

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

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# Why do the poor stay poor?

Passanna Gunasekera & Dr Bala

*"For a poor person everything is terrible - illness, humiliation, shame. We are cripples; we are afraid of everything; we depend on everyone. No one needs us. We are like garbage that everyone wants to get rid of." — a blind woman from Tiraspol, Moldova*

*"Everyday I am afraid of the next" — from Russia*

*"If you don't have money today, your disease will take you to your grave," — an old woman from Ghana.*

**(Courtesy PovertyNet – The World Bank Group)**

International attention has been sharply focused on reducing poverty in the 21<sup>st</sup> century like never before. Fighting poverty, the world's deadliest disease still remains the greatest single challenge in this century. Considering the fact that we now live in a global village with the latest technological advancements where anything seems possible poverty still remains an "unfinished struggle".

There is no single right definition of poverty. We come into terms with poverty when we observe the hunger-stricken children digging into the garbage bins...A mother clutching her dying infant in her bosom...Young children running all over the street with barely an inch of clothing on them...thousands and thousands of helpless outstretched hands that appear in front of you pleading for a coin...millions and millions of people who live the present with fear for the future. These are the voices and faces of poverty that statistics do not reveal.

Poverty is very often defined by a person's income or wealth. However, it is not income alone. It is the denial of a person's basic human rights, the lack of peace of mind; good health; freedom of choice and action; a steady source of income; safety and food. It is all about not belonging to a community but living a dependable livelihood.

With poverty becoming prominent in the 1970s Townsend helped in redefining it as not merely failing to meet minimum nutrition or subsistence levels but failing to keep up with the standards of a given society.

## **Poverty marches on...**

There has been only one basic cause for poverty throughout the history of humankind. It is the lack of access to control and possession of resources. The wealth and income generated by these resources therefore become unevenly distributed. In the Middle Ages, the king awarded land grants to his most important nobles, his barons, and his bishops, in return for their contribution of soldiers for the king's army. At the lowest echelon of society were the peasants (also called "serfs"). The impoverished peasants toiled the land and remained poor while the hierarchy benefited from their hard work.

With the Industrial Revolution these peasants migrated to the cities to join in the labour force for the rich industrialists. Colonialism next in line gave the new Western European nations land, raw materials and cheap labour. They controlled international trade with Britain controlling 40 percent of the world trade in the late 19<sup>th</sup> and early 20<sup>th</sup> centuries. When colonialism started to take a downward glide, developing countries believed that power over resources and decision making would return to them. Soon they realized that neocolonialism was slowly replacing colonialism. Using different strategies the neocolonialists now control power over resources and make all the decisions. Globalization is their strategy. About 20 percent of the world population control approximately 80 percent of the resources and wealth – and poverty marches on...

## **Neocolonialism...**

Following the Second World War, the United Nations (UN), the World Bank (WB), the International Monetary Fund (IMF) and in 1995 the World Trade Organization (WTO) were some of the intergovernmental institutions set up to bring about peace and prosperity. Nevertheless, there was neither peace nor prosperity.

Today, across the world, 1.3 billion people live on less than one dollar a day; another 1.7 billion live on fewer than two dollars a day. The two dollars a day poverty line shows that 56 percent of the world's population lives below this level of income and that in sub-Saharan Africa and South Asia the proportion reaches 75 percent and 84 percent respectively.

The paradox is that poverty is increasing at a time when the global economy has grown tremendously in the last two decades.

The disparities which split the rich from the poor have become more pronounced in recent years. An analysis of long-term trends shows the distance between the richest and poorest countries was about 3 to 1 in 1820, 11 to 1 in 1913, 35 to 1 in 1950, 44 to 1 in 1973 and 72 to 1 in 1992. Wealth today is concentrated in fewer and fewer hands. According to the 2002 Human Development Report, "the world's richest 1% receive as much income as the poorest 57%. The income of the world's richest 5% is 114 times than that of the poor 5%.

## **The gap between the Rich and Poor...**

As Ignacio Ramonet stated, *"to satisfy the entire world's sanitation and food requirements it would cost only \$13 billion, hardly as much as the people of the United States and the European Union spend each year on perfume"*.

According to the World Bank figures in the past 50 years poverty has fallen more than in the previous 500 and reduced in some respects in almost all countries. Yet in 1999 around 1.2 billion people lived in absolute poverty while another 1.6 billion on less than \$2. Although the World Bank (WB) has set the international poverty line at an expenditure level of \$1 per person per day many argue that it has the definition set too low; 521 million people in South Asia; over 300 million in Sub-Saharan Africa and 60 million in Latin America and the Caribbean live in absolute poverty.

Increasing concentration of wealth and growing income disparities is commonly seen in developed, developing and less developed countries. Figures reveal that in Brazil for instance "the poorest 50% of the population received 18% of the national income in 1960, falling to 11.6% in 1995. The richest 10% received 54% of the national income in 1960, rising to 63% in 1995." In Britain, "at the start of the 70s the incomes of the richest 10% were three times higher than those of the poorest 10%. By the end of the 90s they were four times higher. At the same time, the distribution of wealth had also become more uneven over the past 20 years. In 1996 1% of the population owned 20% of the wealth – about 388bn pounds. More than half the total wealth was owned by 10% of the population, and 93% was owned by half the population."

## **The Vicious Cycle of Poverty...**

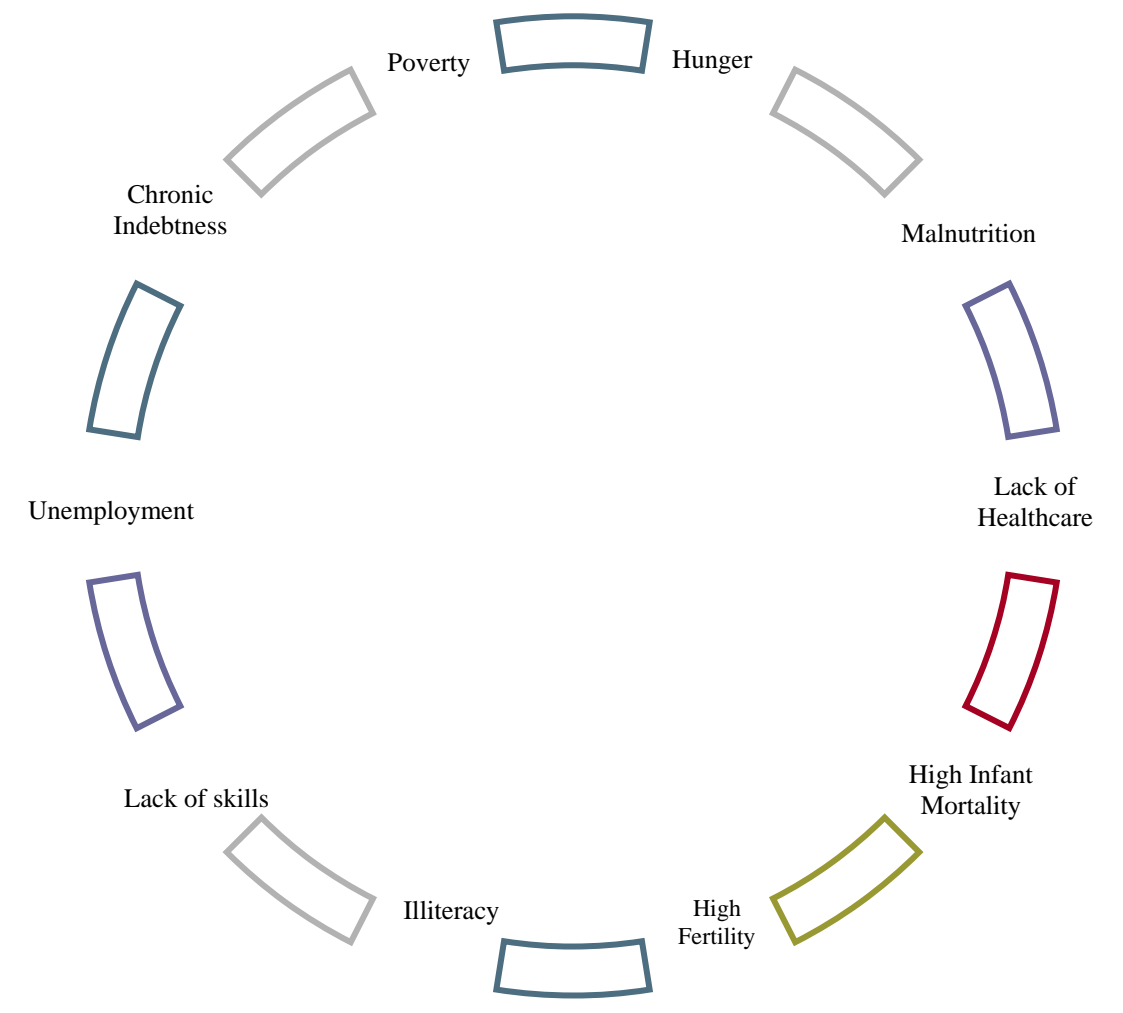
The poor in the third world are caught in a vicious cycle as shown in figure 1 and continue to be entangled in it; poverty is handed down from generation to generation. The only escape from this vicious cycle will be to break it from several entry points in the cycle.

The vicious cycle clearly illustrates the close and vital link between human and social development and health. The following statement underscores this vital link: "Economic and social development based on a New International Economic Order is of basic importance to the fullest attainment of health for all; the promotion and protection of the health of the people is essential to sustained economic and social development and contributes to better quality of life." This was included in the "Declaration of Alma-Ata" unanimously adopted by the world community at an International Conference on Primary Health Care organized in September 1978 by WHO and UNICEF in Alma-Ata, Kazakstan. The Declaration affirmed that Primary Health Care was the key to health for all.

Primary health care (PHC) involves, in addition to the health sector, agriculture, animal husbandry, food, industry, education, housing, public works, communication and other sectors and demands the co-ordinated efforts of all these sectors. The Conference called on all governments to formulate national policies, strategies and plans of action to launch and sustain primary healthcare as part of a comprehensive national health system and in coordination with other sectors.

Comparison of figure 1 describing the vicious cycle of poverty and the sectors involved in PHC listed above, seems to indicate that the Alma-Ata Declaration has been tailor-made to break the vicious cycle of poverty at several entry points and open escape routes to enable the poor get out of poverty. Unfortunately the Alma-Ata Declaration was soon forgotten with World Bank playing a leading role in international health and private sector in developing countries taking over from the public health sector in providing healthcare services.

However, the People's Health Movement, a coalition of concerned NGOs, grass root organizations and socially conscientious individuals from over 100 countries in both developing and developed countries have brought back Primary Healthcare back on the global agenda.



### The escalation of poverty...

The paradox of enormous growth and simultaneous poverty growth was best explained in the Human Development Report 1997 which stated, "A rising tide of wealth is supposed to lift all boats. But some are seaworthy than others. The yachts and ocean liners are indeed rising; but the rafts and row boats are taking on water-and some are sinking fast".

The raft and row-boats are the very poorest and structurally weakest countries, which United Nations classified as “Least Developed Countries” (LDCs). The first list in 1971 had 21 LDCs<sup>1</sup>. A special committee of the UN periodically reviews the list every three years and updates the list.

The last revision was done in April 2000. The number of LDCs have now risen to 49 countries with a total population of 620 million. Two more countries, the Republic of Congo and Ghana were also identified as meeting the criteria for LDC status. But since both these African nations have, for now, refused to have their economic status downgraded, they were not added to the list of LDCs.

The UN Committee for Policy Development which sits in judgement over which country should or should not be ranked as an LDC has identified another 16 countries which meet some, but not all, of the criteria for inclusion in the list of LDCs. These are Cameroon, China, Cote d'Ivoire, North Korea, Guyana, Honduras, India, Indonesia, Kenya, Mongolia, Nicaragua, Nigeria, Pakistan, Sri Lanka, Vietnam and Zimbabwe.

If the economies of some of these developing nations continue to deteriorate – promoted mostly by rising debt, falling commodity prices and sharp declines in development and foreign investments – the ranks of LDCs will keep swelling over the next decade.

If and when their level of development increases, the UN committee will “graduate” them from LDCs to developing countries. But in the 30 years since LDC ranking began, only one LDC had improved its economic status – Botswana.<sup>2</sup>

The growth in the number of LDCs reflects the worsening of economic conditions in the developing countries and consequent escalation of poverty. Unfortunately in the developing world and more specifically in the LDCs where billions of people are caught in the vicious cycle, education, healthcare and other social services have taken a backseat due to the economic and political pressures by the World Bank (WB) the International Monetary Fund (IMF) through their Structural Adjustment Programmes (SAPs) These programmes were designed by the WB and IMF in the early 1980's to enable indebted countries to repay their debts in hard currency. The countries that implemented SAP's had to:

- cut expenditures on social sectors
- raise interest rates
- liberalize trade and investment
- privatize utility services

This period of “short term pain” or as the World Bank called “crossing the desert” put into effect for long term success had its own price to pay:

- Less was spent on health, education and social services – people pay for them or lived without
- Devaluation of the national currency – lowering export earnings, increasing import costs
- Cut back on food subsidies – prices of essentials can soar
- Take over small subsistence farming for large-scale export crop farming instead staple foods. Therefore farmers were left with no land to grow their own food.

Thitinan Pongsudhirak, Chulalongkorn University, in Thailand states it is 'Like making someone with no blood left bleed some more.'

Although these programs were heavily criticized by the developing countries because of continuous poverty the two institutions had gone ahead claiming that these would result in the reduction of poverty.

Critics argued that other motives lie behind the forcement of SAPs. Transnational corporations (TNCs) from the world's richest countries profit enormously from the steady supply of cheap commodities and the investment opportunities that SAPs guarantee. Privatization of state enterprises

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<sup>1</sup> <http://www.un.org/event/ldc3/precom/history.htm>

<sup>2</sup> Least developed countries grow – in numbers. Third World Network – <http://www.Twnside.org.sg/title/grow.htm>

(a central theme in structural adjustment) has allowed TNCs to expand their activities across the South, just as public sector redundancies have provided a ready pool of unemployed people desperate for work at any rates.

The WB and the IMF having effectively closed all possible entry points which can break the vicious cycle in which the poor are trapped developed other strategies to alleviate poverty.

- Ignoring the complex nature of poverty and the vicious cycle in which the poor are trapped the World Bank equates poverty with low income and provides a monetary definition of poverty based on a single parameter – consumption based income poverty-line.
- Set up an arbitrary poverty-line of US\$1 per person per day at 1985 prices.
- Carry out a head count. All those with income of under one US\$ a day are poor. Those with incomes over a dollar a day are non-poor.
- Poverty alleviation programmes are deemed successful when those whose income is less than a dollar a day are pushed up to join those with incomes of two dollars

After almost two decades of enforcing SAPs, the World Bank and the International Monetary Fund have now accepted the failure of SAPs in alleviating poverty. They have been scrapped and replaced by a new strategy outlined in the Poverty Reduction Strategy paper (PRSP). The developing countries have been requested to take their own decisions on their paths to development. PRSPs are the papers which describe the medium term development paths of the poorest countries. A PRSP is a prerequisite for debt forgiveness for all new WB and IMF loans and for all future pledges of bilateral development assistance. The governments of these countries have been requested to prepare their strategies in collaboration with civil society.

### **Measuring poverty and poverty lines...**

We are all familiar with the most commonly used way to measure poverty - based on incomes or consumption levels. When a person's consumption or income level falls below some minimum level necessary to meet basic needs he or she is considered poor. This minimum level is usually called the "poverty line".

#### **National Poverty Lines:**

Data on consumption and income is gathered through sample surveys, during which households are asked to answer detailed questions on their spending habits and sources of income. Such surveys are conducted more or less regularly in most countries to estimate national poverty lines.

When comparing poverty world-wide, the same reference poverty line has to be used, and expressed in a common unit across countries. Therefore, for the purpose of global aggregation and comparison, the World Bank uses reference lines set at \$1 and \$2 per day.

However, there are differences in some national and international poverty lines.

**Table 1****Comparison of national and international poverty lines in 18 selected developing countries**

Country	People living below international poverty line (\$1 a day 1993 PPP US\$) 1983 - 99		People living below national poverty lines 1984 - 99	
	Number of people in millions	As a Percentage of Total population	As a Percentage of Total population	Numbers of People in million
Algeria	0.6	<2.0	22.6	6.7
Brazil	15.1	9.0	22.0	37.2
Egypt	2.1	3.1	22.9	15.1
El Salvador	1.6	26.0	48.3	3.0
Guatemala	1.1	10.0	57.8	6.4
Indonesia	16.1	7.7	27.1	56.6
Jamaica	0.08	3.2	34.2	0.89
Jordan	0.1	<2.0	11.7	0.6
Kenya	8.0	26.5	42.0	12.6
Lao PDR	1.2	26.3	46.1	2.4
Mauritania	0.7	28.6	57.1	1.5
Mongolia	0.35	13.9	36.3	0.9
Morocco	0.59	<2.0	19.0	5.6
Peru	3.9	15.5	49.0	12.3
Sri Lanka	1.2	6.6	25.0	4.7
Tanzania	6.8	19.9	51.1	17.5
Thailand	1.2	<2.0	13.1	8.1
Venezuela	4.3	18.7	31.3	7.4
Total	65			199

*Source: Human development Report 2001*

This table shows the great disparity between the international and national poverty lines. According to the World Bank estimates only 65 million people in 18 developing countries live below the poverty line whereas the national poverty line shows that almost 200 million people live below the poverty line. Therefore, strategies for alleviating poverty based on World Bank measurements and action plans will be unrealistic.

### **New methods in measuring poverty...**

Measuring and analyzing income poverty alone is not sufficient; many other dimensions of poverty should be given a considerable amount of thought such as high-quality social indicators for education, health, access to services and infrastructure. It also includes developing new indicators to track other dimensions -- for example risk, vulnerability, social exclusion, access to social capital -- as well as ways to compare a multi-dimensional conception of poverty, when it may not make sense to aggregate the various dimensions into one index.

Simon Maxwell interpretes in his report "The Meaning and Measurement of Poverty", in a series of Poverty Briefings compiled with the aim of providing up to-date insights on the issues of poverty, that there is no philosophical disagreement with the statement that poverty needs to be understood first and foremost as a problem at the individual rather than the household level, though an understanding of an individual's position within the household is essential to understanding the dimensions as well as the causes of disadvantage. Secondly very often income obtained from common property and state provided commodities particularly social welfare payments though not always health and education provision. Thirdly, a little disagreement crops up from the view that people move in and out

of poverty and that seasonal yet not predictable nor precise shocks are important. Finally Maxwell states that relative poverty and relative deprivation are accepted as relevant in theory but in developing countries poverty still relies on the calculation of the cost of a basket of basic needs but distribution data are normally provided.

### **Shortfalls in the poverty Line:**

The first major drawback of the poverty line is perhaps the assumption that similar goods cost the same for the urban and the poor consumers. The urban consumer buys his/her provision in kilograms or liters from a supermarket in the vicinity at market prices. By the time the goods reach the villages it would have passed a few intermediaries who keep their mark up and then the transport costs will be added on. The poor rural consumers buy small amounts which cannot be measured but doled out by bare fingers. The prices which the poor pay will therefore be much higher than the market price. The WB poverty-line of US\$1 becomes meaningless to estimate costs of a nutritious meal or for any understanding of poverty and to develop strategies to alleviate and abolish poverty.

The second fallacy in their strategy is the assumption that raising the income from US\$ 1 to 2 a day would alleviate poverty. It would probably ease hunger but will certainly not break the vicious cycle in which the poor are trapped. This strategy attempts to treat one symptom of poverty without looking for and removing the causes of poverty. Meaningful strategies should ensure adequate nutrition, clean environment, basic medical services, education, shelter, secure livelihoods and productive and satisfying jobs to all those living in poverty.

### **Other causes of poverty...**

Can anyone give a direct reply as to why there is still so much poverty in the world – when its habitants are becoming both knowledgeable and technologically advanced each day in which case eliminating poverty forever from the face of the earth should not be a Herculean task.

In addition to the lack of access to control and possession of resources another major cause of poverty is the misallocation of resources as a result of wrong priorities. South Asia for instance spent US\$ 15 billion on the military in 1995 "more than what it would cost annually to achieve basic health and nutrition for all worldwide. Sub-Saharan Africa spent 8 billion, about the same as the estimated annual cost of achieving universal access to safe water and sanitation in all developing And East Asia spent 51 billion, nine times the annual amount needed to ensure basic education for all."

Wrong priorities could stem from an interest of financial gain that would prevent the eradication of poverty. In most of the developing countries the upper class society directly or indirectly benefits from projects and businesses and the poor are marginalized. This also leads to corruption, the poor fall even deeper into the precipice when corruption favours the rich at the expense of the poor.

In the Medact publication, "Global Health Studies" Robert Chambers, the rural development specialist argues that several factors overlap to cause poverty. The factors listed out as \* lack of income and assets \* isolation \* physical weakness \* powerlessness \* vulnerability

- 1) It is often stated that a decent income is necessary for basic food, medicine and education but little do we realize that the poor lack any type of assets property, savings, good contacts, skills or physical assets such as access to infrastructure.
- 2) Isolation becomes a hindrance especially for trade to take place. When the poor live in the interior quite a distance from the resources there is no opportunity for trade to take root.
- 3) Vulnerability for the poor comes in the way of natural events such as droughts, famine, floods, war and economic crisis. Personal circumstances such as losing a job, a family wedding, dowry for a child or an illness may cause the poor to perhaps sell their only assets, mortgage their only piece of land, and borrow money at a higher interest rate. For the next few years they had to work even harder to pay off the loan or to buy a new piece of land.

- 4) The poor unfortunately have to live in a world where there's no justice. In their desperate situations they are compelled to accept what they are offered be it a job, loan or land without negotiating. Most of the time they do not have much choice.
- 5) In the job market too the jobs that are available for the poor require hard work and a lot of labour. It is with the utmost difficulty that these less fortunate people manage the three meals. Their meals very often consist of yams or vegetables they have collected from their own garden. They have no money to spend on eggs, milk, and meat.

Furthermore, the poor are not familiar with the saving mechanisms. They are ignorant on how they spend their earnings. In most cases the amount spent is higher than their expenditure. Their priorities are wrong. The poor remain poor and the rich are rich because the former cannot fight the consequences of whatever agreements initiated by the rich and the privilege.

### **Poverty and Health...**

Addressing world poverty implies addressing world health. Poverty and ill health are almost interrelated. Poverty ranks number one cause for ill health and ill health is one of the main causes for poverty. The 2002 World Health Report's first eight leading global health factors; underweight; unsafe sex; high blood pressure; tobacco and alcohol consumption; unsafe water, sanitation and hygiene; iron deficiency and indoor smoke from solid fuels are sufficient evidence to reveal that poverty and ill health go hand in hand.

A closer analysis of these "enemies of health, allies of poverty" reveals some alarming results. Almost three million out of the 170 million underweight children die annually mainly in developing countries. The world's biggest cause of death is HIV/AIDS, which in global risk factors is related to unsafe sex. Over 21 million people including 4.3 million children have died of AIDS since the beginning (in the early 1980s) of the epidemic. At the beginning of 2001 more than 36 million people lived with HIV/AIDS worldwide. More than 14 million women of child bearing age are infected with the virus. 95% of all HIV infections are reported from the developing world particularly from sub-Saharan Africa, Asia and Central America.

The outcomes of poverty such as frustration, depression and helplessness result in the poor to indulge in smoking and drinking. Tobacco is responsible for almost 5 million premature deaths a year and alcohol another 1.8 million deaths. Around 1.7 million die due to unsafe water, sanitation and hygiene through infectious diarrhoea. Iron deficiency is considered the world's most prevalent nutrient disease. Two billion people suffer from this deficiency while a million lives are lost every year. This is commonly witnessed in young children and mothers. Vitamin A, iodine and zinc deficiencies claim to be the single most preventable causes of blindness, mental retardation and brain damage and short stature, impaired immune function, respiratory infections, malaria and diarrhoeal disease respectively. The poor cannot buy food rich in these substances not because these are unavailable but because they are too poor to afford the food.

In conclusion, the data and analysis presented clearly reiterate that among other strategies to alleviate poverty and promote human and social development, Primary Health as outlined in Alma Ata has been tailor made to break the vicious cycle of poverty at several entry points and escape routes to enable the poor get out of poverty. Primary healthcare is the key to Health for all and a major strategy to eradicate poverty.

### **Bibliography:**

Global Health Studies published by Medact

Scaling up the response to infectious diseases – A way out of poverty

Poverty Reduction – Panos, PovertyNet

Global Health Issues affect everyone ([www.global.issues](http://www.global.issues))

Understanding Poverty – By Dr K Bala

Debt crisis – Dr Bala, James Wolfenson

*The Other Crisis*, World Bank, October 1998, quoted from *The Reality of Aid 2000*, (Earthscan Publications, 2000), pg 10

[\*The Politics of Hunger\*](#), *Le Monde Diplomatique*, November 1998

Human Development Report 1999,2000,2002, World Health Report 2002)

The Global rich and the Global poor-seeking

# - NETWORK NEWS -

## **AFRICA**

### **WHO/EDM and HAI Africa working together on country-level pharmaceutical sector surveys**

As part of their programme of collaboration in the region, WHO/EDM and HAI Africa are carrying out baseline surveys that can be used to monitor and assess the pharmaceutical situation at country level.

WHO is carrying out this survey in quite a number of countries around the world, and eleven countries in Africa. Of these, HAI Africa will be collaborating in three: Ghana, Kenya and Uganda. By March, the Ghana and Uganda surveys had been completed and the analysis was being carried out. The Kenya survey was planned to take place before the end of April.

The survey focuses on measuring existing structures and processes in the sector, as well as gathering data on core set of indicators at warehouses, public health facilities, private pharmacies and in households. It was because of the WHO/EDM and HAI Africa collaboration that household data were added to the original survey package. This addition has also provided very useful.

Initial results show that valuable information is being gathered and will help focus work on increasing access to essential medicines and improving medicines prescription and use. It also provides an innovative opportunity for WHO, HAI Africa partners and government health ministry staff to work together in identifying problems and discussing ways to address them.

### **Uganda Access to Essential Medicines Coalition Launched**

The Uganda Access to Essential Medicines Coalition was formally launched in late January after a two-day organizing and strategy-setting workshop of interested NGOs and individuals.

In late November 2002, spurred by fears about a pending intellectual property (IP) bill revision that would not safeguard public health, HAI Africa partner, HEPS Uganda, called a meeting of interested NGOs and individuals to discuss IP, health and medicine issues and how to organize around them.

From this initial meeting, some 40 NGOs, faith-based organizations, community-based organizations and individuals signalled their interest in working together on access issues. To help facilitate them, HAI Africa supported and facilitated an organizational meeting at the end of January so that an action plan and means of working together could be agreed.

The coalition agreed that the group needed to gather important national and local information about the access situation in Uganda, for a start. Other members of the coalition would concentrate on organizing the parliamentary lobby that the coalition expects will be needed later in the year to address anticipated weaknesses in the revised IP Act that is due out in a few months. A sensitization campaign on university campuses was started in March, as well as some initial briefings of MPs on key access issues.

An important networking aspect has been the bridging of the Kenya coalition experience and expertise with the new group in Uganda.

The campaign is being coordinated by HEPS Uganda, with support and technical assistance provided by HAI Africa.

## **Kenya Coalition for Access to Essential Medicines Challenges Presidential Candidates on Key Access Issues**

The Kenya Coalition for Access to Essential Medicines (KCAEM), of which HAI Africa is a founding member, carried out a groundbreaking project to pressure Kenyan presidential candidates to address issues and policies around access to essential medicines in their campaigns in the run up to the 27 December 2002 elections.

Entitled “Promises to Make and Promises to Keep: HIV/AIDS and Kenya’s Next President”, the coalition organised a three-part activity involving banners and placards being held up at major candidates’ rallies, a radio campaign and a televised debate among candidates, where they would be asked to address key access issues and to entertain questions from an audience of campaigners from around the country, including people living with AIDS.

In Kenya, 1.5 million citizens from all sectors of society have died from AIDS since 1984; where an estimated 2.5 million persons are living with HIV/AIDS; and where an estimated 300,000 women, men and children are expected to become infected annually. To date, the government has failed to address the pandemic that is killing an estimated 600 or more Kenyans per day.

Despite these worsening conditions, no candidate was discussing the issue of HIV/AIDS and its impact on the country across sectors such as health, the economy, and security. Neither were candidates acknowledging the impact of HIV/AIDS, nor were they making any policy and resource commitments about health services or the failing health care system as part of their campaign positions. The media seemed willing to let the candidates define the issues in general ways, such as the economy, rather than forcing them to take bold stands on basic rights, such as health.

The coalition campaign to raise the debate to include HIV/AIDS and access issues was therefore very important. Soon after the banner and poster campaign began at the rallies, the media took up the themes and the coalition received media attention specifically about what it was trying to accomplish.

Unfortunately, on the day the TV debate was to be taped, a hotel was bombed in Mombasa. The debate was cancelled. The coalition issued an open letter to the candidates which was published in major newspapers. Questions that had been formulated for the debate were posed, and parties and their candidates were challenged to respond.

Within the coalition, this was a major activity that combined the skills and resources of many member organisations and which directly involved grassroots volunteers involved in these issues. HAI Africa provided technical assistance in project design, on the radio campaign and in fundraising. The project was supported financially by HAI Africa, two Kenyan country offices of MSF and the Kenyan branch of Family Health International.

## **ASIA - Pacific**

### **Activities of TheNetwork**

Pharmaceutical Project at TheNetwork is working for the improved availability, affordability, quality, safety and rational prescription of pharmaceutical products in Pakistan. The project has been involved in several activities during the last year.

#### **1. Availability of Essential Drugs (ED):**

Regular availability of essential medicines in the market has been a great public health problem. TheNetwork regularly scanned the market for the availability of these medicines and advocated for their universal availability, reported it to Ministry of Health, media, manufacturers, and disseminated it through its bimonthly publication Drug Bulletin.

TheNetwork submitted its comments on the new proposed essential drugs list to the Ministry of Health which were later incorporated in the revised version.

Following the Silver Jubilee of essential drug concept TheNetwork published a special issue of its bimonthly publication Drug Bulletin on ED and disseminated the latest essential drug list.

## **2. Drug Pricing:**

TheNetwork did a market study to find out the actual impact on prices of medicines after the 3-4 percent increase in the drug prices by the Ministry of Health in December 2001. Contrary to the announcement in the press the official order said that the increase shall be calculated on the basis of market/brand leader price. TheNetwork study revealed that after the price increase based on the market leader price the prices of medicines increased up to 40 percent. In this regard TheNetwork sent letters along with the study findings to policy makers, including Chief Executive Secretariat, cabinet members and relevant officials of Ministry of Health, urging the policy makers to withdraw the price increase, particularly the price increase linked with market leader price. TheNetwork also raised the issue in media. It also filed a written petition in Rawalpindi bench of Lahore High Court against the unjust tricky pricing formula adopted by the MoH.

## **3. Amendments to Drugs Act 1976:**

When the MoH started a process to amend the Drug Act 1976 to match the proposed changes in the pharmaceutical sector TheNetwork was invited to participate. It attended the meeting held at MoH and observed that the pharmaceutical industry is heavily represented and given undue and unjustified role in the process. TheNetwork opposed the process being followed by the MoH and raised the issue of heavy involvement of industry in the amendments process who are to be regulated by the Act, where as representatives of consumers who are beneficiaries of the Act are only invited at the final stage. TheNetwork also submitted its suggestions/comments on the Drug Act of 1976 to the MoH. The process of amendments in the Drug Act was stopped for the time being.

## **4. Availability of banned and harmful drugs:**

It also highlighted upon the availability of banned, harmful or dangerous medicines in the market and demanded the MoH in altering labelling, banning and deregistration of such products accordingly. Such products included Mefloquine, Phenylpropanolamine, ENO fruit salt, Fenovarine, Lipobay, Nimesulide.

## **5. Availability of essential TB medication:**

One of the five essential elements of DOTS strategy is uninterrupted supply of quality drugs to the patients. A study carried out by TheNetwork aimed to look into the supply of TB medicines in public health facilities of Rawalpindi district. The study came out with the following conclusions.

- \* The TB drugs availability situation has improved from 18.4% (in 2001) to 80.4% (in 2002) in the health facilities of Rawalpindi District.
- \* Much of this improvement came in 2002 after extension of DOTS programme to the primary and secondary care levels in the district.
- \* Implementation of DOTS program in Rawalpindi district has helped improve TB drugs availability situation in the health facilities, however to achieve the desired goal of 100 percent availability, program's management systems, need to be looked into

TheNetwork carried out a cross-sectional survey in thickly populated urban areas of Rawalpindi district to check the adherence of private practitioners with tuberculosis treatment guidelines. The study results reveal that only two practitioners out of 53 could meet up the standard treatment as laid down in national TB control program guidelines. Lack of awareness among physicians regarding the WHO/NTP guidelines is alarming, and raises an issue that requires immediate redress.

## **Nepal**

### **Antimicrobial Resistance: a global public health problem**

Dr Mohan Joshi, member of HAIAP participated in the World Congress of Pharmacy and Pharmaceutical Sciences 2002 and at the 62nd Congress of International Pharmaceutical Federation (FIP) held in Nice, France. He served as an Executive Member of the Pharmacy Information Section of FIP. In the Congress, he presented a paper on the topic "Antimicrobial agents: urgent need to curtail inappropriate use and contain resistance." He also coauthored another paper presented at the

Congress; the title of the paper was "Towards a universal curriculum for teaching children about medicines." Additionally, he co-chaired a Pharmacy Information Section Symposium - Current Issues in Pharmacy and Health Care Information.

A Working Group on Antimicrobial Resistance (AMR) has recently been formed within the Pharmacy Information Section and he was working as its Chair. He prepared a draft of the Group's Working Paper; other Group Members are currently reviewing it and providing comments and suggestions. During the Business Meeting of the Pharmacy Information Section at the FIP Congress, the audience was informed of this progress and a dedicated symposium on AMR and rational antimicrobial use was proposed for next year's FIP Congress going to be held in Sydney. This has been provisionally accepted by the Section.

He has also worked as Principal Investigator for the evaluation study entitled "Assessment of Strengthening Drug Management at District Level (SDMD) Program." Report submitted to Management Sciences for Health (MSH), USA by Valley Research Group (VaRG), Kathmandu, Nepal, 2002. He has also worked as a co-investigator for the WHO-funded study entitled "Pesticide poisoning data in Nepal." Report submitted to World Health Organisation (WHO), 2002.

## **AUSTRALIA**

### **Antibiotic Resistance**

Dr Ken Harvey reports:

The World Health Organisation recently stated that antibiotic resistance is a major threat to public health, "Curable diseases, from sore throats and ear infection, to tuberculosis and malaria, are in danger of becoming incurable". In the light of this concern it is useful to go back to the beginning of the antibiotic era and reflect upon the ongoing battle that followed; a war between microbial evolution and human ingenuity.

Since the initial discovery of penicillin, by Alexander Fleming in 1929 and isolation and use by Florey and Chain in 1940, many more antimicrobial drugs have been discovered. But without exception, bacterial resistance soon emerged. More recently, the development of new antibiotics has slowed while bacterial resistance has continued. There are now NO antibiotics left to treat certain infections.

Some patients demand antibiotics inappropriately; some doctors prescribe inappropriately while some pharmaceutical companies inappropriately stimulate demand. In addition, antimicrobial use in food production has contributed to increased drug resistance. Currently, 50 percent of all antibiotic production is used in animal husbandry and agriculture.

### **How can we postpone the end of the antibiotic era?**

Action plans to postpone the end of the antibiotic era include: Research; allocating more resources to discover new antibiotics, infection control; containing the spread of resistant micro-organisms and their genes and being more prudent when using antibiotics.

Australia was one of the first countries to produce best-practice guidelines on the use of antibiotics in human medicine and has now reached their 12<sup>th</sup> edition. However, it was soon found that antibiotic guidelines by themselves achieved little; they needed to be incorporated in a comprehensive national program of outreach education and drug audit and therefore are undertaken by the National Prescribing Service.

Antibiotic use in Australia peaked in the 1990's and has since steadily declined. Antibiotic use in veterinary practice and food production has also been addressed. Antibiotics crucial to human medicine are now banned from animal use. The National Health and Medical Research Council now monitors bacterial resistance and antibiotic use in both human and animal populations.

## What can YOU do to help?

First, make sure your vaccinations are up-to-date. There are an increasing number of good vaccines for the young and the old, these can prevent infection and reduce the need for antibiotics. Talk to your GP about it.

Second, most coughs and colds are due to viruses. Antibiotics don't work against viruses. Always discuss the need for antibiotics with your doctor.

And finally, set a good example with respect to infection control. Wash your hands when they are contaminated. Stay home if you are infectious. Help postpone the end of the antibiotic era.

*Source: From a transcript prepared by Ken Harvey. For more details log onto <http://www.abc.net.au/rn/talks/perspective/stories/s745380.htm>*

## US Trade Deal Threatens Australian Families' Access to Medicines

The Australian Consumers' Association called on the federal government to take the PBS off the table in trade talks with America.

A bilateral trade agreement with the United States poses a serious threat to Australia's Pharmaceutical Benefits Scheme, by moving towards a US-style drug market in which prices would soar and millions of people could no longer afford the medicines they need.

"If the American drug makers get what they want, costs of the PBS will blow out even further, endangering the whole scheme," said Martyn Goddard, the ACA's senior health policy officer.

"On average, Americans pay three times as much for their medicines as Australians do. This situation in America has made the big pharmaceutical makers the world's most profitable corporations. Now they want to replicate this in Australia, and they're going to use the free trade negotiations to achieve their goal."

The ACA's warning comes after the main US drug industry lobby organisation urged US trade representatives to demand a watering-down of Australia's PBS as a condition of a free trade agreement between the two countries.

At hearings in Washington leading up to the start of bilateral negotiations in March, the Pharmaceutical Research and Manufacturers of America (PhRMA) told the head US negotiator that the PBS is stopping companies from charging what they want for their products in Australia and should be changed.

"The PBS, which costs the government more than \$4.5 billion dollars, is already facing long-term sustainability problems from relentless cost increases of between 10 percent and 20 percent every year. Changes such as those demanded by the American companies would probably mean the end of the scheme as we know it."

*Source: Media Release Australian Consumers Association, 20 January 2003. For further information please contact Martyn Goddard, senior health policy officer: (02) 9577 3373; (mobile) 0411 788 076*

## Changing prescription software to favour generics could save Australia £40m a year

Martyn Goddard, senior health policy officer at the Australian Consumers Association, supports the requirement by the Australian government that the default in doctors software be set to prescribe generic drugs.

The existing software which is sponsored by the manufacturers of brand name drugs automatically ticks the "not for substitution" box. From 1 February a prescription must not be prepared by software with the default stating that generic drugs cannot be substituted for a brand name drug.

Doctors will be able to select brand name drugs but they will have to uncheck the default box. The government estimates that the change will save the government funded Pharmaceutical Benefits Scheme A\$111m (£40m; \$64m) over four years.

It is outrageous that the prescriber software that is sponsored by the drug companies directs doctors to the brand name drugs first. We can't afford to spend 20 percent more on brand name drugs just to get the brand name. It is a luxury the system can't afford." Martyn Goddard stated. The government's requirement has sparked opposition from doctors' groups and the target pharmaceutical industry body.

Carmel Martin, Director of Public Health and Ethics at the Australian Medical Association, argues that the change may lead to increased costs from hospital admissions of patients (especially old patients) who take double doses as a result of confusion.

A spokeswoman for Senator Kay Patterson, the federal minister for health and ageing, rejected the associations claims: "If doctors think patients are going to be confused they should prescribe the brand name drugs." The changes, she said, would bring Australia into line with the United Kingdom and the United States.

Steven Haynes, the director of strategic relations for Medicines Australia, the largest pharmaceutical industry association, claims that doctors are "being dictated to by health bureaucrats" and that they should have the option to prescribe brand name drugs.

Goddard believes that claims made by doctors and brand name drug manufacturers about adverse effects are exaggerated.

**Source: *Changing prescription software to favour generics could save Australia £40m a year by Bob Burton on BMJ 2003;326:184 (25 January)***

## **EUROPE**

### **A question of children's health**

WEMOS reports:

International bodies that are tasked with protecting children's health are looking for the solution to health problems through far-reaching cooperation with the private sector. A number of United Nations agencies, including the World Health Organization (WHO), are accepting commercial financing because national governments are contributing progressively less. There are great expectations from collaboration with companies as regards to improving the health of people all over the world. However, can we expect the corporate sector to put the interests of health above business interests? What are the implications of this cooperation for children's health worldwide?

### **Profit for companies**

We are of the opinion that the WHO should regard health as a fundamental human right and not as a mean to improving productivity and economic growth.

The number of alliances between companies and the WHO has grown explosively over the last few years. Wemos is concerned about this trend. This is because it is still very unclear whether the health of people in developing countries actually benefits from this cooperation. There are substantial risks associated with public-private initiatives. Do companies have direct or indirect influence on the decisions that international bodies take? Do these bodies take the private sector into account, consciously or unconsciously, when they are formulating public health policy?

One of the first and largest public-private initiatives set up with support from the World Health Organization is the *Global Alliance for Vaccines and Immunisation* (GAVI). The purpose of GAVI is to distribute money to developing countries that want to expand their vaccination programmes. The largest financial contribution comes from Bill Gates of Microsoft. The pharmaceutical industry also has a major voice in the management. Unlike earlier vaccination programmes, GAVI is focusing on

the development of new, expensive vaccines against such diseases as Hepatitis B and HIB (a form of meningitis). Ninety percent of the budget is spent on this research. Only ten percent is spent on improving health care systems. As a result of this there is a high probability that the vaccines will not reach the group that needs them most.

Wemos has observed that it is usually 'Northern' organizations or companies that have influence in public-private initiatives, even if they are operating in developing countries. Developing countries and civil society organizations are barely represented in the management of such alliances.

Transparent partnerships with companies can only exist if international health agencies and national governments are pulling the strings and make clear agreements with corporations about the goal of the cooperation and its practical implementation. Governments have the responsibility of aiming to attain the highest possible level of health for their populations. Companies do not have this responsibility. Developing countries and civil society therefore need to be given a say in public-private initiatives. They can see to it that the interests of health come first. This is at least one necessary condition for public-private initiatives to result in improved access to health care.

### **Vital importance**

Codex Alimentarius is an example of an international body in which the private sector plays a major role. It is an agency of the United Nations that sets worldwide food standards. Codex is tasked with protecting health and promoting trade simultaneously. Both the corporate sector and social organizations therefore try to influence the Codex.

The decisions that are taken here are of vital importance to the health of children all over the world. The influence of the commercial sector in the Codex can endanger children's health. The baby food industry, for example, will do anything to be allowed to recommend its cereal, fruit and vegetable products for very young babies. However, the WHO stated in its annual meeting, the World Health Assembly (WHA), that exclusive breastfeeding is best for the healthy growth and development of all babies up to six months. It estimates that approximately 1.5 million infants a year die because they are not breastfed. Wemos advocates that decisions that are made in the WHA should also apply to the Codex.

International regulation is not a harmonious process between equal partners. Companies, international health institutions and national governments have different roles and responsibilities. Wemos believes that the World Health Organization should act in accordance with its responsibility and do everything it can to defend the global right to health. This means that it should state openly and clearly which parties it is negotiating with. That it makes clear agreements about public-private initiatives, whereby international health bodies and national governments are demonstrably in the driving seat. That it provides adequate participation opportunities for developing countries and civil society organizations. And that the WHO and the Codex Alimentarius work on coherence of policy, whereby health interests should always prevail over business interests.

***If you have any questions or would like more information please contact:***

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## **Government takes responsibility for Women's Health!**

In this year's Call for Action the Women's Global Network for Reproductive Rights (WGNRR) places women's rights to health as part of the larger demand for a fresh look at women's health needs within the framework of primary health care. This Call is part of the 3 year Women's Access To Health Campaign (WAHC) that WGNRR will launch this year.

We join the People's Health Movement to observe the year 2003 as the year of Alma Ata to remind UN Agencies and governments and other key actors of the WHO's Alma Ata declaration who promised to deliver Health For All by the year 2000.

As part of our annual Call for Action we will be sending out campaign materials to our members. This will include clear background information on the missing issues of women's sexual and reproductive rights within the framework of primary health care, case studies and suggestions for activities your organization can elaborate.

The Call for Action of WGNRR is meant to be an inspiring and stimulating contribution to our members' work to make the 16<sup>th</sup> International Day of Action for Women's Health a huge success.

***For more information contact:***

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## **- JOURNAL SCAN -**

### **The daily drink : a killer or a lifesaver ?**

Many drugs can save your life or kill you, depending on how much of them you take. However, alcohol has become the sharpest double-edged sword in medicine.

Thirty years of research has convinced many experts of the health benefits of moderate drinking for some people. A drink or two a day of wine, beer or liquor is, experts say, often the single best nonprescription way to prevent heart attacks. Moderate drinking can help prevent strokes, amputated limbs and dementia. But moderate drinking also comes with some health risks, such as a slightly increased risk of breast cancer in women.

Thirty years ago, health officials were so uncomfortable with this idea that a federal agency tried to suppress early data on alcohol's beneficial effects. Now, with the data long out of the bag, policy-makers say this may be one of the few areas in medicine where general recommendations are simply not possible and individual doctors and patients will have to make decisions on their own.

The cardiac benefits of low-dose alcohol are evident in study after study. All over the world, moderate drinkers have healthier hearts than teetotalers, with fewer heart attacks from fatty plaque clogging the heart's arteries and blocking blood flow. In countries like the United States where heart disease is a major cause of death, this translates into a survival advantage: moderate drinkers live considerably longer on average than nondrinkers. "The science supporting the protective role of alcohol is indisputable; no one questions it any more," said Dr. Curtis Ellison, a professor of medicine and public health at the Boston University School of Medicine. "There have been hundreds of studies, all consistent."

The most compelling evidence for alcohol's benefits comes from large population studies, which have had impressive results. In a study of more than 80,000 American women, those who drank moderately had only half the heart attack risk of those who did not drink at all, even if they were slim,

did not smoke and exercised daily. Moderate drinking was about as good for the heart as an hour of exercise a day. Not drinking at all was as bad for the heart as morbid obesity.

\* In thousands of middle-aged Danish men with high cholesterol, moderate drinkers had 50 per cent less risk of developing heart disease from blocked arteries than abstainers.

\* Among more than 100,000 California adults, moderate drinking after age 40 was associated with reduced death rates during every subsequent decade of life -- in some people by as much as 30 per cent.

Recent research has shown that alcohol can benefit other organs as well as the heart. Moderate drinkers seem to have fewer strokes that result when the brain's arteries become clogged with fatty deposits. They are less likely to develop fatty plaques clogging the large arteries to the legs, which can lead to incapacitating leg cramps, gangrene or, at worst, amputation.

A large study from the Netherlands, reported in *The Lancet* medical journal last year showed that moderate drinkers over age 55 had about a 40 per cent lower risk of developing dementia than nondrinkers, possibly because they were spared the multiple small strokes, which can mimic Alzheimer's disease in the elderly.

But for every one of alcohol's health benefits there is an equal and opposite risk if a single glass turns into three or four.

The hazards of drinking begin with the small but significant increased risk of breast cancer among women who are moderate drinkers.

Even among those with no family history of breast cancer or other risks, studies have repeatedly found that women who regularly have a drink a day contract breast cancer 10 per cent more often than nondrinkers. Heavy drinking raises the risk even higher.

And once drinking rises from moderate to heavy, health risks escalate. Heavy drinking raises the risk of high blood pressure, heart failure and half a dozen forms of cancer; it may cause diabetes, pancreatic failure, liver failure and severe dementia.

Heavy drinkers have mortality rates far higher than moderate drinkers; these statistics do not even include the effects of car accidents and alcohol-fueled violence that destroy not only the drinker but others as well. These effects especially visible in the young show that drinking three to five drinks a day had death rates twice as high as nondrinkers.

The net health effects of alcohol are heavily influenced by its dangers. The World Health Organization estimates that overall, alcohol causes as much illness and death as measles and malaria, and more years of life lost to death and disability than tobacco or illegal drugs.

Thirty years ago, policy-makers just preferred to keep the whole conundrum quiet. The Framingham study, which began to examine risks for heart disease in 1948, was one of the first big studies to find heart benefits from alcohol.

Ultimately the Framingham findings were published in the company of dozens of similar ones. Now, most policy-making organizations take the lead of the American Heart Association, which suggests that moderate drinkers need not stop drinking, but that teetotalers should not aim for a few drinks a day.

**Source: This article was posted on WHO's website for Non communicable diseases and mental Health on 7 January 2003 and is originally by Abigail Zuger, *Times Colonist* (Victoria).**

**The results of a survey carried out recently revealed that our readers were interested in topics which go beyond health and pharmaceutical issues. Gender was one such topic.**

## **Gender and its relation to health**

### **What is gender?**

The term “sex” refers to the biological differences between women and men. The term “*gender*”, in contrast, refers to those characteristics of women and men that are socially and culturally determined - that is, the different behaviour, roles, expectations and responsibilities all women and men learn in the context of their own societies.

### **Why is gender relevant to health?**

Gender differences in women’s and men’s roles and responsibilities and gender inequities in access to resources, information and power, are reflected in gender differences and inequalities in women’s and men’s:

- vulnerability to illness
- health status
- access to preventative and curative measures
- burdens of ill-health
- quality of care

These differences are context specific; that is, they are particular to a certain time and place, and social, cultural, economic and political situation. Gender differences and inequalities often work to the disadvantage of women, sometimes to the disadvantage of men. Because gender differences and inequalities in any particular place combine with the effects of other forms of social division such as class and ethnicity, not all women or all men experience gender related health problems or issues in the same way.

Gender is therefore relevant to health because it affects equity in health and health care. The concept of equity suggests fairness, rather than necessarily equal treatment. A focus on equity in health aims to reduce avoidable or unnecessary unfairness or disadvantage in health and the provision of health services.

### **Current approaches to gender and health:**

Health policy makers and practitioners are beginning to recognize the importance and value of gender issues to the health field. Interpretations of gender analysis in the health fields have been varied, but two main approaches have been identified (Standing, 1997):

- a *women’s health needs* approach
- and a *gender equity* approach (also known as a gender inequality approach)

A *women’s health needs* approach is “concerned with the implications for women of differences in the epidemiological profile between the sexes” (Standing, 1997). This approach stresses that women’s particular health needs have been neglected as a result of male-centred models of health and therefore argues for the need to address these needs in a way which views women and their lives holistically - that is, it addresses the full range of women’s health problems, rather than just their reproductive health problems, and does this throughout their life cycle. Within this approach there are a broad range of political perspectives.

A *gender equity approach* is “concerned with the role of gender relations in the production of vulnerability to ill-health or disadvantage within health care systems” (Standing, 1997). So far it has focused particularly on the influence of this on access to and utilization of formal health services. The concept of ‘equity’ is an ubiquitous one in analyses of the health sector but it has been notoriously difficult to fix its meaning. However, ‘equity’ can be distinguished from ‘equality’ in that *while equality*

*carries some notion of 'sameness', equity carries some notion of 'fairness'.* Therefore while a focus on equality would argue that men and women should be treated exactly the same, a focus on equity argues that men and women may have different needs and face different barriers to meeting those needs or having them met. Additionally, different needs and barriers may not lead to equal disadvantage for both sexes. An equity approach therefore stresses that health policy must consider the different and inequitable needs of men and women in *allocating resources for health* promotion, prevention and care (also considering needs according to other aspects of disadvantage, such as class, race, ethnicity, age and disability) and in *designing, implementing and monitoring health systems*. Within this approach there are still different perspectives. For example, 'equity' can be interpreted as ensuring that everyone has their basic health needs met by a guaranteed package, or it can be interpreted as redistributing resources to those with the greatest need. These different approaches illustrate that decisions about what is 'equitable' or 'fair' are inevitably *political*.

**Source: The above article is an extract from "Guidelines for the analysis of Gender and Health" published by Gender and Health Group at the Liverpool School of Tropical Medicine**

### **Have some bacteria lost their resistance to older antibiotics?**

Recent reports have lent support to the potential use of older generation antibacterial drugs to treat infections caused by new resistant bacteria. The Morbidity and Mortality Weekly Report recently described two isolates from the United States of vancomycin resistant *Staphylococcus aureus* with a minimum inhibitory concentration 32 µg/ml, both of which were found to be sensitive in vitro to co-trimoxazole as well as to other older antimicrobials. Co-trimoxazole was successfully used to treat one of these patients. Unpublished data from our institution and elsewhere show that in the last 15 years isolates of methicillin resistant *S aureus* (MRSA) have progressively, and by now almost universally, become susceptible to co-trimoxazole.

Preliminary data indicate that this drug can be used as an alternative to vancomycin to treat infections due to MRSA and include a case report about co-trimoxazole being used successfully to treat a patient with endocarditis that failed to respond to linezolid.

Chloramphenicol, a drug introduced 50 years ago and essentially abandoned in the past three decades, has been reintroduced recently to treat severe infections caused by vancomycin resistant enterococci. A report from India describes the re-emergence of susceptibility to chloramphenicol in *Salmonella typhi* isolates that are increasingly resistant to quinolones and lactams. The authors suggest reintroducing this drug to treat typhoid fever.

In a recent report from France, Stein and Raoult used colistin, an old and rarely used antibiotic, to treat bone infections caused by a strain of *Pseudomonas aeruginosa* with resistance to all other antibiotics tested. The same drug has been used to treat infections caused by multiresistant strains of *Acinetobacter baumannii*. Sulbactam, a drug introduced in the early 1980s, is increasingly being used for the same purpose. As an alternative to third generation cephalosporins and vancomycin, high doses of penicillin are being proposed to treat pneumococcal infections caused by strains with intermediate levels of penicillin resistance (minimum inhibitory concentration 4-8 µg/ml).

Despite extensive research the pace of development of antibacterial drugs has not kept up with the increase in bacterial resistance. As more and more organisms develop resistance, concern is growing that we may be approaching the end of the antibiotic era. The intensive use and excessive abuse of antibiotics have resulted in the selection of bacteria that are resistant to many and sometimes all antibiotics. For unclear reasons, these multiresistant organisms either retain or regain susceptibility to certain antimicrobials.

Measures to counter the threat of rapidly escalating antimicrobial resistance include surveillance of susceptibility to and consumption of antibiotics, rational use of antibiotics, better compliance with measures to control infection, and increasing development and use of vaccines.

Are we reverting to the pre-antibiotic era or advancing into the post-antibiotic era? One of the crucial questions is whether the above mentioned examples will remain anecdotal or whether a real chance exists for the strategic use of forgotten drugs on a large enough scale to affect clinical management.

*Source: Old drugs for new bugs by Silvio Pitlik, (BMJ 2003;326:235-236 1 February, 2003).*

### **Interactions between complementary medicines and Warfarin**

Many complementary medicines have confirmed or potential interactions with warfarin. These interactions can increase or decrease the anticoagulant effect of warfarin and have the potential to cause serious adverse events. A number of herbs and foods alter the metabolism of warfarin by acting on cytochrome P450 enzymes. Other potentially interacting complementary medicines include those with possible effects on platelets and those containing natural coumarins. Warning both consumers and prescribers of warfarin about the potential for interactions with complementary medicines may reduce the risk of these interactions. Such warnings are appropriate for a drug that has a narrow therapeutic window and requires regular monitoring. In view of these interactions, prescribers should check the international normalized ratio within a week of a patient commencing or ceasing a complementary medicine.

*Synopsis of article by S.P. Myers appeared in the Australian Prescriber Vol. 25 No. 3 2002*

### **New drugs with novel therapeutic characteristics: have they been subject to randomized controlled trials? - Joel Lexchin**

**Canadian Family Physician 2002, Volume 48  
Pages 1487-1492**

Published randomized clinical trials (RCTs) provide doctors with a source of independent information to enable them to prescribe new medications correctly. Having RCTs available is especially important when new drugs that are completely unrelated to existing products appear in the market. The purpose of this study was to determine if there are RCTs dealing with either safety and/or efficacy when new drugs are first sold in Canada and whether these trials contain certain key elements of information that would allow physicians to prescribe the drugs appropriately.

Sixteen new drugs, made by 12 different companies, that were introduced in Canada between 1990 and 2000 were selected. A MEDLINE search was run for each drug to identify all published trials that were available when the drug was first sold. A count was made of the number of trials that dealt with safety and/or efficacy for each of the drugs. In addition the following information was extracted from each trial: the number of patients taking the study drug, length of time of the trial and whether the product being investigated was compared to a placebo or another drug.

The number of available RCTs was highly variable. For four products there were three or fewer trials prior to their marketing while for three others there were over 16 trials. For 8 out of the 16 drugs, there were multiple large studies (more than 100 people receiving the study drug). However, the 9 trials on cisapride (Prepulsid which has now been taken off the market in North America) only included a total of 254 people. Seven out of 8 studies on zopiclone (Imovane) had less than 50 people taking the drug. For 5 drugs information comparing it to other medications used for the same purpose was lacking as all of the trials were placebo controlled. Trials also tended to be of relatively short duration. Only 9% lasted longer than 26 weeks while over 1/3 were shorter than 4 weeks.

This study shows that for 25 percent of the products (4/16) there were 3 or fewer published RCTs at the time that they were marketed. Even when more RCTs were published many of them were of short duration, enrolled small numbers of patients and were placebo controlled. If only small numbers of patients have taken the drug then physicians cannot be confident that their patients are appropriate candidates for the medication. Six to eight week trials of drugs meant for long-term use such as cisapride, losartan and risperidone may mean that long-term safety and efficacy are unknown. In the absence of active controls how are physicians suppose to know where a drug like montelukast fits

into the therapeutic spectrum of asthma medications or how bupropion compares to nicotine replacement therapy for smoking cessation?

Currently Health Canada regards all the clinical trials that companies submit as part of the new drug approval process as confidential and will not release these studies without the consent of the company. Such consent is rarely forthcoming. To make up for the lack of published information on the safety and efficacy of new drugs Health Canada needs to rethink its position about the confidentiality of information that companies supply.

### **More vaccines? Using economic analysis to decide by Ulla K. Kou**

In the bulletin of the World Health Organization 2002 (pp.264 –270), Hinman et al. review the results of economic evaluation studies of rubella vaccine published between 1970 and 2000. Most of the studies they include were designed to answer the question of whether the introduction of rubella vaccine into national immunization systems is economically justified. Five out of the 17 economic evaluation studies they used were carried out in developing countries. In addition, they looked at five cost analyses from developing countries. The overall conclusion of the review is that incorporation of rubella vaccine gives economic benefits comparable to those derived from the use of hepatitis B and *Haemophilus influenzae* type b (Hib) vaccines.

Vaccination is often recognized as a more cost-effective measure than other health interventions, simply because of its preventive nature. Compared to other preventive measures, it is a relatively easy intervention to deliver because it requires only one contact, or a very small number of them, with a well-defined target group. When considering whether to introduce a new vaccine into a national immunization schedule, the level of disease burden (mortality, morbidity and disability) in the absence of vaccination, as well as treatment costs avoided from introducing the new vaccine, should be weighed against the costs of delivering the vaccine. In cost-effectiveness analyses of this kind, rubella constitutes a special example, because vaccination of women against rubella prevents birth defects due to rubella virus. The results of a cost-effectiveness analysis should be compared to similar analyses of other available health interventions. Alternatively, in countries with limited information about the economic value of other interventions, the results of the analysis should be examined in relation to the national health budget with a view to assessing affordability.

There are only a few cost-effectiveness studies of high quality available from developing countries, of which Hinman's review provides a good example. One can only speculate about whether more cost-effectiveness studies on underused vaccines, such as rubella, mumps, hepatitis B, yellow fever and *Haemophilus influenzae* type b (Hib) vaccines, could have led to a faster and more committed introduction of these vaccines into developing countries. While the decision to introduce a new vaccine is influenced by a large number of medical, political and economic factors, there is no doubt that cost-effectiveness evidence is a key tool for rational decision-making in this area.

**Source: *Bulletin of the World Health Organization 2002***

## Reporting of adverse drug reactions by nurses

Schemes for spontaneous reporting of adverse drug reactions are important to post-marketing safety surveillance worldwide. In the UK, doctors, dentists, coroners, and pharmacists are allowed to report through the yellow card scheme, but nurses were not until October, 2002. We used a similar programme to assess the role of community and hospital nurses in reporting of adverse drug reactions. The proportion and quality of reports received from nurses was similar to that of those received from doctors: we received reports from one in seven nurses eligible to report, compared with one in eight doctors; 137 of 177 nurse reports and 676 of 984 doctor reports were judged to be appropriate according to regulatory authority criteria (95% CI for difference between proportions 1.4-15.0,  $z=2.3$ ,  $p=0.02$ ). Our findings suggest that nurses, who form the largest proportion of health-care staff in the UK, can play a valuable part in improvement of pharmacovigilance.

**Source: Lancet 2003; 361: 1347-48**

## Preparing the traveler

The four steps for giving travellers the foundation for healthy journeys are to assess their health, analyse their itineraries, select vaccines, and provide education about prevention and self-treatment of travel-related diseases. This process takes time. Since there is a risk of information overload, travellers should leave the clinic with some written advice for reinforcement. The order of these steps can be tailored to what best suits the travel clinic, but vaccinating early in the process allows monitoring for adverse reactions. Face-to-face discussion is vital for explaining the use and side-effects of medications. Those who provide a travel medicine service should be seeing many travellers and should seek specialist training. In 2003, the International Society of Travel Medicine introduced a certificate of knowledge examination in travel medicine. We cannot make travellers bullet-proof but it is possible to make them bullet-resistant. The pre-travel visit should minimise health risks specific to the journey, give travellers the capability to handle most minor medical problems, and allow them to identify when to seek local care during the trip or on return.

**Source: Lancet 2003; 361: 1347-48**

## - Resources -

### **Scaling Up the Response to Infectious Diseases – A way out of poverty**

**Published by WHO, UNICEF,UNAIDS,UNESCO,UNFPA and the World Bank**

‘Today perhaps for the first time in history it is possible to launch a truly global response to the major infectious diseases that keep people in poverty, focusing initially on HIV/AIDS’ so begins the report on infectious diseases 2002 titled “Scaling Up the response to infectious diseases - a way out of poverty” published by the WHO, UNICEF, UNAIDS, The World Bank, UNESCO and UNFPA.

Scaling Up is the final outcome of a two year written project undertaken by the Commission on Macroeconomics & Health. Throwing light on the investment the Developing World could put into health and thereby the number of lives that could be saved the report also brings out the few conditions responsible for the high proportion of avoidable deaths in poor countries. Aiming to provide a study of the existing initiative against HIV/AIDS, Tuberculosis and Malaria it predominantly emphasizes the efforts drawn up to control these diseases.

The publication comes in four chapters each clearly divided into related subjects with models, strategies and resources. The introduction builds up on the three diseases AIDS, Tuberculosis and Malaria, intensively dealt with through out the publication and gives a statistical analysis on the spread of these three diseases. It is almost a summary on AIDS, TB and Malaria with steps on how to curb these diseases.

According to the report these three diseases were responsible for over 5.7 million deaths in 2001 and caused many more millions to be invalid. 36 million people suffered from HIV/AIDS alone while fourteen million women in child bearing age are infected with the virus, passing the virus onto the child. Two billion people are carriers of the Tuberculosis “bacillus” virus, while Malaria is responsible for more than three thousand deaths a day bringing the figures to one million annually. Furthermore, 5.3 million of new HIV/AIDS cases, 8.8 million of Tuberculosis cases and 300 million of new Malaria cases are reported every year. Infants, children, young mothers and fathers in the productive years of their lives fall victim to these diseases. We must take into consideration both sides of the coin at this juncture: it states, is it that these conditions of ill health contribute to poverty in a big way or is it that these infectious diseases are a cause of poverty?

Chapter 1 documents the interventions and deals with the existing tools and medicines, prevention and treatment strategies. Chapter 2 titled Health Services outlines the strengthening and expansion of health services in Developing countries to provide these interventions. Chapter 3 is on mobilizing and encouraging healthy behaviour for even if the most effective health services are freely available the choice is up to the affected people to adopt it or refuse the required healthy behaviour. Chapter 4 on “going to scale” examines on how we can curb the three diseases.

According to *Scaling up the Responses: A way out of poverty* at present we have the sufficient knowledge on health and technology to prevent many untimely deaths and perhaps reduce the suffering of millions of lives. It also analyses the major efforts against diseases of poverty stating that poverty overrides the cost of their control.

- When these diseases are targeted we can give direct assistance to the most vulnerable; (infants, young and pregnant mothers, fathers...). Poor health has always been a hindrance to survival.
- Controlling these three diseases to the minimal would hopefully result in eradicating the poor of poverty up to some extent. These victims will be able to keep their home fires burning, the future generations will not consist of more orphans growing without education, parental guidance and support and finally would be instrumental in increasing the cost of healthcare to poor families.

Controlling these diseases would also mean:

- Decreasing the business costs and increasing the productivity through reduced absenteeism, low recruitment and less expenditure on medical care.
- Stop losing ground against drug resistance.
- Reducing the risks of disease spread. International travelers can now easily cross borders carrying viruses, bacteria and parasites along with them.
- Preventing these diseases from spreading to Asia and Eastern Europe
- Strengthening health services so that trained health service providers can attend to several health needs in the rural areas.

This publication is considered a useful resource for those who have just got involved in the fight against diseases of poverty for it provides a basic “map” on the existing initiatives against HAI/AIDS, Tuberculosis and Malaria. Taking real world examples from countries around the world it comes with simple diction and an easy to comprehend style of writing.

*To order copies and for more information contact: WHO, CDS/IRC, 20 Avenue Appia, CH-1211 Geneva 27, Switzerland or via email [cdsdoc@who.int](mailto:cdsdoc@who.int)*

**‘We the Peoples’ or ‘We the Corporations’? – Critical reflection on UN-business ‘partnerships’**

**Published by IBFAN/GIFA  
Author Judith Richter**

The publication ‘We the Peoples’ or ‘We the Corporations’? was launched by IBFAN, Geneva and the NGO Forum for Health in January 2003, during the WHO Executive Board Meeting in Geneva.

The publication concludes with the statement that UN agencies are at the risk of trading away public interests in order to receive heavy funding from corporations and foundations under the pretext of

“public-private partnerships” It summarizes the whole issue in one line, “Indeed, the UN is at risk of selling it off”.

The publication explores public private partnerships as a policy paradigm basing it on a few assumptions such as: interactions with business actors based from the outset on trust and mutual benefits should be considered as “partnerships” or the PPP’s are ‘win win’ situations or more still that this policy paradigm is the policy innovation of the new millennium.

In this publication, the risks these assumptions could carry are widely argued. Since this partnership works in a manner that each party has something to gain by the corporate donations or joint ventures they come with ulterior motives. This would invariably result in one party winning something while the other losing something. Therefore, the biggest problem lies in these gains or “wins” of the private/corporate sector at the expense of the public interests. The publication argues that any interaction between the private and the public partnerships should be preceded after careful scrutiny after the gains, risks, costs and losses have been taken into consideration.

It also describes specific private public partnerships: a new phenomenon and suggests that the term interaction should be used instead of ‘partnership’. An assessment of the above mentioned partnerships should differentiate between the policy paradigm and actual public private interactions. Two kinds of public private partnerships are dealt with in this publication. Global Health alliances, joint ventures constructed on ‘public private partnerships’ model where corporations hold decision-making positions. The second, “social experiment”, in order to get engaged with the industry UN is compelled to involve themselves in the business world, such as the annual World Economic Forum in Switzerland and in various roundtable discussions between the two parties.

We the Peoples’ or ‘We the Corporations’? – Critical reflection on UN-business ‘partnerships’ brings out the actions interested networks and citizens can take against the spread of PPP’s and the PPP paradigm. As stated in the introduction “The aim of this paper is to encourage critical discussion among public interest organizations about the trend in the international health arena towards public-private ‘partnerships’. It tries to clarify some issues and to suggest actions that could help to prevent, or at least limit, the potential of public-private interactions to work against peoples’ health, social justice and democracy and to harm international public-policy making.

*For copies please contact Baby Milk Action, 23, St. Andrew’s Street, Cambridge, CB2 3AX, UK. Tel: 01223 464420/+44 1223 464420 (international contact numbers) Fax: 01223 464417 Fax: +44 1223 464417*

## **Rigged Rules And Double Standards – trade, globalization and the fight against hunger Published by Oxfam International**

Rigged Rules & Double Standards, trade, globalization and the fight against poverty is a book published by Oxfam International which brings into light a strong case for change against global poverty. The main objective of this publication is to build a movement that would transform the lives of the poor masses in a way never seen before. The publication opens with, “Increased prosperity has gone hand in hand with mass poverty...” and goes onto present the human costs of unfair trade, how the governments of rich countries use their trade policy to conduct what amounts to robbery against the world’s poor by locking them out of their markets and thereby closing all doors to escape from poverty.

This report also carries a number of chapters on Oxfam’s analysis of the rules that govern world trade. According to the Oxfam’s Trade Campaign, three reasons have been stated as to why campaign on trade and specifically why now. The first is that the existing trade system is indefensible. The second being ‘enlightened self-interest and the third the conviction that change is possible.

The first chapter carries an interesting report on Trade & globalization where they examine Globaphobes and Globaphiles and how increased trade does not guarantee poverty reduction. The second chapter is on trade as a force for poverty reduction. It demonstrates how aid could be generated in billions if developing countries increased their world exports by 5%. The chapter on “Left behind: poor countries & poor people” in the global trading system analyses how the expansion of world trade has produced some notable successes as well as disappointing outcomes for poverty reduction. Chapter four, “Market access & agricultural trade: the double standards of rich countries”

deals with how the rich countries reserve their most restrictive trade barriers for the world's poorest people therefore the full potential of trade is unable to reduce poverty. The chapter on "Trade Liberalization and the poor" analyzes how removal of trade barriers in rich countries or how carefully designed and properly sequenced import liberalization in developing countries. It also states how the IMF, the World Bank and most Northern governments are strong advocates of trade liberalization. Chapter six is all about "Primary commodities: trading into decline". How the low and unstable prices for commodities are among the most powerful influences that prevent trade from working for the poor. The problem arises because developing countries depending heavily on primary commodities and moreover half of their export earnings are on such fewer commodities. Chapter seven covers Transnational companies and technological change has it made globalization possible. But transnational companies have made it happen through their investment, production and marketing activities. Chapter eight and nine are dedicated to international trade ruling as an obstacle for development and making trade work for the poor respectively.

For anyone working on or interested in poverty and international trade this publication is a must for it deals with these two issues and still more in very simple language.

### **Dr Lee to be the next WHO Director General**

Dr Jong Wook Lee was nominated on 23 January, 2003 by World Health Organization's 32 member Executive Board for the post of Director General of the agency. The new DG is WHO's chief technical and administrative officer and sets the policy for the Organization's international health work.

Born on 12 April 1945, in Seoul, Republic of Korea, Dr Lee received a Medical Doctor (M.D.) from Seoul National University and Master of Public Health degree from the University of Hawaii. He became a tropical disease Specialist and began his WHO career in 1983 as a Consultant on Leprosy.

He has worked at WHO for 19 years in technical, managerial and policy positions, notably leading the fight against two of the greatest challenges to health and development: tuberculosis and vaccine preventable diseases of children. After heading the WHO Global Programme for Vaccines and Immunizations and serving as a Senior Policy Advisor, he became, in 2000, Director of the Stop TB programme, a coalition of more than 250 international partners including WHO member states, donors, non-governmental organizations, industry and foundations.

Dr Lee speaks English, Korean and Japanese and reads French and Chinese.

### **Training Manual On Effective Writing Available Online**

A major training resource designed to help those working in the not-for-profit sector with their writing skills in order to influence, persuade and bring about positive social change has been made available free of charge on the internet, thanks to the support of the International Development Research Centre (IDRC).

Writing for Change, originally published as an interactive CDROM by Fahamu and IDRC, is designed mainly for researchers, scientists, project managers, team members, campaigners, fundraisers, social activists and writers. Available in English, French and Spanish from Fahamu's web site (<http://www.fahamu.org>) the resource is thought to be one of the most comprehensive available, running at about 900 pages per language.

Writing for Change comprises three sections: Effective Writing: core skills, Writing for Science, and Writing for Advocacy. Extra features of this include a resource centre with suggestions for further reading and links to useful web sites and resources.