Monitoring of HIV/ Aids Agreements

Riaz Tayob
SEATINI

Mumbai 2004

Imperialism in the health sector is not often referred to but its presence is stark. I agree with the previous speakers who referred to the World Bank (WB), International Monetary Fund (IMF) and the World Trade Organisation (WTO) as institutions whose policies constrain health services in Africa. There is also a hypocrisy about the heroes of the Aids struggle which the media actively aid and abet. In particular, the mainstream media recently applauded ex-President Clinton for securing a deal that reduces the prices of Anti-retrovirals (ARVs) for developing countries thereby hopefully increasing access to treatment. It should be remembered that it was under the term of Clinton that the notorious and infamous, TRIPs (Trade Related Intellectual Property Rights Agreement) of the WTO was signed and unfairly imposed on developing countries. This agreement, together with the bloody minded pharmaceutical industry, created much of the access problems by reducing the policy flexibility available to developing countries. Yet we applaud Clinton's actions as if he was a hero.

Africa is bottom of the pile. In many reports sub-Saharan Africa (SSA) has a special row or column because the indicators are so bad. In Southern Africa it is estimated that 10 million people died from HIV related illnesses with a million having passed on in 2001. This does not include the other twin challenges of Tuberculosis and Malaria that afflicts the region. As regards under five child mortality OECD countries had 14 deaths per thousand compared to 174 in SSA. The pattern of inequality that imperialism promotes can be seen by juxtaposing a map of HIV/AIDS prevalence with that of developing countries or the poor countries and the globalisation of inequality (and economic apartheid). Even if somehow enough resources are made available to fight the pandemic, the question still remains as to who will implement the programmes to combat these diseases. The doctor : population ratio in the 1980's in developed countries was 1: 300 compared to 1: 10,800 in SSA or even 1: 30,000 in specific countries. So we as Africans export not just capital but doctors also. A study is being conducted by our partner Equinet on the effect of the brain drain and the concomitant subsidy it inevitably entails from Africa to the rich north.

When monitoring the implementation of the programmes like that of donors and of agencies like the Global Fund, we find, as the previous speaker pointed out, they are failures or do not meet the needs of the majority of the people. The point is that things are so bad that many of the initiatives will have limited successes because the problems are systemic within the health system. Even with the knowledge that things are bad, donor countries (who are richer than ever) continue to reduce Official Development Assistance. Since the 1960's to 2000 the wealth per capita of OECD citizens more than doubled. In this same time period, development assistance has dropped by more than four times! So all this noise from the G8, the Global Fund or even Bush's 15 Billion are there to placate the Europeans and Americans. In this way they can say, look we are doing something about the problem. The reality of a walk through Mumbai Hospital or to Baragwanath in Johannesburg shows that things are wretched. In the meantime, those who monitor the status of health provision argue over definitions of equity and resource allocation, people are dying. We should start counting our dead and recognise that much of the misery, suffering and death is preventable. For activists in the health sector, approximate definitions and categories are enough for our needs and we do not need to be distracted by definitions from the Group of Eight, New Partnership for Africa's Development, the World Health Organisation (G8, NEPAD, the WHO) or Millennium Development Goals (MDGs) and get caught up in the reliability and validity questions of measurement to the specificity required of these institutions.

The health sector, like other areas of concern at the World Social Forum, needs to come to terms with this perverse reality that is imposed on the developing countries. Aside from the meaningless platitudes that something is being done for the poor, a scratch just below the surface reveals an entirely different picture.

For a long time the general and specific circumstances for providing health care have not been people centred. The Dunkel orchestrated Uruguay Round establishing the WTO has imposed disciplines that undermine development and foster underdevelopment in developing countries. The WB/IMF continue to impose policies that undermine the role of the state and that promote the exclusion of the poor. There are noises that these three institutions must work together to develop coherent policies so that development is not compromised. The General Agreement on Trade in Services (GATS) prevents governments from regulating services in a manner that ensures equitable distribution of resources. Governments cannot for example refuse a licence for a hospital in a city where there are many hospitals and coerce the investor to establish a hospital in an under serviced rural area. The WTO says that there is an exemption for government services and governments retain the right to regulate the health sector. While this may be true in part, the governmental exemption in the GATS is narrow. The exception does not include services provided in competition with the private sector or services provided on a commercial basis. Most public health services are also provided by the private sector in many African countries. Therefore the comforting words of the WTO, saying the GATS does not limit governments flexibility, are nullified by what is happening presently. The World Bank and IMF then come along with their requirements and undermine the second part of the exemption by imposing conditionalities demanding user fees and principles of cost recovery on Governments. By charging people for using health services, that governmental service is operating on a commercial basis thereby rendering the service subject to the GATS. This is an indication of not just coincidental coherence but a high degree of coherence! It also represents a move where practices of deregulation (and the withdrawal of the state) were simply policies before, now are institutionalised and legally binding commitments.

The TRIPs agreement is another case in point. The developing countries at the Uruguay Round were not happy with the inclusion of intellectual property rights (IPRs) at the WTO but were coerced, browbeaten and bullied to accept the agreement. TRIPs created space in which developing countries could bypass patent laws to protect the health of their people by allowing parallel importation and compulsory licensing. When the South African government wanted to use this perfectly legal provision, they were bullied with threats of sanctions by the pharmaceutical industry using the US government as their proxy. With this pompous imperial behaviour civil society rallied and won a modest victory at the Doha trade ministers meeting of the WTO. The victory in many senses was hollow because it in large part restated rights that developing countries enjoyed in any event. After Doha, when countries had the problems of low production capacity and the inability to parallel import sufficient quantities of drugs, the US and EU then promptly set about to water down TRIPs and the Doha clarification by imposing onerous components to the agreement. They set numerous restrictions on the production, packaging and distribution of generic drugs. Not only that, they even won a statement in the Motta text (as it is referred to) that these conditions now also cover active ingredients and not just drugs. So the US and EU were able to glean a victory from the successful campaign of health activists in Doha.

We are told, knowing what is good for us, that protecting IPRs promotes innovation and investment in research and development which would not occur in the absence of such protection. Pharmaceutical multinational companies (MNCs) spend more on marketing than on research and in any event spend less on research for developing countries' diseases than on commercially viable research like balding and anti-aging. But the problems do not stop there, the concept of "what is novel" is also a loose concept. Much of Africans indigenous knowledge and biodiversity is not recognised by TRIPs as novel and therefore are not recognised as formal intellectual property. African governments have been slow in recognising the need to protect such knowledge and bio-pirates are still having a field day making money off our people's knowledge. The African concept of health knowledge is not suffused with the concept of exclusivity but with sharing. Knowledge about the value of plants and ways of improving life are communal and shared. The concept of protecting exclusivity and innovation at the cost of human life is a grave abomination to many people.

In looking at what the Northern countries actually do to promote health care we need to point out that SEATINI and EQUINET value equity and believe that all people, rich and poor should have access to adequate health care. It is a human right that is available and should be made real for all without discrimination especially on the basis of ability to pay. The donors and international organisations like the Clinton Foundation, DFID, USAID and others take a poverty based approach to helping developing

countries. They say, okay your health spend per person per capita is x amount so we will supplement it for a limited target group for so much. They are not concerned with equity or with addressing the real problems. This is feel good money so that they can drive their own agendas and keep their home constituencies happy. Since we are not funded by any of these organisations (and are grateful to Action Aid for creating space for an organisation like SEATINI) we can therefore say what we like. We therefore avoid this propensity to be overly concerned with measurements, definitions and statistics. The problems are enormous and we should direct our resources internally instead of being drawn to distraction. We want all our people to have access to health care as it is their human right. When the mainstream donors get angry or upset when we do not want conditionalities, they frequently say they know what is best for us. They then proceed to impose what is best for on us. This is health imperialism and must be opposed.

Developing countries have an acute understanding of their problems, as they cannot be missed. Interference in our affairs is unacceptable especially when it is demonstrably bad for our people. We need to reclaim the policy flexibility that we had in the absence of TRIPs, GATS and WB/IMF conditionalities to improve the health system not just for HIV/AIDS patients, but for all who need health care. The HIV/AIDS issue is a symptom of greater malaise that afflicts our nations and their peoples. It is the institutionalised and globalised inequity that, we are told to accept as the natural order of things, is the problem.

We cannot focus only on the single issue of HIV/AIDS. For instance in health the key determinant of health status is nutrition. If we look at food production we see that food security/sovereignty is virtually totally undermined. The US does to African peasant farmers what it did to Iraq. They first disarm, then bomb. First they ensure that we lower our tariffs, then they bomb us with cheap subsidised imports. This decimates food production and fosters evermore dependence. If we cannot even control our destinies in so far as having enough to eat, then it is true that some people are more equal than others.

Our governments are bankrupt in real terms as they are burdened with foreign debt. They are pursing foreign imposed policies of reduced spending, deregulation, privatisation and liberalisation. The combination of these approaches, “Washington Consensus” and debt repayment, is resulting in the “primitivisation” of Africa. They do this because they know what is good for us, but the evidence on privatisation and equity in health services is ambiguous at best! If the empirical evidence is not there, how do they know what is good for us?

Furthermore, the agreements on TRIPs, that now are supposed to make access to drugs greater, still need to be monitored. Companies can price generics at levels that ensure that the development of local production capacity is stunted. Differential pricing and the cost of active ingredients will still need to be looked at and monitored as we cannot trust these companies that have shown such disregard for preventable human death.

Traditional healers service most of our peoples health needs. Not only is the work not marginalised but we do not give them credit for the inter-generational knowledge they carry. We can deal with the HIV/AIDS pandemic. It is a problem that we can tackle, but we have to do so on our terms. These trade agreements have the effect of favouring the wealthy and excluding the poor. Health is an interdependent variable. It depends on many factors. Water, food, shelter are all important determinants of health. Our water is being privatised and made into commodities and the poor are being excluded. Our food production systems are being destroyed. Patients do not have access to drugs because they have to pay royalties to the rich. This is unacceptable.

As Africans we need to articulate our need for self-reliance. The trade agreements, on balance, undermine our self-reliance. We need to ensure that we have access to medicines and health services even if we have an economic crisis as happened in Mexico and Argentina. This means that we must develop regional programmes to cater for our needs and not be at the mercy of those whom Clinton makes deals with. Pharmaceutical companies are predatory and we must be prepared to take action to ensure that all our people have access to health care. Health is a right and we can meet the needs of our people.