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SoPH BULLETIN

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INTERVIEW WITH PROF RATIE MPOFU
OUTGOING DEAN OF THE FACULTY OF COMMUNITY AND HEALTH

Prof Ratie Mpofu

Shun: Prof. Mpofu, thank you for the chance to interview you on your deanship. I'd like to ask you to reflect on three things: Firstly, your experience of being Dean of the Faculty of Community and Health Sciences, in the context of the University's own development. Secondly, you are leaving UWC but surely you'd have some thoughts about where things are happening, going to happen, need to happen in the Faculty. And thirdly, about your relationship with us in the School of Public Health and where you think we are going. So firstly, about your deanship…

Ratie: It was a journey that started in 2001. The previous incumbent, Prof. Pretorius became the DVC. I was persuaded to take on the responsibility, I suppose also because of the work I had done in Physiotherapy on a number of collaborative issues, such as the development of core courses, the Winter and Summer Schools that (the School of) Public Health was organizing, where I presented a modular course on Community-based Rehabilitation.

When I became Dean, fortunately I think I was aware of what responsibilities the deanship would entail, having been the head of the Department of Physiology and dealing with many issues from the Faculty perspective. I made a point of learning about other aspects of the university, and there were so many people willing to help.

What I found at the time was that the Departments in the Faculty were working in silos, and not really opening up to each other; there was suspicion and not wanting to share. The other problem that I encountered was that the health sciences in particular had a lot of staff appointed merely on the basis of their professions, some with just a first degree or diploma. Given the historical and educational hurdles many of them had to confront, one had yet to find a way to encourage them to undertake further study. I made this one of my tasks.

We also looked at the curricula and the need to transform what was being taught and its euro-centrism during the apartheid era, and the responsibility to serving South Africa. In this work of curricula transformation it was again very clear to me that there was a lot of overlap. This was something I together with Prof David Sanders had been working on before I became Dean. We had done similar work in Zimbabwe. We were able to advise on curriculum development, particularly when it came to approaching and entering communities and what students should be doing in community based education. We tried to get the whole Faculty to understand stand that community was the basis from which to build the curriculum for health sciences. This was to shape what we were doing in the field and in the classroom. Fortunately, this was the kind of research I did in my PhD.

We also tried to encourage at least one person per semester to take time off to concentrate on their studies. The one day per week for this purpose that many Departments granted academic staff was not working. Staff would use this time for preparing their teaching. There was very little publications emerging, even from those with PhDs. One or two people in Psychology were prolific. I had to speak to almost every academic in the Faculty one on one to try and encourage them to self-develop. The VLIR scholarship Programme and the Dynamics of Building a Better Society (DBBS) initiative of UWC really gave us an impetus to get a number of academics to join the programme and complete their study.

There were other challenges. The Department of Nursing, for example, was losing staff who were not being replaced. They were not academically sound in what they were doing at that time. On top of that we had the Minister of Education announcing that UWC will take over training in nursing. That was a big challenge: as Dean I had to make sure that the curricula were to what was required. Fortunately, from my international experience in this regard, I was aware of international practice and what the curricula for nursing should be. We had to recruit staff; we had to develop staff capacity within. That meant that the Faculty had to learn to share resources. This was very difficult for Departments that were working in silos! But we managed to convince them.

There were very strong Departments, like Physiotherapy and Psychology that wanted to move ahead. They had to learn to move together with everybody. This frustrated them sometimes.

Shun: What do you count as successes as you look back on your Deanship?

Ratie: The growth of the Faculty academically. That is a huge success. Now we are competing with other Faculties in the number of Professors that we have and the number of publications that are coming out. We never had a problem with the number of students. And because we are no longer just taking everybody that applied, the kind of student we have now is of a better quality.

And then as you know the Public Health Programme was housed in what I called 'Shacks'. So when the Atlantic Philanthropies wanted to help with funding, I could see immediately what this assistance should be for. It took some persuasion to get the university to see what this should be: that it should be directed to putting up the building. There was worry about who is going to maintain the building, but then with time it proved to be the best decision. And this relationship with Atlantic Philanthropies had a spillover effect on the rest of the university, with their huge support for the Life Sciences Building.

Today we boast of the best School of Public Health and the best situated School of Public Health! That is a huge success.

Shun: As you look ahead, what challenges do you see

Ratie: This is the time to produce world class Research Centres. At the moment we have identified three in the Faculty, but that is only a start. And those three Centres are interdisciplinary, something that people forget quickly. I deliberately chose the interdisciplinary route because we are too fragmentary to make an impact.

If we want to see ourselves competing internationally (nationally I think we are there) we should look at building our centres and encouraging those researchers who are capable and serious. We are not talking about 'stethoscopic research' but about 'social responsibility' type of research, whereby we can say that with the education that we have, this is how we can change society. I would want to see that being the direction. By saying that I am not discouraging those who want to do research on their own. But for me service and making a difference can only be done collaboratively. So taking health for example, the huge call at the moment is for research on non-communicable diseases. Every one of our Departments is looking at non-communicable diseases. So if we came together to work on NCDs, you can imaging the force and power we can exude. The same power that has been shown by the AIDS champions.

Shun: Is this in line with where the university also wants to go?

Ratie: Yes, to a certain extent I think the university wants to see movement in that direction as well. But at the moment I feel there is more emphasis in the sciences, the hard sciences more than in the social sciences. I would also want to see UWC having a great emphasis on the social sciences. We have to do this both ways if we want to change society.

Shun: Do you have a word for the School of Public Health? What is it that we need to be looking, looking out for?

Ratie: Initially there was only David Sanders and a secretary as permanent university staff doing public health. The rest were on contracts based on outside funding. So you can imagine the instability of having contract staff funded from outside. Fortunately, the School maintained itself because they were good at fundraising. David was also good at recruiting the right people onto the staff. And they worked hard. It is one of those Schools that came from a very small Unit and because of their passion, hard work and self-drive, they moved. But in that movement, they left the rest of the Faculty. My job then was to encourage them to 'run with everybody else'. In the beginning they did help, for example, they assisted Nursing and involved Nursing in the teaching at the School of Public Health. They helped to refine the curriculum, to define the teaching methods and improve the delivery of Nursing

The School of Public Health has a number of programmes that they have put together. They have identified their strengths. I would like to see the Scholl of Public Health taking leadership in the Faculty so that the whole Faculty can be looking at Public Health as a leader. They are working in a silo.

Shun: How cans this happen?

Ratie: In all the areas that they have elected to take on, you will find all our Departments are grappling with issues of a similar nature. Their systems approach is something others could learn from. Research is another area that Public Health could give the lead on as they have the know-how on research. They have made inroads into a number of opportunities which others could benefit from.

Shun: Do you have a message for the new Dean?

Ratie: Yes I do have a word for the new Dean. This is a very sound Faculty with a solid base. And I think she should use it to leapfrog the Faculty's further development. We have set up administrative, teaching, collaborative systems which work and can be used. I am certainly not saying that the new Dean should not bring new ideas. That is not possible. But she will find something good here.

Shun: And what about your own time ahead?
RM: I would like to write about and share my many years of experience in working with others in different countries. And also pick up on some of the research that I planned to undertake. I will be supervising students. And I will be in Cape Town anyway!
SH: On behalf of all of us at the School of Public Health, I wish you everything of the best!

Alarm as Corporate Giants Target Developing Countries

Diabetes, obesity and heart disease rates are soaring in developing countries, as multinationals find new ways of selling processed food to the poor
Felicity Lawrence guardian.co.uk, Wednesday 23 November 2011

Nestlé is using a floating supermarket to take its products to remote communities in the Amazon. Unilever has a small army of door-to-door vendors selling to low-income villages in India and west and east Africa. The brewer SABMiller has developed cheap beers in some African countries as part of a "price ladder" to its premium lager brands, and, as a leading Coca-Cola bottler and distributor, is aiming to double fizzy drinks sales in South African townships.

As affluent western markets reach saturation point, global food and drink firms have been opening up new frontiers among people living on $2 a day in low- and middle-income countries. The world's poor have become their vehicle for growth.

Sisters, Nthombi, Patricia and Thembu Ndlovu, eat the R10.50 ikhota (bread, chips, polony, Russian and Viennas, with tomato sauce and mustard) in Orange Farm, Drieziek, South Africa. *Photograph: Greg Marinovich/Storytaxi.com*

The companies say they are finding innovative ways to give isolated people the kind of choices the rich have enjoyed for years and are providing valuable jobs and incomes to some of the most marginalised. But health campaigners are raising the alarm. They fear the arrival of highly processed food and drink is also a vector for the lifestyle diseases, such as obesity, diabetes, heart disease and alcoholism, which are increasing at unprecedented rates in developing countries.

A UN summit in New York in September confirmed the scale of the health crisis. Nearly two-thirds of all deaths worldwide in 2008 were attributable to lifestyle diseases. By 2030 these non-communicable diseases (NCDs) are expected to be the cause of nearly five times as many deaths as the traditional, infectious scourges of poor nations such as TB, malaria and Aids.
Last year 39% of acquisition deals by consumer goods companies were in emerging markets, compared with just 1% in 2008, according to the Grocer's OC&C Global 50 league table.

As diets and lifestyles in developing countries change, their patterns of disease are following those seen in industrialised countries in the north equally rapidly. But for poor countries there is a double whammy: they have started suffering from high rates of NCDs before they have managed to deal with hunger and malnutrition. The double burden is devastating both their economic growth and their health budgets. In South Africa, about a quarter of schoolchildren are now obese or overweight, as are 60% of women and 31% of men. Diabetes rates are soaring. Yet, nearly 20% of children aged one to nine have stunted growth, having suffered the kind of long-term malnutrition that leaves irreversible damage.

Moreover, obesity and malnutrition often occur in the same household, according to Leonie Joubert, a researcher at the University of Cape Town's centre of criminology, and author of a forthcoming book on food security. "It's not a case of having massive starvation on one end of the spectrum, and gluttony on the other. We have this kind of 'hidden hunger', almost pervasive in poorer communities where it's easy to fill the hole in one's belly with low-nutrient, cheap, empty-calorie foods to satisfy one's hunger now, but not meet the body's long-term nutritional needs."

The South African minister of health Dr Motsoaledi is a medically trained former anti-apartheid activist, and does not shy away from the dramatic. He marked the day the 7 billionth child was thought to have been born in to the global population by scrubbing up and delivering a baby himself by caesarean section. He then tied the new mother's tubes as his contribution to family planning.

Taking radical action

Pushing through radical action on NCDs is of his priorities. He said: "When I was a medical student under apartheid, heart attacks were a rare thing for black people."The main illnesses then were TB, malaria and kwashiorkor [malnutrition from protein deficiency]. That's no longer true. Africans are eating more and more junk processed foods instead of their traditional diet. My mother hardly went to the shop. Anything you wanted to eat you grew and took straight from the soil. We had free range chickens, vegetables. I used to walk a long distance to school. My children hardly walk a metre from the car. Children are put in front of the TV and they eat junk in front of it. It is not a life of activity. It's a globalised world; we can't expect to be left untouched."

He wants to curb the marketing of tobacco and alcohol and regulate junk food, starting with reducing salt in bread and eliminating transfats, but he anticipates a fight. "There's going to be war over this next year."

"It is like climate change. Are we going to do something about it when we are looking down the barrel of a gun and it is at its worst, when budgets have become unmanageable because of the sheer weight of disease? If those of us in power don't do something now, that is what will happen. Anybody who dilly dallies on non-communicable diseases will be forced to act when the situation is out of control."

The main obstacle to action was profit. "Industry is resisting very strongly, of course. The only reason people are not doing enough is the bottom dollar." Governments trying to restrict the marketing activity have found themselves challenged in court. Motsoaledi is watching the case brought by the tobacco industry against the Australian government, which wants to ban all branding on cigarette packs. "I want a similar structure for alcohol control," he says.

He knows that he is likely to be the target of determined lobbying as well as legal action.
Unlike the UK secretary of state for health, who has invited food and alcohol companies to join his "responsibility deals" on public health, Motsoaledi sees no place for industry in helping draw up policy. "You cannot make policy with them, they will just shape it for their profits. You can't sit in the same room with a national brewer and come up with a policy on alcohol to benefit the nation." The interests Motsoaledi is taking on are indeed powerful and quick to defend themselves. SABMiller, the largest brewer in South Africa, points out in documents on its "alcohol responsibility" web pages that it supports 3% of the total employment in South Africa, and generates taxes – mostly from excise duty on its products – that account for 5% of the government's tax revenue. It believes industry can play a role in tackling health problems and argues that its marketing promotes brand loyalty, not greater drinking. Kristin Wolfe, head of alcohol policy at SABMiller, said: "We market to our target consumer; we don't go after non-drinkers. What the UN wanted in New York was a whole societal approach. Marketing is seen as just one factor. It has to be responsible, but there's a distinction between harmful drinking and marketing. It's a more enlightened approach to get industry to do what it can; we will make better progress." The company points to its investment in projects to tackle alcohol harm and bring unlicensed outlets within regulation.

Prof Thandi Puoane

Thandi Puoane, a professor at the University of the Western Cape, has tracked the increase in NCDs since the end of apartheid. With sanctions lifted and freedom of movement introduced after the multiracial elections in 1994, there was a rapid change in the profile of disease. Large numbers of black people have moved from rural areas where they had to walk miles for water and fuel to the townships on the edge of the cities. The townships are overcrowded, unemployment is high and infrastructure, such as electricity and sanitation, poor or nonexistent. Fast-food outlets and imports of processed foods proliferated after markets re-opened. Large numbers of people moved to townships, where infrastructure is poor.

"People coming here buy fatty, sugary food and drink because it's cheap and it feels a luxury not to cook," Puoane said. "Cooking fuel is expensive. They can buy from street vendors on credit. Fear of crime, often fuelled by alcohol, stops them taking exercise. They think they are happy because they are fat and when they go back to their rural areas people say, 'you must be

doing well, you have put on weight'." Being thin and losing weight is associated with Aids and TB, which makes being overweight seem more acceptable.

Opening health clubs

Khayelitsha, a township that sprawls for miles alongside the highway from Cape Town to the Cape flats, is one of the largest and fastest growing in South Africa. Unofficial estimates put its population at a million. Here you can see the crisis of obesity and other NCDs writ large. Unemployment is nearly 60%, and 70% of residents live in shacks with no running water. Alcohol use and violent crime are high and many people are overweight, particularly among women and teenage girls.

The faculty of public health at the university has pioneered health clubs to address the problem.

Lungiswa Tsolekile

Lungiswa Tsolekile, a dietitian working on the health project, described some of the cultural barriers to being healthy in this environment, as she took me on a tour. A said access to affordable fresh food was limited. Street stalls sold cheap but often fatty foods, such as the chicken skin discarded by poultry factories, or chicken feet, tripe and sheep's heads. Processed soup, often high in salt, is popular as a cheap gravy to go with the staple of maize porridge. Every other shack shop, and even a church hall, is adorned with Coca-Cola branding. Retail giants have arrived, and Walmart has just taken over one of the large South African chains, but a taxi to the nearest supermarket for fresh fruit and vegetables costs four rand, more than many can spare. She pointed out the numerous billboards advertising alcohol, too.

The ShopRite supermarket we visited was packed with people pushing basket-sized trolleys – the average spend here is small by European standards. There was fresh food available, but a kilo of tomatoes cost more than a 2-litre bottle of cola. At the entrance to the store, leaflets were promoting cut-price alcohol with free mobile phone deals; the aisle ends had special offers for Nestlé's coffee-style caffeine drink Ricoffy listing dextrin (a starch sugar) and dextrose (a form of sugar) as its two main ingredients, and Nestlé's Cremora, a coffee creamer whose principle ingredients are glucose syrup solids and palm fat. The checkout was stacked with sweets alongside "funeral plan pay-as-you-go" starter packs.

"We use physical exercise in the health clubs as a vehicle to help with other aspects of health, including cooking sessions on how to prepare healthy food with traditional ingredients. We pick up a lot of hypertension, high blood glucose and diabetes," Tsolekile said.

Nestlé meanwhile sees itself as "providing products that are healthier, safe and affordable for consumers wherever they are". It says it gives consumers the information they need to make healthier choices, through the labelling and sponsored education programmes."Often in emerging markets, processed food appeals to consumers because it is guaranteed to be safe. It can also help address deficiencies. We fortify many of what we call our popularly positioned products to help meet this need," a Nestlé spokesman said. "Our range of products in South Africa and in Brazil is wider than that offered by many of our competitors. We are always looking for ways to improve both the taste and nutritional value of our products."

Unilever believes its door-to-door sales network has helped lift people out of poverty. Trevor Gorin, its global media relations director, said: "It has essentially empowered people in rural communities, largely women, to become entrepreneurs, generating income – with all the concomitant benefits this income generates." "Most of the Unilever products sold through it are home and personal care products to improve sanitation and personal hygiene. The food products are usually things like stock cubes and tea."

Nestle floating supermarket

Nestlé's floating supermarket took its maiden voyage on the Amazon last year and has been distributing its products to around 800,000 isolated riverside people each month ever since. Christened Nestlé Até Você, Nestle comes to you, the boat carries around 300 branded processed lines, including ice creams, and infant milk , but no other foods. The products are in

smaller pack sizes to make them more affordable. The boat also acts as a collection point for the network of door-to-door saleswomen Nestlé has recruited to promote its brands. Targeting consumers from socioeconomic classes C, D and E is part of the company's strategic plan for growth, it says. Nestlé has also set up a network of more than 7,500 resellers and 220 microdistributors to reach those at the bottom of the pyramid in the slums of Rio and São Paulo and other major Brazilian cities.

Assessing the Effectiveness of Care for People Living with HIV in the Public Primary Pare Service in Cape Town, South Africa

Researchers: Scott V (School of Public Health, University of the Western Cape), Zweigenthal V (School of Public Health and Family Medicine, University of Cape Town), Jennings K (City Health, Cape Town)

Dr Vera Scott

Increasing access to effective HIV interventions is a priority in sub-Saharan Africa where, in 2008, an estimated 22.4 million people were living with HIV and 1.9 million were newly infected. While much is written about the scale up of HIV counseling and testing (HCT) and antiretroviral therapy (ART), little research has been done on the expansion of routine pre-ART HIV care. Integration of HIV services along the continuum of care from testing to ART has been programmatically poorly implemented in South Africa with different funding streams, personnel, monitoring tools and indicators. Evaluation of pre-ART care is a gap in HIV care programmatic reporting.

The objective of this study was to describe the Cape Town experience of implementing pre-ART care, assess the effectiveness of this care and describe the extent of its integration with ART care in public primary care facilities in the district.

In August 2010, data were collected on the HCT and pre-ART services as part of the routine annual HIV/TB/STI evaluation carried out in Cape Town. Subdistrict TB HIV coordinators organised and led the audit teams, and team members included facility and local programme managers. Routine data, collected in facility-based registers and collated at district level, were drawn from management data systems. Audit teams visited facilities over a period of 1 month. It took approximately 3 hours to interview the facility manager, assess the equipment in consulting and counselling rooms and do a set of HCT, pre-ART, ART, STI and TB folder reviews. Non-probability sampling was carried out, with 10 folders sampled from each facility for each programme. HCT folders were sampled from the HCT register starting at a date 1 month before the audit and working backwards to select five HIV-positive and five HIV-negative patients seen over the preceding month. Ten pre-ART folders were similarly sampled from the HCT register with the additional criterion that the patients had to have attended at least two clinical visits after their HIV diagnosis.

The full audit was conducted in 133 public primary-level facilities in Cape Town, all of which offered HCT. Only 123 facilities offered pre-ART care (midwife obstetrical services and youth centres did not), and 122 of these were audited (99%) for pre-ART care. All 133 facility managers were interviewed and gave information on the training of 1307 clinical staff. Folder reviews were conducted using records of 634 clients found to be positive at HCT (HCT clients) and using records of 1115 known HIV clients attending for pre-ART care (pre-ART clients). Five hundred and twenty-five (47%) of these pre-ART clients were eligible for ART.

It was found that locally defined clinical guidelines exist, but service models for implementation of guidelines do not. Pre-ART services include a set of prevention, early detection and treatment activities and are provided at most public primary care facilities.

The uptake of HCT was 456 145 (17.8% of the adult population). While the location of HCT within the same facilities providing pre-ART care should facilitate access, 77.5% of positive HCT clients had a CD4 count and only 46.6% were clinically staged. Two-thirds of clinical staff (professional nurses and doctors) were trained in pre-ART care. Evaluation of quality of

care was defined as adherence to the current local service guidelines. We found important gaps. Only 50.1% of clients were evaluated for social assistance, and 32.2% of women had ever had a papanicolaou test (PAP smear) done. There were missed opportunities for integrated care with 67.2% being symptomatically screened for tuberculosis at their last clinic visit. There were missed opportunities for positive prevention in the care received: only 48.3% of clients had their contraceptive needs assessed, 61.2% were screened symptomatically for sexually transmitted infections, and 42.5% were issued with condoms at their last clinic visit. Breaks in the continuity of care occurred in pre-ART service delivery: management plans were noted in only 63.9% of HIV-infected patients accessing care. This compromises continuity of care in a context where patients are often seen by different clinicians. We found that patients were not monitored optimally for eligibility for ART (45.7% of pre-ART patients were staged clinically, and 88.5% had their CD4 count measured according to the current protocol). Furthermore, only 47.2% of patients who were monitored and found to be eligible for ART were referred appropriately to an ART service point. ART mostly functions as a separate referral service within the primary care setting.

Key points:

- This evaluation showed a break in the continuum of care between HCT and ART
- Package of preART care is not being fully implemented
- Clients, in care, who are eligible for ART, are not being timeously referred

What does the study add?

Regular periodic audits are an attractive alternative to routine registers.
Audits have the added advantage of creating the opportunity to engage subdistrict managers and facility staff in a quality improvement process that can be linked to operational plans within the facility and sub district.

What policy and service implications arise from the findings?

The scale up of preARt care has been relatively neglected in relation to the HCT and ART scale up. PreART care and referral to ART needs to be strengthened. What is the role of preART care in the broader HIV programme in relation to prevention and care? And what model of preART service delivery is best suited to achieve the objectives?

PROFILE ON SOPH INITIATIVES AND PROJECTS

Collaboration for Health Systems Analysis and Innovation (CHESAI)

In recent years there has been an increasing recognition that health problems need to be addressed in a more comprehensive way. Building the field of health policy and systems research, with an explicit social science perspective, can address this challenge and thus is the centre piece of this project.

Prof Uta Lehmann UWC ***Prof Lucy Gilson UCT***

This will be done through a series of postdoctoral research awards, sabbaticals for practitioner scholars and expert researcher residencies. Most importantly, these awards will be linked to strengthening the knowledge base and methodologies needed to operationalize equitable health systems. This is critical as health problems cannot continue to be addressed one disease at a time (referred to as the clinical/biomedical approach), rather the investment needs to support a more holistic health systems strengthening approach that would ensure sustainable health delivery systems.

This approach is important for developing countries where fragmented health systems cannot serve the health needs and where health research capacity of individuals and institutions is limited. This latter capacity is a critical force to improve health. Thus the project aims to develop the field of health policy and systems research by: defining the broad limits within which HPSR will operate; seek to understand the theoretical and conceptual basis of the field, and develop research methods that would be most relevant to the field of health policy and systems research.

The project will be jointly executed by the University of the Western Cape and University of Cape Town. Both universities have the necessary experience and resources to embark on this work, and are well-placed through their linkages with universities across Africa and links with other key stakeholders and institutions. The project activities to support field building of HPSR and capacity building will include time and space for researchers to debate, consolidate and further develop the field along with individual awards for postdoctoral research, scholarships and residencies.

The project outputs will range from publications, teaching material, podcasts, websites, and other dissemination through conference and seminar attendance. Overall the project will expand and strengthen the African health policy and systems knowledge base and capacity of Southern researchers and institutions.

Addressing Counterfeits without Endangering Public Health

Christa Cepuch of HAI Africa explains how propaganda surrounding counterfeits is being used to advance a wider IP monopoly enforcement agenda to the detriment of public health

Christa Capuch

Patent rights seem to supersede patient rights now that the debate about substandard and poor quality medicines has been hijacked by powerful forces. The fight against substandard medicines has been steered away from human rights and public health, energies have been diverted and language has been manipulated to change the focus towards protecting intellectual property and commercial interests. International trade agreements, regional policies and national legislation against counterfeiting seek to ensure greater enforcement measures of all intellectual property rights, often with the pretence of addressing public health and safety concerns relating to essential medicines. In the area of public health, anti-counterfeiting initiatives are not an appropriate way to address the real health concerns about medicines quality and safety in developing countries.

> Blurring the line between counterfeiting and patent infringement is not just a theoretical problem. To date, at least 22 shipments of generic medicines have been seized at various European ports because of the confusion ... Any seizure disrupts already tenuous procurement and supply chains

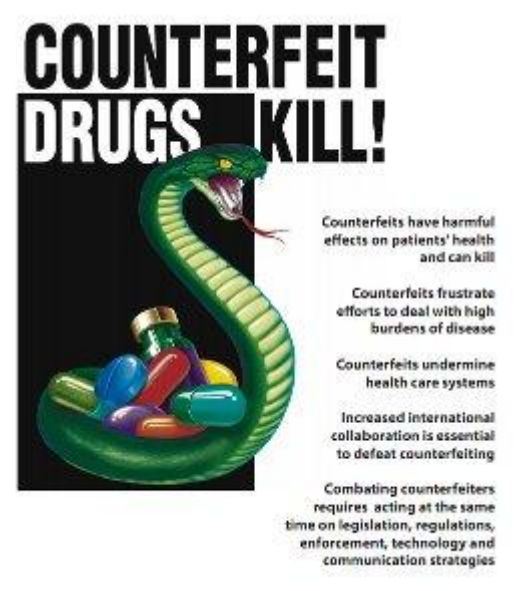
So what is a counterfeit medicine?

The answer depends on who you ask. Just a few possible answers include:

- To an English-speaking lay-person, it generally means fake or “a pill made of chalk”

- To the World Trade Organisation, it means a "trademark infringement" (An illustration of trademark infringement would be someone else using a pharmaceutical company's trade name or trademark on a particular product)
- To the World Health Organisation, it means "deliberately and fraudulently mislabelled with respect to identity or source"

The International Medical Products Anti-Counterfeit Taskforce (IMPACT) uses a nasty-looking, fanged, forked-tongue cobra in a brochure to help clarify its definition of counterfeit medicines.
The puzzling list of definitions does not stop there. Under Kenyan law, for example, counterfeits are addressed through the Anti-Counterfeit Act, 2008. In the act, the definition of "counterfeiting" begins with the phrase: "Taking the following actions without the authority of the owner of intellectual property right subsisting in Kenya or elsewhere in respect of protected goods".



What does this mean? Does it mean fake? Does it mean trademark infringement? Does it mean mislabelling? What it actually means is much broader than all of this. Such laws say that if you infringe any kind of intellectual property (IP), then you are counterfeiting. If you infringe a patent (even, astoundingly, one recognised outside the country) you are now a counterfeiter.

This is a whole new meaning, and this is the essence of the problem with anti-counterfeiting initiatives which appear to be springing up in many African countries, as well as with the global Anti-Counterfeiting Trade Agreement (ACTA). Suddenly patent rights have been brought into the already-confusing counterfeit debate. There is a need to stop this and ensure that the definition of counterfeit is not expanded to include patent infringement.

Patents, trademarks and copyrights

IP is important for trade purposes, but it has nothing to do with quality. When you get a patent, you have been acknowledged for inventing something new. A trademark is a registered sign to identify your product. Copyright is granted to an author of written material or to an artist for a musical creation. Regardless of whether your copyrighted art is enjoyable, or if your goods under trademark and/or patent are sound (ie regardless of the quality of the products), all these types of IP can be granted.

Blurring the line between counterfeiting and patent infringement is not just a theoretical problem. To date, at least 22 shipments of generic medicines have been seized at various European ports because of the confusion. These medicines were stopped en route to various public health programmes, including HIV treatment projects in developing countries. Any seizure disrupts already tenuous procurement and supply chains. Shipment delays (or cancellations, in the worst case scenario) increase the risk of stock-outs in health facilities and can distort medicine prices.

The Real Issue: Quality and Safety of Medicines

The actual root of the problem is grounded in issues of public health, safety and quality. This is where the attention should be focused: to fix the critical reality of substandard and poor quality medicines. However, rather than developing the solution from a public health and regulatory angle (ie How to protect the public by preventing poor quality medicines from hitting the market and/or How to get unsafe medicines off the market), the forces behind the anti-counterfeiting movement are using an 'IP enforcement' approach. Why?

Could it be another – the newest, perhaps most creative – effort by powerful industries to protect their patents, and as such their profits?

Regardless of the public health claims being made by the anti-counterfeiting movement, it is absolutely inappropriate to deal with quality and safety issues by strengthening IP.
HAI Africa and its network partners continue to resist efforts to blur the line between substandard medicines and counterfeits

Rather, the solution must begin in strengthening National Medicines Regulatory Agencies (NMRAs) and their services (registration, post market surveillance, pharmacovigilance, etc). For

medicines, only the NMRA in a country can determine quality, efficacy and safety; not the patent office or customs officials. Indeed, there are patents on many medicines that are completely unmarketable due to quality and safety concerns.

HAI Africa's Approach

Health Action International (HAI), a member of SARPAM's civil society team, is an independent, global network that aims to increase access to essential medicines and improve their rational use through research excellence and evidence-based advocacy. In support of people trying to access the medicines they need as they struggle to realise their right to health, HAI Africa and its network partners continue to resist efforts to blur the lines between generics and counterfeits.
HAI strongly refutes those who claim to be "fighting counterfeits and protecting public health" while their efforts are in reality being used to frustrate access to generic medicines in order to protect enormous commercial interests. HAI Africa acknowledges that there is a genuine concern over substandard and poor quality medicines, which are dangerous for individuals and harmful to the broader public health.

Will enforcing various types of IP address these quality and safety issues?

No. Enforcing IP through the framework of the ongoing anti-counterfeit initiatives puts access to medicines at risk and does not address the issues of the quality and safety of medicines.

More information is needed on these issues in the SADC region. HAI Africa would like to work with partners in the SARPAM network to research and analyse the anti-counterfeiting policy and legislative landscape in SADC countries. A collaborative effort with the SADC secretariat, ministries of health, medicines regulatory authorities, WHO and civil society can both establish the evidence and subsequently chart a rational strategy to address matters (if any) of substandard medicines and counterfeits in the region.

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More Health for the Money

By Muhammad Yunus

Muhammad Yunus is the founder of the Grameen Bank and winner of the 2006 Nobel Peace Prize for his "efforts to create economic and social development from below." He has won a number of prestigious awards and honorary doctorate degrees, and is considered a trailblazer in microfinance and social business. Yunus serves on the board of directors of the United Nations Foundation

Aid from wealthy countries to fight disease and poverty in the developing world has saved countless lives over the past decade. Despite intensified financial efforts toward global health goals, progress seems to be impeded and slow as the 2015 deadline for achieving the Millennium Development Goals draws near.

A recent study by the OECD Development Assistance Committee shows "sobering" results on the Paris Declaration on Aid Effectiveness: Out of thirteen measurable targets, only one – coordinated technical cooperation – has been met. Progress to meet the 2015 health MDGs are being impeded in part due to aid ineffectiveness. As much as $0.28 is lost for every $1 of ODA, and the high volatility in aid adversely impacts patients and health systems.

After more than a decade of steady increases in funding for global health and development programs, foreign aid is flatlining, in many cases dwindling. This will leave millions without prevention and treatment in years to come.

The problems associated with conventional aid, however, extend beyond the funding gap. Among which: (1) traditional aid mostly involves short-term commitments which are inherently unpredictable and unstable, making it difficult for poor countries to plan ahead, and (2) aid is typically paid out against inputs rather than measurable results such as maternal and infant deaths, thus creating failed incentives for improved performance.

With the population of the world now topping 7 billion people, improving global health outcomes has increasingly become a concern in development agendas. In these hard economic times, we can no longer exclusively depend on the good graces of donor governments alone. Rather, we must think creatively about new ways to financially support global health and development goals, without relying on increasing rates of development assistance.

In recent years, scaled-up efforts towards innovative financing for global health have been put in place to effectively address these problems associated with traditional aid financing. The concept of innovative financing is that successful financial instruments in the private sector are recast to suit development objectives, and its goal is to bridge the resource gap and accelerate the procurement of essential health goods to the poor.

Examples of such initiatives include the International Finance Facility for Immunization, or IFFIm, which sells bonds on capital markets that are backed by the long-term commitment of a few donor countries; the Global Alliance for Vaccines and Immunizations, or GAVI, uses these funds to purchase childhood vaccines worldwide; and the advanced market commitment.

A more recent innovation in financing for global health is the use of commercial credit to accelerate health commodity procurement. The Pledge Guarantee for Health, developed through a collaboration of the Reproductive Health Supplies Coalition, the U.N. Foundation and the Bill & Melinda Gates Foundation, is a financial tool that borrows several ideas on trade finance developed by the commercial sector, but applies it to the procurement of health commodities like anti-malaria bednets, contraceptives and medicines, enabling grant recipients to obtain short-term, low cost commercial credit on the basis of pending aid commitments. A donor serves as a guarantor to lending institutions and manufacturers to ensure they will be paid on time and in full. This stretches the value of the donor dollar and hastens the delivery of these commodities to the people who need them. In February, PGH ensured that 800,000 bednets arrived in Zambia months ahead of schedule – and before the peak rainy season. Later this month, PGH will use a receivable financing strategy to enhance affordability and ensure increased access of vital contraceptives developed by leading pharmaceutical manufacturers.

By mitigating the resource gap, the value of donor aid is maximized by smoothing out the unpredictability and instability of the funding source. PGH delivers value for money by removing the risks in the procurement process that lead to price premiums and emergency production. In public health terms, this results in faster, more efficient purchasing of life-saving commodities, while also empowering governments with leverage to negotiate reduced per-item costs.

I have been promoting the concept of “social business” to address health care and other pressing human problems. Social business is a special type of business which is devoted solely to solving problems, rather than bring profit to the investors.

Investors don’t take any profit from these companies, except getting back the original investment. I have created social businesses to produce bednets as a joint-venture with BASF, a water company as a joint venture with Veolia, sanitary napkins for rural women as a joint venture with Uniqlo, a nutrition company as a joint venture with Danone, and many other companies. Many more social business companies can be created if donors and the private sector create social business funds in each Third World country to invest in heath care-related creative social business companies to help the start-ups and replicate successful start-ups. This way, creativity and sustainability will be encouraged and some money can be recycled endlessly. Donor dependence can be minimized.

As the year comes to a close and the 2015 MDG deadline draws near, there is a great challenge to improve aid effectiveness and maximize value for money.

The World Health Organization notes that, in order to meet the MDG goals in 49 of the world’s poorest countries, an extra $250 billion would need to be raised. Being four years away from our

deadline and in light of the global recession, raising this amount through traditional financing will prove to be a gargantuan task.

Innovative financing initiatives, particularly access to commercial credit, are proposed solutions to ensure that funding is available and accelerated to meet the growing demand for global health, in an effort to improve aid effectiveness and progress towards meeting the U.N.'s Millennium Development objectives.

A significant part of the aid money can be used to create social business funds in each recipient country. Local and international investors can utilize this money in each country to create health care-related social businesses

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