.

### Regional HIV/AIDS statistics and features, December 1999

<table>
<thead>
<tr>
<th>Region</th>
<th>Epidemic started</th>
<th>Adults &amp; children living with HIV/AIDS</th>
<th>Adults &amp; children newly infected with HIV</th>
<th>Adult prevalence rate&lt;sup&gt;2&lt;/sup&gt;</th>
<th>Percent of HIV-positive adults who are women</th>
<th>Main mode(s) of transmission&lt;sup&gt;3&lt;/sup&gt; for adults living with HIV/AIDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sub-Saharan Africa</td>
<td>late ‘70s - early ‘80s</td>
<td>23.3 million</td>
<td>3.8 million</td>
<td>8.0%</td>
<td>55%</td>
<td>Hetero</td>
</tr>
<tr>
<td>North Africa &amp; Middle East</td>
<td>late ‘80s</td>
<td>220 000</td>
<td>19 000</td>
<td>0.13%</td>
<td>20%</td>
<td>IDU, Hetero</td>
</tr>
<tr>
<td>South &amp; South-East Asia</td>
<td>late ‘80s</td>
<td>6 million</td>
<td>1.3 million</td>
<td>0.69%</td>
<td>30%</td>
<td>Hetero</td>
</tr>
<tr>
<td>East Asia &amp; Pacific</td>
<td>late ‘80s</td>
<td>530 000</td>
<td>120 000</td>
<td>0.068%</td>
<td>15%</td>
<td>IDU, Hetero, MSM</td>
</tr>
<tr>
<td>Latin America</td>
<td>late ‘70s - early ‘80s</td>
<td>1.3 million</td>
<td>150 000</td>
<td>0.57%</td>
<td>20%</td>
<td>MSM, IDU, Hetero</td>
</tr>
<tr>
<td>Caribbean</td>
<td>late ‘70s - early ‘80s</td>
<td>360 000</td>
<td>57 000</td>
<td>1.96%</td>
<td>35%</td>
<td>Hetero, MSM</td>
</tr>
<tr>
<td>Eastern Europe &amp; Central Asia</td>
<td>early ‘90s</td>
<td>360 000</td>
<td>95 000</td>
<td>0.14%</td>
<td>20%</td>
<td>IDU, MSM</td>
</tr>
<tr>
<td>Western Europe</td>
<td>late ‘70s - early ‘80s</td>
<td>520 000</td>
<td>30 000</td>
<td>0.25%</td>
<td>20%</td>
<td>MSM, IDU</td>
</tr>
<tr>
<td>North America</td>
<td>late ‘70s - early ‘80s</td>
<td>920 000</td>
<td>44 000</td>
<td>0.56%</td>
<td>20%</td>
<td>MSM, IDU, Hetero</td>
</tr>
</tbody>
</table>

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<sup>2</sup> The proportion of adults (15 to 49 years of age) living with HIV/AIDS in 1999, using 1998 population numbers.

<sup>3</sup> MSM (sexual transmission among men who have sex with men), IDU (transmission through injecting drug use), Hetero (heterosexual transmission).
### Table 1: Regional Epidemiological Data

<table>
<thead>
<tr>
<th>Region</th>
<th>Epidemic started</th>
<th>Adults &amp; children living with HIV/AIDS</th>
<th>Adults &amp; children newly infected with HIV</th>
<th>Adult prevalence rate(^2)</th>
<th>Percent of HIV-positive adults who are women</th>
<th>Main mode(s) of transmission for adults living with HIV/AIDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Australia &amp; New Zealand</td>
<td>late ‘70s - early ‘80s</td>
<td>12 000</td>
<td>500</td>
<td>0.1%</td>
<td>10%</td>
<td>MSM, IDU</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td></td>
<td><strong>33.6 million</strong></td>
<td><strong>5.6 million</strong></td>
<td><strong>1.1%</strong></td>
<td><strong>46%</strong></td>
<td></td>
</tr>
</tbody>
</table>

### Parallel Import, Compulsory Licensing

Both of these laws are recognized as legally valid under the Trade-Related Aspects of Intellectual Property (TRIPS). Essentially, they are measures to be instituted in the case of an emergency, which the above data (and the Addenda) clearly indicate exists, not only from the obvious human ethical impact of HIV/AIDS globally, but also due to the geopolitical impact of significant percentages of the working populations being wiped out. Indeed, this situation is so grave, that some elements within the United States government have recognized the devastation of HIV/AIDS as a threat to national security. Others, including named Defendant Senator Trent Lott, have dismissed this threat.

**Parallel import laws** allow a country to "purchase new drugs from third parties in counties where the price is low in order to reduce the high prices of new drugs."

[GEORGE: INCORPORATE]

Date: Sat, 19 Aug 2000 13:36:31 -0400 (EDT)
From: James Love <love@cptech.org>
To: Multiple recipients of list <healthgap@CritPath.Org>
Subject: Parallel Imports - Compulsory licenses

Others have pointed out that there is quite a bit of confusion over the terms parallel imports and compulsory licensing. This is my understanding of the two terms.

1. Parallel imports concerns cross border trade in a firm's products. For example, buying the Canadian version of Schering's Claritin, at the much lower price in Canada, and importing to the US. Or, buying the Glaxo version of Combovir from India, where it is cheaper, because it faces competition from CIPLA, and importing into another country.

2. In general, parallel imports are *not* about buying the CIPLA product, Duovir, from a country where Glaxo does not have a patent, and importing into a country where Glaxo does have a patent. I believe this is a violation of the Glaxo patent in the country where the medicine is imported into.

3. Compulsory licensing is when someone else that the patent owner is permitted (by the government) to use a patent, typically for a royalty. For example, if a country in Latin America or Africa wanted to permit CIPLA to sell its Duovir product in a market where Glaxo has a patent, they would have to issue a compulsory license to CIPLA (or the importer), to do so, and CIPLA would pay a royalty, perhaps of 5 percent of CIPLA's sales price, to Glaxo.

4. There is a case where you can use both compulsory licensing and parallel imports. Suppose CIPLA had a compulsory license to the patents needed for Duovir, and sold that product in the country where it had obtained a compulsory license. There is an argument that Glaxo's rights in the intellectual property for Duovir were "exhausted" at the point of sale, under the compulsory license, permitting the Duovir drug to be parallel imported into a country that had not issued a compulsory license. This is a controversial interpretation of parallel importing and exhaustion. However, under the WTO TRIPS accord, Article 6 say:

   **Article 6**
   
   Exhaustion

   For the purposes of dispute settlement under this Agreement, subject to the provisions of Articles 3 and 4 nothing in this Agreement shall be used to address the issue of the exhaustion of intellectual property rights.

   Article 6 is very strong language limiting the WTO's ability to review these decisions.
At the end of the day, however, the important thing will be the laws in each country. If a country has a compulsory licensing authority, and actually uses it, or permits any form of parallel imports, these approaches are useful. If a country doesn't permit or do any of them, then they are not useful.

Jamie

*Compulsory licensing* permits "a national government to require licensing by a nonpatent-holder that would manufacture the new drugs within the country under certain conditions." Most drug patents are licensed to specific pharmaceutical companies. This gives them certain intellectual property rights over how the drug may be sold or distributed. However, such laws should not be used as a shield to hide price gouging nor should they hold patients hostage to inordinate greed. Compulsory licensing laws are a recognition of the need to permit resource-limited countries the ability to allow them to manufacture the drug in their own country, thus being granted a license to do so should the pharmaceutical company otherwise fail to provide one, and distribute it at the subsequently lower cost.

Engaging in lawsuits and pressuring wealthy governments to sanction resource-poor nations to prevent them from adopting such laws clearly has only one result: the drugs are guaranteed to remain unavailable. And the result of that is disability, disfigurement and very often, death. The Defendants are aware of these facts.

For further and more detailed information, please see [http://www.cptech.org/ip/health/cl/](http://www.cptech.org/ip/health/cl/) as well as [http://www.icaso.org/compulsory_english.htm](http://www.icaso.org/compulsory_english.htm).

**Definition of Genocide**

According to the Convention on the Prevention and Punishment of the Crime of Genocide, Article 2 covers the definition, stating:

**Article 2**

In the present Convention, genocide means any of the following acts committed with intent to destroy, in whole or in part, a national, ethnic, racial or religious group, as such:

(a) Killing members of the group;
(b) Causing serious bodily or mental harm to members of the group;
(c) Deliberately inflicting on the group conditions of life calculated to bring about its physical destruction in whole or in part;
(d) Imposing measures intended to prevent births within the group;
(e) Forcibly transferring children of the group to another group.

Article 2(b) appears to be applicable. By restricting a sovereign nation's ability to obtain treatment at the lowest possible cost, these organizations knowingly create conditions which will cause serious bodily harm—and in most cases for people with HIV, an early death from untreated AIDS.

Article 2(c) also appears to be applicable. We believe that the actions of PhRMA constitute genocide according to this portion of the definition. As noted above, the "group" is people with HIV/AIDS. The conditions of life are the inability to obtain life-saving drugs, despite their existence. That access has been actively thwarted by Defendants' assault on the right of sovereign nations to adopt internationally recognized laws, by the bringing of suits and by recruiting the might of the U.S. government to threaten countries which attempt to do so with economic sanctions. The "physical destruction in whole or in part" is the deaths of millions of people with AIDS simply because they cannot afford these treatments. The companies commit these litigious acts and employ other threatening means with the knowledge that the effect is that inexpensive treatment remains unavailable. Without that treatment, they know that millions are dying.

Clearly, there will be those who oppose using the term "genocide" at all because for some the horror of Nazi Germany has become the measure against which all acts of genocide must be judged. I think that is dangerously shortsighted. The deaths of millions of Africans, Asians, Indians, South and Central Americans—men, women, children and babies—because of pharmaceutical company greed is no less horrific to me than the deaths of millions of Jews, gays and lesbians, Gypsies and others slaughtered by the Nazis.

Indeed, in a report by Jon Henley, "French Produced Zyklon-B Gas for Nazis." Annie Lacroix-Riz has written a book ([Industrialists and Bankers Under the Occupation](http://www.icaso.org/compulsory_english.htm)) documenting the very swift embrace that many French businesses made, before Vichy, with German companies. She documents the voluntary joint venture between a chemical manufacturer,
Ugine, and IG Farben for "combating parasites." Zyklon-B is the cyanide containing gas that Ugine was happy to produce in quantity and ship to Germany. Lacroix's grandfather died in Auschwitz.

She says "The real revelation to emerge from this work is the voluntary and prompt action of French businesses actively seeking to collaborate...The myth has always been that it was the wartime Vichy government that pushed companies into collaboration. In fact, French bankers and industrialists acted well in advance of Vichy and went far beyond its requirements. Believing in a German victory, they simply pursued their capitalist interests." That's not part and parcel with genocide?

The difference today is that these businesses are, in pursuing their capitalist interests, refusing to make drugs available unless they get their wholly artificial and indefensibly high price. Prices which are based on arbitrary and capricious considerations that are certain to be fatal to millions.

**Acts Calculated to Inflict Harm**

One might ask, how has PhRMA "calculated" this? Are they "deliberately inflicting" something? Indeed, implicit, if not stated, in that "calculated to bring about" phrase is the image of individuals gathered together to plot the destruction of a hated minority. However, it does not explicitly require that the group hate the target or have any feelings at all. We feel that the traditional concept of the calculation must be expanded to recognize the very real horror raised by the policies and actions of PhRMA.

The calculation, indeed, is the cost of those drugs and thereby placing a value on the life of a human being. The choice of what price to charge is freely made and dramatically exceeds the manufacturing cost. This is an aspect of business practice (and one that the pharmaceutical industry has closely guarded as a secret). As such, it can have despicable and inhumane aspects, but it is not generally perceived as being genocidal.

The recent move by Pfizer, after significant activist pressure, to supply fluconazole to South Africa to treat cryptococcal meningitis underscores their full knowledge that their pricing policies have lethal consequences. This is rendered particularly evident when the price in South Africa for the drug is around $10/day, whereas in other countries, the cost can be as little as 70 cents a day. While they have chosen to provide drug to South Africa, they decline to do so elsewhere: a death sentence for tens or hundreds of thousands.

However, what PhRMA is doing extends well beyond that. PhRMA has deliberately inflicted these conditions by its practices and policies of fighting to maintain artificially high prices. In calculating the price of a drug, they are also calculating--plotting and fighting by various ways and means--to assure that ONLY that price is obtained for the drug. Indeed, they are fighting to usurp the sovereign rights of nations to adopt parallel importing or compulsory licensing laws that would assure access to drugs at closer to manufacturing cost. PhRMA is not oblivious to the fact that as they force these developing nations to pay outrageous prices for the drugs, many simply give up. PhRMA knows that the result of their efforts to push the U.S. government into placing sanctions against developing nations that do not kowtow to their greedy demands creates the sound of millions of slamming coffins. They know that their actions will result in death on a massive scale. All in the name of preserving the artificially high cost of life-saving treatment. This is genocide.

"Intent"

Much hinges on the term *intent*. There are apparently persuasive arguments that may be made that would suggest that Defendants had no real intent to harm anyone. However, upon closer inspection, these arguments are specious.

Defendants may argue that they had no desire to harm anyone. A commonplace interpretation of the term in the context of the definition of genocide provided above may focus on acts of violence arising from a malevolent desire to exterminate a group. However, such a narrow definition is not written into the law and a broader interpretation may be [and has been?] made. Indeed, the actions of Defendants bespeak an awareness of the results of their actions that certainly do not preclude a finding of intent. Indeed, the definition itself not only does not create such a narrow interpretation but indeed is broad enough to include actions done intentionally with an awareness that harm or death may result.

The Defendants may also argue that they are merely endeavoring to protect the interests of the pharmaceutical industry and their shareholders. And in doing so, they may claim, they are fostering an environment conducive to further research and development ("R&D"). This argument is specious, particularly with regard to HIV/AIDS drugs since very little pharmaceutical investment was expended, with the majority of the costs arising from NIH and university expenditures--let alone the lives of many people with HIV/AIDS who took part in the clinical studies. (See the section on R&D below). Indeed, some might argue that the increased rate of mergers between behemoth corporations actually stymies innovation and creativity, when the bottom line becomes the overarching and driving consideration. (Historically, larger companies become less innovative and less willing to take risks.) There does not appear to be any law that codifies the superiority of intellectual property rights over the lives of human beings. Indeed, to the contrary, laws that do exist endeavor to recognize the rights of human beings to life.
One must ask, what aspect of intellectual property rights are they trying to protect? Clearly, it's not merely the discoverer's public recognition or even protecting the name of the company. The issue, of course, is the drug's ability to generate cash and stocks. When people are denied access to a medication because of an inability to pay in resource-rich countries, companies will provide, in some cases, some form of a compassionate use program. However, these are not available in most resource-poor nations. Indeed, the one option that may provide lower cost access to the drug is being actively fought against. This is the basis for the charge of genocide against them, not merely that lives are held hostage by high prices, but that attempts to seek redress and fairness are actively fought against, despite the consequences.

Therefore, should Defendants put forward these types of arguments, they would not overcome the responsibility Defendants must bear for their actions. Actions which are "[c]ausing serious bodily or mental harm to members of the group."

As is described herein, PhRMA has colluded with the US government in an attempt to prevent access. They do this intentionally, with the full knowledge that the consequence of this profit-protectionism is suffering and death on a massive scale among the group of people living with HIV/AIDS. As is delineated below, this awareness is manifest in the spasm of guilt evidenced by Pfizer Pharmaceuticals in its sudden willingness to provide a drug (fluconazole/Diflucan) to treat cryptococcal meningitis, knowing that the current pricing scheme in South Africa means most people who become ill die (see below). One which threatens geopolitical stability as much as the morally and ethically bankrupt destruction of human compassion at the altar of greed.

While this description of intent may not be as familiar as the more easily discerned genocide of a Hitler against many different ethnic groups, most particularly Jews, the law as it is written does not preclude a finding of intent, even if it is somewhat indirect. When Defendants commit acts that they know will have the consequences of suffering and death, they are culpable for those acts. Further, the law as written does not require any malice aforethought.

Therefore, by Defendants' conscious activities described herein which have devastating and globally threatening consequences which have already resulted directly in the deaths of millions of people with HIV/AIDS, their intent is quite clear.

Pricing Issues and International Patent Law


Patents as anti-free market and used primarily as shields for price gouging.

Cover the issue that patients must often cover drugs costs on their own. They can't afford it even at cost.

Governments of the countries may shy away from any attempt as they don't cover the cost. This is not a rationale; to the extent that outside aid or other means are made available to obtain and provide treatment (WHO, etc.), the lowest cost possible will enable more treatment. If outside aid must pay full price, fewer people will have access to treatment.

Note that patent life is being extended by devious methods. Not only does this significantly harm the generic industry, it will have incalculable effects on access to AIDS drugs.

New section covering the half-hearted effort by several major companies to substantially cut prices. To the extent these reductions are conditional upon countries' enacting laws against compulsory licensing or parallel import, this offer amounts to little more than a bribe with potentially fatal consequences. Also, only reductions that bring the price close to manufacturing cost will be a truly useful reduction that can be affordable to many nations.

PHRMA's Proactive Role: Lawsuits and Sanctions

Incorporate elements of History of their lawsuit against South Africa; clarify where/how filed and current status. Timeline is attached (and at the cptech.org website, at http://www.cptech.org/ip/health/sa/sa-timeline.txt

Note targeting of countries: India, South Africa, Thailand, Vietnam--get list.

The collaboration between PhRMA and the US Government. Note Freylinghausen HR.

[AGOA - AIDS Genocide on Africa passed?]

UPDATE re Clinton's 5/11/00 Executive Order

Role of International Federation of Pharmaceutical Manufacturers Associations (IFPMA)

To be inserted. http://www.ifpma.org If you have comments about these pages please contact IFPMA at admin@ifpma.org

IFPMA, 30 rue de St-Jean, P.O. Box 758, 1211 Geneva 13, Switzerland; Phone : +41 (22) 338 32 00 - Fax : +41 (22) 338 32 99

7 Indeed, to the contrary, the original discoverer is often a little-known individual; the rights are taken or bought by the company. A case in point: the civil suit over the patent on abacavir? GEORGE: GET CITE/REFERENCE

8 Drug abuses: As pharmaceutical companies go to extraordinary lengths to protect expiring patents, regulators are starting to pay close attention, say David Pilling and Richard Wolffe, *Financial Times*; 20-Apr-2000.
Role of U.S. Government

Sanctions threatened against South Africa and other countries (?) unless they agreed to drop their legal right to compulsory licensing/parallel import laws. "Since the creation of the World Trade Organization (WTO), the United States Government has been extremely aggressive in attacking parallel imports by other countries. Nevertheless, parallel imports of a range of goods routinely flow into the United States itself."9

Role of US Trade Representative/Charlene Barshefsky. Attack on South Africa for compulsory licensing/parallel import. Story of how, under American activist pressure, Gore, USTR and the original cabal that colluded with PhRMA backed off. PhRMA's suit was dropped.

The Despicable Roth Amendment and it's Demise

The United States is seeking, under the guise of a "free trade" agreement with Africa (the Africa Growth and Opportunity Act or AGOA), to force resource-poor countries to kowtow to their will in ways that are stunningly arrogant and patrician. The U.S. has [once again] set itself up as the arbiter of what international laws they like and which they don't. To that end, some legislators, such as Sen. Diane Feinstein, have recognized that resource-poor nations have a sovereign right to adopt such laws and should not be threatened with sanctions. Thus, they have endeavored to include language in [pending] legislation that would maintain these rights, particularly with regard to the HIV/AIDS pandemic. Others, supporting the genocidal policies of the past, seek to eviscerate the amended language (notable Sen. Roth). The language of the two clauses follows:

As of May 3, 2000, all of the language has been deleted that would provide any protections for access to drugs by people with AIDS. According to the Feingold report, the compromise language was stricken today, in a closed meeting involving only Speaker Hastert and Majority Leader Lott. Therefore, these individuals have been named as defendants.

[Roth Amendment and Feinstein amendment language and the article and letter from ACT UP/Philadelphia deleted since Roth amendment failed; need to update passage of AGOA.]

Role of World Bank/International Monetary Fund

Supplying developing nations with loans at interest--when many countries are already hemorrhaging funds to pay off interest on previous loans upon which the principal has long since been paid for ill-conceived Structural Adjustment Programs--is not a very useful strategy. Particularly if the loans are wiped out in paying for the drugs at the inflated costs. This further compromises the ability to improve medical infrastructure, train physicians, obtain needed supplies (gloves, syringes), and testing equipment (such as ELISA, Western blot; CD4 and viral load and other blood tests, etc.)

Jubilee 2000 regarding

The IMF's use of "user fees" and the [probable lie] of the WB claiming NOT to require them.

Please see the letter from Leon Galindo, a World Bank consultant and his experiences at the demonstration in Washington DC on April 16, 2000.

TO BE CITED; Kris will be digging up cites in the next week or two.

At 06:07 AM 3/24/00 , you wrote:

>Role of WB/IMF snip....

I would add to this, the direct and heavy handed approach that both the IMF and WB take to the issue of privatization of health care. Not only do the IMF/WB discourage investment in health and education by demanding loan repayment as the highest priority, thereby taking funds from social programs, but they also have been known to stipulate privatization as a prerequisite for future loans.

This comes in at least two forms. The lending institutions undermine existing government health care programs by demanding the dismantling of universal health care systems in certain countries. A more common occurrence though is the

lending institution's demand for implementation of user fees for health care (where it was previously free). This can occur in countries where there isn't a universal plan per se, but where independent clinics are forced into such situations. Of course even the cheapest user fees will discourage people with little financial means to attain treatment.

A specific example of the latter point is a health care clinic in El Salvador called ASAPROSAR. Not only was the WB demanding that they institute user fees (after the WB has publicly stated that they no longer have this policy), but the USAID who definitely should not be tampering in this area was also making such demands. If the clinic did not comply, they were at risk of losing important funding from these entities.

It is clear that the IMF/WB are acting in the interests of multi-nationals (read, pharmaceutical co.s for this argument), as "free" health care would undermine profits to be gained by drug co.s. I suppose another explanation could be that the zeal for privatization has become so deep seated that they are proceeding out of an unconscious assumption that free market systems are beneficial under any conditions.

Kris Hermes /END

**Consequences of Defendants' Actions: Genocide**

When an organization has enormous power, funding and influence on governmental affairs globally, concomitant with that power is a profound responsibility. And when the products of those organizations are life-saving medications, that responsibility takes on a profound ethical dimension which must not be lost in the haze of grasping and greed.

In this document, we have provided evidence that shows that PhRMA's actions are intended to satisfy that greed at any cost--even when the cost is millions and millions of lives. Their responsibility should be to bend every effort to reduce barriers to access and assist the appropriate dissemination and assure the proper use of these medications. PhRMA has actively thwarted any such effort through the use of lawsuits. They have not only abdicated their ethical and human responsibilities, but to the contrary, PhRMA has wielded its power with the intention of stopping any legally valid and ethical attempt to obtain patented medications at near manufacturing cost. With the result that millions--perhaps as many as 40 million people--will die horribly. Thus, their specific and direct actions are clearly and unequivocally acts of genocide.

It may be that courts will choose to adopt a very narrow definition of the term based on definitions embodied in the Geneva conventions. That would be a gross and deeply immoral error. And it is a nicety of legal distinction that would be undoubtedly lost on those dying, knowing their children are about to be orphaned merely because of PhRMA's unflinching and ignominious efforts.

**Research & Development (R&D)**

One argument raised by the defendants is that their actions are necessary in order to assure that costs for R&D are adequately recovered. This is not intrinsically an unreasonable argument, however it fails to justify their actions.

First, the definition of R&D is not always clear. Indeed, AIDS Action Council has reported that a substantial percentage of what is called "R&D" may be more appropriately labeled "marketing." Such costs are of only secondary value in the contribution toward the development of a drug. Data from AIDS Action:


Second, lower prices don't necessarily mean no profits. Third, the extent to which pharmaceutical companies have invested in the R&D of HIV/AIDS-related drugs and OI treatments has been minimal. Much of the basic research derived from U.S. government laboratories and indeed, much of the expense of the clinical studies has been borne by U.S. and European taxpayers.

Finally, additional arguments may be found at http://www.icaso.org/compulsory_english.htm. [Appended hereto? Permission?]

April 10, 2000: Thiru Balasubramaniam and James Love

Pharmaceutical company expenses: Cost of sales, Marketing, R&D compared

<table>
<thead>
<tr>
<th>Company</th>
<th>Cost of Goods</th>
<th>Marketing &amp; R&amp;D</th>
<th>Administrative</th>
</tr>
</thead>
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<tr>
<td>Abbott</td>
<td>45.4%</td>
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<td>9.1%</td>
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<td>American Home Products</td>
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<tr>
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<td>34.6%</td>
<td>9.1%</td>
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<tr>
<td>Eli Lilly</td>
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<tr>
<td>Genentech</td>
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<td>26.0%</td>
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<tr>
<td>Company</td>
<td>2001 Product Sales</td>
<td>2002 Product Sales</td>
<td>2003 Product Sales</td>
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<tr>
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<td><strong>Median:</strong></td>
<td><strong>21.0%</strong></td>
<td><strong>34.6%</strong></td>
<td><strong>13.7%</strong></td>
</tr>
</tbody>
</table>

*Percentage of Product Sales
Source: Company SEC 10K Filings and Company Annual Reports

**Other Challenges to Access**

There are many serious challenges to providing treatment. These include appropriate distribution programs, evading the grasp of corrupt governments, appropriate training of both physicians and patients and [PULL FROM AND CITE MSF.] However, they do not serve as any kind of rationale for justifying price gouging or PhRMA’s willful attempts to subvert the legal right of countries to acquire medications at the lowest possible cost in the case of a dire emergency.

**Action to be Taken**

We are petitioning you, as an ambassador of your nation to the United Nations, bring a suit against the Defendants, and as a Contracting Party to the Convention on the Prevention and Punishment of the Crime of Genocide, bring suit against the named Defendants in the International Court of Justice. If Defendants, or any member of said group, is found guilty, then appropriate sentences should be meted out. According to the law:

Article 3
The following acts shall be punishable:
(a) Genocide;
(b) Conspiracy to commit genocide;
(c) Direct and public incitement to commit genocide;
(d) Attempt to commit genocide;
(e) Complicity in genocide.

Article 4 states simply "Persons committing genocide or any of the other acts enumerated in article III shall be punished, whether they are constitutionally responsible rulers, public officials or private individuals."

Article 6: "Persons charged with genocide or any of the other acts enumerated in article III shall be tried by a competent tribunal of the State in the territory of which the act was committed, or by such international penal tribunal as may have jurisdiction with respect to those Contracting Parties which shall have accepted its jurisdiction."
Appendices

Additional supporting material that underscores the gravity of the problem and the role of Defendants.


DEVASTATION IN AFRICA

"The devastation of apartheid is quickly being dwarfed by AIDS, a disease that last year alone killed more than 2 million Africans and has, in total, orphaned 10 million African children." from "Rallying congress to fight AIDS in Africa," by Mark Schoofs. <http://www.thebody.com/schoofs/marshall.html>

"AIDS Proves Deadlier Than War in Africa" Washington Times (www.washtimes.com) (03/14/00) P. A15

United Nations Secretary-General Kofi Annan said Monday that AIDS has taken the lives of more Africans in the past year than have all the wars on the continent. Annan called on governments to take action against the epidemic and noted, "We must end the conspiracy of silence, the shame over this issue."


Extent of Disaster Reports:

"AIDS Rising in Cameroon but Containable--World Bank"
Reuters (02/23/00)

World Bank official Serge Michailof reported Tuesday that HIV infections are rapidly increasing in Cameroon, but could be stemmed by quick action. A 1997 count estimated an HIV infection rate of 4.9 percent, a rate which Michailof noted is still low enough to be affected by aggressive actions. Michailof, the bank's director of operations for Central Africa, said that Cameroon has a chance to stop AIDS before it destroys the country as a whole, and he offered the World Bank's assistance for the effort.

"Over 20,000 TB Cases Reported Yearly in Angola"
PANA Wire Service (02/23/00)

Angola's health minister, Julia Hamukuaya, announced that over 20,000 cases of tuberculosis (TB) occur each year in Angola, and diseases like malaria, leprosy, AIDS are also plaguing the country. Hamukuaya attributed the diseases' spread to the nation's deteriorating military, political, and socio-economic situation. Most TB patients receive no treatment due to inadequate screening, and the disease will likely become the chief cause of death among the active population in future years. Hamukuaya also said that 157,000 cases of HIV were reported in 1999.

"Two Die Daily of TB In Malawi"
PANA Wire Service (02/23/00)

New statistics from Malawi's National TB Control Program show that an average of two people die daily in Malawi from tuberculosis (TB). About 22,000 TB cases occur each year in Malawi, with 8,000 deaths. The AIDS epidemic is part of the reason for the increase in TB cases, as 66 of every 100 TB patients in hospitals have HIV. The head of the TB Control Program, Felix Salaniponi, estimated that there will be about 29,000 TB cases in Malawi in five years, mostly among young adults.

"19 Percent of Zambians Have HIV Virus"
Africa News Online (04/05/00); Phiri, Brighton

Zambian officials said Tuesday that over 19 percent of the nation's population has been infected with HIV since the beginning of the epidemic, which is threatening the country's economic development. Lusaka Province Deputy Minister Mulenga urged more people to get tested for HIV and also to try to stay healthy so they could donate blood, which is desperately needed. Webster Mwape of the Community Based Tuberculosis Organization reported that the number of tuberculosis cases in the country is increasing, in part because of a lack of drugs.
"Three Million People With HIV in Ethiopia"
Reuters (04/05/00)

Over 3 million people in Ethiopia have HIV, which is 9.3 percent of the country's sexually active population, according to a new report. Eduard Sanders, program manager of the Ethio-NetherlandsAIDS Research Project, also warned that rural areas of Ethiopia--where the majority of the population lives--may have more infections than reported. Sanders noted that research on so-called low-risk groups indicates that the rate of HIV infection ranged from 7 percent to 23 percent in urban areas.

"Prevention of Mother-to-Child HIV Transmission in Resource-Poor Countries"
Journal of the American Medical Association (www.jama.com) (03/01/00) Vol. 283, No. 9, P. 1175; De Cock, Kevin M.; Fowler, Mary Glenn; Mercier, Eric; et al.

Infants who acquire HIV-1 infection from their mothers number around 590,000 a year, the majority of whom are in developing countries. The problem of pediatric HIV infections is growing, as more women are becoming infected, especially in Africa and Asia. One way to combat HIV in infants is to give antiretroviral treatment to the pregnant woman and possibly to the newborn. Researchers from the Centers for Disease Control and Prevention note that several factors are important, including primary prevention of HIV in women, determining the shortest effective drug therapy, identifying the optimal drug or drug combination, and preventing breastfeeding-related HIV transmission. The researchers add that novel methods are also necessary to increase uptake of voluntary HIV counseling and testing. According to the authors, "Prevention of HIV infection in children requires HIV and AIDS to be addressed as a disease of the family and community and leads to consideration of other interventions, such as reproductive healthcare for women and support for children orphaned by the epidemic."

"AIDS in the Classroom"
U.S. News & World Report (www.usnews.com) (02/14/00) Vol. 128, No. 6, P. 32; Whitelaw, Kevin

The AIDS epidemic is killing Africa's teachers, and with them, Africa's hope for the future. Some estimates show that one-third of teachers are infected with HIV, and in Zambia, two teachers are dying for every one that graduates from training school. Teachers are not the only ones dying, but the impact of their loss is greatly felt in the upcoming generation. Many children are orphaned by AIDS, as life expectancy in 10 African countries has fallen to levels below that of 1975. Many female students are quitting school to care for infected parents. Teachers, who are more likely to be in rural areas, have sex more often outside of marriage, including with students. They can also afford prostitutes, who help spread HIV. The peak of AIDS deaths is yet to come, however, and the educational system is already feeling the effects of the losses. In order to offset the high rate of death, companies often hire two people for one job. New infections occur half of the time in people younger than 25, and schools are not doing enough to teach young students about safe sex. In fact, the classroom rarely discusses sex, which remains taboo in most places. Uganda has set an example by cutting HIV rates in urban areas in half, while countries like Zambia are only now realizing the varied effects of AIDS and the need for change.

"HIV Infection Soars Among S. African Teenage Girls"
Reuters (03/07/00)

A new Cape Town health department survey shows that the rate of HIV among South African female teenagers has climbed even higher for the already at-risk group. According to the study, the rate of infection in 1998 was 21 percent for 15- to 19-year-olds--a 65 percent increase from the previous year. Health director Ivan Thomas blamed the rise on AIDS-related myths, including one that having sex with a virgin can cure the disease.

"AIDS Threatens to Kill 10 Percent of South African Miners"
PANA Wire Service (03/08/00); Mulenga, Mildred

New statistics show that 10 percent of South Africa's 500,000 mine workers could die from AIDS unless aggressive measures are taken. According to Marlea Clarke, a researcher from the University of Cape Town, AIDS-related deaths are increasing for miners, who often visit commercial sex workers. Clarke reported that more than three-quarters of the sex workers living in informal settlements near some of the mines were infected with HIV. Clarke, who reported her findings at the Regional Labor Migration Seminar for Southern Africa, said that many of the HIV-infected workers were also infected with tuberculosis.

"AIDS Proves Deadlier Than War in Africa"
Washington Times (www.washtimes.com) (03/14/00) P. A15

United Nations Secretary-General Kofi Annan said Monday that AIDS has taken the lives of more Africans in the past year than have all the wars on the continent. Annan called on governments to take action against the epidemic and noted, "We must end the conspiracy of silence, the shame over this issue."

"South Africa AIDS Activists Press Pfizer to Drop Prices"
South African AIDS activists are calling on Pfizer to lower the price of fluconazole, which helps prevent and treat thrush and cryptococcal meningitis, two opportunistic infections linked to HIV. According to the activists, the drug company has one week to respond to the demand, or it could face industrial action and lobbying from groups like ACT UP and Medecins Sans Frontieres. The Treatment Action Campaign (TAC) also plans to urge the South African government to allow imports of the drug and generic versions to be sold as well. In South Africa, fluconazole is sold under patent at a wholesale price of 57 rand per 200 mg capsule to the private sector and 37 rand to public services; however, TAC said that most public hospitals and workers could not afford the daily dose of up to 400 mg, and it called on Pfizer to lower the cost to less than four rand per 200 mg for the public sector.

"Report Says Disease Is Security Threat"
Washington Times (www.washtimes.com) (03/13/00) P. A10; Smith, Geoffrey

A new report, "Contagion and Conflict: Health as a Global Security Challenge," from the Chemical and Biological Arms Control Institute and the Center for Strategic and International Studies, directly links health and global security for the first time. The report asserts that national security can be hurt by disease outbreaks, as biological terrorism becomes a worldwide security challenge first pondered after the 1995 Aum Shinrikyo sarin nerve-gas attack in Tokyo. AIDS and drought can now harm a country more than war, as it can take weeks to decipher an outbreak, or decades, in the case of AIDS. It has only been for about a decade that disease has been viewed as an issue of national security, starting when Saddam Hussein was known to stockpile chemical weapons during the Gulf War. Infectious diseases can decimate a population and can spread quickly with the ease of plane travel. According to the report, which said that "the presence of infectious diseases in military populations jeopardizes military readiness," armies in Africa, Asia, and Latin America are at particular risk for personnel losses due to AIDS. The report also noted that a weakening of U.S. economic strength could render the country vulnerable to disease outbreaks.

"South Africa in a Furor Over Advice About AIDS"
New York Times (www.nytimes.com) (03/19/00) P. A21; Swarns, Rachel L.

South African President Thabo Mbeki recently consulted with two American scientists who do not believe that HIV causes AIDS, sparking concerns that already high HIV infection rates in the country will continue to climb. Mbeki spoke with biochemist David Rasnick and Charles Geshekter, a professor of African history at California State University at Chico. Parks Mankahlana, the president's spokesman, explained that Mbeki wanted to speak to everyone and get all opinions. But Dr. Awa Coll-Seck of the United Nations' Department of AIDS Policy in Geneva fears that Mbeki's move could have dangerous results. "People will reassure themselves, perhaps, that they can continue risky behavior because HIV is not the real cause of AIDS," Coll-Seck said of the issue of whether there is a causal link between HIV and AIDS. Most researchers and organizations, including UNAIDS and the World Health Organization, believe the relationship between the virus and AIDS has already been established. Rasnick and others claim that AIDS is caused by malnutrition and recreational drug use.

Ethiopia Among Hardest Hit by AIDS: President
Agence France Presse (04/23/00)

Ethiopia is being hit hard by the AIDS epidemic, according to President Negasso Gidada. Experts estimate that about 9.3 percent of Ethiopians between the ages of 15 and 45 have HIV. Negasso launched on Saturday the National AIDS Council, which will coordinate HIV control efforts. He noted, "The absence of coordinating and integrating anti-HIV/AIDS initiatives made the fight against the killer disease in the past ineffective."

AIDS Decimating African Educational System
Reuters Health Information Services (04/26/00)

African children are losing their teachers to AIDS, as the educational systems are decimated and families are affected. UNAIDS head Dr. Peter Piot spoke at this week's World Education Forum in Senegal, asserting that AIDS threatens global education and is hurting families that cannot afford school fees. Statistics show, for example, that AIDS deaths and retirement are equal and leading factors in reducing the number of teachers in Central African Republic schools. In addition, UNAIDS reported that 1,300 teachers died from AIDS in Zambia in the first 10 months of 1998, which is more than double the number of all teacher deaths in the previous year.
"Nigeria Requests Debt Write-Off"
Washington Times (www.washtimes.com) (04/26/00) P. A13

All African debts should be forgiven because of the overwhelming tolls that both AIDS and malaria have taken, Nigerian President Olusegun Obasanjo said Tuesday. The president made his comments at a one-day African summit on malaria, which kills about 2 million people every year, according to experts.

Need for Prevention:
"A Disease Spread by Silence"
San Francisco Chronicle Online (www.sfgate.com) (03/05/00) P. 1/Z1; Wright, Kai

In South Africa, HIV infects one in eight people, with an estimated 1,600 infections daily. Nearby Botswana, Namibia, Swaziland, and Zimbabwe also have high rates of infection. One obstacle to changing the HIV demographics in Africa is ending the stigma associated with the virus. The Clinton administration has proposed a boost in foreign assistance, from $112 million last year to $325 million in 2001, to help Africa start more AIDS programs. However, the money will not help without an attack on the stigma of HIV, which causes many people to keep their infection status secret. Because of this secrecy, the stigmatization cannot end and discourages testing for HIV. The 1998 murder of Gugu Dlamini, who openly announced she had HIV during a World AIDS Day event, has scared many South Africans into concealing their HIV infection. In KwaZulu-Natal, AIDS activist Mercy Makhamelele founded a group for people with AIDS, where people can come to confide their HIV status and publicly disclose it. Makhamelele, who halted the disclosure campaign following Dlamini's murder, is now focusing on the upcoming world AIDS conference in July, attempting to raise funding and forge global partnerships with HIV and AIDS patients.

"UN Forces Play Deadly Role in Spread of AIDS, Ambassador Says: Condoms to Be Given to All Peacekeepers"
Ottawa Citizen (www.ottawacitizen.com) (03/10/00) P. A11; Bone, James

The United Nations (UN) has begun handing out condoms to peacekeepers following American complaints that UN forces may be spreading HIV in countries they are trying to protect. New budget provisions provide for the supply of "one condom per man per day" to UN troops. Although the UN does not track HIV cases associated with peacekeeping missions, a number of Croatian women reportedly were infected after going out with UN soldiers. Also, some troops returning from Cambodia were diagnosed with an HIV strain found in Southeast Asia. At the urging of U.S. ambassador to the UN Richard Holbrooke, resolutions authorizing peacekeeping missions now include statements "encouraging efforts by the UN to sensitize UN personnel in the prevention and control of AIDS."

"Zambia: Incorporate AIDS Subject in Schools Curriculum"
Africa News Service (03/09/00)

In Zambia, UNAIDS country representative Dr. Kenneth Ofosu Barku has suggested that students entering college in the country should first pass a class about AIDS. At a workshop in Lusaka, Barku said HIV should be a priority in the curriculum so Zambia can successfully fight the epidemic. He noted, "HIV/AIDS is the major problem which has led to all the development problems because people could not get the formal education in the first place regarding the disease."

"Namibia: Women Press Case on Sex Risks"
Africa News Service (03/14/00); Maletsky, Christof

The Women's Manifesto Network is urging the Namibian government to supply rape survivors and HIV-infected pregnant women with the necessary drugs to prevent infection or to prevent HIV transmission to their infants. The group is also calling for comprehensive sex education. At a "Women and AIDS" forum in Windhoek on Saturday, a keynote address from Health Minister Dr. Libertina Amathila noted that women and girls are at risk for HIV, because it is biologically easier for men to transmit the virus to a woman than for women to transmit the virus to men. Many women are reluctant to ask their partners to use condoms, because doing so may be thought evidence of a woman's infidelity or considered disrespectful by a man. Amathila also condemned the practice of widow inheritance--the passing of a widow to a brother--and the dangers of circumcising boys in group ceremonies with dirty instruments.

http://www.africanews.org/health/stories20000327/20000327_feat7.html

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South Africa: Shocking HIV Figures In Defense Force
WOZA Internet (Johannesburg)
April 3, 2000
By Marjolein Harvey
Johannesburg - Sixty to Seventy percent of SA National Defence Force (SANDF) members are HIV positive, according to statement from the New National Party (NNP) Defence spokesperson, Hennie Smit at the weekend.

"Highest level decisions will have to be made on whether we can expose our troops to any more high-risk zones during deployment elsewhere in Africa," says Smit.

The NNP says troops should not be further exposed and decisions will have to be made on the treatment of those already infected with the virus.

"The SANDF faces the dilemma that the United Nations demands that only HIV-free soldiers be deployed elsewhere, while SA does not have sufficient measures for compulsory testing of SANDF staff," says Smit.

Democratic Party (DP) Deputy spokesperson on Defence, Andries Botha also shared his party's concern with revelations that between 60% and 90% of the members of some units of the SANDF are HIV positive.

"I will be speaking to the head of the joint standing committee on defence, JN Mashimbye, to ask him to convene a meeting of the committee at which the SANDF is required to put before parliament a strategic management plan to deal with the situation," says Botha.

The incidence of HIV/AIDS in the military gives rise to a host of problems.

"Given that the primary role of the SANDF in future is foreseen to be peace-keeping in foreign countries and given that the terms of the UN regulations bar soldiers who are HIV positive from participating in such missions, how does the SANDF plan to use HIV positive soldiers?" asks Botha.

He also questions what will the impact be on the role of the South African Medical Health Service, and whether it is prepared to deal with a massive medical crisis.

"Given that soldiers receive free medical treatment, does the SANDF have enough capacity in military hospitals to deal with this situation? How does the SANDF plan to manage the very necessary down-sizing of the force in light of the incidence of AIDS? "What programmes does the SANDF have in place to make soldiers aware of the risks and consequences of AIDS and if such programmes exist, what is being done to improve their effectiveness?" These are some of the questions the DP feels the SANDF needs to answer as a matter of urgency if SA is to avoid chaos in the future management of the force.

"I intend to make full use of parliament's oversight role to ensure that this tragedy is dealt with properly," says Botha.

The SANDF was not available for comment at the time of writing.

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AIDS: Tanzanian Electric Company Loses 567 Workers In Two Years
TOMRIC Agency March 27, 2000
Dar Es Salaam - About 567 workers of the Tanzania Electricity Supply Company (TANESCO) have died of AIDS in two years, placing the parastatal in a list of the most hit companies from AIDS in Tanzania.

Mr. Baruany Luhanga, Managing Director of TANESCO said statistic at the company showed that employees who died of the disease were aged between 26 and 49 years. The company, he said has decided to launch a special campaigns against the killer.

"We have set aside Tshs100 million to fight against AIDS in all of our branches in the country," he said in last week.

He admitted however that efforts employed by the company to educate its employees on the danger and socio-economic side effects were not fruitful because the workers continue to die.

With news strategies, he said the company would focus on education on the effect of the disease at work places and at the family level. HIV/AIDS is a major problem in Tanzania and has become by far the greatest cause of mortality in adults aged between 15 to 60 years. By the end of 1997 the prevalence of HIV was estimated at more than 10 percent in adult women and recent figures show that AIDS patients occupy about 50 percent of beds in hospitals.
In their joint report, The National AIDS Control Project (NACP), the United Nations Development Program (UNDP) and the Institute of Public Health (IPH) at Muhimbili College of Health Sciences, had projected the number of AIDS orphans in Tanzania to reach 800,000 before the end of last year.

The number of orphans was almost double for the past few years. By the end of 1997, half a million people in Tanzania were living with AIDS, over 1.5 million were effected while over 300,000 children were orphaned.

UNDP observes that 50,000 babies are born with HIV infection a year in Tanzania and life expectancy in the country has been decreasing from 52 years in 1990 to 49.7, in last year. In Tanzania the rate of prevalence of HIV among pregnant women ranges between 12 and 20 percent.

**AIDS Is Declared Threat to Security**

By Barton Gellman Washington, Post Staff Writer
Sunday , April 30, 2000 ; A01

Convinced that the global spread of AIDS is reaching catastrophic dimensions, the Clinton administration has formally designated the disease for the first time as a threat to U.S. national security that could topple foreign governments, touch off ethnic wars and undo decades of work in building free-market democracies abroad.

The National Security Council, which has never before been involved in combating an infectious disease, is directing a rapid reassessment of the government's efforts. The new push is reflected in the doubling of budget requests--to $254 million--to combat AIDS overseas and in the creation on Feb. 8 of a White House interagency working group. The group has been instructed to "develop a series of expanded initiatives to drive the international efforts" to combat the disease.

Top officials and some members of Congress contemplate much higher spending levels. The urgency of addressing AIDS has also touched off internal disputes over long-settled positions on trade policy and on legal requirements that aid contractors buy only American supplies.

The new effort--described by its architects as tardy and not commensurate with the size of the crisis--was spurred last year by U.S. intelligence reports that looked at the pandemic's broadest consequences for foreign governments and societies, particularly in Africa. A National Intelligence Estimate prepared in January, representing consensus among government analysts, projected that a quarter of southern Africa's population is likely to die of AIDS and that the number of people dying of the disease will rise for a decade before there is much prospect of improvement. Based on current trends, that disastrous course could be repeated, perhaps exceeded, in south Asia and the former Soviet Union.

"At least some of the hardest-hit countries, initially in sub-Saharan Africa and later in other regions, will face a demographic catastrophe" over the next 20 years, the study said. "This will further impoverish the poor and often the middle class and produce a huge and impoverished orphan cohort unable to cope and vulnerable to exploitation and radicalization."

Dramatic declines in life expectancy, the study said, are the strongest risk factor for "revolutionary wars, ethnic wars, genocides and disruptive regime transitions" in the developing world. Based on historical analysis of 75 factors that tend to destabilize governments, the authors said the social consequences of AIDS appear to have "a particularly strong correlation with the likelihood of state failure in partial democracies."

Another mobilizing factor is American politics. African American leaders, such as former representative Ron Dellums (D-Calif.) and Rep. Jesse L. Jackson Jr. (D-III.), have adopted the cause of AIDS in Africa. Their interest is converging with that of long-standing AIDS activists in the United States and Europe, where the course of the epidemic has been slowed by preventive efforts and life-saving combinations of anti-retroviral drugs. They are angry at policies that price those medicines beyond the reach of the developing world.

In June, those activists disrupted Vice President Gore's presidential campaign announcement in Carthage, Tenn., and two other speeches that week--"blindsiding us completely," as one senior adviser put it. The activists, and several senior Clinton administration officials, say that pressure accelerated the White House's response.
There is no recent precedent for treating disease as a security threat. So unfamiliar are public health agencies with the apparatus of national defense that one early task force meeting was delayed when Co-chairwoman Sandra Thurman, whose Office of National AIDS Policy is across the street from the White House, could not find the Situation Room.

For all the stakes they now describe, Clinton administration officials do not contemplate addressing them on a scale associated with traditional security priorities. Gore's national security adviser, Leon Fuerth, freely acknowledged that the 2001 budget request of $254 million to combat AIDS abroad--a sum surpassed, for example, by drone aircraft in the Pentagon budget--provides "resources that are inadequate for the task." He called the work of the task force "an iterative process" aimed at slowing the plague's rate of increase and alleviating some of its effects. Before this year, federal spending on AIDS overseas remained relatively flat.

Other officials noted that the United States has endorsed U.N. Secretary General Kofi Annan's declared five-year goal of reducing the rate of new infections by 25 percent. That falls close to the CIA's best-case, and least probable, scenario. Because such a turn of events would demand resources from U.S. allies and multinational bodies, the new White House group has been instructed to "develop a series of expanded initiatives to drive the international efforts."

Fuerth, a member of the "principals committee" that takes up the most important foreign policy questions, told representatives from 16 agencies on Feb. 8 that the panel wanted a package of proposals for Clinton within a several weeks. The working group is scheduled to finish drafting its proposals in May. Fuerth said the government is looking for "the kind of focus and coordination on this issue that we normally strive for on national security issues."

"The numbers of people who are dying, the impact on elites--like the army, the educated people, the teachers--is quite severe," he said. "In the end it was a kind of slow-motion destruction of everything we were trying, in our contact programs and our military-to-military programs, to build up, and would affect the viability of these societies, would affect the stability of the region. . . . In the world that we're facing, the destiny of the continent of Africa matters. And it isn't as if this disease is going to stay put in sub-Saharan Africa."

Twenty-three million people are infected in sub-Saharan Africa, with new infections coming at the rate of roughly 5,000 a day, according to World Health Organization figures. Of 13 million deaths to date, 11 million have been in sub-Saharan Africa. In the developing world, the disease spreads primarily through heterosexual contact.

The intelligence estimate portrays the pandemic as the bad side of globalization. Accelerating trade and travel--along with underlying conditions favorable to the disease--are pushing much of Asia, and particularly India, toward "a dramatic increase in infectious disease deaths, largely driven by the spread of HIV/AIDS," the intelligence report said. "By 2010, the region could surpass Africa in the number of HIV infections." The number of infections now is relatively low, but the growth rate is high and governments have been slow to respond.

Infections are also growing rapidly, and largely unchecked, in the former Soviet Union and Eastern Europe. The intelligence estimate said this growth will "challenge democratic development and transitions and possibly contribute to humanitarian emergencies and military conflicts to which the United States may need to respond." The report also anticipates that "infectious disease-related trade embargoes and restrictions on travel and immigration also will cause frictions among and with key trading partners and other selected states."

"The thing that's most staggering, and people are just beginning to grasp, is that Africa is the tip of the iceberg," Thurman said. "We are just at the beginning of a pandemic the likes of which we have not seen in this century, and in the end will probably never have seen in history."

Senior administration officials, some of them apparently frustrated, said that the government does not dispute estimates by the Joint United Nations Program on HIV/AIDS that it would take nearly $2 billion to fund adequate prevention in Africa, and a like sum for treatment. What the United States has been spending, by contrast, "is a rounding error for county budgets" in Fairfax and Montgomery counties, said one disgusted official.

"I don't have a fantasy that we're going to go to the Hill and get $5 billion to build Africa's health care infrastructure," said one senior Africa policymaker. "We're trying to determine effective steps that need to be taken, and can be taken, right now."

After initial resistance from U.S. Trade Representative Charlene Barshefsky, the government has agreed in principle to encourage cheaper access to life-saving drugs by relaxing hard-line positions that protect U.S. drugmakers' intellectual
property. Gore has said publicly that the United States does not rule out the use by afflicted countries of locally made or imported generics of drugs under patent by American companies. Assistant Trade Representative Joseph Papovitch has written to the governments of Thailand and South Africa with new formulas for resolving intellectual property disputes on such medicines.

But several participants in the government effort said the practical meaning of the change, if any, will have to be decided at the Cabinet level or by Clinton personally. An early test comes in May, when Barshefsky's office decides whether South Africa should be removed from the "watch list" of countries facing potential trade sanctions. South Africa is on that list because it passed a law the United States initially described as threatening to the intellectual property of American drug manufacturers.

With the prospect of substantial new spending, agencies ranging from the Centers for Disease Control and Prevention (CDC) and National Institutes of Health to the Labor Department are fighting over the allocation of funds. Undersecretary of State Frank Loy, meanwhile, is said by participants to be resisting the emerging consensus that the international AIDS effort should be centered in Thurman's office.

The task force has also battled over proposals to amend the Foreign Assistance Act, which requires all taxpayer-funded aid to come from American suppliers. Public health agencies want exceptions for condoms and AIDS test kits, which can be acquired more cheaply overseas. Congress willing, the task force is likely to recommend that change.

The high-profile attention from the top is "raising this issue in ways that leaders [of afflicted nations] can't ignore it," one White House official said. Richard C. Holbrooke, the U.S. ambassador to the United Nations, used his rotation as Security Council president in January to declare a month on Africa. He made AIDS the subject of the first Security Council meeting of 2000 and invited Gore to speak. When Clinton traveled to India in March, he successfully pressed the government to issue a joint declaration on AIDS.

Pervading the recent U.S. effort is a strong sense among participants of time misspent. The virulence of the pandemic was accurately foreseen, and "the United States didn't exactly cover itself with glory," said one close adviser to Clinton.

"We saw it coming, and we didn't act as quickly as we could have," said Helene D. Gayle, a physician who directs AIDS prevention at the CDC. "I'm not sure what that says about how seriously we took it, how seriously we took lives in Africa."

Peter Piot, a virologist who heads the United Nations AIDS efforts in Geneva, said "the good news is that the U.S. government is mobilizing. The bad news is that it took so long. This is not a catastrophe that came out of the blue. It has been clearly coming for at least 10 years."

Asked about those comments, Thurman looked pained.

"Oh yeah," she said softly. "It's very late. But better late than never. You rarely ever get a second chance in an epidemic."

Staff researcher Robert Thomason contributed to this report.

THE IMPACT OF AIDS

More than 16 million people have died from AIDS since the 1980s, 60 percent of them in sub-Saharan Africa. Not since the bubonic plague ravaged Europe in the Middle Ages has there been as devastating a disease. U.S. officials have reached the conclusion that the impact of AIDS will be so vast that it has become a threat to U.S. national security.

Percentage of adult population infected with HIV or suffering from AIDS.

Selected countries
Zimbabwe: 25.9%
Botswana: 25.1
Namibia: 19.4
Zambia: 19.1
Swaziland: 18.5
Malawi: 14.9
Mozambique: 14.2
South Africa: 12.9
AIDS already has significantly shortened life expectancy and will cut more years off people's lives by 2010.

**Namibia**  
Life expectancy without AIDS (years): 70.1  
Life expectancy with AIDS (years): 38.9  
Change: 44.5% drop

**Zimbabwe**  
Life expectancy without AIDS (years): 69.5  
Life expectancy with AIDS (years): 38.8  
Change: 44.2

**Botswana**  
Life expectancy without AIDS (years): 66.3  
Life expectancy with AIDS (years): 37.8  
Change: 42.9

**Swaziland**  
Life expectancy without AIDS (years): 63.2  
Life expectancy with AIDS (years): 37.1  
Change: 41.3

**Malawi**  
Life expectancy without AIDS (years): 56.8  
Life expectancy with AIDS (years): 34.8  
Change: 38.7

**Zambia**  
Life expectancy without AIDS (years): 60.1  
Life expectancy with AIDS (years): 37.8  
Change: 37.1

**Lesotho**  
Life expectancy without AIDS (years): 65.9  
Life expectancy with AIDS (years): 44.7  
Change: 32.1

**South Africa**  
Life expectancy without AIDS (years): 68.2  
Life expectancy with AIDS (years): 48.0  
Change: 29.6

**Tanzania**  
Life expectancy without AIDS (years): 60.7  
Life expectancy with AIDS (years): 46.1  
Change: 24.0

AIDS has left about 9 million children without their mothers or both parents, the vast majority in sub-Saharan Africa.

Number of 15-year-olds per 10,000 of that age group who have lost their mothers or both parents to AIDS.
Uganda: 1,100
Zambia: 890
Zimbabwe: 700
Malawi: 580
Togo: 400
Botswana: 390
Burundi: 390
Ivory Coast: 380
Thailand: 30
U.S.: 10

U.S. assistance to combat AIDS has stayed around $120 million for the past seven years. But officials believe much more is needed to halt the disease and treat those infected.

2001 budget request: $264 million

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CDC HIV/STD/TB Prevention News Update; Tuesday, April 11, 2000
"Africa's Plague, and Everyone's"
New York Times (www.nytimes.com) (04/11/00) P. A31; Gordimer, Nadine

South Africa has one of the world's highest HIV infection rates, even though it is the most developed country in Africa, notes Nadine Gordimer in a commentary. Every community in Africa is dealing with the threat of AIDS, and a cure through inoculation is vital to existence. However, the development of a cure or preventive shot depends on money from nations like the United States, which, until recently, has focused on a vaccine for a subtype of HIV prevalent in the Northern Hemisphere. At the World Economic Forum meeting, President Clinton announced the need for a large-scale project to develop vaccines for subtypes C and A, which are prevalent in Southern and East Africa. The International Partnership Against HIV/AIDS in Africa is also an important piece of the money problem. AIDS prevention in Africa requires $2.3 billion a year in aid, but receives around $165 million a year in official assistance from the rest of the world. Because HIV does not discriminate against the rich or the poor, it is a crisis of all humanity that needs the world's help. Gordimer, a goodwill ambassador for the Race Against Poverty project of the United Nations Development Program, asserts that countries with lower rates of infection should contribute towards finding a cure if the world's economy is to be saved.

CDC HIV/STD/TB Prevention News Update; Wednesday, April 12, 2000
"AIDS Drugs Not Reaching Latin Americans--Expert"
Reuters (04/11/00); Winter, Brian

Although AIDS drugs are available in Latin America, high prices prevent many patients from using them, according to Dr. Carlos del Rio, a former director of Mexico's National AIDS Program. Del Rio, speaking at the International Congress of Infectious Diseases, noted that regional healthcare systems are not aimed at treating chronic conditions like heart disease and AIDS, focusing more on acute illnesses. A survey of 12 Latin American nations last year revealed that while highly active antiretroviral therapy (HAART) was readily available, only half of the governments offered subsidies for the costs of drugs, and only Brazil, Argentina, and Uruguay pay for all HAART expenses. Del Rio reported that two-drug therapy costs between $403 and $773 per month, while triple-drug therapy runs about $662 to $1,465 per month.

Date: Thu, 13 Apr 2000 13:09:10 +0000
From: mary@aegis.org
Subject: [AEGiS] American AIDS Research Raises Ethical Questions

American AIDS Research Raises Ethical Questions
By Tervil Okoko, PANA Correspondent
Panafrican News Agency - April 12, 2000

Nairobi, Kenya (PANA) - The US government is funding medical research of questionable ethics on pregnant women with AIDS in developing countries, the New England Journal of Medicine has alleged in its April edition.

In an editorial, the it likened the justification for the 15 studies to the now infamous Tuskegee, Alabama, experiment in which 399 poor black American men with syphilis were left untreated for 40 years - between 1932 and 1972.
Nigeria-AIDS: Nigeria increases budget for verification of AIDS cure claims
Agence France-Presse - Friday, March 31, 2000

ABUJA, March 31 (AFP) - The Nigerian health minister said Thursday that the government has increased almost by threefold its budget on verification of HIV/AIDS cure claims, moving it from 2.8 million dollars to 7.8 million.

The decision to increase the budget was based on the recommendation of the World Bank and UNAIDS, Tim Menakaya said at a news conference, in the presence of visiting Executive Director of UNAIDS Peter Piot.

The minister, however, warned that all recent local claims of breakthrough in HIV/AIDS treatment are still being investigated.

He said that the problem of AIDS is "further compounded" by the frequent announcements of breakthroughs in AIDS cure and preventive vaccines by herbalists, and sometimes by physicians.

Menakaya also announced the removal of import duties on anti-retroviral drugs.

A presidential committee on AIDS, headed by President Olusegun Obasanjo, set up late last year, will soon be enlarged to include representatives of people living with HIV/AIDS, organised private sector, non-governmental organisations and religious organisations, he said.

Nigeria, he said, neither has designated and funded treatment or management centres for HIV/AIDS carriers nor "a coordinated programme to respond to the groans and cries of millions of Nigerians affected" by the disease.

The Nigerian government discussed with visiting UNAIDS officials the issue of vaccine trials and improved access to anti-retroviral therapies, increased technical and financial support from UNAIDS and World Bank for prevention and control of HIV/AIDS in Nigeria, Menakaya said.

President Obasanjo said Wednesday that his government is considering legislation to back up its campaign against the spread of AIDS, including a bill outlawing discrimination against people infected with the HIV virus.

Obasanjo told the UNAIDS boss that his government would welcome advice from international organisations in drafting anti-AIDS legislation.

He said the administration would look at making discrimination against people living with HIV/AIDS illegal, and would consider the appropriateness and practicability of making HIV tests compulsory for couples before marriage.

The president told the UNAIDS chief and representatives of the World Bank, World Health Organisation (WHO) and the UN children's agency UNICEF that he was personally alarmed at Nigeria's current HIV/AIDS general prevalence rate of about 5.4 percent.

With such a rate, and with a population of more than 120 million, Nigeria has about six and a half million people who living with HIV but without adequate care or treatment.

Piot will Friday end his visit to Nigeria with a press conference in Lagos.
"Some countries routinely pay 150% to 250% of world market prices for the essential drugs, while other countries complain of unreliable suppliers and poor quality drugs", stated Dr Hans Hogerzeil, of WHO’s Essential Drugs and Medicine Policy Department, at today’s launch of the guide Operational Principles for Good Pharmaceutical Procurement.

Improper procurement practices lead not only to high prices and poor quality, but can also result in shortages of life-saving drugs. "When lax drug procurement systems lead to national shortages of one or two drugs in a four-drug tuberculosis treatment regimen, treatment failures increase and resistance can quickly develop to those drugs still in stock", commented Dr Hogerzeil.

Produced by the Interagency Pharmaceutical Coordination (IPC) Group, the Operational Principles aim to assist national governments, donor agencies and other organizations involved in drug procurement to obtain lower prices, better quality, and more reliable delivery of essential drugs. Consisting of the pharmaceutical advisers of UNICEF, UNFPA, the World Bank and WHO, the IPC is especially well placed to advise on how drugs of assured quality can be purchased more effectively and more cheaply.

The need is great – one-third of the world’s population lacks regular access to good quality essential drugs. In poor populations adults and children die needlessly of treatable diseases such as malaria, acute respiratory illness and diarrhoeal diseases. Poor pharmaceutical procurement practices are partly to blame.

Good procurement – getting quality medicines to people when and where needed Procurement is the sum total of processes involved in the purchase and delivery of drugs. Ideally, the most cost-effective drugs are bought in the most appropriate quantities from reputable suppliers, delivered where and when required, at the lowest possible total cost.

Experience shows, however, that the process can go badly awry. The number of different agencies involved in procuring drugs – including ministries of health, manufacturers and donor agencies – can render the process highly complex and vulnerable to inefficiency and waste. Other problems such as corruption and lack of transparency, lead to lack of competition with fewer choices, higher prices and poorer quality. At the same time, irregular and limited funding can greatly hinder efforts to secure timely delivery of drugs. External funding from international agencies or bilateral donors sometimes helps. Outdated local regulations and supply procedures not suitable for the special requirements of buying pharmaceuticals can further complicate the problem.

The Operational Principles tackle these problems by providing a solid basis to help ministries of health, donor agencies and others to harmonize their drug procurement practices. Grouped into four categories, the 12 principles cover: (i) transparent management, (ii) selection and quantification, (iii) financing and competition, and (iv) supplier selection and quality assurance.

Even without appropriate policies and procedures, lack of properly trained personnel can doom a procurement system to failure. So, as well as advising on best procurement practices, the Operational Principles are intended for use in training staff responsible for drug procurement.

"The complex process involved in efficient and effective drug purchases is clearly presented in the document", comments Dr Ramesh Govindaraj, Pharmaceutical Advisor for the World Bank. "If the principles are observed, the ultimate result will
be more essential drugs for less money, better quality and fewer deaths from malaria, tuberculosis, childhood illness and other treatable causes”.

For further information, journalists can contact Ms Jacqueline Sawyer, Department of Essential Drugs and Medicines Policy, WHO, Geneva. Telephone (+41 22) 791 3921. Fax (+41 22) 791 4167. Email: sawyerj@who.int

All WHO Press Releases, Fact Sheets and Features as well as other information on this subject can be obtained on Internet on the WHO home page http://www.who.int

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CDC HIV/STD/TB Prevention News Update, Wednesday, May 2, 2000
"AIDS Said Taking Toll on Tanzania"
Las Vegas Sun Online (www.lasvegassun.com) (05/01/00)

Tanzanian President Benjamin Mkapa said Monday that AIDS is hurting the nation's economy, as a significant portion of the work force is dying. Mkapa said that some ministries are losing around 20 workers a month to AIDS, while the disease has taken the lives of more than 300 workers at the Tanzania Electric Supply Company in the past five years. The president sought to garner the support of religious leaders who oppose open discussion of sex and AIDS-related matters, noting that he hopes they "consider the stark reality in the light of the current situation and the given statistics." According to estimates, approximately 20 percent of Tanzania's 33.3 million people are infected with HIV.

CDC HIV/STD/TB Prevention News Update, Wednesday, May 2, 2000
"Envoys Seek Special U.N. Assembly Session on AIDS"
Reuters (05/01/00); Goodman, Anthony

The United Nations ambassadors for Costa Rica, the Czech Republic, Ukraine, and Zimbabwe have called for a special General Assembly session next year to discuss the AIDS epidemic. In a letter to Secretary-General Kofi Anna, the four U.N. envoys noted that AIDS will have a significant social and economic impact, particularly in areas hard hit by the disease. They also pointed out in an accompanying memorandum that there have been 50 million HIV infections since the beginning of the epidemic, with over 33 million people now living with the disease. The envoys called for increased U.N. action against AIDS as well as new measures to increase international cooperation in the battle against the disease.

"AIDS in Africa"
Washington Post (www.washingtonpost.com) (05/03/00) P. A22;
Waldorf, Saral

In a letter to the editor, Saral Waldorf, a former Peace Corps volunteer, discusses how he helped run an AIDS clinic in the Chitipa district of Malawi. Waldorf notes that in 1995, many people in the country believed in a purported herbal AIDS cure called "mchape," which they also said protected people from becoming infected with HIV. Waldorf's office surveyed 115 mchape Chitipans and found that many people thought they were doomed by HIV and saw no reason to change risky behaviors that Westerners said put one at risk for infection. In trying to explain the popularity of mchape, Waldorf writes that 'in the absence of a cure or even access to antiretroviral drugs to slow down the AIDS progress, even educated Malawians 'who should know better,' as one colleague put it, were grabbing at anything that promised hope.'

The above underscores why appropriate drug, herbal and micronutrient treatment from reliable sources is essential for survival. Bogus treatments and bad bootleg drugs are merely gasoline on the conflagration of AIDS.

"About 500,000 Rwandans Have HIV, Government Says"
Reuters (05/02/00)

Over 6 percent of Rwandans--about 500,000 people--are infected with HIV, according to Health Minister Ezechias Rwabuhiihi. Overwhelmed hospitals in the country often put two AIDS patients in one bed, Rwabuhiihi said. Official data from Rwanda's AIDS control agency shows that 11.1 percent of Rwandans ages 12 to 49 are infected with HIV. Life expectancy in Rwanda has decreased significantly in Rwanda since the early 1980s and now stands at 42 years.

"Southern African Health Experts Discuss Regional Epidemic Diseases"
Agence France Presse (05/02/00)
Health experts from the Southern African Development Community have started a four-day conference on epidemic diseases in Africa. Chairman Ayanda Ntsaluba said the forum will focus on ways to combat AIDS, tuberculosis, and malaria, the primary cause of death among adults and children in the area. Malawi's deputy health minister, Phillip Bwanali, noted that "AIDS has become one of the dominating social, economic, and political issues of the past two decades." Bwanali said that limited funding from governments and reliance on donors have hampered national responses to the epidemic.

Date: Thu, 11 May 2000 14:13:09 +0000
To: "aids" <webmaster@aegis.com>
From: mary@aegis.org

AIDS threatens to steal more of S. Africa's future As more young people are infected, many worry that President Mbeki is wasting time debating HIV's link.

By Huntly Collins, INQUIRER STAFF WRITER
The Philadelphia Inquirer, May 11, 2000

JOHANNESBURG - South Africa's AIDS epidemic is spreading rapidly among young people, a new report shows, and medical workers here worry that efforts to combat the disease are being hampered by President Thabo Mbeki's public skepticism that AIDS is caused by the HIV virus.

New data released today show the virus - which has afflicted 4.2 million people in South Africa, or one-tenth of the population - is growing fastest among the young. More than 60 percent of new infections are occurring in people 15 to 25 years old, according to a study by Abt Associates of South Africa Inc., an international consulting firm.

Of those HIV-positive young people, half are expected to die before their 35th birthday, the report said. Teenage girls and young women of childbearing age are the hardest hit, with infection rates much higher than among men.

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CDC HIV/STD/TB Prevention News Update
Thursday, May 11, 2000
"Makers of AIDS Drugs Agree to Slash Prices for Developing World"

Wall Street Journal (www.wsj.com) (05/11/00) P. A1; Waldholz, Michael

Driven by the fear that developing nations in Africa will buy inexpensive generic versions of their HIV drugs produced in Brazil, Thailand, and India despite the fact that the generics are violating patent laws, Bristol-Myers Squibb, Glaxo Wellcome, Merck, Boehringer Ingelheim, and Roche Holding have agreed to slash prices of their drugs for people living in poorer nations. While Pfizer had recently agreed to donate its AIDS-related fungal infection drug Diflucan to South Africa, Bristol-Myers had agreed to contribute $100 million over a five-year time period to improve healthcare services in Africa, and other companies had made similar promises, this agreement marks the first collaboration of pharmaceutical companies on how to address the prohibitive costs of AIDS drugs for developing countries. Glaxo has indicated that it will cut the cost of its Combivir, a cocktail of AZT and 3TC, to $2 a day, or one-third of its current daily cost in Uganda and one-fifth of its price in the United States, but the companies do not wish to suggest that they are selling the drugs at cost, since it would highlight the little-known fact that profit for these and other drugs can reach 90 percent of the prices charged after research and development are reimbursed. However, the pact is problematic, including the risk of creating a black market in AIDS drugs, the likelihood that it will fuel a demand for lower drug prices in the United States, the fact that even at the new prices the drugs will remain too costly for many people in said countries, and the fact that the drugs will be useless unless the health-care system is educated properly about how to administer the drug and is able to monitor the use and distribution of the drugs.

CDC HIV/STD/TB Prevention News Update
Thursday, May 11, 2000
"Clinton Tries to Expedite AIDS Drugs Into Africa"

New York Times (www.nytimes.com) (05/11/00) P. A7; Lewis, Neil A.
President Clinton has issued an executive order that will make AIDS drugs available at lower prices in southern Africa. The debatable order says the United States government will not oppose countries that may violate American patents to produce cheaper AIDS drugs. African countries can now produce generic versions of drugs or import drugs from other countries at a lower cost. Sen. Dianne Feinstein (D-Calif.) had sponsored a similar amendment that was removed from the Africa trade bill, calling for cheaper access to anti-AIDS drugs. Alan Holmer, president of the Pharmaceutical Research and Manufacturers of America, believes the executive order sets an undesirable precedent that focuses on pharmaceuticals. AIDS Action member Jeff Jacobs and other activists support the order. Jacobs said "Americans can be proud of their president today."

CDC HIV/STD/TB Prevention News Update
Monday, May 15, 2000
"Cheaper Drugs to Combat AIDS"
New York Times (www.nytimes.com) (05/15/00) P. A24

The recent announcement that five top pharmaceutical companies will cut the price of AIDS drugs in poor nations offers hope to people living in Africa and other areas with high incidences of AIDS, note the editors of the New York Times. The companies have offered to sell their drugs at prices up to 90 percent below the American price, and the editors point out that while this is more affordable, many regions lack the health care facilities and personnel to administer the drugs. Still, the editors suggest that "drastically cut prices can encourage doctors and health care officials in poor countries to learn how to use these drugs and to develop the clinics needed to deliver them and monitor their use." More affordable drug prices may also encourage more people to get tested for HIV and to seek treatment.

CDC HIV/STD/TB Prevention News Update
Monday, May 15, 2000
"Sudan Staring at Potential AIDS Catastrophe"
Reuters (www.reuters.com) (05/14/00); Lyon, Alistair

Sudan's national adviser to UNAIDS, Abdalla Ismail, said the country faces an AIDS disaster similar to that of neighboring nations unless action is taken to fight HIV. Ismail noted that a lack of political commitment from the country's government, misgivings in the donor community, and denial have hampered efforts to stem the spread of the epidemic. UNAIDS and the U.N. Population Fund have asked the European Union to fund an HIV prevention project in Sudan that would cross civil war battle fronts and help individuals affected on both sides. Civil war has plagued Sudan since 1983, killing more than 1 million people and displacing 4 million more.

CDC HIV/STD/TB Prevention News Update
Monday, May 15, 2000
"Aid for AIDS"
Economist (www.economist.com) (04/29/00) Vol. 355, No. 8168, P.76

The AIDS epidemic is demanding the attention of global leaders like U.S. Vice President Al Gore and the World Bank. The disease is the fourth-leading cause of death worldwide, and is increasingly infecting people ages 15 to 24. Life expectancy, once rising in Africa, is falling by as much as 17 years in some African countries. AIDS is also lowering productivity. Economic growth in countries with an 8 percent infection rate is 0.4 percentage points per year lower than it would otherwise have been. AIDS experts agree that a vaccine is one of the best answers to the epidemic, but funding has been scarce. A possible approach is to create a purchase fund that guarantees to buy vaccines for AIDS at a set price. Another option is for international institutions to buy more existing vaccines and help provide support for an AIDS vaccine in the future.

Date: Wed, 17 May 2000 15:09:47 +0000
From: mary@aegis.org, Subject: [AEGiS] Drop In Drugs Price Will Only Help A Few (Editorial)

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Drop In Drugs Price Will Only Help A Few (Editorial)
The Sowetan (Johannesburg) - May 16, 2000

Johannesburg - The decision by five drug companies to cut the price of anti-retroviral medicines by 75 percent is a commendable gesture. It will without a doubt increase accessibility to the drugs, especially in the developing world, and so reduce the number of Aids-related deaths. And for that the drug manufacturers deserve some credit.

However, it is important that we do not disregard the fact that the multinationals' decision followed a more important ruling by American president Bill Clinton, which will make it easier for developing countries to access drugs from cheaper sources.
Even though access would be conditional, the ruling has had the effect of threatening markets the five drug multinationals currently monopolise. And dropping prices was therefore a logical business decision, largely to protect markets.

Click here for full story:

CDC HIV/STD/TB Prevention News Update, Wednesday, May 17, 2000
"Uganda: 50 Percent of Bundibugyo Infected With AIDS"
Africa News Service (www.africanews.org) (05/16/00); Justus, Sauza

Uganda's deputy director of health services in Bundibugyo, James Ndyeziika, sparked concern recently after announcing that half of the district is infected with HIV. Ndyeziika told participants at a recent workshop on disaster preparedness and response that rebel fighting has increased the spread of the virus, after three years of terrorism and rapes of women. He also said that tuberculosis and venereal diseases are on the rise. Some 30,000 condoms have been given to health centers, clinics, and hotels, and Ndyeziika noted that female condoms may be introduced after women are instructed about how to use them.

"AIDS Devastates Africa, Destroys Human Dignity"
Reuters (www.reuters.com) (06/26/00); Swindells, Steven

AIDS has ruined 50 years of development in Africa, and Malawi is one of many nations dealing with overcrowded hospital rooms and a lack of medicine. AIDS has taken the lives of 12 million Africans so far, and over 23 million in sub-Saharan Africa are living with HIV. United Nations officials have called for a Marshall plan to change sexual behavior and increase the use of anti-AIDS drugs. According to some AIDS workers, a lack of political leadership is also hurting Africa, as funding is often spent on seminars and does not reach the ill.

"One in Four South African Men Admit Rape"
Reuters (www.reuters.com) (06/25/00)

A survey reported in South Africa's Sunday Times found that one in four South African men questioned said they had committed rape before age 18, while eight in 10 said they believed women were responsible for sexual violence. Concern over South Africa's high rate of rapes is warranted, as the number of rapes has risen over five years. Police statistics show that the number of reported rapes in the country increased from 109.8 per 100,000 people in 1994 to 119.1 in 100,000 last year. Of particular concern with the high levels of rape is South Africa's AIDS epidemic, as more than 4 million residents of the country are thought to be infected with HIV.

xxx [add more as they develop]

Websites:
Genocide organizations: http://www.endgenocide.org/, http://www.preventgenocide.org/action/
AIDS Action (re Marketing costs shoved under R&D umbrella) http://www.aidsaction.org/policy/access.html
ICASO: http://www.icaso.org/compulsory_english.htm
International Court of Justice: http://www.icj-cij.org
and http://www.icj-cij.org/icjwww/igeneralinformation/icjgnotn.html
World Policy Institute: http://worldpolicy.org
AIDS and orphans: http://www.fxb.org/orphinfo.html
Consumer Project on Technology: http://www.cptech.org

German definition of genocide
From http://www.preventgenocide.org/law/domestic/germany.htm
Translation: The Penal Code of Germany; Section 16, Crimes Against Life; § 220a,

Genocide
(1) Whoever, with the intention of wholly or partially destroying a national, racial, religious or ethnically distinct group as such,
1. kills members of a group;
2. inflicts serious physical or mental injury, especially of the type described in §224, on members of a group;
3. subjects the group to living conditions likely to cause death to all or some of the members;
4. imposes measures designed to prevent births within the group;
5. forcibly transfers children from one group to another, shall be punished by imprisonment for life.

   (2) Not less than five years' imprisonment shall be imposed in less serious cases falling under subparagraph (1), numbers 2 to 5.

The Penal Code of Germany; Section 16, Crimes Against Life; §224

Aggravated Bodily Harm

   (1) If the bodily harm committed on the victim results in the loss of an important part of the body, sight in one or both eyes, hearing, speech or his procreative capacity, or in a serious permanent deformity, or deteriorates into invalidity, paralysis or mental illness, imprisonment from one to five years shall be imposed.

   (2) In less serious cases imprisonment for up to five years or a fine shall be imposed.


"Recently, there has been increasing mobilization around the idea of a right to essential and new drugs and growing resistance to the notion that intellectual property rights should trump other policy considerations."

"Some controversy remains about whether a country's list of essential drugs should represent the maximum number of available drugs as a ceiling, or the minimum number of available drugs as a floor. Debate also persists about which products to define as essential and by whom. But enough consensus has emerged that even the International Federation of Pharmaceutical Manufacturers Associations, which initially opposed the idea, now accepts the principle of efficient provision of essential drugs in primary health care as a priority when resources are limited."

"But 95% of individuals worldwide who are infected with the human immunodeficiency virus (HIV) live in poor countries, with almost no access to these life-prolonging treatments because of programmatic and institutional problems as well as cost barriers."

Government purchasing: should not have to pay inflated retail prices.

"A few middle-income countries with this [regulatory and manufacturing capacity required for high-quality, cost-effective production of pharmaceuticals] capacity have encountered fierce political pressure from multinational pharmaceutical firms and the U.S. government when these countries have sought to pass national legislation for compulsory licensing as shown by the example of South Africa."

"In addition, successful products from R&D become new drugs, with the potential for limited access in poor countries unless effective mechanisms are built into the drug development process. . . . But implicitly asking poor countries to wait for new drugs to go off-patent before gaining access seems profoundly unfair."

"We need a constructive solution that can both protect the incentives for R&D and reduce the inequities of access. This requires forceful implementation of proven strategies, systematic experimentation with innovative ideas, and vast mobilization of financial resources including debt forgiveness along with public and private funds."
February 24, 2000*

Senate Committee on Foreign Relations
Subcommittee on African Affairs
Washington, DC

Dear Senators Frist and Feingold,

Please include this statement as part of the record of the hearing on AIDS and Africa. Our comments will focus on the following topics:
  - What is US trade policy as it relates to access to medicines?
  - What are the concerns of public health groups with regard to US trade policy?

I. US Trade policy and access to medicines.

For decades, the US government has advanced the interests of large pharmaceutical companies in its trade policy. The pharmaceutical sector is considered a major export industry, and US government trade policy has been focused almost entirely upon the commercial interests of companies like Merck, Bristol-Myers Squibb, Pfizer and other members of trade associations like the Pharmaceutical Research and Manufacturers Association (PhRMA) and the International Federation of Pharmaceutical Manufacturers Associations (IFPMA).

Among the features of US policy, as expressed in countless bilateral negotiations and multilateral fora, are the following:

1. The US government has pushed to end the exemptions for medicines in national patent laws.
2. The US government has pushed for a minimum term of 20 years in patent laws.
3. The US government has put pressure on governments to create patent extensions for pharmaceuticals.
4. The US has pushed for a broader scope of patenting, on issues such as patenting of doses and treatment regimes for medicines, formulations of medicines, patents on second uses of medicines, and patents on biotechnology.
5. The US government has been an aggressive opponent of the use of compulsory licensing of patents on medicines by developing countries.
6. The US government has objected when other countries have proposed US "Bolar" style patent exceptions for testing of bioequivalence of generic products.
7. The US government has opposed efforts by developing countries to require the use of the generic name of a product on pharmaceutical packaging, claiming this violates company trademark rights.
8. The US government has opposed the efforts by developing countries to require generic prescribing, or generic substitution laws, as a violation of company trademark rights.
9. The US government has opposed efforts by many countries to impose price controls on pharmaceuticals.
10. The US government has objected to efforts by countries to use US style "managed care" formularies to obtain better prices on drugs.
11. The US government is seeking extensive non-patent regulatory barriers to entry for generic drugs, such as regulatory exclusive marketing rights for products not protected by patent.
12. The US government is asking countries to provide 10 years of commercial exclusivity for data used in regulatory reviews of the safety and efficacy of pharmaceuticals as a barrier to entry for generic versions -- even though the US laws only provide five years of data exclusivity.
13. US trade officials oppose laws that would permit parallel imports of pharmaceutical drugs, thereby denying countries the ability to get the best world price on branded pharmaceutical products.
14. The US government has rejected proposals by public health groups to permit the World Health Organization to use US government rights in taxpayer funded health care patents, to expand access to medicines in developing countries.
15. The US government has opposed proposals that the World Health Organization advise developing countries on intellectual property policies, as they relate to access to HIV/AIDS drugs.
I could add to the list or simply refer persons to the National Trade Estimates (NTE) reports of the United States Trade Representative (USTR), other US government trade publications and CPT’s extensive reports on trade disputes involving pharmaceutical drugs. These can all be found on the web here: http://www.cptech.org/ip/health.

While US trade officials sometimes claim they are merely protecting the legitimate interests of investors in intellectual property, the US positions are often perceived outside the US as extreme, hypocritical, unfair or protectionist, and increasingly are criticized by the public health community for the negative impact on access to medicines.

II. Public Health concerns regarding US trade policy.
The rising concern over the global AIDS crisis has highlighted the need to change US trade policy. With more than 22 million persons currently infected with HIV/AIDS in Africa, and millions more in developing countries outside of Africa, it is clear that the costs of treatment would be astronomical, if there ever was a serious effort to do so. A typical HIV/AIDS cocktail in the US costs more than $10,000 per year, for the drugs alone. At just $10,000 per year, it would cost more than $222 billion per year to provide drugs to the current population of African persons living with HIV/AIDS, and for significant portions of the population, this would not be effective without other investments in health care infrastructure. But even if one has far more modest treatment goals -- the prices of drugs are important -- as illustrated, for example, by the lack of access to fluconazole, an important, high priced, but cheap to produce, antifungal medicine.

This committee will hear from many informed persons who can describe the nature of the HIV/AIDS crisis in Africa and other developing countries. We will simply note the obvious, which is that this is an overwhelming tragedy that challenges all of humanity to fashion a response equal to the human suffering.

Certainly the Subcommittee will hear how complex are the problems in dealing with HIV/AIDS in Africa. There are many aspects of the problem -- poor medical infrastructure, limited budgets, lack of education, ineffective prevention efforts, discrimination and bias, employment practices, the need to change sexual behavior, the failure of African countries to allocate greater funding to health care, the crushing burden of debt on African countries, the paucity of foreign aid, the high prices of drugs, the rules for the protection of intellectual property and bilateral trade pressures to protect the pharmaceutical industry.

There are many issues that must be addressed to save lives and limit suffering in Africa. There are no silver bullets, no single solutions -- simply a large list of things that must be done. There should be no controversy that this list will include changes in US trade policy, and addressing intellectual property rules. And, while compulsory licensing and other measures will change private R&D incentives, it is worth noting that Africa only accounts for about 1.3 percent of the worldwide pharmaceutical market, and that much R&D on HIV/AIDS related medicines is funded by the US government.

Defenders of current US trade policy sometimes say that the price of drugs isn't the "the issue," pointing the many other problems. But as is often said, when someone says it isn't about the money, it is often about the money, and only a fool would suggest the price of drugs is not important to people in Africa who are infected with HIV/AIDS.

Responding to increasing international and domestic criticism of US trade policies on pharmaceutical drugs, President Clinton announced on December 1, 1999, that he was removing South Africa from the USTR Watch list on intellectual property, and that US trade policy would be changed to facilitate access to medicines. That review is just beginning, and has produced very few results so far.

The WTO TRIPS agreement as a norm for Africa
The World Trade Organization Agreement on Trade Related Aspects on Intellectual Property, known as the TRIPS agreement, is the most important international agreement on intellectual property rights. The TRIPS accord is extensive and comprehensive, covering patents, trademarks, copyright, trade secrets, undisclosed health registration data and other items. Under the TRIPS, all WTO member countries will have to extend 20 years of patent protection to pharmaceuticals. The TRIPS accord places restrictions on government use or compulsory licensing of patents, and provides countless other protections for the owners of intellectual property.

However, the US government does not accept the WTO rules as appropriate for African countries. It seeks much higher levels of protection --- so called "TRIPS plus" levels of protection. US policy on this is itself a seeming violation of the WTO rules.

Article 1 of the TRIPS says:
Members . . . shall not be obliged to, implement in their law more extensive protection than is required by this
Agreement. . . . Members shall be free to determine the appropriate method of implementing the provisions of this Agreement within their own legal system and practice.

The public health community is split on the degree to which the WTO TRIPS agreement should be modified to address public health concerns. There is, for example, much controversy over whether or not poor countries should be required to have 20 year patents on pharmaceutical drugs. However, there is much less disagreement on the issue of TRIPS plus obligations. Given the huge suffering in Africa today, a policy of requiring TRIPS plus -- more than the WTO rules for medicines -- is morally repugnant.

A February 10-12, 2000 meeting of the Trans Atlantic Consumer Dialogue (TACD) produced a set of recommendations on health care and intellectual property that provide a useful overview of public health community views on these disputes. I have attached the TACD resolutions to this letter. We ask the members of this Subcommittee to formally ask the US government to provide a written response to the TACD recommendations.

From these recommendations, I would highlight several issues that are a priority to public health groups.

1. The US and EU governments should not require TRIPS plus levels of intellectual property protection on medicines. This is an issue addressed in the Senate version of the African Trade Bill.
2. The US government should support the call to create a working group on access to medicines within the WTO. This would provide an important and needed forum to discuss a number of important trade related aspects of the access to medicines problem.
3. The US government should permit the World Health Organization, UNAIDS or other international bodies to use US government funded patents in developing countries. It is shocking and ethically indefensible to withhold use of US government funded medical inventions in developing countries.
4. The US government should provide the WTO with a communication supporting an interpretation of Article 30 of the TRIPS that would permit patent exceptions for production of medicines for export.

I will elaborate briefly on item 4, concerning patent exceptions and exports of medicines. Under the WTO rules, governments can issue a compulsory license to a patent, but in most cases, the use must be limited to domestic consumption. The practical effect of this is that only a handful of developing countries will have a large enough domestic industry to manufacture their own products. Moreover, it is inefficient if not absurd to think of more than 100 different manufacturing facilities for each essential medicine that might be a subject of compulsory licensing.

If one was serious about providing treatments for HIV/AIDS medicines in developing countries, one would focus attention on those issues that would lead to the cheapest and highest quality production of medicines. This would involve:

a. Fast-track compulsory licensing (as has been proposed in South Africa and the Dominican Republic); b. Coordinated global procurement, to take advantage of economies of scale, joint bargaining power and the best international production facilities, and; c. An agreement by the WTO that patent exceptions for production of medicine for export would be a reasonable use of TRIPS Article 30.

Finally, thanks to Senators Frist and Feingold for addressing this important issue.

Sincerely,

James Love
Director
Consumer Project on Technology
202.387.8030, fax 202.234.5176
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September 3, 1999 letter from Ralph Nader, James Love, Robert Weissman to Dr. Harold Varmus, Director of NIH, asking for NIH to give the World Health Organization, WHO, access to US government funded medical inventions.

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September 3, 1999

Dr. Harold E. Varmus  
Building 1, 126  
National Institutes of Health  
Bethesda, Maryland 20892

We are writing to ask that you enter into an agreement with the World Health Organization (WHO), giving the WHO the right to use health care patents that the US government has rights to under 35 USC Sec 202 (c)(4) of the Bayh-Dole Act or under 37 CFR 404.7, for government owned inventions.

Under the regulations concerning government owned inventions, the US government has an:

irrevocable, royalty-free right of the Government of the United States to practice and have practiced the invention on behalf of the United States and on behalf of any foreign government or international organization pursuant to any existing or future treaty or agreement with the United States. 37CFR404.7(a)(2)(i)

With respect to government's rights in inventions funded by the US government through grants and contracts to Universities and small businesses under the Bayh-Dole Act, the US government has worldwide rights to practice or have practiced inventions on its behalf (37CFR401.14), and it may require that foreign governments or international organizations have the right to use inventions, under 37CFR401.5(d).

As you must know, the US government has rights to a large portfolio of health care inventions that were invented with public funds. These include inventions in many HIV/AIDS drugs, such as government-owned inventions on ddi, ddc and FddA, and university and contractor inventions such as d4T, 3TC and Ritonavir, as well as drugs to treat malaria and many other illnesses. The private pharmaceutical companies that have obtained exclusive rights to market these products charge prices that are excessive, and too expensive for many patients, including persons in the United States and Europe. Most seriously, the hardships are particularly difficult in developing countries, where countries do not have high enough national incomes to pay for expensive medicines.

In some cases poor countries can issue compulsory licenses to use these inventions, but not every country has the legal authority to issue such licenses, and many countries have small domestic markets without the economies of scale to make compulsory licensing economically feasible. The WHO, with new dynamic leadership, has expressed an interest in using these intellectual property rights. If the WHO uses efficient procurement programs, it can obtain production of these government funded inventions at a small fraction of current world prices. These lower prices would lead to expanded access to essential drugs and stretch public health budgets.
There are number of steps that can be taken by NIH to make these publicly funded inventions more widely available to poor consumers.

1. The NIH should enter into an agreement with the WHO that would permit the WHO to use US government intellectual property rights for public health initiatives. The NIH should specify the terms under with the WHO could use US government intellectual property rights, to ensure that the public interest is served.

2. In those cases where the US government can now give the WHO rights to health care inventions under 37CFR404.7 and 37CFR401.5, the WHO should be authorized to use those rights.

3. The US government should revise its grant and contract practices so that all new grants and contracts reference the WHO's rights to use patents, under 37CFR401.5.

4. The NIH should ask its general counsel to determine the scope of the NIH's rights to government funded university and small business inventions under 37CFR401.14, and to the extent appropriate, engage the WHO, US AID or other international organizations or US agencies to use these rights to expand treatment opportunities for the poor.

This is a matter of extreme urgency. It is immoral for the US federal government to hoard its intellectual property rights to benefit a handful of commercial interests, particularly when the research was paid for by US taxpayers, and the drug companies are already reaping billions in profits from government funded inventions.

We would like you meet with you and your staff to discuss this matter further.

Sincerely,

Ralph Nader
James Love
Robert Weissman

cc: Leon Fuerth, Secretary Donna Shalala
October 19, 1999 letter from NIH Director, Dr. Harold Varmus to Ralph Nader, James Love and Robert Weissman

responding to their request calling on the NIH to provide the World Health Organization, WHO, access to US government funded medical inventions. (Ralph Nader, James Love and Robert Weissman each received separate letters.)

Dr. Harold E. Varmus
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National Institutes of Health
Bethesda, Maryland 20892

James Love
Consumer Project on Technology
P.O. Box 19367, Washington, DC 20036

Dear Mr. Love:

Thank you for your recommendations on how the National Institutes of Health (NIH) could interact with the World Health Organization (WHO) to provide it with commercial development rights to NIH-owned and -funded health care patents. As we are both aware, the licensing of Government inventions has received much attention in recent months from Members of Congress, patient advocacy groups, representatives of industry and the press. The public debate has been galvanized by concerns about the AIDS crisis in developing countries and the role of anti-AIDS therapeutic drugs in addressing that crisis.

This proposal, if implemented, would have powerful repercussions on the current framework for drug development arising from federally supported basic research. I am concerned that your proposal that the NIH employ its "Government use" license authorities to grant WHO standing authority to contract for the production of Government-supported inventions so as to make anti-AIDS drugs available for less cost than offered by pharmaceutical manufacturers would put the current system at risk without necessarily resulting in greater accessibility to these drugs. I am also troubled by the implications of the NIH intervening on behalf of sovereign foreign governments in a situation in which many of those governments have the authority to achieve the same result and in which U.S. intervention on this matter has not been requested.

Moreover, the AIDS crisis in developing countries is a public health problem involving much broader issues than access to anti-viral drugs. The question of the supply of drug products must be considered in the context of the equally important issues of medical infrastructure, public health programs, treatment monitoring and compliance, and emergence of drug-resistant HIV strains. Unilateral action by NIH with regard to NIH-supported patent rights would consequently be ill-advised and unlikely to succeed.

My specific thoughts on the intellectual property aspects of this matter follow.

Programmatic Background
In the early 1980s, Congress enacted the Bayh-Dole Act and the Stevenson-Wydler Technology Innovation Act (with later amendments, including the Federal Technology Transfer Act of 1986) to encourage the transfer of basic research findings to the marketplace. The primary purpose of these laws is economic development: specifically, to provide appropriate and necessary incentives to the private sector to invest in federally funded discoveries and to enhance U.S. global competitiveness. To implement these mandates, the Department of Health and Human Services (DHHS) has designated NIH as lead agency for technology transfer for the Public Health Service (PHS).

While NIH respects and is sensitive to the economic development intent of the authorizing legislation, it carries out this mandate in accordance with its public health mission. For inventions developed within PHS laboratories, NIH (and PHS) Patent and Licensing policies consider public health needs as well as financial and market forces. For example, the PHS Patent Policy states that patent protection should be sought where further research and development is necessary to realize a technology's primary use and future therapeutic, diagnostic, or preventive uses. It is well documented that technologies with potential as therapeutics are rarely developed into products without some form of exclusivity, given the large development costs associated with bringing the product to the market. No benefit accrues to the public if the technology is left to languish and no product reaches the marketplace.

In conjunction with the patent strategy, the PHS licensing strategy gives preference to nonexclusive licenses so that market competition and broad distribution are fostered. Exclusive licenses are granted when such rights are believed to be
necessary to ensure product development. As to inventions developed with NIH funding, the Bayh-Dole Act gives NIH grantees and contractors authority to retain title patents and to license inventions that arise from the NIH funding.

As you have pointed out, the Government has a royalty-free license to practice and has practiced an invention it owns or has funded on behalf of the United States and on behalf of a foreign government or international organization pursuant to a treaty or other agreement with the United States. This royalty-free license provides the Government with no-cost use of a technology it invented or funded. It does not provide rights or access to a licensee's final product. The Government use contemplated by this provision has been interpreted generally to include research use, although its full scope has not been determined. Providing the owner of the technology (licensor) freedom to do further research is a common and reasonable provision of exclusive licenses. To our knowledge, the Government use license has never been employed as you propose, as a blanket measure to facilitate direct competition with a commercial licensee.

**Granting Rights to WHO**

In principle, the U.S. Government can license patent rights to the WHO. Even if the doubts regarding WHO's authority to practice inventions under the Government use license could be overcome, I do not believe that the lack of such a license from the NIH is inhibiting developing countries from addressing their needs. As you stated, many of these countries can issue compulsory licenses, and those that have not enacted that authority to date can do so if they choose. The economies of scale you mention could be achieved by cooperation among these countries or direct interaction with WHO. The role of NIH in these sovereign matters is, appropriately, extremely limited.

NIH can only license or otherwise grant rights to patents in countries where the agency or its grantees have sought and obtained patent protection. Presently, NIH holds patent rights in selected countries to technologies that have contributed to the development of drugs reported as AIDS/HIV-related treatments. In those countries where NIH or its grantees have neither sought nor obtained patent protection, NIH has no intellectual property rights to be licensed or otherwise granted.

In addition, there is an important distinction between having rights to a compound and having rights to the fully developed product. NIH does not license drugs that are ready for marketing. NIH biomedical technologies are early stage and, in almost all cases, require further research, development, and testing, usually in combination with other proprietary technologies, to bring a product to market. To achieve this, NIH and its grantees license the early technology to companies that are able to embark in the developmental and regulatory aspects of drug development. Without patent protection it is unlikely that the companies would invest the resources needed to commercialize these technologies.

The distinction between final product and "raw technology" is important because others may well have filed for patents on non-NIH technologies that are required for the production of the final product. Therefore, even with NIH-granted rights, WHO or a contract manufacturer of such products may infringe patents belonging to others. Because it is the rule rather than the exception that multiple patents cover final drug products, NIH's granting of rights to the early compound or invention would be unlikely to significantly improve access to drugs.

Finally, I am concerned that granting rights to WHO for manufacture and distribution does not address the aforementioned requirement that a commercial entity develop early-stage compounds into safe and efficacious drugs. As a practical matter, it is reasonable to assume that companies will not undertake the development costs of these inventions if they believe the Government will readily allow third parties to practice the inventions.

On balance, I am not convinced of the benefit of the standardized transfer of manufacturing and distribution rights to the WHO or any other nonprofit organization. Critical to successful technology transfer is the assurance that the Government will exercise its intellectual property rights in a responsible, prudent, and consistent manner. Undermining licensed intellectual property rights would, I believe, unnecessarily jeopardize the development of important therapeutic drugs.

**NIH and WHO Interaction**

Not all technologies that would be of use to developing countries are currently licensed. In the past, the NIH and WHO have worked together on licensing joint inventions and in negotiating with third parties. In one notable instance, NIH approached WHO with the possibility of manufacturing certain vaccines important of developing countries. Unfortunately, limitations of resources did not permit WHO to take advantage of such an offer. NIH welcomes, and is pursuing, further discussions with WHO on what can be done to assist developing countries with health care needs. I have directed my technology transfer staff to engage WHO on the intellectual property aspects of this matter. Discussions between my staff and WHO representatives are currently being facilitated by Dr. Stuart Nightingale of the Food and Drug Administration.

I appreciate the opportunity to explain our position on this issue. Sincerely, Harold Varmus, M.D., Director
(c) LIMITATION ON USE OF FUNDS - Funds appropriated or otherwise made available to any department or agency of the United States may not be obligated or expended to seek, through negotiation or otherwise, the revocation or revision of any intellectual property or competition law or policy that regulates HIV/AIDS pharmaceuticals or medical technologies of a beneficiary sub-Saharan African country if the law or policy promotes access to HIV/AIDS pharmaceuticals or medical technologies and the law or policy of the country provides adequate and effective intellectual property protection consistent with the Agreement on Trade-Related Aspects of Intellectual Property Rights referred to in section 101(d)(15) of the Uruguay Round Agreements Act.

(C) POLICY OF UNITED STATES GOVERNMENT TOWARDS BENEFICIARY COUNTRIES - The President shall encourage all beneficiary sub-Saharan African countries to implement policies designed to address the underlying causes of the HIV/AIDS crisis, including through efforts to encourage practices that will prevent further transmission and infections and to stimulate development of the infrastructure necessary to deliver adequate health care services. In addition, the President shall encourage policies that provide an incentive for public and private research on and development of vaccines and other medical innovations that would contribute to combating the HIV/AIDS crisis facing Africa. Where a measure relating to the distribution of HIV/AIDS pharmaceuticals or medical technologies in a beneficiary country has been identified under section 182 of the Trade Act of 1974, the President shall determine whether -

1. the measure is not inconsistent with the Agreement on Trade-Related Aspects of Intellectual Property Rights referred to in section 101(d)(15) of the Uruguay Round Agreements Act;
2. the country is making significant progress toward developing the infrastructure necessary to ensure that the pharmaceuticals or medical technologies are properly distributed to the affected population in the country;
3. the country has engaged in meaningful efforts to improve public understanding of HIV/AIDS and to encourage practices that will prevent further transmission and infection;
4. the country has taken all reasonable steps to ensure the safety and efficacy of the pharmaceuticals or medical technologies;
5. the country has otherwise made reasonable efforts to work with the patent holder to address the problems of supply of the product;
6. the country is not otherwise engaged in a persistent pattern of conduct that denies adequate and effective protection of intellectual property rights.

Where the President determines that the beneficiary country and the measure it intends to adopt satisfies the requirements set out in this subsection, he shall instruct the United States Trade Representative not to seek, through negotiation or otherwise, the revocation or revision of such measure within the beneficiary country.
IN SUB-Saharan Africa the AIDS situation has escalated to nothing short of full-blown war.

During wartime one would expect a war cabinet to take control and have a detailed, co-ordinated plan, which would receive priority on all fronts (including finance) to effectively minimise and combat the threat. When you analyse the SA government's response to AIDS you will find smoke, mirrors, accusations, counter-accusations, confusion, half-truths, scapegoats, denial and an absolute refusal to accept full responsibility at all cost. In short, the AIDS response to date can be seen as a manual for spin doctoring.

Before 1998 you simply ignore the issue in the hope that it might go away. When this is not successful you blame the previous government and politicise the issue, despite the fact that common sense and science dictate otherwise.

Click here for full-text story: http://www.bday.co.za/00/0418/comment/e2.htm

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Always watch for outdated information. This article first appeared in 2000.

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>>THAILAND ACTS AGAINST BRISTOL MEYERS SQUIBB TO PROVIDE CHEAPER AIDS MEDICATION

>> Thailand's government has confronted drug companies for
>> profiteering from HIV/AIDS drugs. The Thai government will provide
>> DDI or Videx an anti-retroviral drug made by Bristol Meyers Squibb
>> in powder form against the wishes of the company. DDI will now cost
>> less than two thirds of its price. This action comes after months
>> of campaigning by local HIV/AIDS treatment activists. The price
>> reduction is welcome news for tens of thousands of people with
>> HIV/AIDS, many in our country who are forced to buy Videx at an
>> inflated price.
>>
>> The Treatment Action campaign welcomes the victory by the Thai NGO
>> Coalition including its people living with HIV/AIDS and Medicins
>> Sans Frontieres (Doctors without Borders). Their work and sacrifice
>> has paved the way for millions of people with HIV/AIDS.
>>
>> However, Bristol Meyers Squibb is preventing the Thai government
>> from buying the compounds for the drug from the cheapest supplier.
>> If the Thai government could buy the drug compounds from the
>> cheapest supplier, it would dramatically reduce the price and save
>> many more lives.
Bristol Meyers Squibb faces three options

It can show courage and reduce its price significantly in Thailand and across the world. It will not lose any money because Yale University researched and developed the drug.

It can allow the Thai government the right to import the compound for DDI at the lowest cost.

Or, Bristol Meyers Squibb can face world opinion and activists as a drug profiteer who will let poor people die to maintain profits.

The Treatment Action Campaign calls on the United States government and the Yale University Board to support the action of the Thai government. We also call on the South African government and the Pharmaceutical Manufacturers Association to act immediately to reduce the price of all medications to treat HIV/AIDS. We stand by the people in Thailand and everywhere who work for affordable treatment.

Issued by Zackie Achmat on behalf of the Treatment Action Campaign

Sydney Levy
Campaign Director
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IGLHRC's mission is to protect and advance the human rights of all people and communities subject to discrimination or abuse on the basis of sexual orientation, gender identity, or HIV status. A US based non-profit, non-governmental organization (NGO), IGLHRC responds to such human rights violations around the world through documentation, advocacy, coalition building, public education, and technical assistance. Our overarching commitment is to defend the rights of people worldwide to define their own sexualities and gender identities. We support the efforts of individuals and groups to organize to create societies free from heterosexism and homophobia.

*****

Date: Wed, 19 Jan 2000 16:50:41 +0200
From: Zackie Achmat <<zackie@pixie.co.za>
Subject: Thailand Drug Victory--TAC statement-- Please forward
To: Shafika Isaacs <<sisaacs@idrc.org.za>

Dear All
Please find the TAC statement on Thailand below.

Thanx
Zackie Achmat
TAC & AIDS Treatment Action Campaign
PO Box 31104, Braamfontein 2017, Johannesburg. Tel: 011-403-0265 Fax: 011-403 2106

E-mail: shasha@netactive.co.za
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Counting the economic cost of Aids
By Ed Crooks in Washington
Financial Times - April 16, 2000
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The statistics on the HIV epidemic to be presented by the World Bank to Monday's meeting of G7 finance ministers in Washington make for chilling reading.

Last year, 2.6m people worldwide died as a result of the Aids virus, making it the world's fourth-biggest cause of death, and the spread of the epidemic continues unabated. At least 34m people are infected with HIV, and 15,000 more succumb every day.

The disease has spread so widely that it now is not only the cause of millions of individual tragedies, but has an enormously destructive impact on economic and social development. Over 95 per cent of people with HIV live in developing countries, which are suffering lower growth and investment and deteriorating health and education services as a result of the epidemic.

Click here for full-text story:
http://news.ft.com/ft/gx.cgi/ftc?pagename=View&c=Article&cid=FT3S1JIY47C&live=true&useoverridetemplate=IXLZHNNP94C

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from GAAN
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Forwarded by David Hoos/AIDS/OPH/DOH on 04/25/2000 01:15 PM ------------------

> In this update, please find:
> 
> 1. News on debt relief
> 2. Updated news on the Africa and Carribean trade bill
> 3. Budget Resolution
> 4. Appropriations
> 
> ACTION ON DEBT RELIEF FACES DELAY
> Earlier this year, President Clinton asked Congress to approve $210 million for debt relief in the supplemental for fiscal year 2000. This amount would go towards US contributions to the World Bank/IMF trust fund that was established to provide debt relief to the world's poorest countries. However, House appropriators did not include this amount in the fiscal 2000 supplemental bill (HR 3908) in spite of all the growing pressure on the IMF and World Bank to relieve the debts owed to them by the poorest countries.
>
> President Clinton also requested Congressional approval of the IMF to revalue its gold stock which is said to be used to for relieving some of the debts owed to this institution.
>
> However, both the $210 million funding and the gold revaluation face delay. Senator Trent Lott (R-MS) has been asked by Senator Phil Gramm (R-TX), Chairman of the Senate Banking Committee, not to act on the debt relief issue until the Senate Banking Committee reviews the debt relief provisions. At this point, it is most likely that the debt relief issue will not be included in the stalled supplemental bill.
>
> Last month, the Senate Foreign Relations Committee had passed a foreign aid authorization bill that included both debt relief provisions. This bill was expected to go to the Senate floor sometime this week. The new developments will most likely delay the authorization bill from being considered in the full Senate.
>
>
NEGOTIATORS REACH COMPROMISE ON THE AFRICA AND CARIBBEAN TRADE BILL

After days of negotiation on the differing terms and conditions set by the House and Senate for trade between the US and African nations, conference committee members finally reached an agreement on the Africa and Caribbean trade bill. This trade bill would grant greater duty-free access to U.S. markets to more than 70 countries in sub-Saharan African, the Caribbean and Central America.

The Africa trade agreement would cap the imports of apparel made from regional fabric for eight years, starting the cap at 1.5 percent of total US imports and rising to about 3 percent. However, the poorest African nations would be allowed to use apparel made from third country fabric for the first four years. The agreement caps imports of apparel made from regional fabric at 250 million square meters for Caribbean nations.

Finally, the agreement also includes a provision that was included in the Senate version of the bill that would require the US Trade Representative to rotate the goods sanctioned as a result of trade disputes. According to Senator Mike DeWine (R-OH), the author of this provision, the sanctions are ineffective when applied to a few marginal products.

Congressional aides believe that this final agreement will make it easier for the bill to pass both the House and Senate floors.

BUDGET RESOLUTION Passes THE SENATE

Last week, the Senate passed the FY 2001 budget resolution by a vote of 50-48. Earlier the House passed the resolution by a vote of 220-208. The appropriators will now have just $600.2 billion in discretionary spending for the 13 fiscal 2001 spending bills. While that total represents a $14.2 billion increase over this year's level, all of that additional sum would go to defense, which receives $310.8 billion under the resolution, or a $20.9 billion increase. Non-defense discretionary spending would fall by $6.7 billion, or 2 percent. For the 150 Account, the Budget Resolution recommends just $20 billion versus a request level of $21.5 billion ($22.7 billion including Wye etc.). While this is a decrease of about $1.5 billion from what the president requested, the level of $21.5 b is the same as FY 2000.

HOUSE APPROPRIATIONS COMMITTEE Sets PRELIMINARY DISCRETIONARY SPENDING ALLOCATIONS

The House Appropriations Committee circulated a preliminary list of discretionary spending allocations. The 150 Account Sub-Committees allocations were: Commerce-Justice-State $35.4 billion (added $427 million), while Foreign Operations gets $12.95 billion, a reduction of $516 million from last year's $13.46 billion. Note: the request for Foreign Operations was $15 billion. By comparison, the Labor-HHS-Education panel would receive a $2.4 billion increase. Transportation subcommittee would grow by $1.4 billion. Also in line for increases are military construction ($148 million) and agriculture ($96 million). However, the Interior subcommittee would see its allocation reduced by $580 million. Likewise, another subcommittee that would receive less money is VA-HUD ($403 million).
Anti-retroviral Medication Therapy Pricing Creates New kind of "Black Market" in Central America
By Richard Stern

Lorena, a 37 year old woman from Nicaragua, is a new kind of drug trafficker. Lorena rides the buses of Central America looking for places to buy AIDS medications in the black market that has sprung up here as a result of the crisis surrounding medications for people with AIDS.

Lorena was in Costa Rica early in April, where she contacts People with AIDS who might have an extra supply of a medication they have discontinued, or simply be willing to sell their own medications for cash. I met with her in a restaurant in downtown San José where we shared a lunch of rice, tortillas, and black beans. Lorena was totally candid with me, and wanted to know if I knew of anybody who might have some Crixivan, Videx, or AZT, anti-retroviral medications which are on her shopping list this trip. Lorena is a short, but corpulent woman who speaks in a very soft voice, articulating her words carefully. But the softness of her voice and her seeming humility belie the hardness of her real life experience, and her determination to survive.

She fills me in on her story. Her husband, a grocery store worker, was diagnosed with HIV seven years ago. He hasn't worked since 1997. She was a housewife and had never heard of AIDS until he told her his diagnosis when he began to get sick. She was tested and is positive, and has had some AIDS related illnesses but their two children, both teen-agers, are HIV negative. Her husband goes off and on anti-retrovirals depending on their availability and she knows this isn't good. Neither of them knows their CD4 count or Viral Load.

Later this month, after returning to Managua, Nicaragua's poverty stricken capital, to distribute those medications that she could purchase in Costa Rica, she was heading for Guatemala, an eighteen hour bus ride to the North. In Guatemala, the two tiered system of health care has created a lucrative black market in anti-retroviral medications, which are sold openly outside the AIDS clinic of the country's Instituto Guatemalteco de Seguro (IGS). About 400 of Guatemala's 3000 AIDS sufferers who are affiliated with the IGS receive their medications free through the Institute. But some of these 400 may have other sources of medications and are willing to sell duplicate pills for needed cash to people desperate to obtain them at the Black market prices. Others simply weigh the pros and cons of life saving medication, or having income for other needs viewed to be equally as urgent.

Lorena makes a living and also is able to obtain medications for herself and her husband by making these arduous journeys across Central American borders. She collects money from a small group of Nicaraguans who are desperate to obtain anti-retrovirals, and then negotiates with sellers that she finds through her extensive network of contacts with People with AIDS throughout the region.

"None of us can afford to buy from the pharmaceutical companies," she says, "but if we can buy from other patients we pay less than half of what the companies are charging."

Lorena spends about half her time in Managua and the other half in her travels, staying in $2 per night hotels along the bus routes.

Does Lorena feel she is doing something wrong as she carries medications for which she has no prescriptions across borders? "How can I feel bad about what I do," she says. "This is our only option to live. There is a proverb, "judge not, lest yee be judged. 'Let the drug company owners (sic) be judged before they judge me,' she adds, her voice quivering with bitterness. "We have two children. If we die, they are going to be in the street."

Guatemalans with AIDS are worried about the growing black market in their country. "This has to be stopped. People are always calling me trying to sell medications," one NGO Director told me, during my own visit to Guatemala City last February. But he recognizes that a black market is likely to continue as long as some people have access to expensive medications and others are left completely out of the health care system. In Guatemala, per capita income is $250 per month and an anti-retroviral cocktail would cost between $650 and $800 monthly.
In Costa Rica the "two tiered" system of attention to people with AIDS is less of an issue as nearly 100 percent of the population is covered by government sponsored Health Care insurance that pays for medications. But in Guatemala as well as Panama, and several other Latin American countries, only certain portions of the populations, generally between 15 and 40 percent, are covered by the Health Care system, which creates the natural tendency for a black market to occur.

Costa Rican AIDS activist Guillermo Murillo is one of the first People with AIDS to have come out publicly in Central America. "The cost of these medications is disastrous for the poor people in Central America," he says "Even in Costa Rica, the costs of triple therapy puts us in a position where we really don't have access to changing our treatment if a particular combination of drugs doesn't work. But for people like Lorena, its a nightmare." The Costa Rican government is currently spending about seven million dollars yearly to supply 900 patients with ARV therapy. But mortality from AIDS has dropped over 70 percent since the therapy was started late in 1997.

(Richard Stern, Ph.D. is Director of the Agua Buena Human Rights Association. The Association is supported entirely by private donations.)

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Developing nations claim they are victims of unfair global economic order
John Ward Anderson in Havana

Strapped by debt, cut off from the technology boom and tied to an international economy that is dragging them down, the leaders of the world's poorest countries who gathered here last week said they were the victims of an unfair economic order, and sided with the protesters demonstrating in Washington against globalization.

Members of the Group of 77 (G-77), an organization of underdeveloped countries that represents about 80 percent of the world's population, said they shared many of the same concerns and goals as the protesters, who disrupted meetings of the World Bank and International Monetary Fund (IMF).

"I, for one, support the demonstrators," said Arthur Mbanefo of Nigeria, the official spokesman for the group during its three-day summit. "Many countries have rejected the results of various policy initiatives of the World Bank and IMF." He cited privatizations of state-owned industries, crushing debt burdens and a "one-size-fits-all" attitude that did not account for economic, cultural and political differences among nations. "We are very supportive of demonstrations that could forcefully handle those concerns."

The G-77 was formed in 1964 by a group of underdeveloped nations - most in the southern hemisphere - to try to influence the wealthy northern countries. It now has 133 member states. The group's goal is to help them develop more rapidly and alleviate poverty.

During the summit, members complained that global economic policies dictated by the rich nations had locked them into a cycle of poverty. Instead of stabilizing economies, said Belize's prime minister, Said Musa, such policies "have stabilized poverty."

President Fidel Castro of Cuba referred to the deep philosophical and economic differences that divide the world's rich and poor countries in general, and Cuba and the United States in particular. He called the gap between the north and south a "new apartheid."

In a speech closing the meeting on Friday last week, he said: "The current economic order imposed by the rich countries is not only cruel, unjust and inhuman . . . but also carries a racist view of the world which inspired the Nazi Holocaust and concentration camps."

Although the summit generally steered away from thorny bilateral issues, the gathering unanimously expressed its support for an end to the U.S. embargo of Cuba because it seemed purely "punitive" and "has had tremendous adverse consequences on the women, children and the people of Cuba in general," Mbanefo said.

The demonstrators in Washington might not agree with all of the pronouncements made in Havana, but many statements would resonate with them, particularly those aimed at the World Bank, the IMF and the World Trade Organization. These three organizations are financial powerhouses, funded mostly by rich Western nations, which act as the world's chief
lending institutions and trade bodies. For access to their money, developing countries often are forced to implement painful political and economic reforms to conform more closely to Western-style democracy and free-market economics.

The summit's final declaration called for a greater voice in global economic decisions, increased aid and exports to underdeveloped nations, greater technology transfers, and the cancellation of unsustainable debt that forces many countries to pay more in interest than on social services.

Reflecting a sense that the G-77 had to work together to force change, South African President Thabo Mbeki said: "We believe consciousness is rising, including in the north, about the inequality and insecurity globalization has brought . . . about the plight of the poor countries." He cited the campaign to reduce foreign debt, the conflicts at the WTO's meeting in Seattle last year and the hostility to the meeting in Washington as evidence of "a changing atmosphere which a more coherent Third World voice can take advantage of."

"It is indeed time to recover our fighting spirit," said President Olusegun Obasanjo of Nigeria, the G-77 chairman. "No doubt that from here we go forward, determined to make a difference."

_The Guardian Weekly_ 20-4-2000, page 27

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REGARDING DOMESTIC DRUG PRICING:
From: "Khalil Elouardighi" <gerrold@wanadoo.fr>
To: "George M. Carter" <gmc0@ix.netcom.com>
Subject: Re: Americans subsidizing low prices around the world
Date: Sat, 15 Apr 2000 18:57:40 +0300

George,

Why not impose a maximum profitability threshold on inventions, beyond which inventions would not be protected, regardless of time elapsed since subject matter development and marketing?

For example, if the threshold had been set at five times investments, *all* ARV would have fallen out of patent protection a few years after marketing. But for this to work, it would have to be applied to stock market investments too, and I don't see any powerful politicians willing to put a ceiling on stock market surpluses (I don't know if surplus if the right word; my dictionary doesn't seem to know any true translation for French word "plus-value", which means the difference between what you paid to acquire a commodity, such as a house or portfolio of shares, and what you sell it for).

The problem with a fixed % guaranteed profitability of inventions, is that it fails to encourage R&D cost control. A reasonably high profitability threshold would tend to minimize this effect, since then the objective for the company, is to reach the threshold as fast as possible (maximum capital utilization)

I agree with you that our current patent system is very hurtful and is going to prove even more hurtful as technological advances accelerate. I don't know if this is our [aids drug-access activists] fight. It seems like something we could support if others were leading it, but we're having enough problems assuring concrete-advances-generating activism as it is, IMO, to be able to carry this.

Khalil.
U.S. to South Africa: Just Say No
by Lakshmi Chaudhry
3:00 a.m. Apr. 25, 2000 PDT

The Clinton administration has been the pharmaceutical industry's favorite attack dog when it comes to protecting patent rights.
For the past three years, the White House has been pressuring the South African government to drop its plans to seek cheaper alternatives to AIDS medications.

Officials were upset when the South African government in 1997 passed a law that would permit it parallel imports of AIDS drugs or the ability to compulsorily license AIDS medications, such as AZT, which studies have shown can reduce the rate of transmission between pregnant women and their babies.
Parallel importing would let South Africa import patented drugs into the country from nations other than the U.S. at cheaper prices, since multinationals often charge different prices for the same drug.
Compulsory licensing would force manufacturers to license their patented drugs to South African companies that then could produce and distribute the product at much lower costs.
Activists say compulsory licensing is essential for developing countries such as South Africa that are battling a full-blown AIDS epidemic.
With 4.3 million AIDS patients in the country, "the only way they could possibly treat everybody is through compulsory licensing," said James Love, director of the Consumer Technology Project.
AIDS activists claim the much-needed drugs could be profitably produced in South Africa for a per patient cost of $200 annually. A United Nations study estimates 2 million South Africans will die of AIDS by 2005 without an effective treatment program.
"Anyone not in favor of compulsory licensing is opposed to treating infected people," Love said.
But when the South African government passed the law allowing the licensing to begin, it was promptly sued by drug companies that charged the government was violating intellectual property laws.
The U.S. government backed the companies, claiming the law violated the Trade Related Aspects of Intellectual Property Rights provisions of the World Trade Organization agreement, which requires member countries to grant a 20-year term for patent protections.
A 1999 State Department report states the "U.S. Government agencies have been engaged in a full court press with South African officials from the Departments of Trade and Industry, Foreign Affairs, and Health, to convince the South African Government to withdraw or amend the offending provisions of the law."
When South Africa continued to defend its law, asserting it was in full compliance with TRIPS requirements, the U.S. Trade Representative placed South Africa on the Special 301 Watch List, which lists countries under scrutiny for possible intellectual property violations.
Getting on the 301 list usually spells trouble for any country seeking foreign investment.
"While we don't say it explicitly, it's a warning for investors going to that country that there are potential problems with respect to protection of intellectual property," said a U.S. trade official who requested anonymity.
Between 1997 and the end of 1999, almost every department of the U.S. government attempted to pressure South Africa into compliance. Leading the charge was none other than Vice President Al Gore, who headed the U.S.-South Africa Binational Commission.
The State Department reports that during a 1998 meeting with South African President Thabo Mbeki, Gore made an issue of intellectual property rights protection, and that South African officials attempted to persuade Gore to intervene with the U.S. pharmaceutical industry to terminate its lawsuit. But according to the report, the White House "decided that such an action might undermine the leverage that U.S. companies were exerting through their legal challenge."
U.S. officials told the South Africans that "since the U.S. government is not a party to the litigation, (it) was unable to agree to this request."
But as it turns out, neither compulsory licensing nor parallel importing violates the TRIPS agreement.
"While the wording prohibits parallel imports ... you can't sue anyone for doing it," the U.S. trade official said.
"There is no substantive meaning to it."
And TRIPS allows compulsory licensing "as long as both parties have made a reasonable effort to negotiate," he said.
The United States itself has invoked compulsory licensing on anti-pollution devices used to comply with the Clean Air Act.
But in pressuring South Africa, the White House was not in fact enforcing the TRIPS agreement, but rather what it calls "TRIPS plus."
"We consider TRIPS to be a minimum standard," the trade official said. But under congressional mandate, mere TRIPS compliance is not sufficient to keep a country off the dreaded 301 list.

While the trade official would not specify exactly what TRIPS plus entailed, he said both compulsory licensing and parallel importing were "not considered appropriate."

The term means "whatever they happen to want," Love said.

The White House finally eased off when its South Africa policy became a source of major embarrassment back home.

In June 1999, the AIDS organization ACT-UP began following Gore around the campaign trail, accusing him of "medical apartheid."

The White House officially changed its policy last December. "We were trying to discourage compulsory licensing in the area of health," the trade official said. "We will not apply TRIPS plus with respect to countries with medical emergencies."

And the administration also is promising to be less zealous in promoting the interests of drug companies. "We've told them that they can't count on us to pressure countries where they have disputes," the trade official said.

But consumer activists say that South Africa is the exception to the U.S. government's policy.

"The rest still have to comply with TRIPS plus," Love said. "The strange thing is that they're the toughest with places that have the best shot of dealing with the problem, like Thailand and India."
Time-line of Disputes over Compulsory Licensing and Parallel Importation in South Africa

Version 1.03
August 5, 1999

1994. The US/South Africa Binational Commission (BNC) is formed, co-chaired by Vice President Al Gore and Deputy President Thabo Mbeki.

March 1, 1995, BNC holds first meeting in Washington, DC.

April 7, 1997. Andrew Stoller of USTR writes letter to UN Ambassador from South Africa Selebi concerning the questions of the U.S. about implementation of TRIPS. Questions touch on such topics as compulsory licensing.


May 20, 1997, Aldridge Cooper, a Vice-President of Johnson & Johnson and Chairman of the U.S.-South African Business Council, writes Secretary of Commerce William Daley about the proposed changes in the South African Medicines Act.

June 2, 1997. Representatives of Bristol-Myers Squibb, Merck, Johnson & Johnson, Eli Lilly, and American Home Products meet with the South African Ambassador to the U.S. Franklin Sonn, to discuss the proposed Medicines and Related Substance Control Amendment Bill and the issue of registration of a generic version of Taxol (Paciltaxel).

June 3, 1997. Aldridge B. Cooper, a Vice-President of Johnson & Johnson and Chairman of the U.S.-South Africa Business Council, again writes US Secretary of Commerce William Daley to claim that the proposed amendments to the South Africa Medicines Act will have "grave consequences for not only the US pharmaceutical industry, but all US direct investment in South Africa." Cooper notes that the US government has set up "an inter-agency task force has been established under the direction of the Department of Commerce, involving the Office of the US Trade Representative, the State Department and the Department of Health and Human Services," and that a recent Congressional delegation raised the SA Medicines Act amendments in a recent trip to Africa. He asks that this be a subject of the July 1997 BNC meetings.


July 24, 1997. US Representatives Menendez, Royce, Payne, Chabot, Rothman, Pallone, Davis and Andrews write letters to Deputy President Mbeki and Vice President Gore expressing concern about intellectual property of pharmaceuticals in South Africa. The letter addresses the pharmaceutical industry concerns over parallel imports and proposed requirements that drugs prescribed by public health doctors be identified by generic names, which the industry claims violates trademark rights under the WTO/TRIPS accord on intellectual property.

July 29, 1997. Ralph Nader, James Love and Robert Weissman write Vice President Gore, asking for a meeting with US government officials to discuss dispute with South Africa's pharmaceutical policies. The letter focuses on parallel imports, generic drug substitution and registration of generic versions of Taxol. "We see no grounds for U.S. government intervention on behalf of the international pharmaceutical companies. Indeed, the U.S. should be supportive of the South African government's thoughtful initiatives, and use the opportunity to assert that U.S. foreign economic policy with respect to pharmaceuticals will subordinate commercial concerns to broader public health interests," they wrote. Vice President Gore was also urged to expand USTR's IFAC-3 advisory committee on intellectual property to include consumer interests.

July 29, 1997. PhRMA meets with Minister Zuma and others from South Africa in Washington, DC to discuss intellectual property of pharmaceuticals. The US government pushed for the meeting. The South African Ministry of Health wanted to invite intellectual property and trade experts but PhRMA objected. The meeting was chaired by Franklin A. Sonn, the Ambassador of the Republic of South Africa, and attended by Alan Holmer, the President of PhRMA, Tom Bombelles (PhRMA), Cathie Bennett (Pfizer), Dr. Khalil (Merck), Mitchell Cybulski (SKB), Brian Healy (Merck), Minister Zuma (SA MOH), Dr. Olive Shisana (SA MOH), Dr. Ian Roberts (SA MOH), Gregg Burton-Durham (SA DTI), and others. Dr. Zuma tells PhRMA that parallel importing will only be done for selected drugs, when it benefits patients, and that "it is unacceptable for South Africa to pay higher prices than Australia." PhRMA attacks parallel import authority as well as South African plans to promote use of prescribing drugs by generic name.


October 4, 1997. Ambassador James Joseph writes letter to Dr. Abe Nkomo of the Portfolio Committee on Health describing U.S. objections to section 15(c) of the Medicines Bill. Ambassador Joseph says "my Government opposes the notion of parallel imports of patented products anywhere in the world. We argued for a prohibition of such parallel imports in the TRIPS Agreement. They are illegal in the United States, both as an infringement of patent rights and, because in the case of medicines, our Food and Drug Administration (FDA) believes it cannot adequately monitor quality."

October 6, 1997. James Love, on behalf of the Consumer Project on Technology, presents comments, via fax, to the Portfolio Committee on Health Parliament, Cape Town, on the Medicines and Related Substances Control Amendment Bill and South African Reform of Pharmaceutical Policies. The CPT comments reviewed the legality of parallel imports under the WTO/TRIPS Agreement (legal under Article 6), and in recent cases in Japan and the European Union. CPT also presented evidence from the UK on parallel import savings on HIV drugs, and discussed the Taxol issue. October 10, 1997. MSD South Africa (Merck) writes a position paper expressing concern about Section 15C of the SA Medicines Act.

October 14, 1997. Dr. Elizabeth Ominde-Ogaja, the Director of the National Quality Control Laboratory in Kenya, writes the Peter Foib (sp?), the Director of the South African Medicines Control Council, to express opposition to parallel importation, which Kenya has outlawed.

October 24, 1997. Simon Barber, writing in the Johannesburg Business Day, reports that Senator Jesse Helms may hold up ratification of the new U.S./SA Tax Convention, in retaliation for South Africa having "abrogated" the patent rights of US drug companies by permitting parallel imports. Barber reports that Helms' is acting on behalf of Glaxo, the British drug company that sells AZT and other drugs, with offices in North Carolina.


November 25, 1997 - Ambassador Erwan Fouere, the Head of the European Commission delegation in South Africa, writes letter to Dr. Olive Shisana, the Director General for the South African Department of Health, advising South Africa that "The European Commission has received complaints from the European Pharmaceutical Industry that the South African bill Section 15C, to amend the Medicines and Related Substance Control Act from 1965 (MRSC) appears to be in violation of the TRIPS Agreement and in particular Article 27 (non discrimination) and 28 (rights conferred by the patent)." No mention is made of the extensive use of parallel imports within the European Union, or of Articles 6 or 31 of the TRIPS.

December 12, 1997. President Mandela signs into law amendments to the South African Medicines Act, including Section 15C.

January 8, 1998. Dr. Nathaniel Murdock of the U.S. National Medical Association (NMA) writes a number of letters expressing opposition to the SA Medicines Act.
January 21, 1998 - The U.S. National Black Nurses Association writes to President Mandella expressing concern that the South African government might "inadvertently encourage the production of drugs that are not authentic," and urges changes in the South African Medicines Act.

January 23, 1998 - The National Black Caucus of State Legislators sends letters, signed by Lois DeBerry, the Speaker Pro Tem of the Tennessee House of Representatives and Roscoe Dixon of the Tennessee State Senate, to Minister of Health Zuma and President Mandella. The letters ask for a new amendment to the SA Medicines Act to prohibit parallel importation of patented products.

January 27, 1998 - The Executive Board of the World Health Assembly recommends the adoption of EB101,r24, the Revised Drug Strategy. The resolution asks member countries to "ensure that public health rather than commercial interests 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." The resolution, which was introduced by Dr. Timothy Stamps, the Minister of Health for Zimbabwe, is attacked by the international pharmaceutical industry and governments in the US and the EU.

February 2, 1998 - 47 members of U.S. Congress write letter to USTR Charlene Barshefsky urging her to take actions against the recently passed amendments to the SA Medicines Act.

February 11, 1998. The US Department of State tells USTR that the New York Times is researching an article on the South African trade dispute. Steven Fox from USTR tells Jay Ziegler in South Africa to use the following statement "We are very concerned about the implications of these amendments. We have conveyed our concerns to the Government of South Africa in strong terms and are consulting closely with affected U.S. companies about appropriate action." The NYT story runs on March 29, 1998.

February 11, 1998. Anthony Carroll from The Services Group (TSG, located in Arlington Virginia), send a fax to USTR's Rosa Whitaker, with suggestions for talking points on parallel imports. February 13, 1998. USTR's Joe Papovich attends interagency meeting chaired by Leon Fuerth of Vice President Gore's office to discuss addressing the Medicines Bill at the upcoming South African BNC meeting.

February 19, 1998. Tom Bombelles of PhRMA sends USTR's Rosa Whitaker talking points and articles on parallel importation.

February 23, 1998 - Pharmaceutical Research and Manufacturers of America (PhRMA) asks USTR to designate South Africa as a Priority Foreign country under the Special 301 Review. PhRMA says that "South Africa has become a 'test case' for those who oppose the U.S. government's long-standing commitment to improve the terms of protection for all forms of American intellectual property, including pharmaceutical patents."

February 23, 1998. Bristol-Myers Squibb (through Collier, Shannon, Rill & Scott and the Gorlin Group) presents comments to Joseph Papovich at USTR, asking that South Africa be "designated a priority foreign country" under Special 301. The compliant focuses on the decision of South Africa to permit registration of a generic from of Paclitaxel (BMS brand name Taxol).


March 10, 1998. Tom Bombelles of PhRMA writes USTR's Steven Fox, thanking him for "meet with our PhRMA group today, and attaching notes from the July 29, 1997 meeting between PhRMA and Minister Zuma and her staff.


March 17, 1998. USTR Barshefsky responds to Congressman Menendez and 46 other members of congress stating that "This issue is a centerpiece of our annual 'Special 301' review of countries' intellectual property practices. Our concerns about the Medicines Act were the central focus of a bilateral IPR teleconference we conducted March 11. We will raise the issue again during the President's visit to South Africa. USTR and other agencies with both trade and health policy responsibilities will continue to press the South African Government in all possible fora as long as possible."
March 19, 1998 - USTR's Rosa Whitaker, Liz Artky and Stephen Fox meet with Congressman Menendez to discuss the SA Medicines Act.

March 20, 1998. USTR's Stephen Fox discusses with Jim Caruso in the US embassy in Pretoria a March 23 meeting with the European Union, asking the EU to push Minister Zuma on the SA Medicines Act.

March 23, 1998 - Sir Leon Brittan, VP of the European Commission, writes to VP Mbeki describing his concern with Section 15(c) of South African Medicines and Related Substances Control Act, saying the Act "would negatively affect the interests of the European pharmaceutical industry." Brittan does not know that parallel imports of pharmaceuticals are common within the European Union.


March 26, 1998 - Secretary of Commerce Daley met with South African Health Minister Zuma. According to the US State Department, Daley emphasized the USG resolve to ensure South Africa would not use 15(c) to undermine pharmaceutical patent rights or allow parallel imports. Minister Zuma tells Daley the South African laws do not violate any international agreements.

March 27, 1998. In a radio broadcast in South Africa, Tom Bombelles of PhRMA says the dispute over the South African Medicines Act is "the single most important economic or trade issue." The report says that Bombelles "alleges that South Africa is being used by India and Argentina as a test run to see how world wide agreements could be broken relating to the protection of intellectual property rights." Samir Khalil from Merck is also quoted.

March 29, 1998. The New York times publishes "South Africa's Bitter Pill for World's Drug Makers," by Donald G. McNeil, Jr. The NY Times article reports that South Africa pays prices that are sometimes eight or nine times as high as other countries for common drugs.

Spring 1998 - Assistant U.S. Trade Representative for Africa Rosa Whitaker raises U.S. government concerns with both the Minister of Health and Minister of Trade and Industry in South Africa.

April 9, 1998 - Congressmen Menendez and Royce write to Secretary of State Albright asking to use Special 301 against South Africa.

April 14, 1998. Peter Collins, Steve Fox and Claude Burcky send a memorandum to Ambassador Richard Fisher, with talking points about why South Africa needs to be cited in Special 301. Among them: "Our Special 301 decisions will have no credibility with our industry or with the South Africans if we do not name South Africa in this year's announcement." And, "This law is a mistake, and identifying South Africa in the Special 301 announcement is a gentle reminder." Attached is a 4 page memo, "U.S. Support for South Africa's Health Care Goals," which claimed that prices in South Africa now "represent some of the lowest prices in the world," and "parallel importation . . . does not work . . . Parallel importation often is only a way for middlemen to make more money."


May 1, 1998. USTR puts South Africa on the Special 301 Watch list. The USTR announcement focuses on the SA Medicines Act, including the authorization of parallel imports and empowering the Minister of Health to "abrogate patent rights," as well as the registration of a generic form of Taxol, and insufficient enforcement of copyright laws.

May 7-8, 1998. Seven public health and consumer groups from around the world (including CPT, HAI and Consumers International) hold a conference in Washington, DC on the issue of health care, intellectual property rights and international trade agreements. The USTR and the US FDA refuse to participate. The Department of State, the NIH and other federal agencies do participate.
May 11, 1998. The World Health Assembly (WHA) begins meetings in Geneva. An executive board resolution on the WHA "Revised Drug Strategy" draws heated opposition from the US, the EU and Japan. In negotiations on the resolution, Dr. Olive Shisana from the SA MOH is the lead negotiator for the African countries. The US government threatens diplomatic pressure remove Dr. Shisana from the negotiations. The EU DGI does not permit Finland and other Nordic EU members to support the resolution. Italy and the US move to defer action on the resolution.

June 30, 1998 - White House announces that four items, for which South Africa had requested preferential tariff treatment under the Generalized System of Preferences (GSP) program will be held in abeyance pending adequate progress on intellectual property rights protection in South Africa. The South African press refers to the withheld GSP tariff reductions as "hostages."

June 1998. According to the US Department of State, US Embassy official travel to Midrand, South Africa to speak at "Pharmecon SA '98" pharmaceutical industry conference about strong US negative views on Article 15(c).

July 1998. French President Chirac raises France's concerns about Article 15(c) in state visit to South Africa. Swiss and German presidents also raised issue privately with Deputy President Mbeki.


August 1998. During U.S.-South Africa Binational Commission meetings in Washington, Vice President Gore made the issue of pharmaceutical intellectual property rights protection a central focus of his discussions with Deputy President Mbeki.

September 1998. Commerce Secretary Daley, in trip to South Africa, made pharmaceutical patent protection a key item in discussions with South African Trade and Industry Minister Alec Erwin.

September 1998. Discussions between Assistant USTR for Services, Investment, and Intellectual Property Joseph Papovich and the Deputy President Mbeki's legal advisor takes place. The South African government asks the US government to intervene with the US pharmaceutical industry to suspend or terminate its pending legal challenge to Article 15(c).

October 1998. The US Embassy dispatches an economic officer to Cape Town to monitor committee and full chamber debates on the South African Medicines Act. He "forcefully advocates" the US position and advised parliamentarians that new law should not include provisions that jeopardize patent rights.

October 12-16, 1998. In Geneva, the World Health Organization hosts a meeting of the "Ad Hoc Working Group" to discuss the WHA's Revised Drug Strategy. 59 countries participate in often bitter discussions. South Africa is the leading country in favor of a strong public health statement, and the US is the leading country representing the industry point of view. The Ad Hoc Working Group approves a resolution that asks countries to "ensure that public health interests are paramount in pharmaceutical and health policies," "to explore and review their options under relevant international agreements, including trade agreements, to safeguard access to essential drugs," and the WHO is asked to become involved in trade disputes involving pharmaceutical health policies. According to Nordic countries, the US seeks to water down the resolution, but after support for the US position collapses among the participants, the U.S. drops opposition and announces it will support the resolution. The US and PhRMA offer nearly the opposite interpretation of events. Public health groups endorse the new resolution.

October 21, 1998. HR 4328 passes, and becomes PL 105-277. This omnibus appropriations law contains a provision inserted by Rep. Rodney Frelinghuysen (R-NJ) that cuts off aid to the government of South Africa, pending a Department of State report outlining its efforts to "negotiate the repeal, suspension, or termination of section 15(c) of South Africa's Medicines and Related Substances Control Amendment Act No. 90 of 1997."

November 1998. A new medicines bill is passed in South Africa with provisions identical to Article 15(c).

November 1998. The U.S. State Department's Economic Minister Counselor in Pretoria meets with South African Department of Foreign Affairs officials to discuss resolution of the pharmaceutical patent controversy.
December 4, 1998. Joe Papovich, the Assistant USTR for Services, Investment, and Intellectual Property, sends a letter to Deputy President Mbeki's legal advisor Mojanku Gambi noting the USG's interest in Health Minister Zuma's discussions with pharmaceutical industry executives.

December 1998 - Secretary Daley meets with Mbeki and Erwin. The Department of State says that pharmaceutical patent protection was the most important topic discussed.

January 26, 1999. The WHA Executive Board meets in Geneva, and approves the Revised Drug Strategy resolution that was proposed by the Ad Hoc Working Group in October, 1998. Dr. Desmond Johns from South Africa presents comments to WHA Executive Board that specifically mention parallel importing and compulsory licensing.

January 1999. The State Department's Economics Minister Counselor in Pretoria raises pharmaceutical patent protection issue with Deputy President Mbeki's economic advisor.

February 5, 1999. The US Department of State sends a report to the US Congress, entitled, "US Government efforts to negotiate the repeal, termination or withdrawal of Article 15(c) of the South African Medicines and Related Substances Act of 1965." According to the report:

All relevant agencies of the U.S. Government - the Department of State together with the Department of Commerce, its U.S. Patent and Trademark Office (USPTO), the Office of the United States Trade Representative (USTR), the National Security Council (NSC) and the Office of the Vice President (OVP) - have been engaged in an assiduous, concerted campaign to persuade the Government of South Africa (SAG) to withdraw or modify the provisions of Article 15(c) that we believe are inconsistent with South Africa's obligations and commitments under the WTO Agreement on Trade Related Aspects of Intellectual Property Rights (TRIPS).

... Since the passage of the offending amendments in December 1997, U.S. Government agencies have been engaged in a full court press with South African officials from the Departments of Trade and Industry, Foreign Affairs, and Health, to convince the South African Government to withdraw or amend the offending provisions of the law, or at the very least, to ensure that the law is implemented in a manner fully consistent with South Africa's TRIPS obligations.

February 16, 1999. PhRMA's 301 submission to US government asks that South Africa be listed as a Priority Foreign Country under Special 301. PhRMA's complaint focuses on parallel imports, compulsory licensing and "data exclusivity" (the Taxol issue). A new element in the 1999 submission is PhRMA's attacks on South African government's public statements at the World Health Assembly, including a bitter attack on the South African governments statements during the negotiations on the Revised Drug Strategy. PhRMA added:

"From the recent remarks and actions, the apparent intent of the Government of South Africa is to not only defend its diminishment of the effectiveness of patent protection in South Africa, but to urge other countries to similarly weaken patent protection for pharmaceutical products. Such a posture is plainly antagonistic to the concept of effective patent protection for pharmaceuticals, and is likely to give rise to a substantial diminishment of the effectiveness in protection not only in South Africa but elsewhere."
February 17, 1999. The US Department of State briefs the pharmaceutical industry on international HIV/AIDS policy, and on international efforts to promote compulsory licensing of HIV/AIDS drugs.

February 17, 1999. Vice President Gore, Secretary of Commerce Bill Daley, Attorney General Janet Reno, Agriculture Secretary Daniel Glickman, Energy Secretary Bill Richardson, surgeon-general David Satcher and 65 senior officials and advisors and 100 or more administrative and security persons begin a meeting of the US/South Africa Binational Commission.

February 18, 1999. The US Department of State briefs non-government public health groups on international HIV/AIDS policy, but refuses to permit discussion of trade disputes involving compulsory licensing, parallel imports or other intellectual property issues. Ralph Nader and James Love write Secretary Madeleine Albright, "strongly objecting" to the decision to forbid discussion on IP issues, and asking for a second NGO briefing focusing on the IP/trade issues.

February 23, 1999. Representative Jess Jackson, Jr. introduces HR 772, the HOPE for Africa bill, which includes Section 601, which would cut off funding to any department or agency that sought "through negotiation or otherwise, the revocation or revisions of any sub-Saharan African intellectual property or competition law or policy that is designed to promote access to pharmaceuticals or other medical technologies," as long as the laws comply with TRIPS.

February 1999. USTR officials and Mbeki's advisors meet.

February 1999. Vice President Gore meets with Mbeki, and again raises US concerns regarding South Africa Medicines Act. Leon Fuerth, the Vice President's National Security Advisor is among those attending the meeting. The Vice President's staff later gives different versions of the discussions. Following the Vice President's talks with Mbeki, the US PTO speaks out against the use of compulsory licensing in a meeting in Geneva, South Africa is placed on the USTR watch list for intellectual property violations, scheduled for an out-of-cycle review focusing on the Medicines Act, and criticized by the US government for its intention to use compulsory licensing and parallel imports, for speaking out at the World Health Assembly and for approval of generic versions of Taxol, an unpatented drug that was invented by the US government.

March 25-27, 1999. CPT, MSF and HAI sponsor meetings in Geneva on compulsory licensing of essential medical technologies. Lois Boland, representing the US Patent and Trademark Office (US PTO), acknowledges that the USG position on compulsory licensing is not reflected in the TRIPS.

The fact that [the USG] view is not reflected in the TRIPs agreement, in the multilateral context, is fully acknowledged. In our bilateral discussions, we continue to regard the TRIPs agreement as an agreement that establishes minimum standards for protection and, in certain situations, we may, and often do, ask for commitments that go beyond those found in the TRIPs agreement.

The South African government attends the meetings, but in deference to pressures from the US, does not participate on panel discussions.

April 8, 1999. Ralph Nader and James Love write Vice President Gore asking for a reversal of US policy on South African Medicines Act and parallel import and compulsory licensing.

April 11, 1999. Lisa Richwine from Rueters writes the first major U.S. wire story about the South Africa/Thailand trade dispute over access to HIV/AIDS drugs.


April 28, 1999. Merrill Goozner writes a page one story in the Chicago Tribune, "Third World Battles for AIDS Drugs." This is the first major US newspaper story on this issue. The President reads the story on Air Force One.
April 30, 1999. USTR announces that South Africa is placed on the "watch list" in its Special 301 Review, and schedules an "out-of-cycle" review for South Africa to conclude in September 1999. According to USTR, South Africa's "barriers to trade" are parallel imports, compulsory licensing, registration of generic forms of Taxol, and speaking out at the World Health Assembly. "During the past year, South African representatives have led a faction of nations in the World Health Organization (WHO) in calling for a reduction in the level of protection provided for pharmaceuticals in TRIPS."

May 12, 1999. CPT and Act Up meet with the Department of Health and Human Services (DHHS) to discuss trade disputes involving intellectual property rights and health care, to ask DHHS to moderate US trade policies in order to improve access to drugs. DHHS is also asked to give the World Health Organization and foreign governments to right to use US government use rights in patents obtained with federally funding.


June 7, 1999. The International Issues subcommittee of the Presidential Advisory Council on HIV/AIDS (PACHA) holds a public debate on compulsory licensing and parallel imports. The Clinton/Gore Administration declines a request to explain US policy. CPT asks that PACHA recommend that the US end trade pressures on compulsory licensing and parallel imports, and that the US government enter into an agreement with the WHO giving the WHO the right to use federal "public use" rights for pharmaceutical patents based upon government funded research.

June 16, 1999. HIV/AIDS activists begin campaign to disrupt Vice President Gore's campaign to draw attention to US trade sanctions against South Africa and Thailand.

June 22, 1999. CPT, Public Citizen and HIV/AIDS activists meet with Sandra Thurman, Director of White House Office of National AIDS Policy, Thomas Rosshurt, Vice President Gore's foreign policy spokesman and others to discuss compulsory licensing and parallel imports.

June 24, 1999. The US Supreme Court rules that State governments cannot be sued for patent infringement. (Florida Prepaid Postsecondary Education Expense Board V. College Savings Bank et al.)


June 25, 1999. Vice President Gore writes James Clyburn of the Congressional Black Caucus, saying "I want you to know from the start that I support South Africa's efforts to enhance health care for its people including efforts to engage in compulsory licensing and parallel importing of pharmaceuticals -- so long as they are done in a way consistent with international agreements."

June 26, 1999. CPT writes James Clyburn asking the Black Caucus to seek clarification from the Vice President on his interpretation of international law concerning parallel imports and compulsory licensing.

July 2, 1999. The House of Representatives, by a vote of 117 to 307, reject the "sandors amendment" to the Department of State appropriation bill. The Sanders amendment was fashioned after section 601 of the Hope for Africa bill making it illegal for the Department of State to lobby Asian or African countries against access to essential medicines, if the country was TRIPS compliant. Seven members of the Black Caucus and 110 democrats vote against the amendment.


July 28, 1999. South Africa Trade and Industry Minister Alec Erwin and US Trade Representative Charlene Barshefsky have 3 1/2 hour video conference negotiation over South Africa Medicines Act, steel dumping dispute and discuss US concerns over South Africa procurement practices. The South African press reports a deal is at hand on the Medicines Act dispute.

August 4, 1999. Representative Jackson, et all introduce HR 2700, the "Highly Essential Life saving Pharmaceuticals for Africa Act" or the "HELP for Africa Act".
Tomorrow, (May 12, 2000) at 10:00 AM, the USTR will hold public hearings for the GSP 1999 Annual Review. GSP stands for Generalized System of Preferences. At 10:15 AM the Government of the Dominican Republic will make its case. At 10:45 AM, PhRMA will testify; they want the Dominican Republic's GSP benefits revoked because its draft patent legislation is allegedly "TRIPS-inconsistent."

Jamie and I will attend as observers. I encourage anyone who can to attend.

Thiru

Here is an explanation of GSP from the US Treasury Department website [http://www.customs.ustreas.gov/travel/gsp.htm](http://www.customs.ustreas.gov/travel/gsp.htm).

**What is GSP?**
GSP (Generalized System of Preferences) is a system used by many developed countries to help developing nations improve their financial or economic condition through exports. In effect, it provides for the duty-free importation of a wide range of products that would otherwise be subject to customs duty if imported from non-GSP-status countries.

**When did GSP go into effect for the United States?**
GSP went into effect on January 1, 1976. The program has expired on several occasions since that time, most recently on July 31, 1996. On August 10, 1996, President Clinton signed legislation renewing the GSP program retroactively from August 1, 1995 and extending it through May 31, 1997.

**What products are eligible?**
Approximately 4,284 items have been designed as eligible for duty-free treatment from beneficiary developing countries (BDCs). The eligible articles are identified in the Harmonized Tariff Schedule of the United States Annotated and the designated countries are also listed therein. For the traveler's convenience, an advisory list of the most popular tourist items that in general have been accorded GSP status, is listed below.

**What items are not eligible for duty-free treatment?**
Under the Trade Act, many items, such as most foot-wear, most textile articles (including clothing and carpets), watches, some electronic products, and certain glass and steel products are specifically excluded from GSP benefits.
Nature articles:

Gore's humanitarianism loses out to strong-arm tactics, Nature 1999;400(1).

Now that the giant drug manufacturers are stamping their feet over proposed compulsory licensing as a means of easing South Africa's AIDS crisis, Al Gore's "values of conscience" appear to have withered away.

Aspiring Democratic presidential candidate Al Gore, who as Vice-President Gore has commonly embraced AIDS-related causes, has been forced to defend himself recently against charges that, on one particularly desperate AIDS issue, he is a cold-hearted lackey of the pharmaceutical industry (see Nature 399, 717; 1999).

In South Africa, where antenatal clinic surveys conducted this spring showed 22 per cent of sexually active adults to be infected with HIV, AIDS is expected to slash life expectancy to below 40 years by 2010. The drug cocktails that have curtailed sickness and death in the developed world are unaffordable by all but the most privileged South Africans.

Confronting this, the government passed a law in 1997 under which the health minister may authorize local manufacturers to circumvent patents and make far cheaper versions of these drugs, paying only fixed royalties to the rights-holder -- so-called compulsory licensing. The law also allows South Africa to import the drugs from countries where drug manufacturers make them available more cheaply.

The international pharmaceutical industry has cried foul, and sued in South Africa, delaying implementation of the law. Meanwhile, Gore and the US Trade Representative have mounted what the US government itself has described as an "assiduous, concerted campaign" to convince South African officials to rewrite or overturn the law.

To be fair, the aggressive language used to depict the US effort was cooked up by the State Department last year only under pressure from congressional Republicans. Led by Rodney Frelinghuysen, a congressman from New Jersey, the home of many giant drug-manufacturers, they had written a foreign-aid bill to withhold aid to South Africa until the Clinton administration convinced them that it was acting on behalf of the drug industry.

Nevertheless, whatever its motivation, the facts of Gore's recent record remain. Using his role as co-chair, with South African President Thabo Mbeki, of the US-South Africa Binational Commission, the vice-president has repeatedly sought to force a sovereign nation confronting a disastrous epidemic to forswear one of the few means of getting medicine to its desperate people. Coming from a presidential candidate who has been preaching about the importance of "values of conscience" to US political life, this sticks in the gullet.

There are those, including some in the pharmaceutical industry, who argue that South Africa's health infrastructure is insufficiently prepared for these sophisticated drugs. Utilitarian critics also say that the country's finite resources should be used for prevention, not for treating those unfortunate enough to be infected already. Both arguments miss the point. It should not be a case of "either/or", but "both/and". And, indeed, South Africa's move to access state-of-the-art medicines is part of an effort to address the epidemic on all these levels.

There is one final point. Gore and the industry complain that the South African law is in blatant violation of the World Trade Organization (WTO) intellectual-property agreement known as "TRIPS". The agreement allows for compulsory licensing in cases of "national emergency or ... extreme urgency". But there is enough fine print in the agreement, and enough ambiguity in South African law as it is written, to allow honest disagreement on whether South Africa may be in breach of TRIPS.

Here is where the hypocrisy comes in. Instead of using the WTO's well-defined dispute-settlement mechanisms (as it has done recently in disputes with Europe over, for instance, bananas), the United States, led by Gore, has found it convenient to use back-room tactics to try to strong-arm South Africa into changing its ways. This leaves one suspecting that the vice-president's critics are right when they claim that he has been more than a little influenced by the pharmaceutical kings.


Gore under fire in controversy over South Africa AIDS drug law, Nature, 1999;399:717-718

[WASHINGTON] US Vice-President Al Gore's campaign for the presidency has become caught up in an escalating controversy over his opposition to a South African law aimed at providing low-cost AIDS drugs.

Gore, who officially launched his campaign last week, has actively opposed South Africa's Medicines and Related Substances Control Amendment Act. This seeks to bypass existing patents to allow the manufacture or import of expensive AIDS drugs at significantly lower costs than those currently charged by the pharmaceutical industry.

The law was approved by the country's parliament in 1997. But it has not been implemented because 41 pharmaceutical companies, led by the Pharmaceutical Manufacturers' Association of South Africa (PMASA), have challenged it in the High Court in Pretoria.

The law would allow compulsory licensing and parallel importation of medicines by South Africa. This means either that manufacturers inside the country could bypass patents and make the drugs more cheaply, paying only royalties to the patent holder; or that South Africa could import the drugs from third countries in which they are already less expensive.
The AIDS epidemic has exploded in South Africa, where recent surveys in pregnancy clinics indicate that 22 per cent of sexually active adults are infected (the figure was 14 per cent in 1997). But the latest AIDS therapy costs US$800 a month in South Africa, where the average annual income is $2,600.

"We have a Third World country that has this horrifying pandemic, and we can't afford the drugs," says Robert Shell, a demographer at Rhodes University in Grahamstown, South Africa, who tracks the epidemic. "It is a question of life and death."

But the South African law has riled the US government and the pharmaceutical industry. They claim that it is striking at the heart of the patent protection necessary for drug development. Led by Gore and the US trade representative, the US has pressed South African officials to rescind or rewrite the law.

A spokesman for Gore says he and Thabo Mbeki, the South African president, "are committed to working together to chart a course that will meet the medical needs of those infected with HIV or AIDS, without cutting off the commercial incentives that fuel medical research".

Gore and Mbeki co-chair the US-South Africa Binational Commission, an economic diplomacy group. The spokesman adds that Gore "has a very strong record of efforts to fight AIDS in South Africa and his stands have been consistent with that".

But the perception that Gore is leading an effort to deny cheap drugs to a country in a desperate plight is making its mark in the United States. International health and AIDS activists dogged Gore on the campaign trail last week, chanting "Gore's greed kills".

"History will judge people harshly as to how they acted in this crisis. And it's going to be a harsh judgement on Gore," says James Love, director of the Consumer Project on Technology, an advocacy organization affiliated to Ralph Nader.

Love and Nader wrote to Gore in April accusing him of using "an astonishing array of bullying tactics" to stop South Africa expanding access to AIDS drugs.

Even members of the Presidential Advisory Council on HIV/AIDS are challenging Gore. "He is wrong," said council member Debbie Runions, a former Gore campaign volunteer, speculating whether "he's in the pockets of the pharmaceutical companies".

Critics allege that the vice-president, who has typically embraced liberal causes such as the fight against AIDS, is being swayed by ties to the drug industry. For instance, a key lobbyist for the Pharmaceutical Research and Manufacturers of America (Pharma), Tony Podesta, is the brother of the president's chief of staff, John Podesta, and is also a Gore adviser and friend.

According to the Center for Responsive Politics, a Washington-based public-interest group, Gore's political action committee received $56,000 from individuals connected to pharmaceutical companies in 1998.

The vice-president's office denies that he has been influenced by drug makers. Officials point out that when Pharma asked the government last year to threaten South Africa with trade sanctions, it was rebuffed.

The country was merely placed on a 'watch list' of countries suspected of violating US intellectual property rights - a category that does not trigger sanctions. But two months later the White House announced that it was denying preferential tariff treatment for four South African imports.

South Africa's new health minister, Manto Tshabalala-Msimang, told Nature that the law is meant to address the "legacy of apartheid". "We don't want to interfere with the patent rights, but we want to get drugs of quality at a price we can afford," she says.

"Why would you want to buy the drug at SAR80 (US$13) when if you import it you would get it at SAR30?" she asks. "In situations of emergency, what do you do? This is the question I would pose to PMASA."

Nonetheless, she says, she is making it "very high on my priority list" to meet the drug makers. She says the government is willing to negotiate the implementation of the law "in such a way that it meets the needs of the pharmaceutical industry".

That will take some doing, according to the drug companies. "This is a major issue," says Jeff Trewhitta, spokesman for Pharma. "The cost of research is very high. Patent protection is the lifeblood of the industry."

Miryena Deeb, chief executive officer of PMASA, says the law is so broad that it "undermines the patent law system" and allows the health minister to "just take away the patent right".

An official at the office of the US Trade Representative (USTR), which has aggressively lobbied South Africa to reverse the law, calls it "offensive". "They've decided that the way to solve the [AIDS] problem is to deny intellectual property rights."

The USTR, Gore and the drug groups argue that the law breaches an important World Trade Organization (WTO) agreement on trade-related aspects of intellectual property protection, the 'TRIPS' agreement.

But Gore's critics read the agreement as allowing precisely the kind of action South Africa has taken. The agreement says compulsory licensing is permitted in cases of "national emergency or extreme urgency". 
Some observers say that the TRIPS language is sufficiently ambiguous for there to be honest disagreement on whether South Africa is in breach of it. What angers some, says one international health official, is that "commercial interests are leading [the US government to use] pressure tactics", rather than using WTO dispute mechanisms.

According to a State Department report presented to Congress in February, Gore, the USTR, the Department of Commerce and the State Department have mounted an "assiduous, concerted campaign" to overturn the South African law.

Some argue that the issue goes beyond patent rights. Tom Coates, director of the AIDS Research Institute at the University of California, San Francisco, warns of the danger of drug resistant viral strains developing if the drugs are not imported in the right combinations and quantities, and administered with proper oversight.

MEREDITH WADMAN
At summit, Castro suggests trying capitalist states for causing world suffering

By JOHN RICE, Associated Press

HAVANA (April 13, 2000 10:46 a.m. EDT http://www.nandotimes.com) - Leading a procession of poor nations in criticism of wealthier states, Cuban President Fidel Castro suggested a war crimes-type tribunal to judge capitalist states for the hunger and disease of the developing world.

"The images we see of mothers and children in whole regions of Africa under the lash of drought and other catastrophes remind us of the concentration camps of Nazi Germany," he said Wednesday.

Referring to war crimes trials after World War II, the Cuban leader said: "We lack a Nuremberg to judge the economic order imposed upon us, where every three years more men, women and children die of hunger and preventable diseases than died in the Second World War."

He called for abolishing the International Monetary Fund, which he said served the interests of the United States and other rich nations rather than those of poor nations forced to implement its free-market austerity policies in exchange for aid.

Castro's speech was the fiercest in a series of attacks made Wednesday at the opening of a three-day summit of developing countries. Leaders from some of the nations involved in the summit accused rich countries of imposing heartless or misguided policies that have kept developing countries impoverished and technologically backward. Malaysian Prime Minister Mahathir Mohammad defended some free trade, but denounced efforts to force it wholesale upon developing countries. He said "rogue currency traders" plunged his country and East Asia into financial crisis by undermining their currencies. Millions were thrown out of work and made destitute," he added. "The international economic institutions moved in ostensibly to help with loans but in reality to facilitate the takeover of the country's economy and even politics."

He suggested that rich countries should permit free flows of labor as well as capital.

"If money is capital for the rich, labor is the capital of the poor countries," he said. "They should be allowed to migrate to the rich countries to compete for the jobs there just as the powerful corporations of the rich must be allowed to compete with their tiny counterparts in the poor countries."

Other speakers were more conciliatory in tone as they called for debt relief, increased aid and sharing of the technology that has helped knit the world more closely together.

"Never has the world witnessed such massive disparities in international social and economic activities," said Nigerian President Olusegun Obasanjo, whose country chairs the summit. He warned that failure to reform international aid policies that have maintained the wealth gap "constitute a major threat to international peace and security."

The summit was a meeting of the so-called Group of 77. Since its 1964 founding, the group has grown from 77 to 133 developing nations, representing around 80 percent of the world's population. U.N. Secretary-General Kofi Annan urged the poor countries to coordinate for an upcoming U.N. Millennium Summit in September, but urged cooperation with developed states and others. "I believe governments need to work together to make change possible but governments alone will not make change happen. We have to engage the power of private investment," he said.

In New York City, Abraham Foxman, national director of the Anti-Defamation League, said Castro "lives in his own time warp, and so while I'm disappointed, I'm not surprised" at the Holocaust comparisons. "But I am surprised by the other world leaders that were there. I would have hoped that they would have found an opportunity to distance themselves from those types of remarks," he said. "Poverty is serious, it's painful and maybe deadly, but it's not the Holocaust and it's not concentration camps."
Global Justice is Not a "Nebulous Thing"
by Leon Galindo 1:38am Tue Apr 18 '00, Washington, D.C.

On Saturday, April 15 I was illegally arrested and imprisoned for 23 hours, together with hundreds of peaceful protesters and at least a dozen innocent bystanders of which I was one.

As a consultant to the World Bank, a citizen of a developing country, and a person who has committed his life to the work of development I was appalled by the conduct of the police and by the way the "system" works. As a consequence, I am now far more sympathetic with the demands of the protesters and just a tad more cynical about the "establishment."

I was arrested with no explanation, no prior warning, and for no legitimate reason. I was standing close to the protesters because I disagreed with much of what I had heard them say in the media prior to coming to Washington D.C.. I wanted to hear in person what they had to say in order to decide for myself whether their arguments were reasonable or not and to summarize conclusions in a note for the World Bank's daily internal newsletter. I was not the only one, Magali Laguerre, a Haitian colleague at the World Bank, had the same purposes and was also arrested. So were several tourists and local residents who were literally just passing by.

I had been there for less than five minutes when the police closed both sides of the street and did not allow anyone to pass even though nothing except a peaceful march was taking place. No warning was given. No explanation was made. When I asked to pass or for an explanation on what was happening, no response was given. After an hour in which dozens of additional police arrived, police started handcuffing people one by one and marching them onto school buses. Not one protester was violent or in any way unreasonable.

My experience was similar to that of hundreds of others, including women and many teenagers. I was roughly handcuffed for over 17 hours (my arms and shoulders are still sore), repeatedly lied to, and denied an explanation of any kind or access to a telephone or to any means of informing my wife what was happening until 5:00 am the next day, 12 hours later. A demonstrator who had come from Texas with his son was not able to receive any information from the police on the status of his teen age son who had no money, no contacts in Washington D.C., and who had done nothing except protest peacefully. Several were looking for their girlfriends and also were not given any information, and Jim, a biologist with a health problem, was repeatedly told by police that they could do nothing to help him retrieve his medication. I could not help but think that it was through illegitimate and unjust arrests such as this one that the terrible nightmares of political prisoners from around the world had begun. I could not believe that this was happening in the United States of America. Contrary to declarations in the press today by Chief Ramsey, I did not see much professionalism among the police on the inside, where there was no media to ensure accountability. Instead, I witnessed harsh threats, incompetence, and injustice, very worrying to see in the police force of a democratic and powerful nation.

Unfortunately, we were in the United States, and it only took 19 hours before a lawyer appeared, and 5 more before a mock trial took place, and so we did not "disappear" as common people, similar to us, may have had this occurred in a different country. The way they handled us, it certainly felt like they could do so if they chose to. I was released after 23 hours on Sunday at 4:00 p.m. with no charges, because it was neither in the interest of the court nor in mine to keep the record. For me, this open letter is the record.

The group I was with was transported to three different facilities, all heavily guarded. The first was a detention center for mentally ill patients. We spent three hours in an overcrowded room in which it was so hot that it became difficult to breathe and all were sweating. Only when the more than 50 people in the room started to really get angry did they allow us to use the bathroom or have a drink of water, some five to six hours after being detained. In almost 24 hours the only food provided was one sandwich with baloney that was almost green.

For all practical purposes, the police proved to be the greatest allies of the protesters in this demonstration because they perfectly proved the point the protesters were trying to make in this march: poverty and suppression of liberty go hand in hand and lead to further social injustice. In my own case, this first-hand experience of American police and prisons was an enlightening, life-changing event that helped me to fully understand the sometimes incoherently expressed, but otherwise perfectly legitimate and profound arguments that I now firmly believe the majority of the protesters were out to make.

In this particular demonstration, protesters had centered their diverse arguments on the relationship between the "Prison-Industrial Complex" and the Structural Adjustment Programs enforced by the International Monetary Fund and World Bank in developing countries. As a passerby earlier in the day I had scoffed-I know the World Bank, respect its work enormously, and agree with someone who said that blaming the World Bank for causing world poverty is like blaming the Red Cross for beginning World Wars I and II. I did and still do believe that many of the protesters have not bothered to educate themselves on what these institutions do. If they had they would have greater respect for these institutions and would perhaps even seek ways to coordinate efforts with the World Bank to achieve their goals, as many other non-profit and other organizations already do.

On the other hand, after a day in prison listening to, and speaking with a number of the protesters, many of them highly educated and decent people with coherent arguments, I understood their point and it is a simple and valid one. In essence, they argue that too many powerful institutions and individuals, both in the United States and in developing
countries, are ignoring the fundamental principles and liberties that are the sine qua non foundations for a free society and an open economy. I agree, especially after having been imprisoned and being subject to the ruthlessness with which people with power can treat those who have no power.

As Noble Laureate Amartya Sen recently argued in Development as Freedom, political freedom and economic development must go hand in hand. As Joseph Stiglitz and others have repeatedly pointed out, the World Bank and particularly the IMF and especially governments of their client countries still have much to do be more accountable to the common citizen. As the protesters in this march against the "Prison-Industrial Complex" argue, and direct experience this weekend confirmed, there are institutions in the United States that would like to believe they are beyond accountability, beginning with the police force which is supposed to uphold and not repress freedom of expression. It is an unfortunate day when the image of great institutions is tarnished, especially when their mission is precisely to serve the public, reduce poverty, and build free and fair societies. And yet the World Bank, the IMF and the governments of both developed and developing nations are not helping their own cause or serving their citizens when illegal arrests take place, especially when it results from dissent of opinion.

I refer not only to the arrests that took place this weekend but to others that take place around the world all the time. I have witnessed demonstrations since I was a child in my own nation, Bolivia (where six people were killed last week in demonstrations). The IMF and World Bank are identified, rightly or wrongly, as symbols of global capitalism. As a consultant to the World Bank and someone who firmly believes in its mission and integrity, I believe it is a big mistake to further substantiate the claims of radicals who throw the World Bank and IMF in the same bag as the "Prison-Industrial Complex" and "greedy corporations." And yet that is exactly what happened this weekend. By ignoring the demonstrators, freezing communication, and delegating intermediation to the police the World Bank and the IMF did not deal with difference of opinion, and this is precisely, in my view, the severest critique made by demonstrators. If this is how they dealt with dissent in Washington D.C., who is to argue that it is not possible at least indirectly, that the Bank and the IMF would turn a blind eye to similar tactics used by governments and their police forces in developing nations.

As a result, there are now more people who are convinced that the World Bank and IMF might in some way be linked to injustice in developing nations. Constructive alternatives, such as an open forum in which representatives of these groups could express their concerns and in turn learn more about the work of the IMF and the World Bank, would have had had the opposite effect, nurturing allies for the war on poverty instead of misinformed and disgruntled opponents.

The significance of this weekend's events lie not so much in whether one side or the other is ultimately right in its arguments. Rather, it is that there are people who have legitimate concerns to share publicly, that these people have to take to the streets in order to be heard, and that for better or worse the image and legitimacy of good institutions were damaged.

If the World Bank, the IMF, and governments refuse to listen to well-educated and caring people who come all the way to their doorsteps, and if street protests, prisons, and the use of police force are the preferred tools to avoid engaging in dialogue, we are all headed down a dangerous path. The protesters of course are not all innocent or correct-among them there are clearly ignorant, misinformed, and downright dangerous types who do believe in violence and do not respect or even care about the rights that many of their fellow protesters do believe in.

Nonetheless, as poorly expressed and incoherent as the arguments of the protesters may seem their fundamental cause is correct and noble. And, it is completely in tune with what thousands of people at the World Bank and IMF work hard for every day: ensuring that human beings everywhere have the chance to live a decent life.

To allow the police of any nation to intimidate and suppress voices through illegal and totally stupid procedures as those used in Washington D.C. this weekend-methods that sometimes have far worse consequences in developing countries-is for these institutions, the United States Police, the World Bank, and the IMF, to agree or at least condone what a U.S. Marshall screamed in my ear as he violently slammed me into a wall when reminded that he was violating my fundamental rights: "Down here there is no democracy. This place is a dictatorship and I am God. If you open your mouth again I will kick your ass till you are sorry."

To cite the front page of this week's, The Economist, this is a "testing time for the world economy," and unless the IMF, the World Bank, and governments around the world fully embrace the classical principles upon which free societies are built and which Amartya Sen reminds us of-political freedom and economic development must go hand in hand--old and "forgotten dangers" will come back to haunt us. After being illegally arrested for 23 hours, handcuffed for 17 of those hours, and seriously threatened and intimidated for a crime I had not committed, I clearly understood what the protesters are after. "Global justice" is not a "nebulous thing", as The Economists' April 15th article on the protesters puts it. Very simply stated, global justice is the call for institutions and individuals worldwide to respect and seriously uphold the basic principles upon which free, civilized, humane, and prosperous societies are built.

Leon Galindo
Press releases below: joint PR of HAI/MSF/ACT UP & excerpts of ACT UP pr

ACT UP

HEALTH ACTION INTERNATIONAL (HAI)
MEDECINS SANS FRONTIERES (MSF)

PRESS RELEASE

Public health advocates call for transparency on global medicine pricing information

Geneva 17th May 2000. On the day that the 53rd World Health Assembly (WHA) discusses HIV/AIDS; confronting the epidemic (resolution EB105.R17), public health advocates call for the WHA to provide global pricing information on quality medicines available to treat people living with HIV/AIDS and other opportunistic infections. Member states should also be advised on the management, legal and regulatory issues that must be addressed to ensure access to these medicines.

Information on quality generic and patented drug prices enables countries to rationalise their purchasing policy. Developing countries could use this tool to maintain control over their public health policies.

It is clear around the world that where generic competition exists, prices of medicines are considerably lower. However, there continue to be regulatory and legal barriers to purchasing and importing medicines. These need to be resolved.

"This is the World Health Assembly not the world intellectual property assembly," said Ellen ët Hoen, MSF health policy advisor. "The WHO and countries are here to ensure that the public health of populations takes priority over private profit. Member states need information and choice to ensure the best healthcare for their people." she added.

The pricing data would empower developing countries to purchase greater quantities of affordable life-saving medicines to ensure that treatment options are not restricted to limited conditional price reductions which are dependent on corporate generosity.

Last week's statement of intent between UNAIDS and several multi-national pharmaceutical companies camouflages the real issue that long term sustainable solutions are needed on an international level. This agreement does not encourage transfer of technology, nor does it stimulate countries' rights to produce or import inexpensive quality drugs, an important part of the long-term solution to improving access to medicines.

Affected countries in Africa were not included in the preparation discussions of the price reduction and public/private partnership. Affected countries around the world must be included in the process to find long term sustainable solutions.

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PRESS RELEASE FOR IMMEDIATE RELEASE

ACT UP

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U.S. UP TO OLD TRICKS OF BULLYING DEVELOPING COUNTRIES FROM TAKING STEPS IN PROVIDING ACCESS TO AIDS MEDICINES IN FACE OF EPIDEMIC
Public health advocates call for transparency on global medicine pricing information
(Geneva) 17th May 2000. At the 53rd World Health Assembly in Geneva, The U.S. delegation, led by Dr. Tom Novotny, is up to all its old tricks--mobilizing opposition in the face of even the slightest positive movement by member states of the World Health Organization to treat people living with HIV/AIDS and other opportunistic infections.

Brazil and other delegations have put forth several important amendments to the WHO HIV/AIDS resolution. Brazil’s amendment would be a first step towards giving poor countries tools in order to gain access to affordable AIDS medication: it charges the World Health Organization with constructing a database of drug prices, so countries could easily determine the most accessible version of a medicine.

[snip]

Last week an Executive Order was issued by President Clinton easing U.S. pressure campaigns against African nations using WTO-legal means to provide generic versions of life saving patented medications. "At the WHA, bullying tactics of the U.S. delegates are morally reprehensible and hypocritical in light of the Clinton administration grandstanding about access to treatment," said Abdul Akim of Act Up Philadelphia, "and contradict the spirit of the Executive Order."

The U.S. delegation is in opposition to this amendment. Led by Dr. Tom Novotny, they are acting against countries having access to pricing information.

"The U.S. government is again acting as pharmaceutical industry's puppet. The industry is afraid once data is widely accessible that illustrates the dramatic differences in prices in nations that have strong generic production, their murderous fiction regarding the necessity of high prices will go up in smoke," said Asia Russell of ACT UP/Philadelphia.

"There is a lot of pressure on the countries hand selected by the U.S. delegation to capitulate to U.S. opposition. This process is completely non-transparent, and completely preferential," said Paul Davis of ACT UP/Philadelphia.

Many countries have expressed strong support for this amendment, because they know a pricing database would enable purchase of greater quantities of affordable life-saving medicines to ensure that treatment options are not restricted to limited conditional price reductions which are dependent on corporate generosity.

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Source: San Francisco Chronicle (Editorial, Saturday, May 13, 2000)

HIV Drugs: Price reduction or public relation ploy?
Reducing the Costs Of the War Against AIDS

AT FIRST glance, the announcement this week in Geneva that five pharmaceutical companies had agreed to reduce the typically exorbitant prices they charge for drugs used to combat AIDS in Africa and other developing regions is cause for celebration.

But a closer look at the agreement suggests that it is premature to break open the champagne. The accord provides simply a framework for how the drug companies might proceed, and leaves a host of questions still unanswered.

First, it is far from clear just what has been agreed to.

A UNAIDS press release described what occured in Geneva as simply the beginning of "a new dialogue" and that companies have agreed to offer "to improve significantly access to and availability of a range of medicines."

The drug companies themselves -- Bristol- Meycr Squibb, Merck, Glaxo Wellcome, Hoffmann-La Roche and Boehringer Ingelheim -- issued a flurry of press releases, but provided few details of how much they will charge for the drugs. Only
Glaxo Wellcome said it might sell Combivir, a combination of AZT and 3TC, for $2, instead of the average price of $16 it has been charging worldwide.

Reports from the Geneva meetings indicate that the companies are willing in principle to discount the drugs by 80 percent or more off the U.S. price. But some question whether even that reduction will be big enough. Peter Lurie, deputy director of Public Citizen's Health Research Group, questioned why the discount wasn't on the lower rates levied in Europe. "It is a mouse-step forward," he said.

It is also far from clear whether the move by the drug companies reflects a genuine desire to make their drugs available to the largest number of people, or a rearguard effort to protect their virtual worldwide monopoly on the manufacture and distribution of the drug.

It may have just been a coincidence that the Geneva announcement came just two days after President Clinton issued an executive order which represented a frontal challenge on a company's patent rights over anti-AIDS drugs in poor countries.

The pharmaceutical companies may now feel they have grounds to argue that if they offer the drugs at lower prices there would be no reason for any country to force them to grant foreign licenses to companies that can produce the drugs more cheaply, as allowed under the executive order. That would leave developing countries with less flexibility in securing drugs at the best possible prices than they currently have.

Finally, even those who negotiated the agreement recognize that lower drug prices constitute only one piece of the larger challenge. Most developing countries don't have the public health infrastructure to distribute the drugs, and then monitor the progress of those who take them.

But the fact that the companies were willing to discuss cutting prices is an important step forward, and a necessary one. Now much depends on whether the companies will do what they and the other participants in the Geneva meetings claim they have agreed to. Otherwise, the accords will remain but a public relations ploy, while AIDS continues to take its terrible toll on the plains of Africa.

San Francisco Chronicle
OMUGO, Uganda -- Jabbing, apologizing and then jabbing again, it takes Harriet Ayikoru nearly 20 minutes to find a usable vein beneath the sleeves of the sad old Tweety Bird T-shirt that Sentina Drajiru wears, and when the melarsoprol goes in, Ms. Drajiru winces.

Again and again she lightly touches her arm to show exactly where she feels the sharp tip of the pain as the medicine simmers up it.

It is like eating chili peppers, she says, only it is inside her.

"Once you use this drug, the vein is spoiled," says Miss Ayikoru, a nurse in the thatched clinic here. "As it is corrosive, it erodes the inside layer. So the relapses like her are the hardest cases -- the scar tissue is there even six months later."

Melarsoprol, invented almost 70 years ago, is melarsen oxide dissolved in propylene glycol -- literally, arsenic in antifreeze. It kills 5 percent of those treated with it. But it is the only medicine available to treat advanced sleeping sickness, one of the historic scourges of Africa, which was nearly wiped out 50 years ago, but has made a comeback.

The only alternative ran out in July. The manufacturer, which abandoned it as unprofitable when it turned out to be useless against its intended target, cancer, has made one last batch, enough for 1,000 patients. But 300,000 people are infected each year.

Sleeping sickness is perhaps the most vivid example of the disconnection between the world's pharmaceutical giants and the fatal or debilitating diseases of the third world's poor.

These ailments go untreated or badly treated not just because the poor cannot afford the drugs they need, though that is a serious problem, but because the drugs themselves do not exist. The pharmaceutical industry has little incentive to invent them. Companies decline to invest the huge sums needed to chase a cure they know their potential customers cannot afford.

According to IMS Health of Westport, Conn., a marketing research firm that studies the industry, Africa accounts for 1 percent of world drug sales, while North America, Japan and Western Europe account for 80 percent. It is for them the companies invent a stream of high priced, highly profitable drugs.

"The poor have no consumer power, so the market has failed them," said Dr. James Orbinski, international president of Doctors Without Borders/Médecins Sans Frontières, the medical agency whose work in war zones and in the third world won it the Nobel Peace Prize last year. "I'm tired of the logic that says, 'He who can't pay, dies.'"

Pharmaceutical executives reluctantly concur with his assessment. Told that the industry's critics say it would rather find a cure for a bald American than a dying African, François Gros, a spokesman for Aventis, the French-German pharmaceutical company that makes three of the four sleeping sickness drugs, ruefully acknowledged: "That's not completely wrong. We know what's happening in the third world, but we don't act."

He went on to explain: "We can't deny that we try to focus on top markets -- cardiovascular, metabolism, anti-infection, etc. But we're an industry in a competitive environment -- we have a commitment to deliver performance for shareholders."

"Predictable Behavior"

Health experts also recognize this reality. "A blockbuster drug makes them $1 billion to $1.5 billion a year," said a senior World Health Organization official. "If you're running the R & D department of one of these companies, you're under a lot of pressure, and they're going to invest in things they see a market for. Their behavior is perfectly predictable."

As a result, many health policy makers now argue that the world's governments must somehow force the world's pharmaceutical manufacturers to turn their attention to diseases like sleeping sickness, malaria, tuberculosis, leishmaniasis..."
and the various burrowing worms that kill or cripple millions each year in Africa, Asia and South America. The last truly new drug for tuberculosis, for example, which kills two million people a year, was invented over 30 years ago.

To do so, they say, rich nations must either pay the manufacturers directly, offer them tax breaks, dangle before them the carrot of longer patents on their most lucrative drugs, or, in acute crises, simply allow poor countries to declare health emergencies and seize the patents to make their own generic versions or buy them from India, Brazil or other countries that ignore Western patent law.

[Earlier this month, five major pharmaceutical companies announced that they were entering negotiations with the W.H.O. to voluntarily lower their prices on their AIDS drugs to Africa by as much as 80 percent. But last week, at a global convention of health ministers at the W.H.O.'s headquarters in Geneva, the ministers of many poor nations said that was not enough. They asked the W.H.O. to create a database of all prices for AIDS drugs, including the cheapest generics from countries that do not honor American or European patents, and to help them change their patent laws so they could buy them.]

The pharmaceutical industry invests $27 billion a year in research, but most of that is a hunt for drugs to lengthen or brighten the lives of consumers who are already relatively healthy. Among the biggest sellers are drugs to grow hair, relieve impotence or fight cholesterol, ulcers, depressions, anxiety, allergies, arthritis and high blood pressure.

"Pharmaceutical companies will always aim for maximum profits by marketing a new obesity drug rather than pioneering a novel malaria treatment," said Dr. Bernard Pecoul, who heads the Doctors Without Borders campaign to get affordable drugs into the more than 80 countries where the group works. "When new vaccines or medicines are developed, most of the world's population is left out of the picture."

Market research is now just as important as science in guiding the decisions of pharmaceutical companies. While executives decline to say publicly how much potential profit a drug must have to interest them, many spoke privately to W.H.O. researchers doing a 1998 study of why new tuberculosis drugs were not being made.

"The major companies are aiming for $1 billion at peak sales," the study concluded. "Targets vary for companies, but many want to generate a minimum of $200 million per annum."

According to a study led by Dr. Pecoul, of the 1,233 new medicines patented between 1975 and 1997, only 13 -- 1 percent -- were for tropical diseases.

Even of those, only 4 came from efforts by pharmaceutical companies to cure humans. The 9 others came from work done by the United States Army for the Vietnam War or from research on drugs for livestock or for the pet market, which industry representatives say could be a gold mine. Already, Novartis makes a drug to treat separation anxiety in dogs and Pfizer has one to treat dog Alzheimer's.

No major company is doing new research on sleeping sickness.

The town of Omugo in northwest Uganda, a strip of crumbly red clay stores and thatched mud houses that resemble chocolates in straw hats, is at the centre of the sleeping sickness epidemic that goes deep into both war-torn Congo and war-torn Sudan nearby.

The colonial-era programs that sprayed insecticide, cleared riverine brush, treated patients and moved whole villages away from fly-infested areas are no more than an ancestral memory now. Fifty years of shifting civil wars have rebuilt the two reservoirs of the disease: biting flies and untreated people.

And a new outbreak has begun in Uganda's southeast, said Dr. Dowson S. Mbulamberi, who heads the Ugandan Health Ministry's efforts against vector-borne diseases like sleeping sickness. His is a daunting task. Uganda's public health budget amounts to $12 per citizen per year, less than the cost of one tsetse fly trap.

Sleeping sickness is actually far too benign a name for human African trypanosomiasis. The illness is spread by the bite of tsetse fly, the scissor-winged glossina species found from Senegal to Somalia to South Africa. In its saliva, the small fly injects a protozoan that it picks up from feasting on another infected person.
The symptoms start with low fevers, itchy skin, joint pain and lethargy. But weeks later, when the parasites enter the brain, patients begin hallucinating or acting wildly. They have been known to chase family members with machetes, shout all night, throw themselves into latrines, and pillage other villagers' plots of cassava or bananas to feed ravenous appetites. Their skins get so sensitive that cool water or a gentle touch makes them scream. Only at the end do they lapse into a lassitude so great that they cannot feed themselves. Then they sink into a coma and die.

At one time, British tsetse control reportedly included "fly boys" -- young men who stood shirtless in the bush slapping flies and were paid a bounty for each killed. Because the fly likes dense brush near water, the illness particularly affects women and the babies they carry on their backs as they collect water or wash clothes. If infected, even babies must suffer melarsoprol treatment.

Witchcraft Blamed, Too
Villagers fear sleeping sickness so much that some laboratory workers say they are testing for malaria, which is known to be treatable. In the villages, rumors say it is spread by eating pork, by sex and by witchcraft, said Martin Andama, who visits villages to test people for the disease as part of a Doctors Without Borders programme.

Jovina Oleru, a woman who was cured and returned to nurse her son, still stubbornly believes that she is sick because her family is angry at her husband.

"My husband only paid three cattle for me when I got married, and I have given him three children," she explained. "So my family really got nothing for bride-wealth, and they feel bad about me and perhaps wish me to die."

That, she indicated, made more sense to her than the idea that flies make humans sick.

"Hospitalization" here is cheap; the 60-foot-long ward has a cement floor, brick walls, a straw roof and plastic sheeting for windows. Patients are charged nothing, but each has to bring an "attendant" from home, who sleeps on the floor, collects firewood and cooks over a fire in the brick hut in the field outside.

One day recently Alfred M. Guma, 32, a farmer who grows sorghum and tobacco on his small plot near Omugo, smoothed the rough brown blanket on his cot in the ward where he was waiting out the 21-day stay required for melarsoprol treatment. He was in Stage 2, meaning the parasites had reached the spinal fluid bathing his brain, which is serious, though the disease had been caught early.

"My brother Steven had a mental breakdown," he said. "He began to see things that others could not see -- wild animals, dead people coming to him at night. He feared having a bath and became aggressive if you touched him, jumping back as if he had touched fire."

For 14-year-old Steven, the family finally improvised an ambulance: they used old clothing to tie him into a box on wheels behind a bicycle and took him to a hospital. That was five years ago; Steven, cured, is now in high school.

Only four drugs are known to work against sleeping sickness and all four are in trouble. Their problems show how the open marketplace that works so well for Americans still fails the world's poor.

One is from Bayer, the German pharmaceutical giant. Three are made by Aventis, whose headquarters are in Strasbourg, France. That is a coincidence; Aventis was formed in a chain of mergers of French, German and American companies, three of which just happened to make drugs used against trypanosomiasis.

At $50 for a course of treatment, melarsoprol is relatively inexpensive, and Aventis has promised to keep making it for as long as it is needed.

"But it's a terrible drug -- you don't feel proud injecting it," said Dr. Christine Genevier, director of the Doctors Without Borders program in Uganda. "It's caustic, it burns them, and you don't know if you are going to save your patient or kill them."

Now a strain of melarsoprol-resistant sleeping sickness is spreading. Up to a quarter of the Omugo patients have it, so even if they survive the painful injections they may die anyway.
"It's a risky product," admitted Alain Aumonier, director of international corporate policy for Aventis. "We won't claim the opposite."

The second drug, Efornithine, known as DFMO and sold under the name Ornidyl, is the best treatment for those melarsoprol-resistant patients. Originally developed as an anticancer drug, its usefulness against sleeping sickness was uncovered by chance in the 1980's; it proved so spectacular at pulling people out of their final comas that it was nicknamed "the Resurrection Drug."

But it is expensive -- about $210 per course. Worse, the manufacturer, an American subsidiary of Aventis, abandoned the compound in 1995 when it proved ineffective against cancer.

Last year, pressed by the W.H.O. and Doctors Without Borders, whose supply was running out, the company found 500 pounds of a precursor chemical in Indianapolis and made one last batch of 7,800 vials. The chemical is difficult to work with because it is unstable and corrodes piping; assuring a steady supply would mean building a whole new production line, Mr. Aumonier said, which the company declines to do.

Instead, in December, it signed the patent rights over to the W.H.O., which is seeking a new manufacturer. An Egyptian candidate proved unable to meet quality standards. A Texas company offered to make it at $60 a vial, treble the old price. That is too much; the search goes on.

A More Exciting Prospect
Mr. Aumonier said Aventis made the last batch and turned over the patent out of a sense of charity. "And now we feel trapped by what we've done," he said. "We are reproached for not doing enough when we could have done nothing."

Meanwhile, to the disgust of Dr. Pecoul, interest in the precursor chemical has suddenly soared because it might prevent the growth of facial hair in women. Gillette, the razor company, is doing research on it, "because they think it might be a huge market," he said.

The third drug is Pentamidine, which is useful only against Stage 1, when the parasites are confined to the blood. Treatment takes only 10 days. Under the brand name Lomodine, the drug has been around since 1941. But in the AIDS epidemic of the 1980's it was slightly reformulated and renamed Pentacarinat, and its price soared from $1 a vial to $30 when it was found to work against pneumocystis carinii pneumonia, once one of the chief killers of people with AIDS.

Despite the price increase, the manufacturer, a British company that became part of Aventis last year, has been supplying it free to the W.H.O. for use against trypanosomiasis. But last year, Mr. Aumonier and health agency officials said, Aventis told the W.H.O. it wanted to raise the price gradually to market level, probably $14 a vial, by the year 2004. The health agencies protested and the company is reconsidering, Mr. Aumonier said.

Finally, there is Suramin, made by Bayer, which has been used since 1920, also only against Stage 1. It costs less than $50 per course of treatment.

It has no other uses, so, a 1999 W.H.O. report said, "Bayer wished to stop production, but maintained it on the grounds that no other alternatives were available."

Franz-Jozef Bohle, a Bayer spokesman, said the company was trying to be a good corporate citizen, and was discussing the supply of three drugs for tropical diseases with the W.H.O.

Pharmaceutical industry executives say they cannot be expected to shoulder the burden of diseases of the poor alone. "The industry has never been philanthropic," said Mr. Gros, the Aventis spokesman. "It has always produced products with an aim to getting a return on investment."

If rich nations are unwilling to pay for drugs for poor ones, if poor countries continue to spend fortunes on weapons and if their doctors keep leaving to work in the West, he said, it is not the fault of the pharmaceutical industry.

"I like that statement 'Access to medicine is a human right,' " said Mr. Aumonier of Aventis, quoting an aphorism frequently used by health advocates. "But it's a right that should be enforced by the whole community. May I suggest that the pharmaceutical industry is only part of that community? It also includes the health care system, the social system, even the patient."
"What's to be done if the poor are too poor to buy drugs on the free market? Does government act sufficiently? To say to industry, 'You make money, so you must enforce this human right alone' -- this, somewhere, is wrong."

The Cause of Chaos
Mr. Bohle made a similar point, saying Bayer was willing to make some drugs available cheaply, but wiping out an epidemic took much more: hospitals, follow-up tests, record-keeping, tsetse fly control and other elements.

Daniel Berman, who works with Dr. Pecoul at Doctors Without Borders, said he was troubled by such industry arguments.

"O.K., they didn't actually cause the problem," he said. "But are they an important factor in the drugs not being produced? Absolutely."

"When we're there we can distribute them," he said. "The limiting factor for us is price. But when a company abandons a drug, there's chaos."

Taking account of the trend of the last decade in which many companies have been forced into mergers because their relatively low stock prices made them tempting targets to competition, Mr. Bohle conceded that Bayer did little research on tropical disease.

"You have to relativize this," he said. "A company can support some research without being paid off, but not much. Especially with the pressure on shareholder value. I remember when shareholder value was not important at all, and now it's the main driver. There's always the threat of being taken over."

What is most disturbing is the marked increase in the death rate of the younger generation of people between 20 and 50' Bobby Jordan

Sunday Times, South Africa - May 28, 2000

Bodies are piling up in greater Johannesburg due to an alarming increase in AIDS related deaths, health authorities warned this week, prompting an official move towards cremation instead of burial.

The city's official death rate has doubled over the past five years, according to the latest figures released by the Greater Johannesburg Metropolitan Council.

Johannesburg's director of cemeteries and crematoriums, Dr Alan Buff, said the mortality figures showed about 70,000 people in the city died last year out of a population of four million, of which 30,000 were buried or cremated by the council.

A large proportion of young adults make up the latest body count.

"There are many influencing factors... but what is most disturbing is the marked increase in the death rate of the younger generation of people between 20 and 50," Buff said.

Many of the city's 27 cemeteries were nearly full. Fourteen are already classified "passive" cemeteries, with bodies buried one on top of the other in "family" graves.

A move to promote cremation had yet to bear fruit, with communities still favouring traditional burials, Buff said.

The 100% increase in mortality recorded by the council over the past five years far outstrips the city's population growth for the same period. Health officials say it provides conclusive proof that AIDS has hit town with full force, and should finally put an end to the widespread public perception of an "invisible disease".

Another telling figure is the estimated 6,000 pauper burials each year in the city. Unclaimed bodies buried in nameless graves, many are believed to be AIDS victims abandoned by relatives.

There is also mounting concern about a rapid increase in AIDS orphans, many of whom move or are sent to Johannesburg from rural areas, and the debilitating effect the pandemic will have on the country's economy.

AIDS-related insurance claims rose 28% in the year ending June 1998, compared with the total number of insurance claims registered for the previous 10 years.

Concern over Johannesburg's mortality rate follows shocking evidence of AIDS related deaths in KwaZulu Natal - considered the AIDS epicentre in South Africa. The number of people dying in Durban has increased by 250% since 1994, according to a statement last week by Agriculture and Environmental Affairs MEC Narend Singh.

Singh said the number of burials and cremations had risen from 2,592 in 1993/94 to 8,983 in 1997/98.

"If mortalities are going to continue increasing at that rate... disposal of the dead is going to become a critical problem," he said.

Dr Liz Floyd, director of Gauteng's AIDS programme, said Johannesburg's mortality figures might be inflated due to the influx of AIDS patients who seek treatment in the big city. AIDS was nevertheless painfully evident throughout Gauteng.
"AIDS deaths became noticeable in 1998. By 1999 we were able to see a different approach among communities, who up until then were in denial about the cause of the many deaths within their communities. Right now, only a few people are still in denial. For most people, there is an incredible seriousness about AIDS," she said.

She said the Gauteng Health Department was focusing on upgrading the province's 300 clinics to deal with the situation. "At the moment, about 50% to 60% of our clinics can cope with someone who is HIV-positive. This has to increase to 80% to 90%.

Dr Malcolm Steinberg of the research group ABT Associates South Africa, said projections suggested that more than 3.5-million South Africans are HIV-positive, and the figure was expected to more than double over the next decade. Average life expectancy could plummet from about 60 years to around 40 years by 2008.

By 2005 there are expected to be around 800 000 orphans under the age of 15. This figure will rise to more than 1.95 million in 2010.

"The impact of the pandemic is here. AIDS deaths are upon us," he said.