Children, what do you want to be when you grow up?
ALIVE!
ABOUT AIDS AND RIGHT ALLIANCE FOR SOUTHERN AFRICA (ARASA)

• ARASA is a regional partnership of 106 non-governmental organisations

• Work collaboratively to strengthen capacity of civil society for evidence-based advocacy around rights-based responses to HIV, SRHR and TB in southern and east Africa.

• It is the only regional organisation that is structured in the form of a partnership of country-based civil society organisations (CSOs) working together to promote human rights approaches in the context of access to HIV, SRHR and TB health care.

• ARASA) strengthens civil society’s role in governance of health and rights by monitoring policy, legislative and programmatic responses at national, regional and international levels.
SADC Countries
# LDC and non-LDC in SADC

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<th>LDC</th>
<th>Non-LDC</th>
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<td>DRC</td>
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<td>Tanzania</td>
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Where are our countries in adopting TRIPS flexibilities

**ANGOLA**: Industrial Property Law No.3 of 1992 was passed in 1992 before TRIPS. NO flexibilities adopted; No patent duration...

**BOTSWANA**: Industry Property Act 1996 (Amended 1997) before TRIPS flexibilities. 20 year patent term Goes beyond TRIPS requirements. Competition Bill of 2009, to prevent anti-competitive practices
PROGRESS: AMENDMENTS TALKS!!!

Where are our countries in adopting TRIPS flexibilities

**TANZANIA:**

**LESOTHO:** Industrial Property Amendment Act (1997); before DOHA Declaration on Public health. Has not updated its Industrial Property Act. Currently considering the adoption of certain TRIPS flexibilities this year.

**ZAMBIA:** Patent Act of 1958, amended in 1980 & 1987. 16 years patent life; but has until 2033. Some sections feature flexibilities. For example the allowing of compulsory licenses (Sec37) for insufficient use or violation of a patent license
Where are our countries in adopting TRIPS flexibilities


SEYCHELLES: Patent Act (1901) protection is obtainable via a national filing. Seychelles has other laws protecting Trademarks and Copyrights. Not TRIPS compliant and no flexibilities offered in TRIPS and DOHA
Culture of incoherence

- Lack of understanding about TRIPS flexibilities
- Conflicting interests between industrial policy, public health and revenue collection
- Confusion or lack of clarity about which government agency takes responsibility e.g. Health or Trade & Industry, Finance
- Lack of political will to drive the processes through
- Trade agreements negating benefits of TRIPS flexibilities e.g. TRIPS+ through bilateral trade agreements
- Inertia in parliamentary processes in getting to Bill stage then Act of Parliament
Status of TRIPS Flexibilities Use in SADC

- 8 LDCs exempt from granting and enforcing patents for pharmaceuticals until 2033
- Other 7 countries (non-LDCs) can use TRIPS flexibilities provided included in national IP/patent legislation i.e. domesticated
- LDCs in SADC can produce generics of patented products until 2033 – can produce and export those generics that India no longer allowed to produce
- The inadequate utilisation of TRIPS flexibilities at domestic level (incl. compulsory licence, parallel importation, paragraph 6 system).
- Mozambique, Zambia and Zimbabwe have issued compulsory licenses for antiretrovirals. Very cumbersome processes within legislations, not easy to use
Status of TRIPS Flexibilities Use in SADC

• Status of TRIPS flexibilities in IP/patent laws assessed by Southern African Regional Programme on Access to Medicines & Diagnostics (SARPAM) project in 2012 using a number of criteria. Results on: http://ttatm.sarpam.net/sadc/

• Database of 25 regional experts in IP Legislation created with emphasis on maximising TRIPS flexibilities was created

• SADC countries assisted to review their IP/Patent legislation through Technical Working Groups.

• Currently reviewing Intellectual Property (IP) / Patent law in 6 countries: Botswana, Malawi, Seychelles, Swaziland, Zambia and Zimbabwe

• Lesotho, Mauritius, Mozambique and Tanzania) expressed interest in reviewing their IP/Patent laws and required support.
• Work supported by AIDS Fonds (2015-2017): ARASA & SARPAM

• Focus is on:
  - Domestication of TRIPS-flexibilities by putting pressure on governments to amend their Patent laws
  - Strategic thinking around procurement / regional manufacturing of 2nd & 3rd line ARVs, TB and Hepatitis C medicines

• Implemented in three countries: Mauritius, Zimbabwe & Botswana

• Ensuring that CSOs are at the negotiation table, for better monitoring of progress

• Capacity strengthening of CSOs (online, in-country trainings) to undertake actions/advocacy around access to medicines, as a human right
Jukebox rhetoric

• Jukebox rhetoric leads to incoherent strategies

❖ 3 by 5 Initiative: global TARGET to provide 3 million PLHIV in low- and middle-income countries ART by the end of 2005.

❖ Universal Access by 2010: Towards universal access: Scaling up priority HIV/AIDS interventions in the health

❖ 0-0-0 by 2015: Zero new HIV infections, zero discrimination and zero AIDS-related deaths

❖ 90-90-90: 2020, 90% of all PLHIV will know their HIV status. By 2020, 90% of all people with diagnosed HIV infection will receive sustained antiretroviral therapy. By 2020, 90% of all people receiving antiretroviral therapy will have viral suppression.

❖ ENDING AIDS: Fast-Track strategy to end the AIDS epidemic by 2030.

What does it all mean? Do we need new or are the old medicines sufficient?
Re-calibration of approach: Articulating rights-based approaches to Access to essential medicines

• Man cannot survive on ‘PILLS’ alone

• Need rights-based discourse at the centre of the health response (e.g. Ebola, ZIKA, TB and other vaccines for neglected disease)

• The human rights arguments underpinning fight against HIV over the last 30 have failed, to provide a similar foundation for success against other diseases such as multidrug-resistant TB (MDR-TB).

• Appreciation that we cannot win this fight, one disease at a time - No ending HIV/AIDS without ending TB

• Other non-communicable disease need to be prioritised

• Dismantling broader status quo: WHO should not be allowed to get away with providing sub-standard recommendations for developing countries, NO BLUE SKY
An Example of MDR-TB WHO Guidelines

WHO recommended unsound medical treatment for MDR-TB patients in resource-poor settings for almost a decade - since 2000.

Citing cost considerations, WHO did not recommend the available standard of care that had been successfully used to contain and defeat MDR-TB in rich countries.

WHO has essentially facilitated the global implementation of a double standard for TB care in low- and middle-income countries (LMICs).

International human rights law was violated.

Current proposal: Policymakers should reject double standards of this kind and instead embrace the challenge of implementing the highest standard of care on a global level.
Key questions

• What does it all mean?

• Do we need new or are the old medicines sufficient?
Thank you

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