



April 2013

# HAI AP News

Penang, Malaysia

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Health Action International Asia-Pacific (HAIAP) is part of an independent global network, working to increase access to essential medicines and improve their rational use through research excellence and evidence-based advocacy. HAIAP is an informal network of non-governmental organisations and individuals in the Asia-Pacific Region committed to strive for health for all now. HAI AP News is the organ of Health Action International – Asia Pacific and presents the happenings in the regional campaigns for more rational and fairer health policies and carries material in support of participants' work.

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## **Message from the Coordinator**

This first issue of HAI News for 2013 brings new tidings and prospects for a revitalized HAIAP. Following HAIAP's departure from the School of Pharmacy at USM in February 2012, there was a brief hiatus during which time, various possibilities were explored for its relocation. The AIMST option was never operationalized as HAIAP's link person there resigned before any work could even start - de ja vu? I get the

sense that HAIAP has not been fortunate with university type collaborations.....

The good news is that, HAIAP has been 'adopted' by the Third World Network or TWN in Penang! I am sure this will be welcome news to all. TWN is a highly respected and key player on the global public interest scene and a long time friend, pioneer and partner of HAIAP. As you all know, HAIAP (then called Action for Rational Drugs in Asia) had its beginnings in Consumers International (then called International Organization of Consumers Unions) amidst a vibrant civil society environment in the mid 1980s. For HAIAP this placement at TWN is a 'coming home' of sorts – we return to an international civil society environment, with shared philosophical frameworks and an inclusive working partnership. In the months to come HAIAP and TWN will collaborate on areas of mutual interest – trade agreements, antimicrobial resistance, rational use of medicines, to name a few – through shared activities and resources.

On 29 January 2013, several HAIAP members participated at the Consultation on 'Post 2015 Developments on the MDGs', held in Bangkok, Thailand as a side event of the Prince Mahidol Award Conference. Coorganized by PHM Global in collaboration with key members, including HAIAP, TWN, HANDS, and PHM-India, the occasion also provided an opportunity for a informal dinner meeting of core HAIAP members who

were present (Mira, Tanveer, Zafrullah, Niyada, Delen, Claudio and Evelyne) to discuss pressing HAIAP concerns. The group agreed that Dr Ken Harvey's wishes to relinquish the post of Chair of the Governing Council should be respected and suggested that Dr Niyada Angsulee share the responsibility as Co-Chair. HAIAP is happy to announce that it now has two Chairs in the persons of Dr Ken Harvey and Dr Niyada Angsulee!

A good start to the year!

Shila Kaur, HAIAP Coordinator

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## **Profits and pandemics: prevention of harmful effects of tobacco, alcohol, and ultra-processed food and drink industries**

### **Lancet Series: Non-communicable Diseases 4**

*Rob Moodie, David Stuckler, Carlos Monteiro, Nick Sheron, Bruce Neal, Thaksaphon Thamarangsi, Paul Lincoln, Sally Casswell, on behalf of The Lancet NCD Action Group*

*Excerpts are shared below. Please find the full article and references at [www.thelancet.com](http://www.thelancet.com) Vol 381 February 23, 2013*

### **Abstract:**

The 2011 UN high-level meeting on non-communicable diseases (NCDs) called for multisectoral action including with the private sector and industry. However, through the sale and promotion of tobacco, alcohol, and ultra-processed food and drink (unhealthy commodities), transnational corporations are major drivers of global epidemics of NCDs.

What role then should these industries have in NCD prevention and control? We emphasise the rise in sales

of these unhealthy commodities in low-income and middle-income countries, and consider the common strategies that the transnational corporations use to undermine NCD prevention and control. We assess the effectiveness of self-regulation, public-private partnerships, and public regulation models of interaction with these industries and conclude that unhealthy commodity industries should have no role in the formation of national or international NCD policy. Despite the common reliance on industry self-regulation and public-private partnerships, there is no evidence of their effectiveness or safety. Public regulation and market intervention are the only evidence-based mechanisms to prevent harm caused by the unhealthy commodity industries.

### **Introduction**

At the 2011 UN high-level meeting on non-communicable diseases (NCDs), the political declaration presented the case for prevention of NCDs in low-income and middle income countries. Participants agreed that no one factor could fully address the burden of NCDs and called for collaboration with “non-health actors and key stakeholders, where appropriate, including the private sector and civil society, in collaborative partnerships to promote health and to reduce non-communicable disease risk factors”. To achieve the agreed goal to reduce premature mortality due to NCDs of 25% by 2025, will need a massive scale-up of concerted action to reduce consumption of unhealthy commodities—mainly tobacco, alcohol, and ultra-processed food and drink products (see below).

National governments, non-governmental organisations, academics, and civil society need to consider what the appropriate role of the private sector will be in NCD prevention and control. The debate is most contentious about the unhealthy commodities industries, which are major drivers of NCD epidemics worldwide. What role should these industries have in NCD prevention and control? What type of interaction—defined here as a reciprocal action or influence — with these industries promotes health and protects the public from conflicts of interest? The global health community has different views about how to proceed, which range from collaborative partnerships to outright criticism.

Although there is now consensus that the tobacco industry's conflict of interest with public health is irreconcilable, whether the competing interests of the alcohol, food, and drink industries are similarly irreconcilable is debated. This lack of clarity stems partly from the absence of a coherent and agreed upon framework for interaction; the normalisation of unhealthy commodities in many countries; the financial and institutional relations many public health researchers,<sup>11</sup>

non-governmental organisations, and national and international health agencies have with these companies; and little appreciation that the purpose of corporations is to maximise profits. These conflicts are largely unstudied in public health. The science of the effect of corporate behaviour on health is an emerging area of public health that needs to be developed substantially; it studies the health risks of transnational corporations and the distribution of the unhealthy commodities that they make and market. The term industrial epidemic has been used to describe health harms associated with various goods including tobacco, alcohol, vinyl chloride, asbestos, cars, and the food and drink industries. In industrial epidemics, the vectors of spread are not biological agents, but transnational corporations. Unlike infectious disease epidemics, however, these corporate disease vectors implement sophisticated campaigns to undermine public health interventions. To minimise the harmful effects of unhealthy commodity industries on NCD prevention, we call for a substantially scaled up response from governments, public health organisations, and civil society to regulate the harmful activities of these industries.

### **Ultra-processed products**

Ultra-processed products are made from processed substances extracted or refined from whole foods—eg, oils, hydrogenated oils and fats, flours and starches, variants of sugar, and cheap parts or remnants of animal foods—with little or no whole foods. Products include burgers, frozen pizza and pasta dishes, nuggets and sticks, crisps, biscuits, confectionery, cereal bars, carbonated and other sugared drinks, and various snack products.

Most are made, advertised, and sold by large or transnational corporations and are very durable, palatable, and ready to consume, which is an enormous commercial advantage over fresh and perishable whole or minimally processed foods. Consequently, their production and consumption is rising quickly worldwide. In the global north—ie, North America and Europe—ultra-processed products have largely replaced food

systems and dietary patterns based on fresh and minimally processed food and culinary ingredients that have less fat, sugar, and salt. In the global south—ie, Asia, Africa, and Latin America—ultra-processed products are displacing established dietary patterns, which are more suitable socially and environmentally.

Ultra-processed products are typically energy dense; have a high glycaemic load; are low in dietary fibre, micronutrients, and phytochemicals; and are high in unhealthy types of dietary fat, free sugars, and sodium. When consumed in small amounts and with other healthy sources of calories, ultra-processed products are harmless; however, intense palatability (achieved by high content fat, sugar, salt, and cosmetic and other additives), omnipresence, and sophisticated and aggressive marketing strategies (such as reduced price for super-size servings), all make modest consumption of ultra-processed products unlikely and displacement of fresh or minimally processed foods very likely. These factors also make ultra-processed products liable to harm endogenous satiety mechanisms and so promote energy overconsumption and thus obesity.

### **Recommendations of action for non-communicable diseases**

#### **For public health policy making, research, and programmes**

- Unhealthy commodity industries should have no role

in the formation of national or international policy for non-communicable diseases

- Interactions with the tobacco industry should be restricted and made consistent with recommendations of the Framework Convention on Tobacco Control
- Discussions with unhealthy commodity industries should be with government only and have a clear goal of the use of evidence-based approaches by government
- In the absence of robust evidence for the effectiveness of self-regulation or private–public partnership in alcohol, food, and drink industry, rigorous, timely, and

### **Key Messages**

- Transnational corporations are major drivers of non-communicable disease epidemics and profit from increased consumption of tobacco, alcohol, and ultra-processed food and drink (so-called unhealthy commodities)
- Alcohol and ultra-processed food and drink industries use similar strategies to the tobacco industry to undermine effective public health policies and programmes
- Unhealthy commodity industries should have no role in the formation of national or international policy for non-communicable disease policy
- Despite the common reliance on industry self-regulation and public–private partnerships to improve public health, there is no evidence to support their effectiveness or safety
- In view of the present and predicted scale of non-communicable disease epidemics, the only evidence-based mechanisms that can prevent harm caused by unhealthy commodity industries are public regulation and market intervention

independent assessment is needed to show that they can improve health and profit

**For public health professionals, institutions, and civil society**

- Highly engaged, critical action is needed to galvanise an evidence-based constituency for change to implement effective and low-cost policies, to place direct pressure on industry to change, and to raise public awareness of the unhealthy effects of these industries
- Funding and other support for research, education, and programmes should not be accepted from the tobacco, alcohol, and ultra-processed food and drinks industries or their affiliates and associates

**For governments and international intergovernmental agencies**

- Evidence-based approaches such as legislation, regulation, taxation, pricing, ban, and restriction of

advertising and sponsorship should be introduced to reduce death and disability from non-communicable diseases

**For governments, foundations, and other funding agencies**

- All approaches in the prevention and control of non-communicable diseases — ie, self-regulation, public-private partnerships, legislation, pricing, and other regulatory measures — should be independently and objectively monitored
- Funding of policy development research into modes of regulation and market interventions should be accelerated and prioritised
- A new scientific discipline that investigates industrial diseases and the transnational corporations that drive them, should be developed.

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## HANDS Case Study

### Benefits of local calendar events

HANDS initiated the MARVI community based health worker service delivery project in the marginalized areas of Umerkot District in Pakistan [See HAIAP Newsletter December 2012] because those areas were the places without proper health facilities including Family Planning and Reproductive Health services. Through MARVI Workers these services are now provided at the peoples' door steps.

Moli Bai from Malhi Paro, Busstan is one of these MARVI Workers working on Family Planning and Reproductive Health services in Umerkot District. When Moli Bai initially came for 60 days training, she talked about many difficulties she faced in providing services. Almost everyone in the community was surprised to see her working as a Health Worker. She had to face many questions. When Moli came back to office, she said she could not proceed any further. People did not understand her explanations and did not want to take medicines.

The HANDS/TRDP team advised her that if she started arranging local calendar events, community members would come to her and would probably join her regularly. Then it would be easier to convey messages. Moli took this advice seriously and she started gathering people for local calendar events.

She managed the first event with a gathering of 50 women at her home. The HANDS team also participated in that event and provided information about the MARVI project, peoples' needs and the community involvement required to reap benefits from the program. The guests accepted the information and from then on cooperated enthusiastically with Moli and shared their problems with her.

Moli's confidence increased markedly and she is now visiting homes regularly, providing services with diligence. People in the community are so happy that they voted Moli as the best Social Worker.

Participation has increased substantially in the local calendar events after Moli's initiatives. In addition, people are now aware of the Family Planning and Reproductive Health resources that are available. Ideas were shared with other MARVI Workers who have now started to adopt the same strategy. This approach also enables the MARVI workers to engage the community in social work.

The MARVI Project is a joint venture of HANDS and TRDP, funded by Packard Foundation.

## Feature: 200<sup>th</sup> anniversary of the birth of John Snow

*Compiled by Beverley Snell, largely from material devoted to the life and times of Dr John Snow by the UCLA Department of Epidemiology School of Public Health on the 200<sup>th</sup> anniversary of the birth of John Snow*

John Snow (1813-1858) was the English physician best known for being responsible for removing the handle of London's Broad Street pump. However John Snow did much more than that. His investigation methods earned him the honour of being widely viewed as the father of contemporary epidemiology. He is also well known for his work on the use of anaesthetics during surgery.

2013 marks the 200<sup>th</sup> anniversary of his birth (March 15, 1813) and just over 150 years since his meeting with the Board of Guardians of St James' Parish that resulted in the removal of the Broad Street pump handle.

John Snow was born in York, the eldest son of a farmer. He was educated at a private school in York until the age of fourteen, when he was apprenticed to William Hardcastle, a surgeon living at Newcastle-on-Tyne.

There was an outbreak of cholera at Killingworth colliery, where Snow was working as an apprentice. He came up with the then heretical idea that the disease was spread via diarrhoea rather than the bad air arising from the corpses. He saw the colliery as a huge privy (toilet) with unwashed hands, shared food and, above all, contamination of the drinking water the cause of the disease.

In 1836 he moved to London to become a student at the Hunterian School of Medicine in Great Windmill Street.

### ***Beginning of the London Epidemiological Society***

When the second cholera epidemic occurred, in 1848–49, Snow and others founded the London Epidemiological Society, intending to advise the government on ways to combat the disease. Snow reasoned that cholera was caused by some sort of microbe that could be spread directly through faeces or contaminated water, and soiled clothing. However, that theory was not accepted. The belief remained that cholera was spread by bad air, or miasma, arising from decayed organic matter.

Meantime, in 1839, Snow became a GP in the Soho district of London and developed a special concern about anaesthetics. In 1846, he became interested in the properties of ether, then newly adopted in America as an anaesthetic agent. He made significant progress in refining the dosage and administration of the drug and was permitted to demonstrate his results in the dental out-patient room at St. George's Hospital. He had introduced the scientific use of ether into English surgery but still appreciated the value of other

anaesthetizing agents like chloroform, which he administered to Queen Victoria on 7 April 1853, during the birth of Prince Leopold, and again on 14 April 1857 at the birth of Princess Beatrice.

'By testing precisely controlled doses of ether and chloroform on many species of animals, as well as on human surgery patients, Snow made the use of those drugs safer and more effective. Surgeons who wished to anesthetize their patients no longer risked killing them by the unscientific application of chloroform-soaked handkerchiefs to their faces'.<sup>1</sup>

### ***The battle against cholera***

An outbreak of cholera in London in 1849 claimed 11,000 lives.

Snow examined the outbreaks of cholera in London neighbourhoods receiving water from two different companies. One company relied on inlets coming from the upper River Thames, located away from urban pollution, and the other company relied on inlets in the heart of London, where the contamination of water with sewage was common. His essay on the mode of communication of cholera, which was first published in 1849, was awarded a prize by the Institute of France and in 1855 a much more elaborate investigation of the effect of the water-supply on certain districts of South London during the epidemic of 1854 was published.

Snow felt that the miasma theory could not explain the spread of certain diseases, including cholera. During the outbreak of 1831, he had noticed that miners working deep underground, where there were no sewers or swamps were infected. It seemed most likely to Snow that the cholera had been spread by invisible germs on the hands of the miners, who had no water for hand-washing when they were underground.

### ***The birth of epidemiology***

In September of 1848, he decided to track the progress of the disease to see if he could determine exactly how it was spread. He discovered the first victim, John Harnold, a merchant seaman, arriving from Hamburg by ship on September 22, had gone ashore and rented a room in the London community of Horsley Down where he had quickly developed cholera symptoms and died. Then another man, named Blenkinsopp, rented the

<sup>1</sup> David Vachon *Old News* 16(8), 8-10, May & June, 2005.  
<http://www.ph.ucla.edu/epi/snow/fatherofepidemiology.html>

room and contracted cholera shortly after and died eight days later.

Snow reasoned that as the first symptoms of cholera are digestive problems, it was indicated that the disease must be ingested with polluted food or water - not absorbed as cholera poison or 'miasma' from polluted air that would have caused symptoms in noses or lungs.

He began writing pamphlets and giving lectures and talks to explain his view that a kind of 'poison' that had the ability to 'multiply itself by a kind of growth' within the membranes lining the digestive tracts of cholera victims, before being spread to new victims via polluted food or water caused cholera. He avoided the use of the terms 'living organism' or 'germ'. Other physicians remained highly skeptical of Snow's theory, but still praised his work on anesthetics.

When cholera broke out again the following summer, Snow suspected the source was Thames river water and systematically examined the municipal records comparing the methods of different water companies in drawing their water and delivering it to different areas. He compared the mortality rates of consumers and the different sources of water.

Snow began the arduous task of tracing where different homes drew their water and correlated the information with the records of deaths. He believed the results showed 'very strong evidence of the powerful influence which the drinking water containing the sewage of a town exerts on the spread of cholera when that disease is present.' But still critics were not impressed.

In August 1853 cholera broke out within five minutes walk of Snow's home in Soho. Within three days, people were fleeing the neighborhood as the dead were being hauled away in carts.

Snow knew that companies supplied clean water to the Broad Street pump, the main source of water in the area, but he thought it might have been contaminated through a leakage from sewer pipes.

He discovered that seventy-three of the eighty-three deaths had occurred in homes closer to the Broad Street pump than to any other pump. Authorities still believed the deaths were due to unsanitary conditions and inspected the homes. They reported that, to their surprise, many of the victims had had clean homes.

Meanwhile, Snow visited a small coffee shop near the Broad Street pump where the proprietor mentioned that she normally served water from the pump with dinner and that nine of her customers had died. He also found that local pubs mixed the water with spirits they served, and several shops put an effervescing powder into the water and sold it as 'sherbet'; and he learned that eighteen of two hundred workers at a local factory had died; the factory supplied drinking water that came from the pump. At a dental supply house all seven workmen had died after drinking pump water. He gathered more and more hard evidence about cases that, at first, did not appear to be connected to the epidemic.

He was curious about places in the neighborhood where a high incidence of cholera was expected but there was a low incidence.



For example, he found that in a neighbourhood workhouse, only 5 of 535 inmates had died. The miasmists at the Board of Health had expected a higher than average rate where the inmates were poorly nourished, unclean, and of low morals. The workhouse had its own source of water.

Snow talked to Sarah Lewis. She described how when her baby was sick, she had cleaned the baby's nappies in a bucket, and then emptied it into the drain near a cesspool in front of her house. The cesspool was within a few feet of the Broad Street pump and the well beneath it. It was so poorly constructed that it actually blocked the drain, forcing sewage to back up. The brickwork lining was loose, and the distance between the leaking cesspool and the pump well was just 2 feet 8 inches. The soil between the cesspool and the well showed signs of a steady percolation of waste from the cesspool into the well.

John Snow demanded a meeting with the local Board of Guardians of St James' Parish. His proposal was to take the handle off the Broad Street pump near Golden Square, and thus stop its use. It was obvious to Snow this was the source of the epidemic.

At the meeting there were the usual arguments and raised voices about money and inconvenience and recriminations. Polluted water, which actually looked fine, was not high on anyone's agenda. The councillors pointed out that everyone knew cholera was due to miasma. But they said 'Take the damned handle off the Broad Street pump'. So they did, and the epidemic



stopped. (There is evidence that the epidemic was dwindling anyway).

The General Board of Health dismissed Snow's conclusion. When he died of a stroke on June 16, 1858, his theory about the spread of cholera had not gained any ground. The miasmists still prevailed. He died without knowing that the bacillus that causes cholera had been discovered in 1854 by Italian scientist Fillipo Pacini using a microscope to examine the intestinal walls of people killed by cholera but his work remained obscure, and his reports were not translated into English.

The germ theory of disease was not widely accepted until the 1860s, when the French chemist Louis Pasteur demonstrated by experiments that microscopic organisms can cause illness. Snow's final vindication came in 1884, when German microbiologist Robert Koch rediscovered, isolated, and cultured the cholera bacillus, *Vibrio cholerae*.

For his persistent efforts to determine how cholera was spread and for the rigorous statistical and mapping methods he initiated, John Snow is widely considered to be the father of epidemiology.

John Snow's life in the mid-19th century coincided with the first real stirrings of consciousness and dismay at the suffering among what were then called the lower social orders. Edwin Chadwick, around 1850, forced the government of the day to improve sanitation; Elizabeth Fry brought about significant prison reform until her death in 1845; Lord Shaftsbury 1801-1885, (the reformer) championed children's rights, especially in coal mines and introduced the Ten Hour Act, to restrict child working to ten hours a day. He began the Ragged Schools movement, which gave poor children some education for the first time; and Charles Dickens, novelist and human activist stirred moral outrage by his writings about disadvantaged and impoverished people.

Snow died unmarried on 16 June 1858, and was buried in the Brompton cemetery.

\* <sup>1</sup> <http://www.ph.ucla.edu/epi/snow.html>. This University of California site is devoted to the life and times of Dr John Snow (1813-1858), a legendary figure in the history of public health, epidemiology and anesthesiology.

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## Feature:

### A conversation with Yusuf Hamied, leader of India's giant company, Cipla.

*Martin Khor, published in The Star 25 Feb 2013* <sup>1</sup>

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**Putting the AID in AIDS: His rivals called him a 'pirate' but grateful millions whose lives were saved by his cheap generic medicines consider him a Robin Hood – Yusuf Hamied, leader of India's giant company, Cipla.**

Last Thursday, I spent a day with a giant of a man who arguably has done more than anyone else to save millions of lives of people with AIDS and other diseases in the developing world. The meeting took place in Mumbai at the headquarters of Cipla, one of India's biggest generic drug companies.

Dr Yusuf Hamied, the co-owner, managing director and leading personality of Cipla, is most unusual. Ideas and words flow from him like a mighty river, as he moves from one topic to another, his eyes twinkling. This seems to come from the combination of a brilliant scientific mind (he has a PhD in Chemistry from Cambridge), a passion to overcome injustice and do good for the poor of the world, skills to turn ideas into



practical results and the business imperative to make money at the same time.

Hamied is world famous as the major driving force in making high-quality HIV antiretroviral medicines cheap enough that the poor in developing countries, especially in Africa, can access them. In the process, he and a network of health activists and international organisations had to confront an entrenched system where a few drug multinationals, backed by patents, monopolised the AIDS medicines market.

Treatment used to cost US\$12,000-US\$15,000 per patient per year. Hamied combined three antiretrovirals into a single pill called triomune, making it easier and more effective for patients to take, and offered it at the rate of US\$350 a patient a year. That was in 2001 and his announcement caused acute anxiety for the drug multinationals who called him a 'pirate' for offering a generic version of a combination of three patented medicines.

But he also evoked great excitement and hope among AIDS patients and their support groups around the world. To them, he is a Robin Hood.

Back in 2001, only 4,000 Africans could afford the high-priced branded products. Last year, more than eight million people were using generic AIDS medicines, whose cost had gone down to around US\$85 per patient per year, according to UN agencies.

Evidence shows many lives have been saved or prolonged due to the medicines, 80% of which come from Indian companies. But since there are almost 40 million worldwide suffering from AIDS, much more need to be done.

Malaysians have also benefited. I reminded Hamied that in 2003, Malaysia was the first country to issue a compulsory licence, and it was for importing three AIDS drugs produced by Cipla. That slashed the price of the medicines the Health Ministry was buying, enabling more patients to be treated.

Hamied is now turning his attention to cancer. Last year, Cipla slashed prices of three generic anti-cancer drugs by up to 75%. 'The time has come to do a similar thing – to provide affordable medicines for cancer, as we did for AIDS,' he says.

In the case of one cancer drug, sorafenib, the original patented product by Bayer had cost 280,000 rupees (>US\$ 5000) for a month's treatment, which is way beyond the means of Indian patients.

Another Indian company Natco obtained a compulsory licence and sold its generic version for 8,800 rupees (US\$ 161) while Cipla last year cut its own version's price to 6,840 rupees (US\$ 125).

Hamied is also on top of the latest scientific situation on other diseases, and seeking solutions.

When asked about the bird flu epidemic of a few years ago, the spread of drug-resistant malaria and the threat of multiple drug resistant tuberculosis, Hamied responded each time with his attempts, past and present, to make generic drugs available. He gave me a scientific paper on a particular drug which he thinks is the best chance of tackling the deadly resistant forms of TB, indicating he is exploring how to produce it.

Cipla now makes over 2,000 products, in 65 therapeutic categories, hires 20,000 people, has 34 manufacturing facilities, sells in 170 countries, and makes a healthy profit with annual sales exceeding US\$1.4bil.

It has made its mark as a champion of generics, fired with the nationalist and self-reliance spirit sparked by Mahatma Gandhi, who visited this same Cipla office in 1939. He requested the then owner, K.A. Hamied (Yusuf's father), to initiate the local manufacture of

medicines due to shortages caused by the onset of the war in Europe.

Hamied sees several looming problems that may cloud the future of the Indian industry.

First is the 2005 introduction of product patents in India, in line with the WTO's rules. Local companies now require a compulsory licence (CL) from the government to produce generic versions of new medicines that are patented. "It is a very cumbersome process to apply and get a CL for each patented medicine," he says. "What is needed is a system of automatic compulsory licence, with payment of 4% royalty to the patent owner." Canada and India had such a system in the past, and this should be revived, as India and other developing countries cannot afford monopolies and high prices in medicines.

Second are the free trade agreements (FTA) which several developing countries including India are negotiating with Europe or the United States. Hamied points out that these FTAs contain clauses which would seriously hinder or stop the production and use of new generic medicines in those countries that sign the FTAs.

Third is the need to produce active pharmaceutical ingredients (APIs), which are the essential materials in the medicines. While many countries are able to make the finished products in the forms and dosages required, only a few developing countries (India and China principally) have the ability to make the APIs.

Hamied warns that India is already making less of the APIs that its industry needs. "If China and India don't supply APIs to the world, the world pharmaceutical industry may face collapse."

According to Hamied, India also needs a better drug pricing policy and a more efficient drug regulatory system as there are many new generic medicines in the queue for safety clearance but lately there has been a long delay in decisions.

A few weeks ago, Hamied announced that he will step down as Cipla's joint managing director in April. His brother M.K. Hamied and nephew, backed by a team of professionals, will take over the helm. That has caused speculation about the future direction of Cipla. But after spending a day with Yusuf Hamied, one gets the feeling that at least in his lifetime, Cipla will remain true to the cause of making medicines affordable to the sick in India and other developing countries.

<sup>1</sup> [newsdesk@thestar.com.my](mailto:newsdesk@thestar.com.my)



## News from the region

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### Pakistan: Ongoing challenges of vaccine preventable diseases

*Dr Tanveer Ahmed*

#### ***Measles outbreak in Pakistan***

It is very frightening that the World Health Organisation (WHO) has reported measles outbreaks throughout Pakistan, since the beginning of 2103; describing the situation as alarming due to a steady increase in measles cases and deaths.

The WHO reports about 200 measles outbreaks in Punjab and Sindh over the last two months, exposing the provincial governments, who claimed that the situation is 'normal' in the provinces. Respective health officials have denied measles outbreaks in any part of the provinces so far. According to the WHO, Sindh has the second highest number of measles outbreaks after Baluchistan, where nearly 80 outbreaks were reported only in January and February 2013.

The WHO report says that measles claimed lives of more than 200 children throughout the country from January onward. Of them, 80 children died in Sindh, 33 in Baluchistan and 60 in Punjab. The WHO report says that transmission of measles virus to healthy children increased manifold in January 2013 compared to the same month last year: 2,447 measles cases were reported during last two months, while only 447 cases were reported in January 2012. The report warns of spread of the disease if stakeholders do not take it seriously.

In the first three weeks of January, 1211 measles cases were reported in Sindh Province, 290 in Khyber Pakhtunkhwa and 483 in Balochistan. 'The highest number of measles cases and deaths was reported in the Naseerabad district (220 cases and 20 deaths), followed by Jaffarabad (73 cases and five deaths), Killa Saifullah (39 cases and four deaths) and Jhal Magsi (23 cases and one death).'

According to the WHO, the monthly trend of measles cases in 2012 shows that the number of cases started increasing in April 2012 and reached the peak in May-June 2012. The second upward trend started in October 2012.

The report carries month-wise comparative study of measles outbreaks in Pakistan with clear indication of the huge impact of the disease, which spread beyond expectation in the start of the new year compared with the last year.

HANDS and other civil society organizations have raised their voices against the deaths of children from measles. During the outbreak there were more than 80 child deaths in only Sindh Province and the majority of the cases were reported in flood hit areas. The stagnant water and lack of cleanliness accelerated the spread of disease. HANDS and the other civil society organizations protested to the authorities who are accountable for timely vaccination and post disaster health management, especially for malnourishment in mothers and children.

The Health authorities were forced to act following the notice taken by HANDS, media and other civil society stake holders who blamed the health departments for the epidemic, saying it was due to their 'criminal negligence'. HANDS also demands accountability from related departments as billions of rupees have been allocated to the health department for vaccination but no vaccination campaign was initiated in many areas. The performance of the health department through failure to initiate vaccination campaigns against measles in children is seriously questionable.

#### ***Killing of polio team in Pakistan***

Pakistan is one of only three countries in the world where polio is endemic, but efforts to stamp out the disease have been hampered by resistance from the Taliban. Polio cases in Pakistan have risen sharply in recent years, hitting 198 in 2011 -- the highest figure for more than a decade and the most of any country in the world last year, according to the World Health Organization.

Rumours about the vaccine being a plot to sterilize Muslims have long dogged efforts to tackle the disease in Pakistan. Vaccination teams have been banned from some areas even within the metropolitan city of Karachi. Six women and a man working for a charity involved in polio vaccinations were shot dead in the northwestern



district of Swabi, and the same month two women polio workers were attacked in the eastern Karachi neighborhood of Gulshan-e-Buner.

The very tragic incidents of killing health workers were protested by the Peoples Health Movement (PHM) – Sindh Pakistan, along with HANDS. Those killed were among thousands who work selflessly across Pakistan to eradicate polio. A sad demonstration was held by PHM (Pakistan) Secretariat and HANDS in front of Karachi press club on Dec 20<sup>th</sup> Dec 2012 to condemn the miserable killings of polio vaccination campaign's health workers in Pakistan. Members of the PHM Sindh Chapter and HANDS conveyed their grievances and sympathies to the families who have been victimized through the brutal acts.

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## **Thailand: EU and Thailand launch negotiations for Free Trade Agreement** *Source MSF*

On 6 March 2013, European Commission President, Jose Manuel Barroso, and the Thai Prime Minister, Yingluck Shinawatra, launched negotiations for a Free Trade Agreement (FTA) between the European Union and Thailand. EU Trade Commissioner De Gucht and the Thai Minister of Commerce Boonsong had met the day before to formally agree on the start of negotiations. The ambition is to conclude a comprehensive agreement covering tariffs, non-tariff barriers and other trade related issues, such as services, investment, procurement, regulatory issues, competition, and sustainable development.

### ***EU-Thailand Trade Relations***

Thailand is one of the 10 members of the Association of South East Asian Nations (ASEAN). The ASEAN countries together are the EU's third largest trading partner outside Europe with annual bilateral trade in goods and services of some 213 billion Euros.

Thailand is the EU's third largest trading partner inside ASEAN. Conversely, the European Union is Thailand's third largest trading partner (after Japan and China).

EU exports are dominated by high tech products including machinery and electrical appliances, pharmaceutical products, vehicles, precious metals and optical instruments.

Thailand's key export items include machinery and electrical appliances, foodstuffs, plastics/rubber, vehicles and precious metals/pearls.

On the same day, Health Action International (HAI) Europe, Oxfam, Action Against Aids Germany issued a joint press release voicing their concerns.

## ***EU-Thailand FTA Negotiations: What Fate for Access to Medicines?***

*Press release 6 March 2013 Leila Bodeux, Oxfam International*

From 4-6 March, the Prime Minister of Thailand and her negotiating team visit Brussels to meet with EU officials and officially launch negotiations on a new Free Trade agreement (FTA) between the EU and Thailand. Based on our experience with earlier EU FTA negotiations, we have serious concerns over the repercussions this FTA will have on access to medicines in Thailand and the region.

The EU's position on intellectual property protection in previous FTAs, including the earlier failed negotiations between the EU and ASEAN, suggests that we can expect that the EU will push for intellectual property standards in the EU-Thailand FTA that go beyond Thailand's WTO obligations under TRIPS and will limit access to medicines.

Overreaching IP protection and enforcement restricts and delays legitimate competition from generic manufacturers, thereby sustaining market monopolies, high monopoly prices, and significantly affecting access to affordable treatment. Stringent TRIPS-plus intellectual property (IP) provisions in earlier negotiated EU and US FTAs have reduced the availability of generic medicines, leading to an increase in medicines prices. The EU's initial demands in the EU - India trade negotiations have sparked great opposition from international agencies, developing country governments and civil society. The EU Parliament also recently rejected strong IP enforcement measures in the Anti-Counterfeiting Trade Agreement (ACTA), an agreement that would also have hindered generic competition.

Moreover, public health NGOs, the European Parliament, UNAIDS, the UN Development Programme, the UK Commission on Intellectual Property Rights and Development Policy, the UN Commission on HIV/AIDS and the Law, international IP academics, and also the World Health Organization (WHO) all recognise the link between TRIPS-plus IP provisions that disproportionately favour rights-holders, and poor access to medicines.

Further, we are concerned that the EU is likely to introduce investor-state dispute provisions in the FTA. Under such provisions pharmaceutical companies can claim that the government's health regulations undermine enjoyment of their IP-related investments. This could lead pharmaceutical companies to sue the government of Thailand, arguing that the government's measures to promote access to medicines, for example the issuance of compulsory licenses, will negatively affect their IP investments in Thailand. It may seriously threaten the possibility for the government of Thailand to

take measures to reduce the costs of medicines: the World Bank has estimated that if Thailand uses compulsory licensing to reduce the cost of second-line antiretroviral therapy to treat people living with HIV by 90%, the government would reduce its future budgetary obligations by US\$3.2 billion discounted to 2025.

The past weeks, civil society organisations and citizens in Thailand have taken to the streets and alerted their government to their concerns on how this comprehensive trade package with the EU will affect the prices of medicines, seeds and agricultural products in Thailand. They have also complained that the consultation with civil society on these FTA negotiations organized by the Parliament of Thailand was largely flawed. Last week more than 1,500 citizens and activists gathered outside Government House in Bangkok to voice their concerns.

The EU should refrain from demanding IP provisions that go beyond TRIPS as well as investment provisions and not misuse the instrument of an FTA to support the commercial interests of the pharmaceutical industry, while damaging the opportunities for innovation and access to medicines in Thailand.

*The EU should ensure that its trade policy is in line with its development objectives, including specifically enhancing access to medicines. It must consider the broader context and effects of its IP demands, not only for public health, but also for socioeconomic development. Erecting more monopoly barriers will only sustain the status quo of inequity in health and development that exists between citizens in developed, emerging, and developing countries.*

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## Trans-Pacific Partnership Agreement TPPA

For more information see  
[Access\\_Briefing\\_TPP\\_ENG\\_2013.pdf](#)

On 15 March it was announced that Japan intended to join the TPPA negotiations, and Médecins Sans Frontières (MSF) called on Japan and the rest of TPP negotiating countries to reject rules that threaten to dismantle internationally-agreed public health safeguards and restrict access to medicines in developing countries. The TPP negotiations, which currently involve eleven Asia-Pacific countries, are being conducted in secret, but leaked texts reveal the United States is proposing the most aggressive intellectual property (IP) measures ever suggested in a trade deal with developing countries. The proposed IP rules would grant the pharmaceutical industry a wide-ranging set of legal mechanisms designed to prolong monopoly protection for medicines and delay the availability of more affordable generic versions.

Furthermore, U.S. negotiators have said the TPP will be a template for its future trade agreements across the globe, setting a damaging precedent.

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## China (and the USA): Antibiotic over-use in farm animals

According to Bryan Walsh (February 12, 2013) in Time - Science and Space<sup>2</sup> 'Proceedings of the National Academy of Sciences shows that China, already the world's largest producer and consumer of antibiotics, is heavily using the drugs in animals as a way to enhance growth and prevent disease in crowded conditions. And just as happened with the overuse of Tamiflu, China's animal drug addiction is leading to increasing antibiotic resistance, which in turn could lead to serious problems for people who depend on those drugs to fight infections.'<sup>3</sup>

In 2005 during the epidemic of H5N1 (avian flu) there were disastrous effects on domestic and farmed birds, particularly in South East Asia, and an enormous impact on the livelihoods of small farmers. The most effective means to control the spread of the infection at that time was culling of flocks. Now there are surveillance programs and rapid response mechanisms in place in most countries that if implemented, will prevent the spread of an epidemic in birds without the need for culling.

H5N1 can spread to humans with fatal effects and in 2005 emergency response involved the use of oseltamivir (branded by Roche as Tamiflu), an antiviral medicine that could be effective against the infection in humans. That drug was stock piled throughout the affected regions for possible use.

Unfortunately Chinese chicken farmers were dosing their birds with oseltamivir as prophylaxis making it difficult for health officials track H5N1 outbreaks. The dosed chickens could still become infected and spread the virus but without showing the symptoms. In addition, over time, the over-use of the drug undermined its effectiveness and resistance developed. Should an epidemic of H5 N1 occur in humans, we could be powerless to control it.

A new study in the *Proceedings of the National Academy of Sciences* shows that China, already the world's largest producer and consumer of antibiotics,<sup>4</sup> is still heavily using the drugs in animals as a way to

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<sup>2</sup> <http://science.time.com/category/ecocentric/>

<sup>3</sup> <http://science.time.com/2013/02/12/why-meat-in-china-and-the-u-s-has-a-drug-problem/>

<sup>4</sup> Layne Cameron, James Tiedje unchecked antibiotic use in animals may affect global human health  
<http://msutoday.msu.edu/news/2013/unchecked-antibiotic-use-in-animals-may-affect-global-human-health/>

enhance growth and prevent disease in crowded conditions. And just as happened with the overuse of oseltamivir, China's animal drug addiction is leading to increasing antibiotic resistance, which in turn could lead to serious problems for people who depend on those drugs to fight infections.

Chinese farmers use high levels of antibiotics in animal feed to enhance their growth. However the drugs are poorly absorbed and researchers have found significant quantities in the manure enriched soil around pig pens. This soil can be spread as fertilizer, or sold as compost and can end up in rivers or groundwater, carrying antibiotic resistant genes (ARGs) along with it. Researchers sifted through the manure-enriched soil found near three large-scale Chinese pig farms, searching for the presence of antibiotic-resistant genes. They found 149 unique antibiotic-resistant genes, some at levels 192 to 28,000 times higher than control samples. Those antibiotic-resistant genes can spread to other forms of bacteria, decreasing the overall effectiveness of the drugs in human beings.

'Our research took place in China, but it reflects what's happening in many places around the world,' said Tiedje, part of the research team led by Yong-Guan Zhu of the Chinese Academy of Sciences. 'The World Organization for Animal Health and the U.S. Food and Drug Administration have been advocating for improved

regulation of veterinary antibiotic use because those genes don't stay local.'

In 2011, 29.9 million pounds (13.5 million kg) of antibiotics were sold in the U.S. for meat and poultry production — nearly four times the amount sold to treat sick people. And most of the animals taking the drugs aren't sick; as in China, the antibiotics are used for growth promotion and to help the pigs or chickens survive crowded conditions on industrial farms.

Producers of meat and poultry are not required to report how they use the drugs, which drugs they use, on which animals and in which quantities. That makes it difficult for scientists to directly connect the heavy use of antibiotics in animals with antibiotic resistance in people. But efforts by the government in the past to more tightly regulate antibiotics in animals have met with failure, thanks in part to powerful agriculture interests.

Bryan Walsh believes there is some hope: last year the FDA issued draft guidelines that would ask the pharmaceutical industry to change labeling and marketing practices so that antibiotics would be used only on sick animals, rather than for growth promotion on healthy ones. But even those guidelines would only be voluntary. In China and in the U.S., drugs are likely to remain a part of commercial meat production — and the rest of us may pay the price.

## Where There are no Pharmacists— available in French



**Là où il n'y a pas de pharmaciens**, the French translation of *Where There are no Pharmacists* is available from TWN. The text was translated by Elisabeth Coffin and Anke Meiburg of Ecumenical Pharmaceutical Network (EPN), with the support of the German Institute for Medical Missions (DIFAM). The book was prepared for publication by Beverley Snell (HAIAP) and Lean Ka-Min (TWN)

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HAIAP News is produced 3 times a year.

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