The role of nongovernmental organizations in providing health care

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The role of nongovernmental organizations in providing health care

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Abstract

NGOs constitute a very heterogeneous group of organizations. Our worldviews, responsibilities, capacities, roles and actions are all different. Even though NGOs are supposed to originate from civil societies, the reality today is different. Many NGOs receive, for instance, substantial funding from governments. This makes it legitimate to ask the question whether they can keep their operational independence. Some will argue that government funding necessarily ties humanitarian action to the foreign policy agenda of governments and that such NGOs in reality are subcontractors of the various governments. Moreover, the NGOs adapt different roles. Some see their role on a more long-term, development perspective, while MSF focuses on more pure humanitarian work and wants to distance itself from the more "development-oriented" way of thinking. In our opinion the medical humanitarian action should be independent from initiatives recommending models for development and models for society. However, increasingly humanitarian action is also supposed to work under certain "strategic frameworks" of long-term development perspectives and peace building activities. This wish to use humanitarian action as a first step to promoting peace and democracy, threatens a fundamental principle: humanitarians should provide aid solely dependent on needs and not political agendas.

We also see that humanitarian action is promoted as a first step towards free market/neo-liberalism. The focus on poverty alleviation tends to focus attention on economic inequity - it does not expose the political role in creating and sustaining inequity and the political solutions above and beyond good policy that are required to generate real progress in health and society. NGOs cannot compensate for this broader failure by providing technical or material assistance. They can shine a hard light on the need to politicise the understanding of human society, conflict, progress and equity - in which economic analysis plays an important but NOT exclusive role. The fact that MSF delivers health care in the world today is a sign of serious failure, nothing else. For MSF the crucial questions will be: Should NGOs really compensate for the state's retreat? Isn't the state's legitimacy being eroded by privatization of fundamental public services? Is it really the role of an NGO to provide health care as part of a permanent or sustainable solution?

Providing health care and other kinds of humanitarian assistance to populations in distress, involves also moral dilemmas. In our striving for access to our patients, there are limits in our willingness to compromise humanitarian principles. We need freedom to independently assess the needs of the population; retain unhindered access to the population; conduct, monitor and evaluate the distribution of aid commodities; and obtain security guarantees for expatriate and local personnel, and property. Our aid must not be manipulated and should not support a system that in the first place gave rise to the misery.
Access to patients is, however, only just one of the problems we face as a medical humanitarian organisation. We witness today more and more that the world's poor are not considered a market by the multinational pharmaceutical companies. Some of the reasons why people die from diseases like AIDS, TB, Malaria, and Sleeping sickness, are that life saving essential medicines are too expensive because of patent protection, because there is a of lack of research and development for these neglected diseases, or because existing drugs are abandoned due to an insufficient return on investment for manufacturers. These three factors are linked to a disengagement of national and international authorities to ensure the right to access health care, an abdication of responsibility for the problem to the multinational pharmaceutical industry, and the weakness of the mandates of IGOs like the WHO and the strength of mandates of other IGOs like the WTO. NGOs have a clear role in this issue to push for change and political responsibility and thereby increase health delivery to people.

Nongovernmental organizations – diversities and new roles

NGOs constitute a very heterogeneous group of organizations. We all face different institutional pressures - some have multiple mandates - we come from different national political cultures and belief systems. Our worldviews, responsibilities, capacities, roles and actions are all different. Some NGOs have clear ideologies of trying to build up certain systems and promote sustainable development and peace according to specific political analyses. Some work classically bottom-up, while others contract with their own national governments or are implementing partners for the UN system. Many NGOs operate only in their own country, while other ones are international. It is illustrative to note that the term used on these organizations, non-governmental, is not a true definition of what they are, but what they are *not*. They are not businesses and usually they have one rather than several purposes in contrast to governments and the UN. They are viewed as having a ‘voluntary’ and non-bureaucratic nature. NGOs are seen as emanating from society, representing the private initiative of citizens taking affairs into their own hands, contesting the state and holding it accountable. NGOs are also seen as providing an alternative to the state, taking the self-help initiative to step in gaps left by the states' deficiencies. To what extent NGOs really constitute parts of civil society is however disputable. The creation of some NGOs has been based on genuine independent civil society

initiatives. They have a clear social basis, and they try to maintain their independence from governments. Other NGOs have originated from political parties or other groups of power. Even the classical humanitarian NGOs differ. They have a common objective to alleviate suffering of victims of conflict, marginalisation, discrimination or oppression around the globe, but there are differences in ideology. The implementation of the humanitarian principles like neutrality and impartiality may differ, as well as their approaches to assist vulnerable populations. MSF has put the right of all people to medical assistance above concerns of state sovereignty based on what the founding doctors had experienced the Biafra crisis. Oxfam advocates for justice in its operations based on their early experience during the British blockade of Greece in 1942, while CARE focuses more on technical aspects of aid.

Another important characteristic of NGOs today, is their financial dependence on the official donors such as national governments and the EU. If an NGO receives 90 percent, or even more than 50 percent of it's funding from governmental sources, can it be called "non-governmental"? Some NGOs argue that they can keep their operational independence despite substantial financial support from governments, while others will argue that government funding necessarily ties humanitarian action to the foreign policy agenda of governments and that such NGOs in reality are subcontractors of the various governments. Some NGOs argue, however, that economic ties constitute an efficient vehicle for lobbying and information sharing. In MSF's points of view, the financial dependence, in addition to increased demand for strict UN co-ordination in the field and implementation of strategic frameworks, threatens what should be one of the humanitarian NGOs' core identities; their independence of action. It is intriguing to note that the narrow and short-term vision of humanitarian action that just wants 'to preserve life and alleviate suffering while protecting human dignity' is perceived as politically incorrect. Criticism towards such an approach has been raised from both politicians as well as solidarity movements. Increasingly humanitarian action is supposed to work under a certain framework of long-term development perspectives and peace building activities.

Sierra Leone is a good example of this blurred vision of humanitarian assistance. A humanitarian co-ordinator of UN (Consolidated Inter-Agency Appeal 2001) clearly argues that humanitarian assistance should be given in such a way as to "*contribute towards lasting peace and economic development*"…"*We must build an army of genuine humanitarians who will help to disseminate value systems crucial for the success of any peace process"*. Later it is stated in the Appeal: "*UN agencies --- working closely with NCRRR, Government line ministries and non-governmental partners as well as UNAMSIL – remain to not only providing immediate relief to the population, but also on investing time and resources in creating the conditions for a return to normalcy"*. In the appeal OCHA also states that the humanitarian agencies agree to adhere to the following common principles: *"……assistance will be provided within the context of efforts to achieve sustainable peace".*

The increasing wish to use humanitarian action as a first step to promoting peace and democracy, threatens the principle that humanitarians should provide aid solely dependent on needs and not political agendas. The same is seen in the 'strategic frameworks' of the United Nations. According to these, humanitarian action only makes sense, should only exist, and will only be financed as long as it contributes to higher political objectives such as peace, respect for human rights, or the promotion of good governance and democracy. All such initiatives have in common that they want to obtain 'secondary benefits' from humanitarian action. By insisting on such an approach, they in fact force the humanitarian action in a system of principles and priorities that is foreign to it. Such a tendency has important consequences for the various NGOs that provide health care based on humanitarian principles. Humanitarian assistance must be provided to those in need without conditions. The beneficiaries suffer from intense need, they have a right to such assistance and a lack of conditions ensures that there is no requirement for negotiation with those in need.
However, even though humanitarian action has no political intent, it may have political effect. This apparent paradox is a main cause leading political leaders to try to influence flows of humanitarian assistance to further their own interests or deny the interests of opponents. Increasingly it seems that outside powers may also be interested to use humanitarian action as an instrument of foreign policy: to persuade political constituencies that they are active when they are not, that their actions are moral by association or that they might pursue other goals through humanitarian action - curtailment of refugee flows; containment of crisis; or infiltration of crisis situations; building peace potential. Independent civil humanitarian actors are not against political actors taking action to meet formal responsibilities and seeking to fill the wishes and desires of their constituencies, indeed we demand it, but this should be done openly and transparently and through the proper channels.

There is also an increasing wish to use humanitarian action as a first step to promoting free market/neo-liberalism. This change of role is illustrated in the ways the international community tried to cope with the substantial socio-economic crisis in Africa starting since the beginning of the 80s. The crisis was partly due to the collapse of the price of exports (primary commodities) and the rising cost of essential imports such as oil. The increasing economic problems also prompted the recognition that the state-led development model introduced after independence in the 1960s was failing. As a response to this, structural adjustment programs or SAPs, devised by the international financial institutions namely the International Monetary Fund and the World Bank, were designed as means to get African economies back on track, above all to restore economic growth on a sound footing. Their underlying philosophy was that of neo-classical liberalism, which generally believes that private economic forces competing in free markets lead to rational outcomes, maximising both individual benefits and public welfare. As a consequence of this philosophy a de facto "roll back of the state" attitude was established that was not only restricted to economic affairs, but also budget cuts affecting social services. Critics of structural adjustment

have sharply denounced this policy of the state's withdrawal and cutbacks in social services expenditures. During the 1990s, the World Bank seemed to change their policy somewhat acknowledging that the state should continue to play a vital role in the socio-economic development, discarding the extreme position that "a smaller state is necessarily a better state" which imbued the initial SAPs of the 80s. According to the World Development report 1997, the state should focus its actions on its capacities, but at least fulfil five fundamental tasks, namely establish a foundation of law, maintain sound economic policies, invest in social services and infrastructure, protect the vulnerable and protect the environment, without which "sustainable, shared, poverty-development is impossible". However, despite this change in policy, The Helen Keller relief agency reported growing health problems like anaemia and malnutrition in Indonesia after adopting a SAP during the economic crisis in 1997. Moreover, common vaccinations for measles, mumps and rubella and other childhood diseases were reported too costly for poor families.

As part of these policy changes we have also seen an increased focus on eradication of poverty as the key objective of liberal economic reform efforts. The importance of social services has been re-appraised in the context of poverty eradication. Social services are also now viewed as a necessary investment to increase productivity and therefore combat poverty. As part of this perspective "civil society" has started to become an important factor. Civil society is generally seen as comprising a free media, civic and non-governmental organizations, trade unions and possibly political parties. Even though there seems to have been a shift in viewing states responsibilities, i.e. social services are again recognized as part of the core responsibilities of states, to which increased attention and funding must be devoted, many questions and concerns still remain. The fundamental thrust of reducing and redefining the state's role and of increasing the participation of the "non-state sector", i.e. NGOs and the local population, has been maintained.

The focus on poverty alleviation tends to focus attention on economic inequity - it does not expose the political role in creating and sustaining inequity and the political solutions above and beyond good policy that are required to generate real progress in health and society. NGOs cannot compensate for this broader failure by providing technical or material assistance. They can shine a hard light on the need to politicise the understanding of human society, conflict, progress and equity - in which economic analysis plays an important but NOT exclusive role.

For MSF the crucial questions will be: Should NGOs really compensate for the state's retreat? Aren't NGO activities fragmented, lacking in continuity and co-ordination? Isn't the state's legitimacy being eroded by privatization of fundamental public services? Is it really the role of an NGO to provide health care as part of a permanent solution? We also want to insist on the necessity of NGOs' transparency and accountability to the beneficiaries.

MSF – a medical humanitarian organisation

MSF is first and foremost a medical humanitarian organization. For us the humanitarian act is to seek to relieve suffering, to seek to restore autonomy, to witness to the truth of injustice and to insist on political responsibility. As such humanitarian action is more than simple generosity, simple charity. In addition to cover needs, we aim to enable individuals to regain their rights and dignity as human beings. MSF has a clear intent to assist, to provoke change and reveal injustice.

For us it is important to acknowledge that MSF is not just a service provider. MSF is not trying to replace political and local responsibility for the development of political society and welfare services. On the contrary, we are trying to demonstrate the failure of the states to fulfil their responsibilities and bring attention to this. We act simply to help the person who is sick. We set up services and the lessons learned can be used to construct new models in service delivery, but we are not trying to cover part of the national service network or even assure access to complete and equitable services for a sub-set of the population outside of a national frame.
To this end we do not see NGOs like MSF as highly efficient privatised providers of service acting in opposition to government. We are NOT part of the liberal economic agenda in which we seek to replace government responsibilities. We try to stimulate government responsibility and international responsibility. The fact that MSF delivers health care in the world today is a sign of serious failure, nothing else.

The definition that we use to describe our framework, was formulated in the early 1990s by Rony Brauman: "MSF helps the members of a society to survive a period of crises (defined as a disturbance of a previously existing equilibrium)". The objective of this definition was to distance MSF from a more “development-oriented” way of thinking and safe guard our humanitarian action as independent from initiatives that recommend models for development or models for society. The core activities of MSF are practical work in the field, and our approach is, to a certain degree, empirical. In terms of the quality of our relief operations, this is a truly effective approach, and it is contrary to what might be termed an unrealistic, "globalising" approach. It is not our goal to eradicate poverty, as we see it in the missions of e.g. the World Bank: "To fight poverty with passion and professionalism for lasting results" or in the NGO Oxfam: "To work with others to overcome poverty and suffering". The poverty objective in our situations is a de-politicized picture of reality. Poverty is not simply a lack of resources but also of political capital/voice. The relationship between poverty and humanitarian action is in our opinion clear. Humanitarian action does not problematise poverty nor does it respond to poverty. Humanitarian action problematises and responds to suffering - and explicitly recognises the ‘abnormality’ of that suffering - the causes of that suffering - and the duty of all human beings to respond to that suffering.

We face today, as doctors, an increased pressure to more or less resign and stop fighting for improved care. Powerful institutions like the World Bank, the IMF and WHO indicate that eradication of extreme poverty within ten years should be the first goal, upon which “Health for All” will be built. Thus, the *health problem* of today is defined as the absence of economical development, rather than individuals’ lack of access to effective treatment. Major pharmaceutical companies seem to agree on such an analysis. While waiting for this prosperous future, there is apparently no need to offer effective medicines at reasonable prices since the economic conditions for using them are not in place. For MSF such an attitude represents a decline of medicine and will lead to an inappropriate and unacceptable response. We cannot accept a neo-liberal order that excludes, that marginalizes, and that literally leaves open to sacrifice the lives and dignity of millions of people in the name of some future economic benefit that will “trickle down” to the poor, given enough time. As long as we have patients in the field, we have to insist on proper treatment.

MSF, therefore, has a clear role to struggle for quality of care on the ground. Our obligations as doctors are clearly defined by the circumstances of our patients. Most patients in the developing world have few choices. The precarious situation in which they live is caused by the indifference, marginalization, discrimination, and the violence they suffer. They do not have the luxury of choosing a new doctor if their current one fails to meet their needs. It is therefore very alarming to see that the doctors, themselves, have increasingly internalised the failures of medicine – they have reduced their aspirations by accepting their constraints. They do not demand more. A medical humanitarian organisation like MSF must not fall into this trap or allow itself to become passive. MSF will hold firm to the basis of our mission: to provide quality health care, and to do it today, to those who need it most. We have to realise that after all, who would provide effective medicines to the poorest of patients, if their own doctors do not demand it?

The HIV/AIDS epidemic is a good example. In the draft declaration for the special UN session on the HIV/AIDS epidemic taking place in June 2001, it is clearly stated “prevention must be the main stay of our response”. Treatment of patients with HIV/AIDS is not given the same priority. For MSF this is unacceptable. All people have the right to adequate medical care. HIV/AIDS is first and foremost a medical condition, and life prolonging and saving treatment exist. This treatment is feasible today, even in resource-limited settings. Prevention and treatment activities are mutually dependent and inherently linked and it serves nobody to pit one against the other. To win the battle against the HIV/AIDS pandemic, we need a global commitment from countries to implement comprehensive programs that provide a continuum of care including fully integrated prevention and treatment activities, and this should clearly be spelled out in the UN declaration of commitment.

MSF has been well known from its emergency interventions, and still this is an important part of our activities. We are able to assist victims of natural catastrophes, huge epidemics and armed conflicts. MSF is currently present in almost 90 different countries worldwide and run more than 400 projects. Around 3000 international volunteers depart annually and they work together with more than 15 000 local staff.
In January this year, in Guinea we faced a major yellow fever outbreak making it necessary to vaccinate over 1 million people. At the same time and in the same country, we enforced our interventions in one of the worst refugee crisis in the world today. More than hundred thousand refugees were trapped in a war zone, with no access to health care and very limited assistance, and worse than this, no possibilities of fleeing.
We are also present in chronic conflicts such the ones we see in Afghanistan, Sudan and Angola. In these countries we support health structures both with medical and logistical personnel and medicines. We find ourselves in activities that must be considered as plain substitution since the governments themselves do not invest sufficiently in their own health system. In Angola MSF last year documented clearly a marked deterioration in the medical and nutritional situation as a clear symptom of the government's neglect of the population. The report was based on over 400 witness statements. Despite the very rich resources in Angola, the government has consistently failed to invest in the well being of the population. At the same time the international community, including governments and the UN and its agencies, are promoting a vision that peace is just around the corner and that the government is making progress. Moreover, a notion of normalcy was introduced to describe the situation in Angola. This notion is dangerous because it may lead to inappropriate suggestions for action. And it is also totally wrong. War continues and we face its consequences in the field daily. Our operation in Angola is one of the largest to date with more than 80 international staff supporting primary and secondary health structures in 9 of the 18 provinces. Without our presence, a large part of the health system will collapse.
In more stable contexts we can carry out innovative medical work as for instance a mother-to-child HIV prevention program in South Africa.

Negative effects of providing health care

However, NGOs providing health care may also have negative effect. We may create the illusion that this should be our role, and thereby slow down or stop initiatives from the various governments. Moreover, our aid may be manipulated to support a system that gave rise to the misery in the first place. We were the first independent humanitarian organization to gain access to North Korea in 1995. There were significant problems during our intervention in North Korea. MSF was unable to gain access to the populations we wanted to assess. Thereby, we were unable to document a nutritional or health crisis and we could not identify the vulnerable. We were allowed to distribute drugs to health facilities, but we were unable to verify if the population had free access to these

health centres. Despite independent reports of major famine in some areas, MSF feeding centres had very low numbers of malnourished children. Moreover, we were denied access to these areas. We chose to leave North Korea in the fall of 1998 because we came to the conclusion that our assistance could not be given freely and independently of political influence from state authorities. We found that the most vulnerable were likely to remain so, as food aid is used to support a system that in the first instance creates vulnerability and starvation among millions. Our humanitarian action must be given independently, with a freedom to assess, to deliver and to monitor assistance so that the most vulnerable are assisted first. This was not the case in North Korea, and leaving was for us the least of bad options. We believed there might be a real crisis, but if so, the North Korean government was trying to cover it up. There was also a desire by foreign governments to support North Korea with vast quantities of aid against their nuclear black mail. In the cross-section of political interest, humanitarian actors were simply unable to serve those in need and were being produced as contractors in a political bargain. Aid must not mask the causes of suffering. And it cannot be simply an internal or foreign policy tool that creates rather than counters human suffering.

Following the genocide in Rwanda in 1994, roughly half a million people fled over the border into Zaire in a period of about 10 days. Initially they had no shelter, no clean water and no food or sanitation. Epidemics emerged very quickly, causing an unimaginable mortality and sickness. MSF and other actors responded quickly to bring the epidemics under control. Over 1 million refugees settled down in different camps in Zaire and Tanzania. By mid 1994, humanitarian actors were successful in controlling the epidemics and developing basic systems and supply lines for the delivery of food and other essential services. However, we soon found that military groups began to re-organize, take control over the refugee camps, re-train and re-equip. Increasingly we began to question our role and the perversion of humanitarian assistance - as the needs lessened and the aid increasingly became co-opted by a growing military structure that was guilty of the genocide in Rwanda in 1994. MSF and other actors made repeated calls for the forceful separation of the genocidaires from the legitimate refugee. MSF tried to register the refugees and was denied access by the camp authorities. We were also violently stopped when we tried to deliver food directly to the people. We knew that the quantity of food delivered was more than adequate, yet we still found malnutrition. It was evident that there was diversion on a major scale by an organised and militarised authority responsible for the genocide.
Also in this case we had to withdraw even though there still was unmet medical needs.

It is obvious from these and other experiences that providing health care and other kinds of humanitarian assistance to populations in distress, involves moral dilemmas. In our striving for access to our patients, there are limits in our willingness to compromise humanitarian principles. We need freedom to independently assess the needs of the population; retain unhindered access to

the population; conduct, monitor and evaluate the distribution of aid commodities; and obtain security guarantees for expatriate and local personnel, and property. We have, however, to realise that in many combat zones, it may be very difficult to obtain all these standards. In such situations we have to weigh the need for and effectiveness of the humanitarian aid against potential harm the aid may do.

Infectious diseases and access to essential drugs

Access to our patients and avoiding negative effects of our intervention are some of the major constraints we face today as a medical humanitarian organisation. In addition to access we need proper medical tools to deliver quality health care, among those tools are the medicines themselves.

It is said that 800 million people globally have no access to any form of basic health care. 1.3 billion people live on less than 1 USD per day, and 2.6 billion do not have access to safe and effective water and sanitation - the most elemental indicator of access to health care. Among these people treatable or curable infectious diseases are the leading cause of death. Each year infectious diseases kill 14 million people, 90% of who live in poor countries. Some of the reasons that people die from diseases like AIDS, TB, and Malaria are that life saving essential medicines are too expensive because of patent protection, because there is a of lack of research and development for neglected diseases, or because existing drugs are abandoned due to an insufficient return on investment for manufacturers. These three factors are linked to a disengagement of national and international authorities to ensure the right to access health care, an abdication of responsibility for the problem to the multinational pharmaceutical industry, and the weakness of the mandates of IGOs like the WHO and the strength of mandates of other IGOs like the WTO.

There are between 300 to 500 million cases and 1-2 million deaths from malaria every year, and the vast majority of these people are poor, and living in the south. Resistance to standard therapy is rapidly increasing and in some countries resistance reach 80-90%. New treatments are either unavailable or unaffordable. AIDS is another major health problem. Since the beginning of the epidemic in the 1980s, more than 20 million people have died, 36 million people now live with HIV world-wide and there are 5.4 million newly infected people every year. The vast majority of people with HIV or who are going to get HIV are in the South. Treatment with patented anti retroviral drugs (ARVs) costs between 10 and 15 thousand USD per year. This treatment does not cure AIDS, but prolongs life probably by some decades. The cold fact is that only approximately 5% of the HIV positive patients in the world have access to treatment with life prolonging patented ARVs. The other 95% have no access to patented ARVs. These patients are among the 2 billion poor, living on less than 2 USD per day. They are our patients - the poor who have need but no purchasing power, and are

therefore not a market for patented ARVs. By the year 2020, half a billion people will be infected with HIV- and some predictions are worse. Entire African nations today are on the verge of collapse, as doctors, teachers, military personnel and civil servants are dying of AIDS. These nations are dying not of AIDS alone, but of "market failure". Access to life prolonging treatment is denied because of patent protection, because of a lack of public health infrastructure, and because of a lack of good quality generic drug production. The availability of drugs is not the only issue - but is the essential issue. Infrastructure and effective treatment delivery will never expand if there is not even a possibility of affordable drugs.
Sleeping sickness is another example. The production of one of the drugs developed to treat this deadly disease, eflornithin, was stopped because the patients who needed the drugs could not pay for it. Once more we witness that the world's poor are not a market. They are people who have need, but not enough money. It is that simple.

Thus, intellectual property rights and patent systems, equal pricing all over the world constitute borders that exclude the poorest from access to health. NGOs have a clear role in this issue to push for change and political responsibility and thereby increase health delivery to people. Based on our field experience, MSF launched an international campaign in 1999 to address this expanding problem and to put it high on the political agenda. We challenge politicians, pharmaceutical companies, WHO and many others. We need to find solutions to this problem and in fact, - there are solutions. There are certain possibilities in trade regulations for poor countries to produce their own drugs or parallel import cheaper generic drugs and thereby bypass the patent rights. These possibilities should be encouraged. However, in March this year a trial in the High Court in South Africa started. Thirty-nine pharmaceutical companies and their trade organizations brought suit against the Government of the Republic of South Africa because the government wanted to promote the use of generic medicines and permit parallel import of drugs to treat patients with HIV/AIDS. This is the only way the government can get affordable drugs for the millions who are infected and who will face an early death. Can we accept that the interest of some companies should prevail over the lives of millions? After major public pressure the pharmaceutical companies decided to withdraw their case unconditionally. This was a very important victory for the poor patients with HIV/AIDS.

As for the drug against sleeping sickness, a solution has been found. A pharmaceutical company will still produce the drug. "Luckily", the drug that would save the lives of hundreds of thousand patients in Africa, happened to be an effective drug for removal of unwanted facial hair in women. So, there was a market after all: Western women with facial hair, and the production could continue.

Lack of research and development (R&D) of new effective drugs is another problem affecting the developing world despite the enormous private investment in drug research over the last quarter century. Of the 1,223 new chemical entities approved during this time, 379 were true therapeutic innovations. Out of these, only 11 were for tropical diseases and most of these were the result of veterinary or military research. Only a few were specifically for tropical diseases. Furthermore, if we look at the number of therapy relevant scientific publications in 1995, the total number was 95 417. Only 182 of these publications concerned tropical diseases. There were 79 publications on malaria, 34 on tuberculosis and only 3 on African Trypanosomiasis (sleeping sickness). Thus, it is obvious that R&D for tropical diseases has ground to a standstill. The pharmaceutical market has been rapidly expanding in North America and Europe in the same period. The North American drug market has gone from just under 80 billion US dollars in 1993 to more than 160 billion projected for 2002. North America makes up 5% of the world's population. In comparison, the market in Africa and Asia has remained the same, while the population has doubled. Today, Africa and Asia make up 72% of the world's population while Africa for instance only constitutes 1% of the projected world pharmaceutical market for 2002. Thus, the size of the market seems to be closely linked to the size of the R&D budget.

It is important to note that while pharmaceutical companies spend billions on R&D for the diseases of concern to industrialised countries, the budget for product development for the Tropical Disease Research programme, which is a common programme of WHO, the World Bank and UNDP, has averaged just 10 million dollars per year during the last decade. The numbers speak for themselves. We face the fact that that most of the world's population is left out of the picture when new medicines or vaccines are developed. R&D activities are responding less and less to the real clinical needs of the developing world. This is a crisis that must not continue. Who is responsible for the solutions?

Roy Vagelos, former head of Merck, said: "it is a social problem that we are faced with, and we cannot ask industry to solve it." However, it is essential that the pharmaceutical industry contribute to the search for solutions. But in MSF's opinion, we cannot rely on industry alone to solve the crisis, nor to set the rules. While one could blame the lack of R&D on "market failure," we also point the finger squarely at "public health failure." Political leadership is crucial for ensuring that research and development does not only serve the needs of the wealthy.

One year ago, MSF took the initiative to set up the The Drugs for Neglected Diseases (DND) Working Group. The group is an international, independent team of biomedical scientists, tropical medicine experts, health economists, legal and regulatory specialists and representatives from health NGOs, the WHO, and industry. Its goal is to identify strategies to promote the development of new, effective, safe, affordable, and easy-to-use drugs. One of the recommendations from this group is to define a clear, need-driven research agenda for new medicines including vaccines. This will assist policy makers, funding agencies,

and the research community in setting the right priorities to address the needs of developing countries. This agenda will drive a coordinated effort to develop 10 to 20 new drugs over the next 10 years, with an estimated cost of $500 million to $2 billion. This amount is not beyond the reach of our societies. The group also recommended creating mechanisms to drive needed research in the private sector. For example, governments could demand that a small percentage of profits go towards developing essential medicines for neglected diseases. Furthermore, when a disease is only prevalent in developing countries, we may need to rely on a fully subsidised system, and when the disease impacts both rich and poor countries, we should implement an equity pricing system. The group also suggested negotiating an international treaty to ensure R&D for neglected diseases. This treaty should promote the search for medicines and vaccines that are effective and easy to use, and must ensure their affordability. It should address quality, efficacy, and safety standards. It should correct the current imbalance between rights and obligations under the present international treaties and agreements, such as TRIPS. It should guarantee that drugs for neglected diseases will be considered global public goods and address the relevant intellectual property issues.

Who is responsible for health care delivery?

The so-called solutions proposed by many UN Agencies, governments and multinational companies have been donations or price reductions of patented drugs, public-private partnerships to support these initiatives, and corporate "community programs" to support highly specific public infrastructure and training programs. We need to questions whether such programs the responsibility of corporations, or of governments. Are donations or price reductions of patented drugs a sustainable solution for access for all? Are public private partnerships viable solutions to the long-term responsibility of states to protect, promote and ensure the right to access health care? Is it acceptable that some foundations should set and drive the international health agenda by virtue of the sheer size and power of their financial resources? Where is the state in meeting these responsibilities? In the case of the HIV/AIDS epidemic, these kinds of initiatives may allow the pharmaceutical industry to side step the threat that compulsory licensing and generic drug competition represents to their profits. More importantly, they perpetuate the notion that private charity - an act of privilege- is a viable alternative to a public or state duty to promote, protect and ensure the right to access health care. It allows politicians to respond with political platitudes, and with what amounts to effectively piecemeal private actions that create a humanitarian alibi for the failure to achieve real access to health care for all.

NGOs, MSF included, have been complicit in this humanitarian alibi. In many ways, NGOs have become co-managers of misery with the state, providing a salve instead of a cure, allowing charity to mask duty, and failing to demand real political change over political platitudes, or statements of "concern". We have

failed to insist on political responsibility not just for the rich or the included, but for everyone - the rich, the poor, the dispossessed, the excluded.
Now that the sufferings and diseases of the poor are a "threat" to national security and to expanding global markets, there is political interest. We must take this new found political interest, and not allow an economic and state security agenda to drive our agenda, which is one that must be committed to real justice for all - the included and the excluded. The economist Amartya Sen has argued that poverty is not just about economics, but also about a fundamental lack of freedoms. For NGOs, how we choose to use our liberty - what we see as our vision, what we do in our actions, and how we use our voice - matters. We must choose to demand more. We have been too passive, too polite, and too deferential to political platitudes and to partial and imperfect private initiatives. We must also fight for the freedom of our beneficiaries. We recognize that their fundamental liberties are constrained. This is nothing but an outrage.

There are many who claim to speak for the poor. We see the World Bank, the IMF, and many UN agencies claiming and in effect, co-opting this voice. For MSF, our voice is our own. We do not pretend to speak "for" anyone - for victims of war, for the marginalized, the excluded, the poor, or anyone else. We speak as ourselves, with our own voice, of our own direct experience of solidarity in our projects, of our own outrage, and of our own demands. And we are able to do this because we are operationally, politically and financially independent. And once more we will state clearly: MSF is NOT part of the liberal economic agenda in which we seek to replace government responsibilities. We try in different ways based on our field experience, to stimulate government responsibility and international responsibility. As such our goal would be not to exist.

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