

Do NGOs Improve Wealth And Health In Africa?

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Introduction

African countries suffer from the world's highest levels of poverty, low life expectancy, disease and poor economic growth. According to the United Nations measure of development, the Human Development Index (HDI), which is a composite of a number of indicators, the 27 countries with the lowest HDI are all African.

Against this background of poverty and disease, some non-governmental organisations (NGOs) and Aid agencies are providing much needed services, such as healthcare and drug distribution, water supplies and sanitation. NGOs such as Doctors Without Borders, Oxfam, Christian Aid and the national aid agencies often do a useful job in this regard. In many cases however, these NGOs and aid agencies often pursue policies that are detrimental to the long-term growth of Africa and even advocate policies that exacerbate poverty and increase death and disease.

In general it is difficult to know how to weigh up the positive versus the negative effects of NGOs, and in Africa it is impossible. Some such as Greenpeace are nearly always malign, whereas groups like the ACA are more benign. The key point is this: although some NGOs provide short run benefits, over time their influence in Africa is malign because their political acts, either directly or via aid agencies, are nearly always detrimental.

This paper discusses the long-term harm NGOs can cause, drawing from the examples of DDT and malaria control, AIDS and drug access, and GM food policy. But drawing on these examples it is useful to first discuss the general political actions of NGOs. Most of the groups that oppose the use of insecticides, campaign against free trade and resist the adoption of new technologies are particularly guilty of exacerbating poverty. These pressure groups have infiltrated most aid agencies creating new problems. Although different, aid agencies act much in concert with NGOs, co-conspirators in a common cause. There is also some cross-over of staff between NGOs and government bodies (including the aid agencies). Much like the perennial problem of game-keepers turning poacher, regulators now become non-executive directors.

Aid agencies that focus their spending on political rather than scientific or medical grounds are equally at fault and, in some extreme cases, could be guilty of criminal neglect for failing to fund interventions that have been proven to save lives, while conducting policy experiments of dubious worth. Frequently, groups wage campaigns, which they claim represent the poor and downtrodden; but for the most part these groups represent an elitist and wealthy Northern constituency. Not only do they misrepresent themselves, but the media, much less the group themselves, seldom hold them accountable for their actions. As a result these groups often are guilty of

diverting funds and attention away from real health and development issues towards their own, often misguided, campaigns.

African Health Systems

Policy mistakes in Africa cost more than elsewhere because the health infrastructures of African countries are amongst the poorest in the world. They also have the fewest number of trained medical staff. One of the important measures of health infrastructure is the number of physicians per 100,000 people. The most advanced country in Africa, South Africa, has around 56 physicians per 100,000 people, while Botswana has only 24, Zimbabwe 14 and Zambia only 7. This compares with 270 physicians per 100,000 in the United States, 395 in Belgium and 413 in Norway.¹

Access to essential medicines varies greatly in most African countries. It is estimated that South Africa manages to ensure that around 80 per cent of the population has access to essential medicines,² while all rich countries assure either 99 per cent or 100 per cent access to essential drugs. In Malawi only 44 per cent of the population has access to essential drugs, and the figure drops to 36 per cent in Kenya and only 10 per cent in Nigeria.^{3 4} With poor access to clean water and sanitation (in Mozambique, only 47 per cent of people have access to proper sanitation and only 60 per cent have access to clean water) the incidence and spread of diarrhoeal diseases is high, claiming millions of lives every year.

This lethal mix of poverty, poor health infrastructure, unsafe water and negligent and corrupt governments (in some cases deliberately making problems worse) means that the life expectancy in some African countries can be around half that enjoyed in rich countries. In Malawi, life expectancy at birth is only 36.3 years, while in Norway it is 78.4 years. Many countries, such as Mozambique and Angola have experienced long and brutal wars, so one would not expect their life expectancy to be particularly high. Yet even relatively stable and peaceful countries such as Kenya and South Africa do not fare much better, at 48.9 years and 49 years respectively.⁵

Wealth Means Good Health

One of the reasons that Africa is so poor is that so many economies are illiberal. It is clear that governments that afford their citizens the greatest economic freedom and individual liberty also have the highest standards of living, longest life expectancies, and better economic growth. Those countries that exhibit the greatest economic freedom all have small, limited governments and secure private property rights that are defended and protected by the rule of law. The citizens of these countries have access to sound money and can convert that money into other currencies and transfer it out of the country at will.

¹ United Nations Development Programme, 2002. *Human Development Report* (www.undp.org/hdr2002)

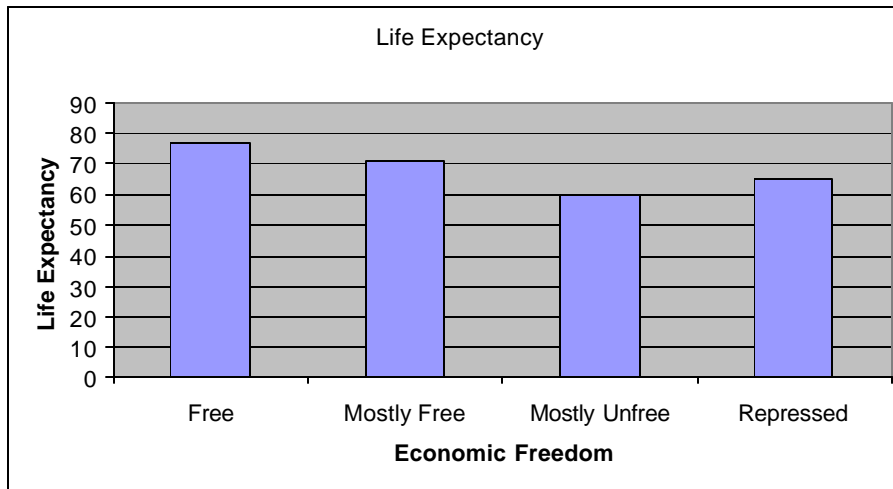
² The South African government however refuses to deliver donated or greatly discounted HIV/AIDS drugs to those that need them, so this figure could be greatly overstated.

³ As recent reports confirm, many of these drugs are counterfeit. 'India agrees to help Nigeria tackle the import of fake drugs' *Lagos* <http://bmj.com/cgi/content/full/326/7401/1234-d>

⁴ UNDP, 2002.

⁵ World Health Organisation, Country data, www.who.int/countries/en

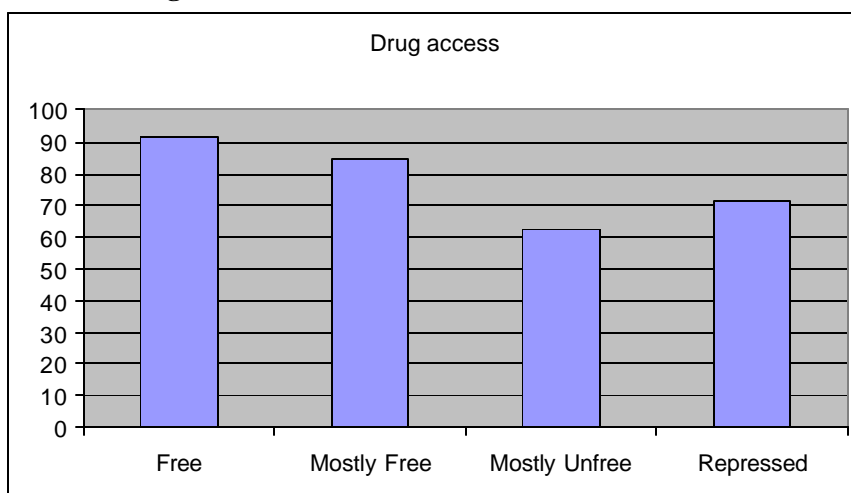
Chart 1: Life Expectancy and Economic Freedom



Source for charts 1-3: United Nations Development Programme, 2002. *Human Development Report* (www.undp.org/hdr2002) and O'Driscoll, G., Holmes, K and M. O'Grady, 2002. '2002 Index of Economic Freedom', *The Heritage Foundation & The Wall Street Journal*.

The fewer barriers to trade that exist, the greater the economic growth and prosperity. Voluntary exchange is a positive sum game: both parties gain. Contrary to the popular view that freer trade harms vulnerable groups, the poorest tend to benefit from freer trade. Minimum wages and other legislation that interfere with labour markets tend to protect those that are already employed or enjoy union protection, the relatively well off in most of Africa. Labour legislation tends to discriminate against the most vulnerable and poorest and interferes with their ability to strike their own employment bargains.

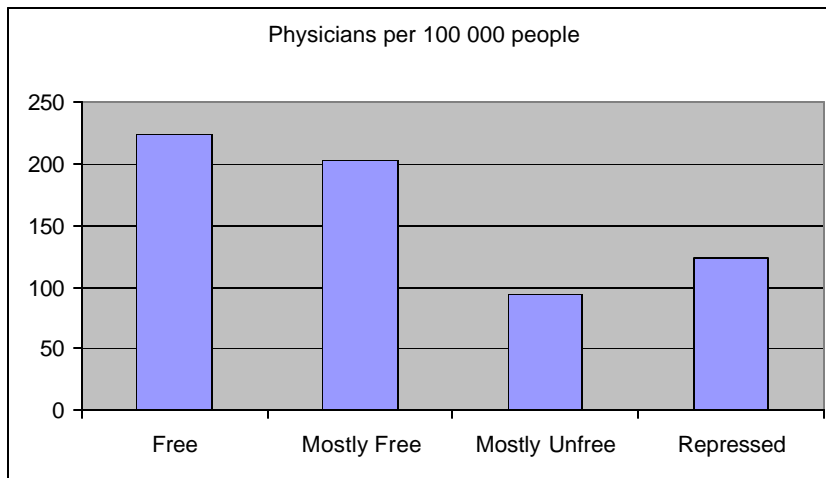
Chart 2: Drug Access and Economic Freedom



It makes little difference whether a country is in the Far East, Europe, North America or Africa. A country's wealth and prosperity do not depend on natural resources or the race of its inhabitants: they depend on the freedom that the government gives individuals to achieve their full potential without political or ideological interference.

Countries that ensure that the above institutions are in place are richer, and they grow faster. People in free countries also live longer and to a very large extent have a better health infrastructure, at least as is measured by the number of physicians per 100,000 people.

Chart 3: Physicians per 100,000 people and Economic Freedom



It is interesting that the most repressed countries in the world have more physicians per 100,000 people than those countries that are mostly unfree. This is because many of the repressed countries, such as Belarus, Uzbekistan and Turkmenistan had priorities set by the Kremlin, of which medical training was considered important.

It does not necessarily follow that these repressed countries have better health technology or that people in those countries enjoy better healthcare. Indeed the case is often made that Cuba – a repressed country - has an excellent health service and good dental care. It is difficult to evaluate Cuban health statistics because of the closed nature of the country. But it is relevant that the residents of Florida do not float on bits of wood through shark-infested waters to get into Cuba in order to see a specialist.

Despite the clear benefits, for all sectors of society, from the institutions of a free society, most NGOs actively campaign against free trade. For example, Friends of the Earth, the UK based lobby group maintains that the global trading system:

- Wrecks the planet;
- Increases the gap between rich and poor;
- Destroys natural resources;
- Abuses the democratic process;
- Threatens human rights; and
- Disregards the environment.⁶

These passionate claims are made despite the fact that increased trade brings clear advantages to the world's poor and need not destroy the planet. It is not just the major

⁶ Friends of the Earth, UK. (http://www.foe.org.uk/campaigns/global_trade/issues/wto/index.html)

environmental groups that promote policies that harm poor countries. The Heinrich Böll Foundation, which is funded by the German government, condemns science, technology and Western institutions. In its Johannesburg Memo, prepared for the World Summit on Sustainable Development, the Foundation criticises policies that would create wealth and economic opportunities for the world's poor. The problem with these policies, the Foundation claims, is that policies that aim at raising the living standards of the poor do not reduce wealth of the rich. Specifically the Johannesburg Memo writes:

In short, they work at lifting the threshold - rather than lowering or modifying the roof ... Poverty alleviation, in other words, cannot be separated from wealth alleviation.⁷

Many of these groups, such as Greenpeace, are, in the words of Niger Innis from the Congress of Racial Equality (CORE), a 'Powerful elite of First World activists whose hardcore agenda puts people last.'⁸ It appears as if most of these groups feel that they are not required to be accountable for their actions. Many of their programmes and campaigns simply keep Africans poor and hungry. In some extreme cases, their agendas costs lives, and the campaign against the use of pesticides in public health, and particularly against the use of DDT, is the most striking example.

Bad Medicine – DDT, Green Activists and Malaria Control

Perhaps the clearest example of NGO influence - and the best example of eco-imperialism - to date relates to the restrictions placed on a chemical that is responsible for saving many millions of lives and restricting malaria to the tropics. Dr. Paul Müller, a Swiss chemist who later received the Nobel Prize for his DDT work, was the first to discover the insecticidal properties of DDT (dichlorodiphenyltrichloroethane). The Allied forces were the first to use DDT in public health programmes in order to halt the spread of parasitic diseases during the Second World War, dusting troops and civilians with it in order to kill parasites such as lice. They also used it to kill the adult *Anopheles* mosquitoes that were spreading malaria in both the European and Far East theatres of war.

So successful was the use of DDT in malaria control that, shortly after the Second World War, the World Health Organisation (WHO), with funding from the US Agency for International Development (USAID), launched a global malaria eradication programme. The use of DDT in indoor residual spraying (IRS) formed the base of this programme. Applicators mixed the insecticide with water and sprayed it on the inside walls of houses where the adult *Anopheles* mosquito rested. The results were almost immediate and startlingly successful.

Within just a few years, public health efforts using DDT had eradicated malaria from southern Europe and the United States. Prior to DDT use, India recorded 75 million cases of malaria per annum with around 800,000 deaths. After the introduction of DDT to malaria control, the number of cases fell to just 50,000. Sri Lanka also

⁷ Peron, J. 2002 'What the Greens Really Want.' *Friedrich Naumann Foundation*, Johannesburg.

⁸ Congress of Racial Equality held a demonstration against Greenpeace in Liberty State Park, New Jersey on 10 May 2003. http://www.core-online.org/news/release_4.htm

achieved dramatic reductions in malaria cases from DDT use when the cases fell from around 3 million to just a few hundred, and malaria mortality dropped to zero.⁹

Despite the initial spectacular successes in malaria control, the eradication plans failed. It soon became clear that basing an entire malaria control programme on the use of one weapon, DDT spraying, was not wise. It was difficult to ensure that the spraying was done correctly, and in many cases the control teams became complacent after the initial easily won successes. In some areas, insecticide resistance to DDT meant that the insecticide was not as effective, and the numbers of malaria cases began to creep upwards.

After the failure of the malaria eradication plans, the WHO abandoned the idea of eradication and embarked on malaria control programmes. The vector management of these control programmes had a far lower emphasis on the use of DDT in particular and, indeed, on indoor residual spraying with insecticides in general. DDT was also used very heavily in agriculture, and this agricultural use sparked an environmentalist backlash against the insecticide. The environmentalist pressure against insecticides and DDT in particular that began in the 1960s with Rachel Carson's *Silent Spring* infiltrated the WHO and donor agencies.

The newly formed Environmental Protection Agency (EPA) banned DDT for agricultural use in the United States in 1972 after a relentless campaign by environmental groups, most notably the Environmental Defence Fund (EDF). The EPA was keen to demonstrate its discretionary power, and DDT was a perfect test case. The EPA ran hearings over 7 months, and scientists presented evidence for and against the banning of DDT. After all the evidence had been presented, the hearing examiner ruled that there was no evidence to support the banning of DDT. However, in a purely politically motivated move, the head of the EPA, William Ruckelshaus - who did not attend a single hour of the hearings - overruled this decision and banned DDT anyway.¹⁰

Most countries followed suit and banned DDT for agricultural use. Although the insecticide is still available in many countries for use in public health, the focus in malaria control is primarily on the use of insecticide treated bed nets (ITNs), with a very minor focus from international agencies, such as the WHO and donor agencies, on IRS.

Although malaria eradication with the use of DDT failed, the insecticide still remains an important component of almost all successful malaria control programmes. South Africa still relies heavily on DDT. Although it removed DDT from malaria control in 1996 after considerable pressure from environmental groups, it had to reintroduce it in 2000 after one of the worst epidemics in the country's history. Between 1996 and 2000, the number of malaria cases rose by around 1000 per cent, and clinics were unable to cope with the number of malaria patients.

The insecticide that replaced DDT, a synthetic pyrethroid, was ineffective as the *Anopheles* mosquitoes developed resistance to it. In fact, one of the most efficient

⁹ Gordon, E. 1999. 'Science, Pesticides and Environmentalist Politics.' *Executive Intelligence Review*, 20-31.

¹⁰ *ibid.*

malaria vectors, *Anopheles funestus*,¹¹ returned to the country despite its eradication in the early 1970s. It was the presence of this pyrethroid resistant mosquito that primarily caused the malaria epidemic.¹²

The use of DDT in well-managed malaria control programmes in Swaziland, Zambia, Namibia, Madagascar and other African countries have kept malaria cases low. DDT has been a vital tool available to malaria control officers. In their haste to abandon DDT use, public health officers lost sight of the fact that it is not the use of the insecticide per se that led to the failure of the malaria eradication plans, but the poor planning, lack of scientific support and poor logistics, and the initial extreme optimism that total eradication was possible. Where these factors are in place, DDT and indeed IRS has been one of the most effective and cost efficient ways of controlling malaria.

Green groups that campaigned against DDT in the 1960s and 1970s continue to demand that the production, trade and use of the chemical is either phased out or immediately halted. Donor agencies, under pressure to conform to environmental standards in the west are reluctant to fund IRS and are particularly unwilling to fund the use of DDT in malaria control. The Swedish International Donor Agency (SIDA), for example, claims that it cannot fund the use of DDT in poor countries because it is banned in Sweden. This argument may seem acceptable and even desirable; if something isn't good enough for the Swedes, can its use be justified on impoverished Africans? Yet SIDA fails to take into account the different risks that Africans face. If around 3 per cent of European children were dying of malaria every year and one of the few effective weapons to fight it was DDT, one could be sure that most European governments would sanction its use, as indeed they did when malaria was a problem in Europe. The argument that Africans should not use technologies that are not acceptable in the West is quite simply dressing up a callous disregard for human life in a politically correct, egalitarian camouflage.

Other donor agencies, such as USAID argue that they are permitted to fund DDT use, but only in emergency situations and as a last resort once all other tools have been used. One wonders exactly how bad malaria deaths have to be before USAID considers it an emergency. Would 3 million deaths force a change in policy? Perhaps 5 million deaths would be considered sufficiently high. USAID will only fund the use of ITNs in what is increasingly becoming a gruesome scientific experiment using Africa as a testing ground. Millions are paying with their lives so that USAID can see whether ITNs work. In the meantime a proven and highly successful life saving tool, IRS, is ignored. (It is fortunate for South Africa that they can fund DDT spraying from their own Treasury, if they were as poor as other African nations their malaria problem would be far worse than it is today).

¹¹ *Anopheles funestus* only feeds on humans and tends to live only in human dwellings. This greatly increases the chances that it will transmit the malaria parasite from one human to another. Other *Anopheles* species feed on animals as well as humans, which makes them less effective at transmitting malaria.

¹² In addition to the insecticide resistance, drug resistance was an increasing problem, and the first line treatment of Sulfadoxine Pyrimethamine was soon to be replaced with more effective Artemisinin based combination therapies.

The Stockholm Convention on Persistent Organic Pollutants (POPs)¹³ is designed to either restrict or eliminate the production and use of 12 POPs, one of these being DDT. The Convention has given DDT an exemption for use in public health, but many groups such as Greenpeace and WWF began the negotiations demanding a complete phase out of the chemical by 2007. In light of the strong position that developing countries, most notably South Africa, were taking in defence of DDT, many of these groups changed their opinion and relented slightly and acknowledged that DDT has an important place in malaria control. Yet the exemption for DDT is worth little if developing countries are unable to use the chemical because the bodies that fund malaria control refuse to fund its use.

The Stockholm Convention requires that the Secretariat establishes and maintains a DDT register. All countries that wish to either produce or use DDT must notify the Secretariat and be included on the register. Although the Convention is not in force yet and the register is not yet established, some countries have expressed their intention to be included on the register. To date, only 3 countries, China, India and Russia have indicated that they will seek exemption to produce DDT. So far, 30 countries¹⁴ have expressed their intention to use DDT in disease control, and 4 countries¹⁵ intend to use DDT as an intermediate product in the production of other chemicals. The Russian Federation intends to produce DDT for disease control only, but so far has not requested permission to produce or use DDT as an intermediate product.

While the option to continue using DDT according to Annex B is desirable and welcome, it comes with a number of onerous obligations on those DDT exempted countries. For instance, the Convention requires that every 3 years the Annex B countries must inform both the Secretariat and the WHO on 'the amount used, the conditions of such use and its relevance to that Party's disease management strategy, in a format to be decided by the Conference of the parties in consultation with the World Health Organisation' (Annex B, Part II, paragraph 4).

The Convention also requires the parties to develop regulatory and other mechanisms to ensure that DDT is only used in vector control (Annex B, Part II, paragraph 5(a)(i)), to implement sustainable alternatives to DDT and to strengthen the healthcare systems to reduce the incidence of the disease. While these conditions may not seem onerous for Western countries, they could be very burdensome for some poor countries, such as Eritrea and Mozambique that are struggling to rebuild after civil wars and may have other far more urgent national priorities.

Paragraph 2 of Part II of Annex B stipulates that DDT may only be used in accordance with WHO recommendations and guidelines and only when 'safe,

¹³ See <http://www.pops.int/> for the full text of the Stockholm Convention.

¹⁴ The following countries have expressed their intention to use DDT in public health: Algeria, Bangladesh, Cameroon, China, Comoros, Costa Rica, Côte d'Ivoire, Ecuador, Eritrea, Ethiopia, India, Islamic Republic of Iran, Kenya, Madagascar, Malawi, Mauritius, Morocco, Mozambique, Papua New Guinea, Saudi Arabia, South Africa, Sudan, Swaziland, Togo, Uganda, United Republic of Tanzania, Venezuela, Yemen, Zambia and Zimbabwe. (UNEP, Stockholm Convention exemptions lists, received 22 May 2001. ref. UNEP/POPS/CONF/INF/1/Rev.3 14 June 2001)

¹⁵ India, Republic of Korea, Brazil and China have requested permission to use DDT as an intermediate. (UNEP, Stockholm Convention exemptions lists, received 22 May 2001. ref. UNEP/POPS/CONF/INF/1/Rev.3 14 June 2001)

effective and affordable alternatives are not available to the Party in question.’ South Africa has arguably the most advanced public healthcare system in Africa and has a very well funded malaria control programme. Yet this country tried to eliminate the use of DDT from malaria control without success. As mentioned above, due to insecticide resistance, the alternative insecticides failed, and the country suffered a devastating malaria epidemic. It is increasingly clear that DDT will probably always be required in malaria control in order to manage resistance. There are only 4 classes of insecticides: organophosphates, carbamates, synthetic pyrethroids and organochlorines. There are no organophosphates that are suitable for IRS, and mosquitoes are increasingly resistant to synthetic pyrethroids. Carbamates are effective, but they are around twice as expensive as the synthetic pyrethroids and four times as expensive as DDT.

If carbamates were to come down in price dramatically and could be used within the budgets of malaria control programmes in poor countries, this would mean that a safe and affordable alternative to DDT would be available. Yet, this would mean also that the malaria control programmes would have only one reliable insecticide upon which to base malaria control, which, given the problem of insecticide resistance, would be highly risky. So even if safe and affordable alternatives were available, mosquito control programmes would probably still need to use DDT in order to manage insecticide resistance.

The problems faced by public health systems in Africa are numerous and highly complex. Introducing new and affordable drug therapies for malaria is a key objective for most departments of health, and indeed South Africa has done this. Yet the introduction of the expensive new artemisinin based combination therapies would have been far more difficult in South Africa had not the use of DDT dramatically lowered the total number of malaria cases. Many countries may find it impossible to improve health care systems (as required by paragraph 5(a)(iii) of the Convention) without DDT to reduce the total number of patients requiring treatment in the first place.

Every three years, in consultation with the WHO, the Conference of Parties (COP) will review the DDT exemption. Given the power that environmental lobby groups have in swaying opinion at the COP negotiations and the poor representation that most malarial countries have, it is conceivable that the exemption could be rescinded while DDT is still required in public health programmes.¹⁶ It is important to note that the head of the US delegation to the POPs Convention, Brooks Yeager, now works for WWF, one of the main groups opposing DDT use.

Most environmentalist groups have lauded the Stockholm Convention as a great victory for the environment and supposedly for human health. Yet while the Stockholm Convention recognises the ongoing need for DDT in public health programmes, it will most likely severely undermine public health efforts. The Convention removes decision making from health experts and scientists in developing countries and burdens poor country governments with excessive reporting and bureaucratic requirements.

¹⁶ During the 5th Intergovernmental Negotiating Committee Meetings of the Stockholm Convention in December 2000, there were approximately twice as many environment activists at the negotiations as there were members from all the sub Saharan African countries.

The DDT issue demonstrates clearly how a green agenda can be turned into international regulation, with little or no consultation with developing countries, and can result in increased poverty, disease and misery. Ironically this kind of legislation and the campaigns behind it can exacerbate environmental problems by keeping people poor and more reliant on the natural environment for survival.

Drug Development, Drug Access and Activism

Another issue that is filled with controversy is the role that the pharmaceutical industry plays in healthcare in poor countries. Here again, as with the DDT issue, campaigns waged against drug companies could be doing long term harm to poor countries and could cost lives in the long run. One of the most controversial issues at all major international health and trade meetings currently relate to drug access in poor countries, and most particularly to access to HIV/AIDS drugs. Drug activists, such as HealthGap and Medecins Sans Frontiers¹⁷ (MSF) have run a largely successful campaign to lower drug costs and undermine drug patents that have been given for HIV/AIDS drugs.

These campaigns have been successful on one level in focussing the world's attention on the desperate conditions of AIDS sufferers in poor countries, most particularly Africa. Drug prices have come down dramatically since these campaigns began, yet access to drugs still remains low and in some cases almost zero. The problem has been that the focus of these campaigns has been on drug patents while largely ignoring some of the basic realities that health systems in Africa face, thereby possibly doing more long term harm than good.

To cut a long story short - the price of drugs is a small factor in lowering access to AIDS drugs. But as the fixation of the left-leaning health NGOs, it has led them to concentrate on this issue at the expense of more important matters. It has been very widely argued that a system of intellectual property protection allows drug manufacturers to make unfair and excessive profits from their patented drugs. Furthermore these drug patents prohibit generic competitors from producing their own versions of these drugs, hence prices remain high and out of reach of the world's poor.

On closer examination, one finds that in Africa, the continent worst hit by the HIV/AIDS crisis and home to the world's poorest people, there is little relationship between the degree of drug patenting and access to those drugs. In a study completed in October 2001 and published in the *Journal of the American Medical Association*,¹⁸ researchers Amir Attaran from Harvard University and Lee Gillespie White from the International Intellectual Property Institute find little or no relationship between drug patents and access to drugs. Attaran and Gillespie White asked a simple question: If drug patents are an important barrier to ARV drug access, how widespread are the ARV drug patents in Africa? The researchers surveyed the extent of patenting of 15

¹⁷ MSF primarily does very important life saving work in many of the world's poorest countries and in some war torn countries, for which it recently received a Nobel Prize. The group also runs a highly active campaign to increase drug access that is largely focussed on undermining drug patents.

¹⁸ Attaran, A. and Gillespie-White, L. 2001. 'Do Patents for Antiretroviral Drugs Constrain Access to Aids Treatment in Africa?' *Journal American Medical Association*, October 17, 286(15).

ARV drugs in the 53 African states. They found that out of the 795 patents that could exist (15 drugs multiplied by 53 countries), only 172 actually exist. In other words, only 21.6 per cent of possible patents actually exist in Africa. The country with the most drugs patented is South Africa, with 13 patents, followed by Zimbabwe (8) and Kenya, Sudan, Gambia and Uganda (7). Crucially, the authors found little relationship between the degree of drug patenting and access to drugs, pointing to other factors such as a lack of donor funding, poverty and poor health infrastructure as reasons for low or non-existent access to ARV therapies.

This finding greatly undermines the arguments put forward by many that Africa would be able to deal with its health crises if only it had the power to import cheap generic drugs or to issue compulsory licences. A country such as Kenya, where fewer than half of the available ARVs are actually patented and which has a local pharmaceutical industry, could have allowed local production of ARVs for many years. Indeed the country could have imported generic drugs from countries such as India, which does not respect patent laws, perfectly legally. Kenya and most African countries do not have to wait for the TRIPS negotiations to come to a conclusion before they start importing generic drugs; they can do so right now for those drugs that are not patented and remain within international law.

In what must be regarded as a low point in the drug activist's history, MSF and other groups endorsed the moves by Zimbabwe in May 2002 to undermine drug patents and authorise the use of generics for its HIV/AIDS programme. In the first instance, only half of the available ARVs are patented in Zimbabwe anyway, and those that are patented have been offered at discounts of up to 90 per cent or even for free. It seems that this step was entirely unnecessary for the government and was a political decision, rather than a decision designed to increase drug access.

In endorsing the move, MSF undermined the local Zimbabwean drug activists who were very critical of the patent-busting tactic. Zimbabwean drug activist Jeter Mxotshwa called for government to improve the health infrastructure and pay doctors and nurses better.¹⁹ The reality is that people in Zimbabwe are not getting access to drugs not because of patents, not because of drug company profits and not because of the capitalist system. People in Zimbabwe do not have access to essential drugs because their leader has been robbing the treasury for the last 20 years. The president has shown more commitment to fighting his personal war in the Congo than to improving the health infrastructure. The government is more concerned with arresting journalists and torturing the political opposition and fixing elections than in delivering drugs. President Mugabe has blamed AIDS on homosexuals; in fact he has pretty much blamed everything on homosexuals and actively advocates violence against and harassment of homosexuals. For all this, the country has been expelled from the Commonwealth.

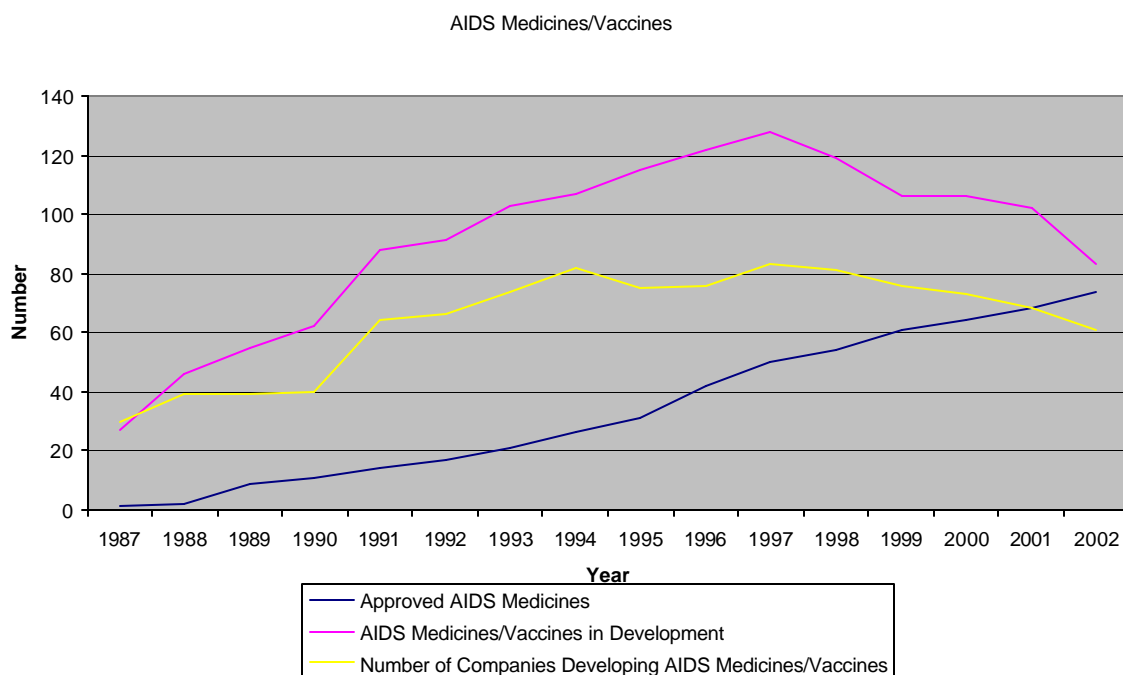
It is extraordinary that a Nobel prize winning group would chose to support and endorse the moves of one of Africa's worst tyrants and of a government that is responsible for untold human rights abuses and misery. Yet perhaps this illustrates that some activist groups are more interested in pursuing an ideological campaign

¹⁹Masunda, D. 'Question mark greets new aids directive.' *Financial Gazette*, Harare May 30, 2002. <http://allafrica.com/stories/200205300187.html>

than in necessarily ensuring a better life for people in poor countries. Tragically, the Zimbabwean move to undermine drug patents has not benefited anyone. No generic drugs have been imported and no additional patients are receiving antiretroviral therapy.

More worrying than the outrageous endorsement of Zimbabwe's government is the effect that these anti-pharma campaigns could have on future drug development. Over the past five years there has been a 33 per cent reduction in AIDS drugs in development. There are several reasons for this; there are already many products on the market, the number of AIDS cases is declining in Western countries, and new forms of research may be refining study areas, but there is no doubt that a significant cause is activist pressure on patents and prices.²⁰ Over the same time,²¹ there has been a consistent increase in the number of medicines developed for infectious diseases. The numbers of new antibiotics, anti-fungals, vaccines, anti-virals and other biologics in development have increased by over 100 per cent in the past 9 years. If one includes responses to bio-terrorism threats, the increase is even greater. At the end of 2002, 256 medicines were in development, 187 were in clinical trials or awaiting approval by the Food and Drug Administration, and 69 were in pre-clinical development.

Chart 4: AIDS Medicines/Vaccines



Source: AIDS Reports from PhRMA. *Progress in Aids Drug Development 1988-2002*.

²⁰ See www.fightingmalaria.org/aidsresearch.htm

²¹ PhRMA Annual Surveys: 'New Medicines In Development for Infectious Diseases', 1994, 1996, 1998, 2000, 2002.

However, the AIDS situation has worsened globally each year. According to UNAIDS, at the end of 2002, there were at least 40 million people world-wide with AIDS, over 26 million of whom are in the most impoverished part of the world, Sub-Saharan Africa. Of these 40 million people, far fewer than a million are receiving treatment. Even though many poor countries are pursuing education programmes against the disease, UNAIDS predicts that the number of cases will increase substantially over the coming years, as many as 25,000 new cases could occur each day - over 7 million new cases in 2003 alone.

As can be seen from Chart 4, the approval of AIDS medicines has gradually increased over time, and each year the total number of drugs approved is higher than the year before - over 75 at the end of 2002. However, the number of AIDS drugs in development and the number of companies developing the AIDS drugs both reached a peak in 1997 and have declined ever since. In 2001, for the first time, the number of approved AIDS medicines was greater than the number of companies developing the medicines themselves. The trend of declining company interest, which is causing fewer new drugs to be developed, looks set to continue in 2003.

This recent decline in AIDS drug development should be contrasted with the significant increase in development of drugs for infectious diseases. This is important because it appears that drug research and development is increasing in general for communicable disease, while declining for AIDS. It is also important to note that the decline in company interest is not manifested within the major companies, such as Merck, Bristol-Myers Squibb and GSK. It is smaller, usually younger companies, often biotech start-ups, which are no longer developing drugs, and enduring the risk of clinical trials in this area. Small companies such as VIMRx Pharmaceuticals, which was working on AIDS anti-cancer and anti-infective drugs in the late 1990s, are no longer engaged in such research.

The decline in small company interest is a worrying trend, because, according to Frank Lichtenburg of Colombia University, there has been a reduction of 6,100 AIDS deaths in America for each new drug developed.²² New drugs have reduced the number of AIDS deaths in America from 51,670 in 1995 to 15,603 in 2001. The trend is especially worrying since 'resistance remains a formidable problem' according to Dr Richard Colonna of Bristol-Myers Squibb. As Dr Michael Rogers, head of HIV Clinical Development at GSK said in 2001 'We are constantly looking for new drugs that can defeat these mutated viruses'. This means that some of the currently used drugs will probably become ineffective in the near future. While the activist campaign has lowered the price in the short run, in the longer run there may be fewer drugs available.

There are 42 million people with AIDS around the world, and every day thousands of new people become victims of the worst plague since the Black Death killed a third of Europe over 600 years ago. However, most AIDS cases occur in the poorest parts of the world, and AIDS is falling in the affluent North (especially Europe, America and Japan). There used to be 60,000 to 80,000 new AIDS cases a year in America, with a similar number in Europe. Today, on both continents, the number is below 45,000 and

²² Lichtenburg, F. 2002. The Contribution of New Drugs to Health and Economic Growth in the United States (November 18th). www.aei.org/doclib/20021229_conf021118c.pdf

falling. This drop off sends a message to drug companies that they are dealing with a disease that affects only a small number of affluent patients. It is ironic that the drug companies are perceived as heartless and driven purely by profit. If that were the case, they would be spending as much money on AIDS as they would on some genetic disorder affecting less than 0.02 per cent of Americans, which is to say not a lot.

One of the unfortunate consequences of the focus on drug patents as a barrier to drug access has been that attention has drifted from the real issues that could improve wealth and health in poor countries. At a workshop in Kenya in February 2003, the Kenyan Minister of Trade and Industry lamented the fact that the Trade Related Aspects of Intellectual Property Rights (TRIPS) treaty was still being negotiated at the WTO.²³ His concern was that attention was not being given to increasing trade in agriculture and in lowering agricultural barriers to trade.

Increasing trade, particularly in agricultural goods, is probably the most effective way of increasing economic growth and wealth creation in poor countries. This in turn puts these countries in a better position to develop their health systems and ensure that they improve healthcare and drug access in the long run. Yet many of the drug activists are guilty of prolonging the negotiations on TRIPS, despite the fact that there is little evidence that TRIPS is the problem. As described above, the health systems in most poor countries are almost non-existent, so it is not surprising that when drug prices come down, even to zero, the drugs are still not available to the poor.

Food Emergency in Southern Africa

The third example of NGO interference and action relates to genetically modified food aid in Africa. While continued European political opposition to genetically modified food may soon cause a trade war with the United States, as the US challenges the EU moratorium at the WTO, European policy, driven by NGOs, is already contributing to starvation in Africa. Earlier this year rejection of American GM food aid exacerbated the food crisis in Southern Africa, where over 14 million people were at risk of starvation and a few million still are.

By way of background, it is important to briefly compare today's situation with the terrible drought and famine that occurred in Southern Africa in 1991-1992, because although today's drought is nowhere near as bad, the rejection of GM food aid is causing all sorts of problems. In 1991-1992 18 million people were at risk. From central Zambia through Malawi and Mozambique southward, there were seasonal rainfall deficits as high as 80 per cent, with cereal production in the region down by 54 per cent. In some Southern African countries, production fell by nearly 70 per cent.

The current drought is far less severe, with yields dropping on average only 7 per cent. Furthermore, the UN World Food Programme started feeding 2.6 million people by February 2002, after drought warnings as early as December 2001. Compared with 1991-1992, the situation is far better; there is far less severe crop damage, an improved famine early warning system that led to food aid, more peace in the region, and a far smaller drought area. Hence fewer people are at risk. However, the news is

²³ Comments made during the closing address of the Inter-Region Economic Network workshop for journalists on the WTO, Nairobi, Kenya, 6 February, 2003.

far from good. Although the drought has reduced yields by only 7 per cent on average, in key countries it has dropped far further. Zambia's yield is down by 35 per cent and Zimbabwe's 71 per cent. Furthermore, per capita yields are lower as population has increased by 15 per cent over the past decade (even with AIDS and malaria a significant problem) in these countries. Donor response has been slower and less generous than in the previous drought, partly because of historic mismanagement in the aid distribution. But donors have been even more concerned by corruption and overtly harmful domestic policies.

Malawi

In 2001 Malawi had a Government surplus of nearly 200,000 tons of grain. A European Commission study concluded that a 60,000-ton reserve would be a sufficient buffer against drought. The EC and the IMF advised Malawi to sell some of its reserves to help offset the budget deficit. However, the Malawi National Food Reserve Agency sold off all but 4,000 tons of its reserves to private grain traders. Much of the local media, many of whom are hostile to business and markets, claimed that the traders hoarded the grain and tried to ramp up prices.

The notion that the grain had stayed in Malawi and corrupt traders were keeping it from the locals is mistaken. When the Malawi Government subsequently asked for help, donors refused on the grounds that the money raised from the sale of nearly 200,000 ton of grain could not be found, and the food had left the country for uncertain destinations. Eventually the Government had to take out a \$35m loan to import 135,000 tons of maize, which took several months to arrive. Save the Children UK and other NGOs complained that the urban elite in Malawi ignored the rural poor: 'Every day that passes without a response to this crisis is a death sentence to hundreds', they said in an open letter to the Malawi Government.

Zambia

In August 2002, Zambia decided to ban the import and distribution of all genetically modified food, including the corn being offered as aid from the United States. Although it had accepted GM food aid for the previous 6 years, environmentalists from Europe had finally managed to influence local scientific opinion. In an assessment provided by Dr Mwananyanda Mbikusita-Lewanika, a biochemist from the National Institute for Scientific and Industrial Research, he claimed that not enough was known about GM food safety. As a result he invoked the precautionary principle and said Zambians should not consume GM products until he was sure they were safe. He also said that if local farmers planted GM corn it could present a threat to the environment, damaging local varieties of maize, millet or sorghum. Zambia's Organic Farming Association also pressured the government not to allow GM food aid because it did not want the country to become known in Europe as one in which GM crops might be grown.

Facing nationwide famine, Zambian President Levy Mwanawasa appeared poised to lift the ban in late October. According to insiders he had hoped that the report he was due to receive from Zambian scientists touring GM experimental sites in Europe and America would give him the go ahead. But since Lewanika was head of this scientific team, and he was taking advice from Friends of the Earth Netherlands and British

Action AID (groups opposed to biotechnology), he maintained his anti-GM stance in the report. Then Opposition Patriotic Front leader Michael Sata's support of GM food aid made Mwanawasa's ability to overturn his own scientist's report impossible. Any politician who follows Sata's lead, claiming GM food must be allowed in because people are starving, is now threatened with arrest.

Zimbabwe

Zimbabwe provides the worst examples of mismanagement in Africa. In addition to President Mugabe's despotic rule, the Agriculture Minister denied, until after the elections were completed in March 2002, that there was any food crisis. Additionally, the Mugabe government has intimidated anyone who has tried to get food aid to locations that are opposition politician strongholds. The Mugabe government even harassed officers from UN World Food Programme and seized the grain the Programme was trying to distribute in October 2002.

Had the African leaders accepted GM food aid, they could have averted the famine in Zambia and elsewhere. But the invocation of the precautionary principle, the Cartagena Protocol on Biosafety and all manner of EU NGO-driven regulation against GM food is killing Africans in droves. While African leaders deserve the most blame, the EU and its NGOs cannot escape their share.

Conclusion

I contend that NGOs do some very good work on the ground, providing immediate relief for the starving and the sick. But they mostly cause harm over the medium to long term when it comes to their placing Western attitudes onto public policy. Their influence, through the media, through aid agencies and through government is significant, and, in the topics on which we work, most certainly malign. Whether its malaria and GM food aid (consistently), or AIDS policy (in the long term) their efforts are detrimental.