Global Health is a Human Right! | **La santé mondiale est un droit humain!**

A NATIONAL CIVIL SOCIETY SUMMIT | **SOMMET NATIONAL DE LA SOCIÉTÉ CIVILE**

21 - 22 May 2003 -- Marriott Hotel, Ottawa | les 21 et 22 mai 2003 -- Hôtel Marriott, Ottawa

Canadian Labour Congress
Congrès du travail du Canada

Interagency Coalition on AIDS and Development
Coalition interagence sida et développement

Canadian HIV/AIDS Legal Network
Réseau juridique canadien VIH/sida

Médecins Sans Frontières
Doctors Without Borders

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GLOBAL HEALTH IS A HUMAN RIGHT!
A NATIONAL CIVIL SOCIETY SUMMIT

21–22 MAY 2003, OTTAWA

FINAL REPORT

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INTRODUCTION

This document summarizes the proceedings of "Global Health is a Human Right! A National Civil Society Summit" held May 21-22, 2003 in Ottawa, Canada. The bilingual Summit was organized by the Global Treatment Access Group (GTAG), a group of Canadian civil society organizations that have been sharing information and undertaking joint activities aimed at improving access to essential medicines and other aspects of care, treatment and support for people living with HIV/AIDS and other health needs in developing countries.

Objectives and Anticipated Outcomes

The objectives of the Summit were to identify ideas for policy advocacy and action related to:

- **The Impact of Trade and Globalization** on Commitments to Achieve "Health for All"
- **Financing Global Health**: Canada's Foreign Aid, the Global Fund, and Debt Cancellation
- **Corporate Social Responsibility** in Supporting Public Health in Developing Countries

The anticipated outcome of the Summit was to mobilize broad support for effective advocacy and action on global health issues. GTAG has committed to drafting a Common Platform on Global Health as a Human Right, and to follow up with all of the Summit participants.

Acknowledgments and Thanks

GTAG wishes to thank all of the speakers, moderators, and participants for their contributions to the Summit. GTAG would also like to thank the following organizations for their generous financial and other support, which made the Summit possible:

Canadian Labour Congress
Interagency Coalition on AIDS and Development
Canadian HIV/AIDS Legal Network
Médecins sans frontières/Doctors Without Borders
Council of Canadians
Rights & Democracy
Canadian Union of Public Employees
United Steelworkers

GTAG also thanks Stop TB Canada and the North-South Institute for their contributions.

Finally, GTAG thanks the members of its Summit working group that organized the event: Marie-Hélène Bonin (Canadian Labour Congress), Carol Devine (Médecins sans frontières Canada), Richard Elliott (Canadian HIV/AIDS Legal Network), Rosemary Forbes (Interagency Coalition on AIDS & Development), John Foster (North-South Institute), Anil Naidoo (Council of Canadians), & Michael O'Connor (Interagency Coalition on AIDS & Development). GTAG extends a special thank you to oline Twiss and Nikki Boon for their hard work in coordinating the Summit and its logistics.

This report and its appendices, as well as longer summaries of speakers' presentations, biographies of the speakers, photos of the march, etc. are available on-line at: http://www.aidslaw.ca/Maincontent/issues/cts/GTAGsummit.htm

This report was prepared by oline Twiss, Summit coordinator, as commissioned by the Canadian HIV/AIDS Legal Network for the Global Treatment Access Group (GTAG). Funding for preparation of this report was provided by Health Canada (International Affairs Directorate) under the Canadian Strategy on HIV/AIDS.

BACKGROUND

On May 21-22, 2003, "Global Health is a Human Right! A National Civil Society Summit" brought together a wide range of Canadian organizations interested in joint advocacy on realizing the human right to health in developing countries, with a particular focus on addressing the global crises of communicable diseases such as HIV/AIDS, tuberculosis and malaria.

Objectives

The Summit aimed to identify ideas for policy advocacy and action related to:

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A Common Vision for Public Health

More than a year ago, Canadians from across the country came together in Ottawa to participate in a first people's conference on the future of health care. That conference issued a statement – *A Call to Care* – supported by more than 150 major organizations representing millions of Canadians. The statement (www.healthcoalition.ca) affirmed the belief of Canadians that health is a fundamental right of every human being and pledged to defend this right by mobilizing for a public health care system that is:

- Properly funded by governments;
- Truly comprehensive and universal, with all health care services provided, publicly insured, publicly delivered, on a not-for-profit basis;
- Accountable through democratic participation and governance at all levels;
- Excluded from all international trade agreements so that the expansion and quality of the system is not subject to review by international trade tribunals;
- Pays decent wages, provides decent working conditions and training opportunities, recognizing that proper compensation is essential to high quality care and the retention of health workers.

A little over a year later, on February 9, 2003, health care activists and concerned Canadians developed an Action Plan at the first National People's Summit on Health Care, which outlined specific objectives for common actions in our workplaces, our communities, our provinces and territories, and across Canada generally. These actions are intended to keep Canada's health care system fully public, fully accessible and responsive to the diverse needs of all Canadians. [For more information, visit http://www.clc-ctc.ca/publicmedicare and http://www.canadians.org]

A Call for Global Action

While mobilization is unfolding at domestic level, a similar process is taking place on a global scale, as the world assesses the impact of the *Declaration on Primary Health Care* adopted 25 years ago in Alma-Ata. The Declaration subsequently led to the adoption by UN member states of a *Global Strategy for Health for All by the Year 2000* – a commitment reviewed by global civil society organizations during a gathering that took place parallel to the 56th World Health Assembly held in Geneva on 19-28 May 2003.

The time is therefore opportune for Canadian activists to examine the current global situation and the achievement of health *as a fundamental human right*, and to assess the results of global and Canadian commitments towards the goals set some 25 years ago, particularly in developing countries. A common vision and platform for action should also emerge from this process.

Health for All is a Human Right

In 1946, member countries of the newly established World Health Organization proclaimed that the "highest attainable standard of health" is a "fundamental human right" of every person. Similarly, the UN's *International Covenant on Economic, Social and Cultural Rights* entered into force in 1976 and 145 countries, including Canada, are parties to this treaty. The covenant stipulated that these countries have not only a moral obligation, but also a legal obligation to take immediate steps towards ensuring the highest attainable standard of health for every person, including actions necessary to prevent, treat and control epidemic and other diseases. Countries such as Canada have pledged to progressively realize this right, both domestically and internationally. Yet for most people, access to needed health goods and services remains unrealized.

Developing countries in particular have been hardest hit by such policies. Global pandemics such as HIV/AIDS, tuberculosis and malaria bring into stark focus the urgent need for affordable access to health goods and services, such as essential medicines, equipment for diagnosing and treating illness, trained health care workers, and other elements of health infrastructure. Yet it is these public goods that are damaged or threatened by under-funding, privatization, an unfair and unequal international trade system and other short-sighted domestic and international policies.

> Many governments are pursuing policies that contradict their obligations to protect and promote the health of their own people and of people in other countries

While developing countries are suffering the most, these policies threaten public, universally accessible health care in Canada as well. Canadians strongly support the principle of public, universally accessible health care, believing that access to health care should depend on need and not wealth.

Canadians also care about the welfare of people outside our borders and believe that we have not only a moral and legal responsibility to support global efforts to address the health crises affecting developing countries; it is also in our interest to do so.

A Citizens' Review of Commitments

Yet governments have failed to truly commit themselves to reaching the goal of health for all by the year 2000. As we enter the 21st Century, the world is facing increasing health inequalities and public health crises, including HIV/AIDS, tuberculosis and malaria.

Meanwhile the capacity of many countries to respond has been weakened by poverty, globalization, and deteriorating health infrastructures.

In response, a worldwide movement by citizens and civil society organizations was born. Over a period of two years, a process of global dialogue engaged thousands of participants in a discussion of what principles and action were needed to realize the human right to health on a global scale.

The process culminated in a People's Health Assembly in Bangladesh in December 2000. Over 1500 participants from 93 countries adopted the People's Charter for Health, setting out a vision premised on the notion of health as a fundamental human right and a call to action on the part of individuals and communities at the national, regional and global level.

At the World Health Assembly, the world's countries have restated their commitment to Health For All in the 21st Century. At the United Nations, countries have adopted declarations and resolutions committing themselves to various goals to reduce poverty and ill-health, such as the United Nations Millennium Development Goals, and the commitments adopted at UN General Assembly Special Session on HIV/AIDS (UNGASS) of June 2001.

But these statements will mean little unless civil society organizes to hold governments accountable for their promises.

In May 2003, building on the declarations in the People's Charter for Health, civil society groups gathered in Geneva to hold an event parallel to the WHO's official World Health Assembly.

Civil society groups renewed their push for government action to follow through on their stated commitments to realizing health for all. Canadian civil society also has a role to play as part of this broader global citizens' movement for health as a fundamental human right.

Panel discussions and background papers

Guest moderators from Canadian civil society organizations introduced the panel discussions, with presentations from both Canadian organizations and partner organizations based in developing countries. The presentations were made available to participants in the form of short backgrounders. Following the panel presentations, there was time dedicated for questions and discussion among all participants.

Strategizing Workshops

Strategizing workshops were devoted to crafting a Common Platform on Global Health as a Human Right. Divided along the 3 themes previously discussed by the panels, the workshops strove to identify specific recommendations that could be directed to the Canadian government and private sector, as well as ideas for an *action plan* (e.g. campaigning and other advocacy initiatives) that participating organizations can implement individually and/or collectively through the Global Treatment Access Group (GTAG). Time at the Summit was not sufficient to craft a refined Common Platform, but sufficient ground was covered to initiate a process that will lead to stronger, coordinated action by Canadian civil society on global health in the future (see below).

Common Platform and Follow-up to the Summit

The Summit organizers (i.e., the co-ordinating body of GTAG) are tasked with Summit follow-up. Reports from strategizing workshops were presented in a plenary session at the end of the Summit. After the Summit, GTAG is taking on the task of producing a draft Common Platform on Global Health as a Human Right, and identifying what steps it can and will take to advocate for the elements of this common platform.

The draft platform will be submitted for consideration and endorsement by GTAG members, civil society organizations that participated in the Summit, and other interested civil society organizations.

For more information about Summit co-sponsors:
Canadian Labour Congress www.clc-ctc.ca
Interagency Coalition on AIDS and Development www.icad-cisd.com
Canadian HIV/AIDS Legal Network www.aidslaw.ca
Canadian Union of Public Employees www.cupe.ca
Médecins sans frontières / Doctors Without Borders www.doctorswithoutborders.ca
Rights and Democracy www.ichrdd.ca
Council of Canadians www.canadians.org
United Steelworkers www.uswa.org

OPENING SESSION

Barbara Byers, Canadian Labour Congress

"The Right to Health at a National and Global Level"[1]

This civil society Summit on Global Health is the coming together of national organizations to discuss common strategies for action beyond our borders to advance our rights to health. It is a first in Canada, and together we will set achievable goals and map out the strategies to achieve them.

We have rights, including a human right to be healthy and to expect proper care when we are sick. And we have goals, grounded in our vision of health as a human right. Indeed, our goals, just like our rights, are grounded in our values as workers, citizens, families, and communities. In our value system, health care is not a commodity.

It comes down to a very simple choice. Either people are at the centre of development, or greater profits for big business are at the centre of development.

The crisis in global health demands our intense, focussed attention. The health of humankind is being compromised, and the world's civil society will demand accountability from governments for the failure to meet their commitments and the deterioration in global health. We are not alone in the world and the pressures on our health system are not all home-grown. There is an incompatibility between economic globalization on the one hand, and the fulfilment of human rights and the social responsibility governments have for the well-being of their citizens on the other.

It comes down to a very simple choice. Either people are at the centre of development, or greater profits for big business are at the centre of development.

As citizens, we have to demand: an end to a global economic system that puts investors and not people at the centre of development; to know why the governments of wealthy countries have cut back on overseas development aid; to know why spending on armaments is over nine-hundred times that of spending for the Global Fund to Fight HIV/AIDS, TB and Malaria; an economic order that fosters equality and the elimination of poverty through an equitable distribution of the world's resources; an economic model and trade agreements in which governments are free to fulfill their social responsibilities such as the achievement of human rights; that the World Bank and the IMF cease facilitating the privatization of health care systems and health insurance.

We need to explore what our own organizations can do, and tackle the question of corporate responsibility for the advancement of global health.

Together we can draft a plan on how to pressure our own Federal Government and Provincial/Territorial Governments in order to force them to defend on the world scene the values we want them to uphold at home, and start to reverse the trend of commercializing health care. The growing solidarity of our organizations and of the peoples of the world will bring better health and new hope for all. I believe that we can change the world and we **will change the world. Let's** get to it.

[1] The transcript of Barbara Byers' address can be viewed online at:
http://action.web.ca/home/clccomm/en_readingroom_speeches.shtml?sh_itm=8a375a0569c1dbabc6376806ea313d23

PANEL 1: THE IMPACT OF TRADE AND GLOBALIZATION ON COMMITMENTS TO ACHIEVE "HEALTH FOR ALL"

Michel Lotrowska, Médecins sans frontières Brazil

"Is International Trade still an obstacle to Public Health? – The Brazilian Experience"

The World Trade Organization's Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) is of interest to us because it covers patents; this in turn affects access to drugs. Notwithstanding the WTO's ostensible mandate for "free trade", TRIPS rules on drug patents restrict trade instead of promoting it, including preventing competitors from entering the market and bringing down the prices of medicines. TRIPS implicates the patent laws, and hence access to less expensive medicine, in all countries belonging to the WTO.

What is a patent? It is an exclusive right to make, use, sell or import an invention in a country, which is granted to an owner for 20 years. Every country has the right grant a patent – there are no "international" patents. No one can make a generic version of a drug for the 20 year term of the patent – the patent owner has a monopoly. In Brazil, foreign companies hold 97% of patents. TRIPS has produced high prices, no technology transfer into the pharmaceutical sector in the country, and no research and development (R&D) for diseases affecting developing countries.

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Avoiding abuses of the patents protected by TRIPS means making use of safeguards such as compulsory licensing. The US has frequently used compulsory licensing, but developing countries do not, for fear of retaliation from the US under Section 301 of its Omnibus Trade Act. Section 301 authorizes the US government to retaliate in any sector with unilateral trade pressure on any country that prejudices the interests of a US company, even if that country is respecting international laws.

In November 2001, the WTO Ministerial Conference unanimously adopted a *Declaration on the TRIPS Agreement and Public Health* that says public health is more important than patents: "[w]e affirm that the [TRIPS] agreement can and should be interpreted and implemented in a manner supportive of WTO Members' right to protect public health and, in particular, to promote access to medicines for all". But some countries cannot make effective use of compulsory licenses because they do not have the domestic capacity to manufacture generic medicines, and must therefore seek to import from other countries. Those possible source countries, however, are, or soon will be, restricted from authorizing the production of generic medicines for export to countries in need by the TRIPS requirements for patent protection. Negotiators are working on a solution to this, but are beyond their December 2002 deadline. There can be an easy solution, but the US and other countries are not supporting this. There must be equal sovereign ability for developed and developing countries to make effective use of compulsory licenses.

Brazil's ARV program has cut by half the number of HIV/AIDS cases projected by the World Bank, and has saved a fortune in health costs. Brazil is one of the few countries with the capacity to do R&D for reverse engineering in order to produce generic medicines - 7 of 15 ARV drugs are produced in Brazil, because they were not patented. The cost for one person on combination therapy is about US$2000 a year, which is more than the US$250 generics combination offered by some Indian generic companies, but below the US$12000 that is the cost in Canada. All of the medicines developed after 1996 are patented, as a result of changes to Brazilian law spurred by TRIPS. Thus, over time, locally produced drugs will be replaced by the imported medicines.

Dora Martinez, Union of State Employees, Argentina Workers Central
"Implications of the FTAA on Latin America's Health Challenges"

The mercantile system of health does not respect health as an undeniable right. In 1976, when Argentineans suffered a coup d'état, there was also exclusion in terms of public health. Hospitals started to disappear - many were dismantled, and there was a lack of personnel as many workers were fired. These effects were associated with a push for trade liberalization, which was exclusionary and did not protect the intellectual property 'of the people'.

In the 1990s, transnational companies were able to use the huge foreign debt (for which Argentineans are not responsible) to gain leverage for imposing social and economic policies in Argentina. Additionally, high levels of poverty have precluded the realization of human rights – in terms of a lack of access to health care, education, and in terms of infant mortality and a rise in diseases. Privatization has meant that only people who can pay get medical treatment.

We understand that health is a human right. We need access and equity in terms of medical care for all, on models that countries are free to determine by themselves.

The extension of neo-liberal policies – through the FTAA - may be the total destruction of the health care system. Disease means profits for the commercial partners of national and international financial groups. They make money from our lives. This kind of globalization does not respect our people.

The US government has been promoting its own partnerships in Latin America in order to block a regional trade agreement that would be of a more integrative nature and could be of benefit to countries in the region. We have the obligation, as a working class in Latin America and around the world, to build an opposing force in order to block the implementation of neo-liberal policies that will benefit private corporations rather than the people. The FTAA will destroy us. In particular, its provisions on intellectual property will tie up research, science and technology, as well as threaten biodiversity and essential elements of life, which will principally affect indigenous people and small farmers.

We understand that health is a human right. We need access and equity in terms of medical care for all, on models that countries are free to determine by themselves. At my union, we are building a different model, by means of which solidarity and social justice will prevail, and be a reality.

Scott Sinclair, Canadian Centre for Policy Alternatives
"Putting Health First: Canada's Global Trade Policies and Public Health"

Two interrelated factors threaten the long-term sustainability of Canada's health care system. *Growing foreign commercial involvement*, combined with *far-reaching (and still expanding), international trade treaties*, threaten to

- undermine our existing Medicare system,
- shrink our reform options, and
- make future change more difficult and expensive.

Ongoing negotiations for a Free Trade Area of the Americas (FTAA) and negotiations under the General Agreement on Trade in Services (GATS) continue to colonize new domains of regulation. Under the theme of "domestic regulation", for example, current talks basically aim to restrict government regulation of all services by applying a "necessity test". If adopted, this would mean WTO and FTAA dispute settlement panels could sit in judgment of completely non-discriminatory public interest regulation – that insures that regulation is no more burdensome than necessary to

commercial interests. It is preposterous that such a fundamental value judgment should be made outside of democratic processes. Canadian health care policies and other public systems are, at root, incompatible with the full application of free trade treaties, as the purpose of these treaties is to commercialize services and privilege investor rights.

It is the public, not-for profit character of Canada's health care system – not the flawed trade treaty exemptions for health – that insulates us from trade challenges.

It should be stressed that it is the public, not-for profit character of Canada's health care system – not the flawed trade treaty exemptions for health – that insulates us from trade challenges. As this defining character is eroded, the risk of trade litigation will grow.

The federal government must transform its approach to trade treaties and negotiations. Domestically, Canadian governments should be avoiding commercialization of health services—and taking prompt action to contain or reverse existing commercialization. This is good public policy, and it also has the benefit of reducing the risk of future trade treaty challenges. They should also change Canada's existing treaty commitments and champion new international health protection treaties that supersede commercial trade agreements.

Internationally, Canadians have an important responsibility to achieve greater coherence between their international trade policies and health policies. Canadian policy, both at home and abroad, should be based on the principle that health is a universal human right.

Panel 1 – Discussion

The discussion revolved around the theme of the privatization of health care. Concerns were raised with regard to research and development, health services, costs of medicines in both developed and developing countries, and health systems. The general consensus is that the responsibility of the state is central to the discussion on ensuring health for all. Beginning to reinvest in the public system is paramount. For example, we need to reinvest in public research, as the pharmaceutical industry has shown that market-driven R&D is not meeting health needs, particularly for developing countries.

Other points that were raised included:

- Social inequalities impede the realization of the human right to health for all. Achieving full enjoyment of the right to health requires that we address these inequalities.
- Brazil has invited the new director of WHO to replicate its HIV/AIDS program in other countries.
- There is a whole campaign by brand-name multinational pharmaceutical companies to discredit generics. In some cases, people living with HIV/AIDS and/or other health conditions are concerned about the quality of generics because of these campaigns.
- Restoring and creating both health systems and access to drugs is a chicken and egg problem. In many cases, both need to be addressed - but the absence of one should not preclude efforts in either area, or be an excuse for inaction.
- We should break the deadlock at the TRIPS negotiating table by working at a domestic levels to push the boundaries of TRIPS. For example, we should be opposing TRIPS-plus legislation, or call for national plebiscites (as is happening in Brazil) on the FTAA. We should also push countries with generic drug industries to authorize production of generics for export, testing the flexibility of TRIPS, rather than leave countries in need of medicines hostage to the stonewalling of wealthy countries like the US and its backers (such as Canada).

- The 20-year patent term is too long. Even developed countries like Canada cannot afford the rising costs of drugs - it is the fastest rising component of our health system and is the part that is most privatized.
- The pricing of drugs in both developing and developed countries does not reflect the costs of production or R&D. The drug companies set prices according to what they think the market can pay, so the issue of whether or not prices can be dropped in both developed and developing countries remains an open question – we do not have to accept the prices that are imposed, and while we should seek "equity pricing" globally, whereby developing countries pay lower prices, this does not mean drug prices and other practices of the pharmaceutical industry in developed countries are beyond question.
- We need a moratorium on the expansion of international or regional trade and investment agreements until we fully understand the grey areas that they present (e.g., on compulsory licensing) and just how well they preserve the freedom of governments to act in the public interest and protect health.
- Integrative regional trade agreements, such as MERCUSOR, hold more promise for the fulfillment of access to health care than agreements like the FTAA that privilege "investor rights" over human rights.

MID-DAY KEYNOTE ADDRESS

Kathleen Connors, Canadian Health Coalition and Canadian Federation of Nurses

"Public-Private Partnerships *or* Private Exploitation of the Public?"

Public private partnerships (P3s) have been embraced by the UN and criticized by people such as Stephen Lewis, the UN Special Envoy on HIV/AIDS in Africa. But the move towards them is not confined to the international scene. P3s are widespread and growing here in Canada - from the tainted blood disaster to the Walkerton E-coli outbreak to Health Canada's drug approval process now funded by drug manufacturers. Civil society, though, is not accepting P3s uncritically.

Some 'partnerships' should never be entered into. As Jane Jacobs, world-respected expert on urban planning, so eloquently wrote, "Governments cannot properly regulate industries if they are in bed with them." To paraphrase Justice Horace Krever, who headed the commission into Canada's bad blood disaster, "government must regulate in the interest of the public, *not the regulated.*"

A particularly virulent strain of the P3 virus in Canada is the race by right-wing governments (especially in Alberta, British Columbia and Ontario) to build hospitals on the model of public-private partnerships. There is no evidence supporting the P3 argument for using private capital to build hospitals. The fact is that P3s are dangerous. For-profit health care kills. We now know -- thanks to Dr. PJ Devereaux and his colleagues at McMaster University[2] -- that private, for-profit health care would result in 2200 additional deaths in Canada every year.

Governments cannot properly regulate industries if they are in bed with them.

Public health care and private health care don't mix: their systems are based on fundamentally different value systems. Health care is *a* public good to be protected from the market and international trade and investment agreements, whereas private, for-profit health care is a commercial commodity to be bought and sold to the highest bidder in the marketplace.

The term 'public-private partnerships' in health care is an oxymoron. The public pays and the private profits. That's not a partnership. Stirring a little bit of the market into the public health care system is like adding dirty water to clean water. It does not produce more clean water.

[2] P.J. Devereaux et al. "A systematic review and meta-analysis of studies comparing mortality rates of private for-profit and private not-for-profit hospitals". *Canadian Medical Association Journal* 2002; 166: 1399.

PANEL 2: FINANCING GLOBAL HEALTH: CANADA'S FOREIGN AID, THE GLOBAL FUND AND DEBT CANCELLATION

Janet Hatcher-Roberts, Canadian Society for International Health

"Is Canada Helping to Rebuild Developing Countries' Health Systems?"

Where we once talked about 'primary health for all' by the year 2000, we are now talking about 'primary health *care* for all' as a main focus of the overall social and economic goals of a country.

A sustainable health system should be based on a foundation of equity: is cost effective; maintains and improves health; has interventions that are appropriate and needs-based; integrates inter-sectoral policy approaches. The elements of a health system include: human resources; treatment; information for decision-making; infrastructure; and financing options (universal versus mixed options).

The impact of decentralization and structural adjustment has caused the continuum of care to be fragmented, which has had an impact on access, coverage, and sustainable financing.

Where we once talked about 'primary health for all' by the year 2000, we are now talking about 'primary health *care* for all' as a main focus of the overall social and economic goals of a country.

CIDA Canada had a strategy in the 1990's for strengthening the health sector. Current investment in health research for development is being done by: the International Development Research Centre (IDRC, a public Canadian corporation helping developing countries find solutions to problems through research, and includes a focus on health equity); the Canadian International Development Agency (CIDA, which provides Canadian development assistance); Health Canada (which focuses on the health of Canadians); and the Canadian Institutes for Health Research (CIHR, which brings together 13 institutes for Canadian health research). Investment is largely going towards strengthening primary health care and human resource development as it relates to reproductive health and HIV/AIDS. There is less investment on other diseases that affect developing regions such as malaria and tuberculosis. Deficits in investment exist in the overall investment in strengthening health systems such as: for capacity building for district planning, resource allocation, and strengthening health information systems. Successful community-based projects tend not to be multi-phased, tend not to be repeated outside of the region, and are rarely transferred to other regions. The Essential Health Intervention Project in Tanzania is a good example of such a successful project that should be transferred and replicated.

How can Canadian donors come together and put together a comprehensive framework for health systems strengthening? How can we strengthen a health system within a decentralized health system with a fragmented continuum of care? How should Canada show its commitment through its ODA in strengthening health systems?

Kingsley Chiedu Moghalu, Global Fund the Fight AIDS, Tuberculosis and Malaria

**"A Global Response to a Global Crisis:
The Global Fund to Fight AIDS, Tuberculosis and Malaria"**

HIV/AIDS, tuberculosis and malaria kill more than six million people each year, and the numbers are growing. The HIV/AIDS pandemic is decimating whole societies. Together, HIV/AIDS, tuberculosis and malaria are jeopardizing efforts to attain the Millennium Development Goals.

The Global Fund to Fight AIDS, Tuberculosis and Malaria was formally established in January 2002. It raises resources and finances for credible programs for the prevention, treatment and palliative care of three diseases, based on the following five principles: 1) A scaled up response to the three pandemics with new, additional resources; 2) Public-private partnership involving governments, the private sector, civil society, and communities of persons living with the three diseases; 3) Local ownership of program design and implementation; 4) Comprehensive support for prevention and treatment; and 5) Accountability.

Financing the Global Fund should go beyond Overseas Development Assistance (ODA) budgets. New money and new approaches are required.

After one year in operation, the Global Fund has had a number of positive outcomes in terms of distributing resources for prevention, treatment, and care and support. But the need for additional resources is urgent. The Fund needs US$1.6 billion to finance Round 3 and US$3.8 billion to finance Rounds 4 and 5 (total: US$5.4 billion). Financing the Global Fund should go beyond Overseas Development Assistance (ODA) budgets. New money and new approaches are required.

Canada has a stake in the Global Fund in terms of: its economic strength and political position in the world; being a member of the G8; its promotion of the G8 African Action Plan; and in supporting stability in African and Asian society which will make for promising trading partners.

Political will is the key to making a difference. Adequately refinancing the Global Fund will be a worthwhile, strategic upfront investment. If this does not happen, the Fund will be remembered as a program born out of passion and silenced by cynical rhetoric, and the judgment of history will be harsh indeed. Must we always be wiser with hindsight?

Pamela Foster, Halifax Initiative

"Cancelling Debt to Finance Health – An Impossible Dream?"

Canada should calling for debt cancellation as part of our strategy for health as a human right. Debt cancellation is one way to get money in to the hands of governments who need it to fight epidemics and realize health as a human right. The debt burden places both monetary and policy constraints on these governments, making it difficult for them to realize the right to health.

The monetary impact of the debt crisis on government budgets has meant that debt payments for developing countries are nearly three times the amount spent on healthcare. Even with the IMF/World Bank's most Heavily Indebted Poor Countries (HIPC) initiative, only some resources have been freed up from the massive amounts tied up in debt repayment schemes.

Canada should calling for debt cancellation as part of our strategy for health as a human right. Debt cancellation is one way to get money in to the hands of governments who need it to fight epidemics and realize health as a human right.

The policy constraints of debt are inextricably linked to the conditionality of these schemes - structural adjustment programs – that requires governments to engage in privatization and currency devaluation, making health care less and less accessible. Participants in the Voices of the Poor discussion group capture this by expressing: "Before everyone could get health care, but now everyone just prays to God that they don't get sick because everywhere they ask for money" or "We do not go to the hospital because it is necessary to bring our bed linens, dishes, sometimes even a bed".

Debt cancellation is important for reasons beyond morality and justice: current debt relief is inadequate, it will support the goals contained in the Millennium Declaration, it makes economic sense, and it will restore government accountability to their public (rather than leaving them hostage to lender institutions).

Panel 2 Discussion

The discussion focused largely on the Global Fund. Points that were made include:

The Global Fund is a public-private partnership, and civil society plays an important part in that reality. Country coordinated mechanisms (CCMs) must exist in the development of proposals. Many countries have not developed health strategies before – and many of them are finding that it works. 46% of Global Fund financing has gone to civil society, not government; 24% of Global Fund financing goes to strengthening human resources.

- The Global Fund itself does not impose conditionality – the only condition is in the technical soundness of proposals, and their ability to save lives.

Regarding the recent US announcement of US$15 billion package for global AIDS, it was originally intended that US$1 billion would go to the Global Fund over 5 years ($200 million/year). But the US Congress controls spending, and the bill that was adopted was quite different from what Bush intended – it says that the Fund can receive up to US$1 billion a year for 5 years. The condition on this money is that it should not be more than 33% of total contributions to the Global Fund in a particular year, imposing an obligation on other donors to come up with US$2 billion to this US$1 billion.

The Global Fund should take a strong feminist-based perspective in terms of sexual reproductive rights and a comprehensive approach to sexuality and reproductive health. This would include access to abortion, and US foreign policy forbids any funding to go to any thing related to abortion. We should be concerned about the potential difficulties this may raise for the Fund.

Canada has contributed US$100 million over 4 years (US$25 million/year) to the Global Fund. The Canadian government is fully aware of the resource needs of the fund, but has not yet made a greater contribution

It is a myth to think that price reductions from drug companies are due to the public-private partnership of the Global Fund. What kind of a role does the private sector have in the Fund? Is it proportional to what they give? Most of the Fund's monies come from governments, but the private sector has not adequately contributed (about 1% of total contributions to date).

The Fund encourages technical assistance where the capacity does not exist to make optimal use of the funds.

Other points that were raised included:

- We need to employ a feminist analysis of HIV/AIDS in terms of financing global health. We need to know what the gender inequities are in decision-making, funding, and the appropriation of resources.
- Developing countries need to have equitable voices at the IMF and World Bank over how the financing at the institutions is spent (currently the G8 holds decision-making power in these bodies). We also need to call for further transparency at the World Bank and the IMF. There have also been calls for a 'debtors cartel' that would refuse to make repayments, based on the view that it is illegitimate debt that people in developing countries had little or no say in incurring and from which they have not benefited.
- In Niger, increasing poverty means that people have less access to health care. When governments like Canada support access to health and education, it is inconsistent with also supporting the international financial institutions' policies that increase poverty and restrict access to health care based on wealth, not need.
- Street mobilization is critical - in combination with all of the analysis, documents, and declarations – if we are to get sufficient numbers of ordinary Canadians engaged in issues around global health.

EVENING KEYNOTE ADDRESSES

Maude Barlow, Council of Canadians
"Collusion and Resistance"

There are more than 32 million men, women and children infected with HIV/AIDS in developing countries; this year alone, a whole generation in some devastated countries will be wiped out.

We are here tonight to speak this truth: these deaths are preventable. With a concerted effort by an engaged and enraged international community, we could radically ease the suffering of millions on our way to eradicating AIDS forever. Why then, in spite of the United Nations Declaration of Commitment on HIV/AIDS, the establishment of the Global Fund, an international action plan, as well as scores of international meetings, is the situation getting worse?

The answer is the second truth that we must speak tonight: our governments, including the Canadian government, say one thing and do another. While mouthing all the right pious platitudes, they have formed a global royalty surrounding and protecting a set of corporate interests historically unprecedented in their power. Tragically the answer – access to cheaper generic drugs – is opposed by one of the most powerful lobbies of all time.

The pharmaceutical industry is dominated by a handful of giants – Merck, Pfizer, GlaxoSmithKline, Eli Lilly, Bristol-Myers Squibb, Johnson & Johnson. The drug companies operate like a cartel, seeking to exercise monopoly control. They wield enormous power in the US, and have the same kind of power base in Canada. So it is little wonder that Canada is supporting a TRIPS-plus regime at the upcoming FTAA negotiations where the drug companies are seeking patent extensions, that Canada is a cheerleader for GATS, exposing Medicare to the cold shower of international competition, and that International Trade Minister Pierre Pettigrew backed off his promise not to extend NAFTA's Chapter 11 investment provisions to the rest of the hemisphere.

The single most important action we civil society groups of the WTO's "Quad" countries can do in this global struggle against HIV/AIDS is to fight our own governments and corporations and the polices and ideologies they are forcing on an increasingly divided world. This is global class warfare.

In fact, in foreign policy, and increasingly in domestic policy, the Canadian government has abandoned any pretence of progressive policy – the recent war being a welcome exception – and embraced the "Washington Consensus" in all its facets.

Here is the third hard truth tonight: because our governments no longer even attempt to appear fair, and listen only to the voice of their corporate elite, civil society – ordinary people - is the only chance the world has for a system of real and sustained social justice. We are going to have to become what some commentators have called "the other superpower," referring to the massive street protests that gathered on the eve of the recent war.

The single most important action we civil society groups of the WTO's "Quad" countries can do in this global struggle against HIV/AIDS is to fight our own governments and corporations and the polices and ideologies they are forcing on an increasingly divided world. This is global class warfare.

The suffering of millions with AIDS is not inevitable; it is the natural consequence of a system based on that puts everything up for sale. It cannot be sustained. Unlimited growth has the same

DNA as the cancer cell. We will not stop the suffering of millions of AIDS-afflicted people until we confront corporate-driven, pro-privatization globalization. To confront this system is our greatest task. It will take the rest of our lives; but then, what else have we to do?

James Orbinski, University of Toronto and Médecins sans frontières
"Access to Treatment and Global Movements for Social Justice: Lessons for Civil Society"

The access to treatment movement is embedded within a larger global social movement that seeks justice – that is committed to an equitable and just social order. The achievements of this access to treatment coalition are partial, and there are indeed some lessons we can learn from these successes and failures over the last five to seven years. These lessons must also be considered against what our broad, political analysis is.

The neo-liberal environment that dominates our world contains a new ideological mantra that many NGOs seem to be taking up without question. That new mantra is one that posits the state in conjunction with civil society and the private sector - charity and volunteerism are an integral part of that new neo-liberal agenda. But is charity the right answer to the issues we face? Charity is not a solution to the egregious reality that the AIDS epidemic represents. Charity is not sustainable; it is not a long-term, politically viable response to the reality of lack of access to medicines or health care.

There is also the reality that the response of civil society, even under the best of circumstances, would be completely inadequate to deal with the breadth and scope of global epidemics. When I reflect on this I say to myself: What are we going to do as civil society? Are we going to simply fall in to this neo-liberal political structure, or are we going to respond in a meaningful and substantive way to address the issues that we are concerned with?

I look at AIDS and think that it is the thin end of the wedge. It is the single most important health care issue in the world today, because it provides us with the opportunity to act – to elucidate, to articulate, to define more broadly, and develop our broad vision of the right to access health care and what that means more concretely. I also think that it is time to stand back now and analyze: how did we achieve what it is that we achieved? We need to examine our processes and the history of social movements, and try to extract from them lessons so that we can apply them to the future.

I see five essential elements to policy-based social movements:

1. Thinking beyond policy analysis - technical analysis has only been successful if it is coupled with local, political action; for example, the opportunity to push for the adoption of the Doha Declaration that presented itself through the anthrax and compulsory licensing incident in Canada and the US.
2. An organized coalition - be it informal, opportunistic, or a 'coalition of the willing'.
3. Understanding the political terrain in which one is playing.
4. Opportunity - being prepared to strike when the iron is hot, and take full advantage of a political opportunity.
5. The historical reality of social movements - of which we must reflect a similar political process:
    - *The articulation of principled ideas* - and engagement of debate and association of people around those ideas

- *Confrontation with sources of power* - which is vital, because we have to understand that no one with power will willingly give over the substance of that power simply because it is the 'right thing to do'.
- *Interaction* (engagement and debate) *with the sources of power*
- *Partnership with sources of power*
- *Co-optation of the principled ideas*, so that those ideas become embedded in the basic fabric, the basic constitutional order of a society

We have to be very careful that there aren't premature partnerships, premature co-optations, or premature interactions before confrontation occurs, or we will lose our opportunity until the next generation, the next iteration, of those principled ideas to re-emerge in society.

There is absolutely no question that we, at the beginning of the 21st century, live in a neo-liberal hegemony. That hegemony represents the emergence of the market state and the devolution of the nation state. Nation states are no longer primarily concerned with protecting, promoting, and pursuing people's basic rights. They are more concerned with promoting the market opportunities of their consumers than the rights of their citizens. We have also seen the emergence of a global regime that privileges trade over any other social or political obligation. That's the neo-liberal context that we live in. And that is the neo-liberal context that we have to oppose.

In order to oppose it, we have to see it in a broad, historical context. These issues of access to medicines, access to health care, and access to greater systems of social justice, are not issues that will be resolved in five or ten years. We have to think trans-generationally – as the historical reality of social movements shows. We have to build a global civil society movement that is more broadly focused on the issue of access to social justice and also more specifically targeted in its actions around the issue of access to health care. We have to build a genuine, global civil society movement that is, in fact, the other superpower.

It is possible to do so, and we must do it.

Civil society organizations cannot, must not, should not, become substitutes for government. Civil society organizations cannot, must not, and should not seek premature partnerships with government and the private sector. We have a role. Our role is to reclaim our position as citizens, and to demand that governments govern. There is no substitute for good government, and there is no substitute for good citizenship.

Civil society organizations cannot, must not, should not, become substitutes for government. Civil society organizations cannot, must not, and should not seek premature partnerships with government and the private sector. We have a role. Our role is to reclaim our position as citizens, and to demand that governments govern. There is no substitute for good government, and there is no substitute for good citizenship.

Humanitarian action affirms how *anyone* is treated *anywhere* is the concern, the responsibility, and the duty of everyone everywhere to ensure that their dignity as human beings is at the centre of the political project, whatever that may be. The only way to achieve any form of a just and social order is to assume our responsibility as citizens and human beings.

PANEL 3: CORPORATE SOCIAL RESPONSIBILITY IN SUPPORTING PUBLIC HEALTH IN DEVELOPING COUNTRIES

James Orbinski, University of Toronto and Médecins sans frontières

"Health Research and Development in the Public and Private Sectors: Who is Responsible for What?"

The roles, interests and responsibilities of the public and private sectors are different in ensuring health research and development. It is the responsibility of governments to ensure the peoples right to health.

Neglected diseases represent a chronic global crisis, and include diseases like HIV/AIDS, tuberculosis, malaria, and many other less well-known diseases that predominantly affect people in Southern countries. Every year, 14 million people die from infectious diseases, 90% of whom are in the South. One-third of the world's population has no access to essential medicines. There is lack of effective, affordable, easy to use medicines for neglected diseases, because there isn't a viable market for those medicines. Drug research and development for developing country diseases is at a virtual standstill, despite the fact that spending on R&D has never been higher. This represents a failure in markets and a failure in public policy.

The roles, interests and responsibilities of the public and private sectors are different in ensuring health research and development. It is the responsibility of governments to ensure the people's right to health.

Recent civil society initiatives attempt to demonstrate that solutions are possible to this crisis in research and development, and the role that governments can play:

- The Drugs for Neglected Diseases Initiative (DNDi) is a not-for-profit global research initiative aimed at developing or adapting drugs for the treatment of the most neglected diseases of the most neglected patients. It is needs-driven, and will focus on what has to date been a fragmented research capacity in the developing world, and link this to developed world R&D capacity in the public and private sectors.
- While access to essential medicines is a complex process requiring delivery infrastructure, it nevertheless begins with the local availability of affordable medicines. The Initiative on Pharmaceutical Technology Transfer (IPTT) is a not-for-profit initiative will transfer pharmaceutical manufacturing technology for anti-HIV/AIDS, tuberculosis and malaria medications to 12 existing private sector manufacturing sites in Africa. The IPTT will be formally launched in 2003.
- The TRIPS agreement is failing to ensure needs-driven health R&D for neglected diseases. Political action is required to ensure needs-driven health research and development. Health oriented civil society organizations are urging the WHO to begin discussions on an international agreement that will accomplish this.

Peter Bailey, National Union of Mineworkers (South Africa)

"New HIV/AIDS Workplace Initiatives in Africa's Mining Sector"

HIV/AIDS is one of the great challenges facing South Africa, and high levels of poverty and unemployment experienced in the country exacerbate the epidemic. The National Union of Mineworkers (NUM) is engaged in efforts to fight the disease at both government and industry levels. As a trade union that organises mining, energy and construction workers, we seek to share

our experiences of the disease in these industries, as well as the processes we are developing to respond to the challenges.

Trade unions in South Africa have a history of political engagement, and they carry on this history by responding to the socio-economic effects of HIV/AIDS on workers. The biggest challenge has been to try to restore the human dignity of the people of South Africa.

Having an industry HIV/AIDS Summit is one way that NUM has found that trade unions can approach the challenges presented by HIV/AIDS. Each company that is part of that industry commits themselves to a joint approach, and joint strategy.

NUM's program to fight the disease led to us signing an agreement with the Chamber of Mines. Also coming out of this agreement was the recent HIV/AIDS Summit held in May 2003 by all stakeholders (i.e. government, mining unions, and the Chamber of Mines). The summit produced a statement of intent, which commits these stakeholders to drive the process of addressing such issues as HIV/AIDS prevention measures, converting of single sex hostels, treatment of opportunistic diseases, active participation of peer educators, alleviation of poverty, research programs, and agreements with mining houses.

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The National Union of Mineworkers HIV/AIDS Policy and HIV/AIDS Mining Summit's Declaration of Intent can be found at: http://www.aidslaw.ca/Maincontent/issues/cts/GTAGsummit.htm

Moussa Tchangari, Groupe Alternative (Niger)

"The Right to Health and Benefit Sharing in Resource Rich Mining Communities"

After three decades of structural adjustment, Niger is one of the poorest countries on the planet – 70% of the population lives on less than a dollar a day. The country remains heavily indebted with CFA900 billion (Francs) in debt. The state, however, must work in consideration of its social contract.

In the Tillabery area, where mining companies mine for gold, the failure to take social responsibility has caused serious revolt. The government invited a mining company into the region without consideration for local social needs. In 1997, young people in the area established an organization called Mutuelle des Jeunes, and shortly associated themselves with the Chefs Coutumiers. Together they made a number of social demands to the government and the mining companies that were entering the area. After it became politically unfavourable for the government and the mining companies to continue to deny the demands, they agreed to enter into discussion with the leaders of the groups.

This public-private partnership failed the community. Throughout the negotiations that took place the government placed itself on the side of the foreign investors.

Agreement was made where the mining companies agreed to the following: 1) to pay compensation to those who had had their land taken away, 2) to give priority to young people and economic operators of the Tillabery region in recruitment and contracts, 3) to invest socially in the areas of health and education, and 4) to ensure compliance with environmental standards. These commitments were compiled to produce a community development plan, with the priorities of the plan being in the areas of drinking water supply, health care, and education.

These commitments are not a sufficient response to the immense problems in the region. But in any event, the mining companies have not generally honoured the key points of their promises. At present the mining companies have abandoned their modest social plans, under the pretext that global market prices for gold are not favourable. This pretext is false, though the research and exploration activities have also been halted. The point is that the government had hoped that the mining companies would subsidize the state on social matters.

This public-private partnership failed the community. Throughout the negotiations that took place the government placed itself on the side of the foreign investors. PPPs can be very problematic, and are often at the expense of the local population – examples abound.

Panel 3 Discussion

The discussion revolved around the question: what are the roles, interests, and responsibilities of government, the private sector, and civil society? Specific concern was raised for how trade and investment agreements can usurp the appropriate role of governments.

It was also highlighted that issues of gender discrimination must be accounted for in all of our discussion and analyses. Public policy, legislation, and civil society strategies that fail to do so will fail women and, ultimately, all of humankind. For example, the NUM works with commercial sex workers as part of their community in their agenda to fight HIV/AIDS.

Other points that were raised included:

- It is the role of government to provide health care, and it is the role of the multinational corporation to pay taxes to government so that government can then provide the services that are required. The state should tax companies and then carry out their responsibilities. The dependence of governments on private foreign investment, as the sole response to development needs, is a distortion of development.
- Civil society can have potentially worthwhile relationships with industry so long as they are well defined, and well structured, so as to achieve meaningful outcomes.
- Concern about how the triple bottom line practices that corporations brand themselves with - profitability, sustainability, social responsibility – are often funded by government programs, such as CIDA.
- The success of push-pull mechanisms[3] in influencing private sector responses to health needs depends on a viable market, which is not the situation for 1/3 of the world's population that face the most neglected diseases.
- Africa is a complex continent, and we are talking about building something new, not restoring a previously existing system of health. The complexity of the continent also exists around the world, however, and it is important to recognize that there is a common political context informing issues around access to health.
- We need to develop a vision of the role of universities and academy in fighting for health as a human right, especially in consideration of the discussions we have been having on private-public partnerships.

[3] Push mechanisms include things such as a public subsidy (ie. tax break) as an incentive for encouraging pharmaceutical companies to do R&D at the beginning of the pipeline of R&D. Pull mechanisms create a "pot of gold" at the end of the process; again it is public money (tax dollars) used as an incentive.

MARCH TO THE PRIME MINISTER'S OFFICE: CANADIANS DEMAND LEADERSHIP ON GLOBAL HEALTH

A highlight of the Summit's second day was a march by participants through downtown Ottawa with a banner proclaiming "Global Health is a Human Right!".

Participants marched to Parliament Hill and the office of Canada's Prime Minister, where marchers delivered over 15,000 MSF postcards[4] from Canadians demanding adequate funding for global health needs and that Canada support changes to the international trade regime to ensure access to less expensive, generic medicines for developing countries. Also delivered was a letter from the Student-Led Access to HIV Medicines (SLAHM) Campaign[5], organized by students with the McGill International Health Initiative and the U of T Students Against Global AIDS Initiative, and endorsed by 14 student unions from across Canada, representing over 164,000 university students.

This "delivery" to the PM jointly represented almost 180,000 Canadians demanding leadership, and political and financial support, to increase access to medicine for the world's poor. Thanks to MSF and the McGill International Health Initiative for all of the hard work that went into these campaigns!

(Photo: Jake Wright)

[4] MSF's postcards can be viewed and signed on-line at: http://www.msf.ca/
[5] The SLAHM campaign letter can be found at: http://www.aidslaw.ca/Maincontent/issues/cts/SLAHMletter.pdf.

STRATEGIZING WORKSHOPS

1) What do we want?
2) Who can make this happen?
3) How can we make this happen?

Workshop 1 – Trade and Globalization

What is happening?

- A network of groups is working on human rights issues in the lead-up to Cancún.
- Common Frontiers has launched a campaign under the theme "FTAA is hazardous to your health"
- MSF is campaigning against inclusion of any intellectual property provisions in the FTAA
- "No FTAA" petition from Québec Nurses Union
- The GTAG continues with ongoing research, lobbying, and public education activities
- We need to consider the impact of the International Conference on Harmonization that is pressuring for harmonization of drug legislation requirements around the world
- Follow-up to the Romanow Commission on the Future of Health Care in Canada is necessary and timely – tracking how money is committed, the accountability of governments for their spending; the Canadian Health Coalition is holding a strategy session September 20-22.

What do we want?

- Health (and education) to be excluded from trade and investment agreements
- Continue working through existing UN human rights mechanisms to strengthen and promote the right to health and the primacy of human rights obligations
- Follow-up on Romanow Commission with respect to amending Canada's patent legislation, to secure greater access here (e.g. avoid patent abuse through 'evergreening'), and facilitate export of generics elsewhere
- Expose the links between TRIPS, GATS and the FTAA in terms of their impact on health.

How can we make this happen?

- We need to be a network for circulating information about organizing and issues.
- We can broaden the network by reaching out to academics, environmental groups, and the friends of Medicare contact list.
- Targeting Members of Parliament, increasing pressure; direct pressure on the Doha Declaration paragraph 6 issue regarding TRIPS-based barriers to using compulsory licensing to access less expensive medicines. Doing focused education.
- Keep people at CIDA aware and active.
- Have a number of groups meeting with the Trade Minister and negotiators on the issues; be clear we expect Articles 7 and 8 of TRIPS to be enforced.
- Mass education materials (eg, a 2-pager on Doha Declaration paragraph 6 issues) and education for the public.
- Organizing nationally – by choosing a day that everyone can mobilize around, make messages accessible: "Medicines shouldn't be a luxury", have a road show, have a minute of silence at local communities during global meetings like the WTO.
- Make links east and west, but also north and south!
- Linking with disability groups – recognizing their voices and stake.

- Use the opportunity to build on the value of public health that came out of the Romanow Commission process
- Bring prominent people from global community of activists and civil society to profile issues for Canadians and mobilize public action
- Monitor common drug review process and provincial drug formularies to avoid efforts to restrict coverage for medicines
- Media strategies – ads (tv, paper, radio), 'flash' messages on websites, screensavers, postcards, posters, coasters, t-shirts.
- Mass mobilizations and other creative actions in the street to get issues in to public eye (eg., hold a 'people's tribunal' and put the government on trial)
- Recognize that all groups have different abilities to mobilize – there are a number of flashpoints coming up for the trade issues:
    - July 28-30 WTO Mini-Ministerial in Montreal – street protests.
    - Fall date TBA FTAA inter-sessional meeting
    - September 10-14h WTO Ministerial in Cancun – Day of action, minute of silence?
    - November 7-8 Common Front is organizing for FTAA in Miami.
    - Nov 17-21 FTAA meeting in Miami – mass mobilizations
    - Other possible dates for actions: World AIDS Day (Dec 1); federal political party leadership campaigns; first Anniversary of Romanow Commission report (Nov 2003)

Workshop 2 – Financing Global Health

What do we want?

- Cancellation of the debt, bilaterally by Canada and by IMF/World Bank
- Global Fund – involvement and the identification and replication of best practices
- ODA – raised to 0.7% of GDP, increased domestic spending for multi-ethnic groups,
- Gender analysis with respect to Canada's financial assistance at organizational level.
- Other ideas included: world health insurance, Tobin tax, fighting stigma and discrimination, taxing of pharmaceutical companies, Canadian financial and political support for UN Special Rapporteur on the right to health and other UN human rights mechanisms for advancing the right to health and other health-related rights.

Who can make this happen?

- Public awareness campaign, to engage the public more, broaden our base
- Federal government
- Our constituencies (including AIDS service organizations, other community-based groups)
- Summit participants themselves

How can we make this happen?

- We will stay networked with each other, and link health with other issues and groups (women, human rights, aboriginal, trade, poverty, economic, labour, security)
- Results can generate raw materials for letter writing, fact sheets etc.
- Ongoing lobbying – letter writing, lobbying our Members of Parliament
- May 30th – Day of solidarity on the Global Fund
- Dialogue with CIDA – how are they spending ODA monies?

Resources include:

- Fund the Fund campaign
- A range of civil society groups and organizations, including AIDS service organizations, health, human rights, women's, faith-based, international development, unions, students, "radicals")
- Allies in the media
- Our own constituencies

Workshop 3 – Corporate Social Responsibility

What do we want to see happen?

- Reclaiming language – develop a common understanding of corporate social responsibility, public-private partnerships.
- Expose underside of corporate interests – consumer advocacy, exposing PR and propaganda efforts.
- Develop a model with a framework for joint activity between sectors – which would include adequate resources, independent management of those resources, high-level commitment from all sectors, a capacity to monitor and enforce the joint-agreements, ensure that the voice of the broader community is represented, and insistence that corporations pay taxes to support services in the regions and countries in which they operate.
- Expanding supports for emerging international social justice movement – build capacity to network, communicate, and act collectively.
- Reclaim the state. Need a democratic role for states to play in the world economy, so that we can control or eliminate ineffective organizations like the IMF/WB, cancel the debt etc.
- We need to systematically incorporate gender analyses into our work.
- Develop a critical analysis of recent CIDA policy on private-sector involvement on policy related to health.
- Create safety in participation for mobilizing and fighting for change, and resources for those who are fighting back when it is dangerous to do so.
- Role of labour movement in providing resources for international solidarity, education, and in envisioning alternative economic structures.
- Labour movement needs to change its approach to North-South relations with workers as one that is equality based. This would be very powerful in confronting corporations.
- Identify long-term and short-term strategies. Need a follow-up session to this one to evaluate what we have achieved, how far we have moved towards our goals.

CLOSING SESSION

John Foster, North-South Institute

The success of this Summit is in whether or not is has an effect on the agendas and work at our own organizations.

The size and scope, challenge and profundity of the dangers and challenges to the right to global health are numbing. This Summit can be a tremendous resource because of the detail with which current challenges were put before us.

We found that after 10 years of NAFTA, 7 years of the WTO, and 50 years and more of the International Monetary Fund (IMF) and World Bank (WB) that we are often on the defensive. Should we seize the idea that has been cited time and again over the Summit that we need to repossess democratic space - be that of governments or in the streets - we may find that our defensive stance will shift.

We also need to expand our political repertoire and take to the streets, as in Québec City and Seattle. This is, however, only one kind of leverage. We need to engage our creativity with the opportunities that lie before us, to put the wealth of information on global health as a human right into plain language.

We also have a clear vision of strengthening existing human rights mechanisms nationally and internationally. We must take leadership in this regard with respect to health, taking lessons learned from other success in this regard such as the international agreement on tobacco control, the Kyoto Protocol, the international criminal court, and the land mines treaty, to name a few.

The question, then, is: are we at the point of conception of the next significant victory? Citizens groups in Brazil were instrumental in creating a focusing of resources that has cut the death rate of HIV/AIDS by 50%. The Doha Declaration on the TRIPS Agreement and Public Health would never have occurred without an alliance between Southern governments, NGOs, and people in the streets, and people 'up the nose' of various cabinet ministers.

We need to engage our creativity with the opportunities that lie before us, to put the wealth of information on global health as a human right into plain language.

There will be access for all, health for all, and human rights for all so long as we are enraged, engaged, and willing to organize for change.

APPENDIX A:
"GLOBAL HEALTH IS A HUMAN RIGHT! A NATIONAL CIVIL SOCIETY SUMMIT" AGENDA

May 21, 2003

8:30 REGISTRATION
9:00 OPENING SESSION
Introductory Comment:
John W. Foster, Principal Researcher, Civil Society, North-South Institute
Introductory Remarks on **The Right to Health at National and Global Level:**
Barbara Byers, Vice-President, Canadian Labour Congress

9:30 DISCUSSION PANEL 1 —
The Impact of Trade and Globalization on Commitments to Achieve "Health for All"
Moderator: Diana Bronson, Coordinator, Globalization & Human Rights, Rights & Democracy
1. Is TRIPS Still an Obstacle to Public Health?
Michel Lotrowska, Coordinator, Campaign for Access to Essential Medicines, Médecins sans frontières, Brazil
2. Implications of the FTAA on Latin America's Health Challenges
Dora Martinez, Union of State Employees, Argentina's Worker Central
3. Canada's Global Trade Policies and Public Health Services
Scott Sinclair, Senior Researcher, Canadian Center for Policy Alternatives

10:30 TEA/COFFEE BREAK
11:00 DISCUSSION PANEL 1 (continuing)
Questions and discussion

12:30 LUNCH — With Speaker
Public Private Partnerships *or* Private Exploitation of the Public?
Kathleen Connors: President, Canadian Federation of Nurses Unions and Chairperson of the Canadian Health Coalition

14:00 DISCUSSION PANEL 2 —
Financing Global Health: Canada's Foreign Aid, the Global Fund and Debt Cancellation
Moderator: Bob Mills, Chairperson, North-American Chapter, Global Network of People Living with AIDS
1. Is Canada Helping Rebuild Developing Countries' Health Systems?
Janet Hatcher-Roberts, Director, Canadian Society for International Health
2. A Global Response to a Global Crisis: The Global Fund to Fight AIDS, Tuberculosis and Malaria
Kingsley Chiedu Moghalu, Head of Resource Mobilization and Global Partnerships, Global Fund
3. Cancelling Debts to Finance Health – an Impossible Dream?
Pam Foster, Halifax Initiative

15:00 TEA/COFFEE BREAK

15:30 DISCUSSION PANEL 2 (continuing)
Questions and discussion

17:00 CLOSING

MAY 21

18:30 SOCIAL EVENT
Reception for summit participants and welcome to international guests

19:30 KEYNOTE SPEAKERS — **Open to the public and the media**
Introductory Remarks and Moderation:
Mr. Jean-Louis Roy, President, Rights & Democracy

Speakers:
Maude Barlow, National Chairperson, Council of Canadians
Dr. James Orbinski, University of Toronto and MSF/Doctors without Borders

May 22, 2003

9:00 DISCUSSION PANEL 3 —
Corporate Social Responsibility in Supporting Public Health in Developing Countries
Moderator: Cynthia Wiggins, Senior Researcher, Social and Economic Department, Canadian Labour Congress

1. Health R&D: The Public and the Private - Who is Responsible?
   Dr. James Orbinski, University of Toronto and MSF/Doctors without Borders
2. New HIV/AIDS Workplace Initiatives in Africa's Mining Sector
   Peter Bailey, Chairperson, Health and Safety Committee, National Union of Mineworkers, South Africa
3. The Right to Health and Benefit Sharing in Mineral and Oil-rich Communities
   Moussa Tchangari, Groupe Alternative, Niger

10:00 TEA/COFFEE BREAK

10:30 DISCUSSION PANEL 3 (continuing)
Questions and discussion

12:00 LUNCH

13:00 STRATEGIC WORKSHOPS (run concurrently)
Towards a Common Platform

1. The Impact of Trade and Globalization on Commitments to Achieve "Health for All"
   Moderator: Richard Elliott, Director of Policy & Research, Canadian HIV/AIDS Legal Network
2. Financing Global Health: Canada's Foreign Aid, the Global Fund and Debt Cancellation
   Moderator: Michael O'Connor, Director, Inter Agency Coalition on AIDS and Development
3. Corporate Social Responsibility in Supporting Public Health in Developing Countries
   Moderator: Marie-Hélène Bonin, Representative for Africa, Canadian Labour Congress

15:00 TEA/COFFEE BREAK

15:30 REPORTS FROM STRATEGIC WORKSHOPS — Plenary session (3 x 15 min.)

16:15 DRAFT CONCLUSIONS FROM THE SUMMIT — Closing Session (45 min.)
Conclusions and Follow-Up Remarks:
John W. Foster, North-South Institute and GTAG Coordination Committee
Closing Comment:
Barbara Byers, Vice-President, Canadian Labour Congress

APPENDIX B: PARTICIPANT LIST, "GLOBAL HEALTH IS A HUMAN RIGHT! A NATIONAL CIVIL SOCIETY SUMMIT"

Organization	Name
Action Canada for Population and Development (ACPD)	Suki Beavers
Action Canada for Population and Development (ACPD)	Jennifer Kitts
Action Canada for Population and Development (ACPD)	Katherine McDonald
Africans in Partnership against AIDS	Darnace Torou
Aide Médicale pour la Palestine (AMP-CANADA)	Henry Glorieux
AIDS Committee of Toronto	Lori Lucier
Alberta Community Council on HIV	San Patten
Alternatives	Charles Muginareza
ATTAC-Québec	Karine Peschard
BC Persons with AIDS Society (BCPWA)	Jeff Anderson
Canadian Aboriginal AIDS Network (CAAN)	Lisa Dixon
Canadian AIDS Society (CAS)	Anna Alexandrova
Canadian Auto Workers Union (CAW)	Annie Labaj
Canadian Centre for Policy Alternatives (CCPA)	Scott Sinclair
Canadian Council for International Co-operation (CCIC)	Michael Bassett
Canadian Health Coalition	Michael McBane
Canadian HIV/AIDS Legal Network	David Patterson
Canadian HIV/AIDS Legal Network	Richard Elliott
Canadian Labour Congress (CLC)	Barbara Byers
Canadian Labour Congress (CLC)	Marie-Helene Bonin
Canadian Labour Congress (CLC)	Steve Benedict
Canadian Labour Congress (CLC)	Cynthia Wiggins
Canadian Labour Congress (CLC)	Nancy Peckford
Canadian Labour Congress (CLC)	Sheila Katz
Canadian Nurses Association	Tim Stutt
Canadian Public Health Association (CPHA)	Michael Adams
Canadian Society for International Health (CSIH)	Janet Hatcher-Roberts
Canadian Treatment Action Council (CTAC)	Louise Binder
Canadian Union of Postal Workers	Irwin Nanda
Canadian Union of Postal Workers	Victoria Wenglasz
Canadian Union of Public Employees (CUPE)	Deborah Duffy
CARE Canada	Liz Smith
CECI (Centre Canadien de Coopération Internationale)	Pierre Dongier
Central de trabajadores argentinos (ATE_CTA)	Dora Martinez
Council of Canadians	Anil Naidoo

Organization (con't)	Name (con't)
Council of Canadians	Maude Barlow
CUPE National Office	Corina Crawley
Department of Foreign Affairs + International Trade	Tania Andrews
Dignitas International	James Fraser
Fédération des infirmières et infirmiers du Québec	Florence Thomas
Global Fund to Fight AIDS, TB & Malaria	Kingsley Chiedu Moghalu
GNP+ North America and CTAC	Bob Mills
Groupe Alternative	Moussa Tchangari
Halifax Initiative	Pamela Foster
Independent	oline Twiss
Independent	David Garmaise
Interagency Coalition on AIDS & Development (ICAD)	Nikki Boon
Interagency Coalition on AIDS & Development (ICAD)	Rosemary Forbes
Interagency Coalition on AIDS & Development (ICAD)	Michael O'Connor
International AIDS Vaccine Initiative (IAVI)	Stephanie Nixon
International Development Research Centre + CCPA	Matthew Sanger
International Health Division, Health Canada	Ross Duncan
McGill International Health Initiative	Karen Iny
McGill International Health Initiative	Srinivas Murthy
McGill International Health Initiative	Faiz Ahmad
McGill International Health Initiative	Maryse Bouchard
Médecins sans frontiers, Brazil	Michel Lotrowska
Médecins sans frontiers, Canada	James Orbinski
Medecins sans frontiers, Canada (Toronto)	Carol Devine
Medecins sans frontiers, Canada (Toronto)	Simona Powell
Media	Françoise Nduwimana
National Union of Mineworkers (South Africa) (NUM)	Peter Bailey
North South Institute	John Foster
North South Institute	Chantal Blouin
North South Institute	Kevin MacKay
Ontario Federation of Labour (OFL)	Irene Harris
Ontario Public Service Employees Union (OPSEU)	Gavin Anderson
PATH Canada	Sian Fitzgerald
Quaker International Affairs Programme	Tasmin Rajotte
Results Canada	Alexander Soucy
Rights & Democracy	Jean-Louis Roy
Rights & Democracy	Diana Bronson
Service Employees International Union Canada (SEIU)	Lynn Simmons

Organization (con't)	Name (con't)
St. Michael's Hospital	Philip B. Berger
Steelworkers Humanity Fund (USWA Humanity Fund)	Judith Marshall
Student University Network for Social and International Health	Amina Bougrine
UN - Office of the High Commissioner for Human Rights	Lisa Oldring
UN Special Envoy on AIDS in Africa	Anurita Bains
United Church of Canada	Jim Marshall
United Steelworkers of America (USWA)	Jorge Garcia-Orgales
Women & Health Protection	Joel Lexchin
World Vision	Ellen Kupp
YouthCO AIDS Society	Elgin Lim

APPENDIX C:
SELECTED LIST OF RESOURCES AND WEBSITES

BACKGROUND DECLARATIONS, STATEMENTS, AND CHARTERS / DÉCLARATIONS DE RÉFÉRENCE, EXORCIATIONS ET CHARTES

ENGLISH

Alma Ata Declaration for "Health for All": http://www.who.int/hpr/NPH/docs/DeclarationAlmaAta.pdf

"Standing Together for Medicare: A Call to Care", the joint statement from CLC and CHC conference on Oct 12, 2001: http://www.healthcoalition.ca/chc-romanow.pdf

Declaration of Action (25 Aug 2002) from the launch of the Pan-African HIV/AIDS Treatment Access Movement:
http://www.globaltreatmentaccess.org/content/press_releases/02/082202_PTM_PP_PLAN_ACT.pdf

People's Health Charter from the People's Health Movement: http://phmovement.org/pdf/charter/phm-pch-english.pdf

The Declaration of Commitment on HIV/AIDS from the UN General Assembly Special Session (June 2001):
http://www.un.org/ga/aids/docs/aress262.pdf

FRANÇAIS

Résolution adoptee par l'Assemblée générale; Déclaration d'engagement sur le VIH/Sida
http://www.unhchr.ch/Huridocda/Huridoca.nsf/0/469ecc4fd4209221c1256aaa005743f3/$FILE/N0143485.pdf

La Charte populaire de santé http://phmovement.org/pdf/charter/phm-pch-french.pdf

Alma Ata 1979 – Les soins de santé primaries http://whqlibdoc.who.int/publications/9242800001.pdf

ESPAÑOL

Alma Ata 1978 – Atencion Primaria de Salud http://whqlibdoc.who.int/publications/9243541358.pdf

HUMAN RIGHTS / DROITS DE LA PERSONNE

ENGLISH

Statement to the 3rd Ministerial Conference of the WTO, by the UN Committee on Economic, Social and Cultural Rights (1999)
http://www.unhchr.ch/tbs/doc.nsf/(Symbol)/E.C.12.1999.9.En?Opendocument

General Comment No. 14: "The Right to Health" of the UN Committee on Economic, Social and Cultural Rights (2000) at:
http://www.unhchr.ch/tbs/doc.nsf/(symbol)/E.C.12.2000.4,+CESCR+General+comment+14.En?OpenDocument

Revised Guideline 6 of *HIV/AIDS and Human Rights: International Guidelines* (on access to HIV/AIDS prevention, treatment, care and support) at:
http://www.unhchr.ch/tbs/doc.nsf/(Symbol)/E.C.12.1999.9.En?Opendocument

Commission on Human Rights -- 2003 resolution: "Access to medication in the context of pandemics such as HIV/AIDS, tuberculosis and malaria"
http://www.unaids.org/whatsnew/conferences/unhchr59session/AdoptedCHRresL33_%20Access_en.pdf

FRANÇAIS

Déclaration du comité des droits économiques, sociaux et culturels de l'organisation des nations unies à la troisième conférence ministérielle de l'organisation mondiale du commerce (Seattle, 30 novembre n 3 décembre 1999) : . 18/03/99.
http://www.unhchr.ch/tbs/doc.nsf/(Symbol)/E.C.12.1999.9.Fr?OpenDocument

Le droit au meilleur état de santé susceptible d'être atteint: 11/08/2000.
E/C.12/2000/4, CESCR OBSERVATION GENERALE 14.
via: http://www.unhchr

INTERNATIONAL TRADE / COMMERCE INTERNATIONAL

ENGLISH

FTAA MSF comments on second draft of the FTAA-ALCA text 28 February, 2003
http://www.accessmed-msf.org/prod/publications.asp?scntid=4320031157162&contenttype=PARA&

The Declaration on the TRIPS Agreement and Public Health
http://www.wto.org/english/thewto_e/minist_e/min01_e/mindecl_trips_e.htm

Patents, International Trade Law and Access to Essential Medicines
(14-page info sheet by Canadian HIV/AIDS Legal Network & MSF Canada)
http://www.aidslaw.ca/Maincontent/issues/cts/Patents-international-trade-law-and-access.pdf

GTAG letter of 17 December 2002 to Government of Canada re TRIPS post-Doha negotiations:
http://www.aidslaw.ca/Maincontent/issues/cts/letter17dec2002.pdf (in English only)

"Prescription for Pain", editorial by James Love, Consumer Project on Technology,
Le Monde Diplomatique, March 2003 at:
http://lists.essential.org/pipermail/ip-health/2003-March/004508.html

"Free Trade and Medicines in the Americas" by Robert Weissman, Essential Action
Foreign Policy in Focus, vol 6(13), April 2001
http://www.fpif.org/briefs/vol6/v6n13meds.html

"No Mandate: To trade away our health care system: Tightening The Trade Noose On Public Health Care"
Council of Canadians, http://www.canadians.org/documents/mandate-t-h.pdf

"Fatal Imbalance: The Crisis in Research and Development for Drugs for Neglected Diseases"
http://www.msf.org/source/access/2001/fatal/fatal.pdf

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Declaration sur l'accord sur les ADPIC et la sante publique
http://www.wto.org/french/thewto_f/minist_f/min01_f/mindecl_trips_f.htm

Les brevets, le droit commercial international, et l'accès aux medicaments essentials
(feuillet de 14 pages, publié par le Réseau juridique canadien VIH/sida et MSF Canada)
http://www.aidslaw.ca/Maincontent/issues/cts/Patents-international-trade-law-and-access.pdf

Pas de Médicaments pour les pays pauvres. L'Europe et les Etats-Unis prolongent l'apartheid sanitaire
http://www.monde-diplomatique.fr/2003/03/LOVE/9999

GLOBAL FUND / FOND MONDIALE

ENGLISH

AIDSPAN page on the Global Fund, including information from the Global Fund Observer http://www.aidspan.org/globalfund/index.htm, and in particular the paper: "How Much Money Does the Global Fund Need? How Much Does it Have?" (24 March 2003) that is downloadable

"Africa Shortchanged" The Global Fund and the G8 Agenda, By Marc Lee
http://www.policyalternatives.ca/publications/btn4-4.pdf

OFFICIAL DEVELOPMENT ASSISTANCE & DEBT / AIDE AU DÉVELOPPEMENT & LA DETTE

ENGLISH

The Federal Budget Plan for 2003 -- Fulfilling Canada's Commitment to Increase Aid by 8%. Analysis by CCIC's Policy Team (February 2003) (PDF Format) http://www.ccic.ca/devpol/federal_budget_2003/The federal_budget_plan_for_2003.pdf

MSF Briefing Document for G8, Evian, France 5 May, 2003
http://www.accessmed-msf.org/prod/publications.asp?scntid=55200393522&contenttype=PARA

FRANÇAIS

Le plan budgétaire 2003 du gouvernement federal:
Le Canada remplit sa promesse d'augmenter l'aide de 8%
http://www.ccic.ca/francais/devepol/budget_federal_2003/analysis_francais_brian2.pdf

CORPORATE RESPONSIBILITY / RESPONSABILITÉ CORPORATIVE

ENGLISH & FRANÇAIS

International Development Community Applauds Foreign Aid Increases:
CCIC news release and budget analysis document via: www.ccic.ca.

S Rosen & JL Simon. "Shifting the burden: the private sector's response to the AIDS epidemic in Africa."
Bulletin of the World Health Organization 2003; 81(2): 131.
http://www.who.int/bulletin/pdf/2003/bul-2-E-2003/81(2)131-137.pdf

MISCELLANEOUS / DIVERS

ENGLISH

Series of UNAIDS Fact Sheets on Global HIV/AIDS Epidemic
http://www.unaids.org/worldaidsday/2002/press/index.html#facts **(English and Français)**

Fact sheet "Meeting the Need" at:
http://www.unaids.org/worldaidsday/2002/press/factsheets/FSneed_en.doc

"Access to Treatment and Care in Africa: Policy Advocacy for the G8 Summit in Kananaskis (Canada), June

2002 – Ideas for Canadian Advocates"
http://www.aidslaw.ca/Maincontent/issues/cts/policyadvocacydocument-G8.pdf

"Look at Brazil: The world's AIDS crisis is solvable."
by Tina Rosenberg, *New York Times Magazine*, 28 January 2001
http://www.nytimes.com/library/magazine/home/20010128mag-aids.html

"Community-based approaches to HIV treatment in resource-poor settings."
Paul Farmer et al. *The Lancet* 2001; 358: 404.
(requires free on-line registration to access; gives example from Haiti of successful use of ARVs in the poorest country in hemisphere)
http://pdf.thelancet.com/pdfdownload?uid=llan.358.9279.editorial_and_review.17087.1&x=x.pdf

"Brazil: A Model Response to AIDS."
by Pascual Ortells, Special Report in *Americas Policy*, April 2003
http://www.americaspolicy.org/reports/2003/0304aids.html

"Access to HIV/AIDS Treatment in Developing Countries"
The vast majority of people in developing countries who are living with HIV/AIDS are unable to access life-saving treatment for HIV infection and related opportunistic infections. This problem is not unique to people living with HIV/AIDS; it affects all people with serious diseases and conditions.
http://www.icad-cisd.com/content/factsheet_detail.cfm?id=11&lang=e

"Access to Treatment and Care in Africa for HIV/AIDS and Other Diseases"
http://www.icad-cisd.com/content/factsheet_detail.cfm?id=33&lang=e

Massive Effort: A Global Campaign Against HIV/AIDS, TB and Malaria
http://www.massiveeffort.org/

Alternatives to Fatal Imbalance, Overcoming the Crisis in R&D for Neglected Diseases, Rio de Janeiro, Dec 2 2002, Public Event 2 December, 2002
http://www.accessmed-msf.org/prod/publications.asp?scntid=2822003143397&contenttype=PARA

The Drugs for Neglected Diseases Initiative (DNDi): An Innovative Solution 19 February, 2003
http://www.accessmed-msf.org/prod/publications.asp?scntid=19220031120226&contenttype=PARA

International meeting on a global framework for supporting health research and development (R&D) in areas of market and public policy failure [presentations] 5 May 2003
http://www.accessmed-msf.org/prod/publications.asp?scntid=5520031444394&contenttype=PARA

HIV/AIDS patient stories: Report from the field: Hope in small doses (HIV/AIDS in Mozambique) 1 Feb 2003
http://www.accessmed-msf.org/prod/publications.asp?scntid=532003117187&contenttype=PARA

FRANÇAIS

Aide-mémoire 2002 Répondre aux besoins
http://www.unaids.org/worldaidsday/2002/press/factsheets/FSneed_fr.doc

Accès aux medicaments anti-VIH/sida dans les pays en développement
http://www.icad-cisd.com/content/pub_details.cfm?id=4&CAT=9&lang=f

L'accès aux soins et traitements pour le VIH et d'autres maladies en Afrique
http://www.icad-cisd.com/content/pub_details.cfm?id=16&CAT=9&lang=f