PERSPECTIVES ON GLOBAL ISSUES
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Editor's Letter

In 2004, a panel of economists and Nobel Prize winners were posed the question, "What would you do with $50 billion?" They were given a list of ten of the world's worst problems and asked to rank them in the order that would benefit humanity most. The panel ranked health issues like disease and malnutrition as those most deserving of funds. Certainly a healthy society is fundamental to the development and growth of any nation, yet globally, there is still a lack of healthcare. These global health issues become a priority for everyone and every nation because no one, rich or poor, is exempt from the affect of health issues. For these reasons, the editors of *Perspectives on Global Issues* have decided to devote the Spring 2008 issue to the broad range of health topics affecting populations the world over.

This issue begins with an interview with Dr. Chris Beyrer, a professor at Johns Hopkins University and Director of the Fogarty HIV/AIDS International Training and Research Program. Dr. Beyrer's interview provides an insightful perspective on public health policy, especially as he discusses the connection between public health and human rights. His discussion also provides insight into the way international practitioners and academics can work with foreign governments to create changes in public health.

Health and human rights are inextricably connected to one another. In the following articles, authors discuss this link from different perspectives. In *A Methodology for Iraqi Refugee Health*, Christopher J. Varady and Najla Chahda of the Caritas Lebanon Migrant Center look at issues of access for urban refugees. They examine health challenges for the growing population of Iraqi refugees, specifically a new methodology for working in refugee healthcare in urban settings. This is an especially relevant piece because although the total number of worldwide refugees is declining, the phenomenon of urban refugees continues to escalate. Next, Claire Thomas looks at the connection between education and health in *Lack of Sanitation = Lack of Education: Creating "Girl-Friendly" Schools in Sub-Saharan Africa*. Education is a right for every human being, but the argument can be made that the right to health is a prerequisite to the right of education. The author discusses this connection by demonstrating the importance of education for females and examining how the lack of sanitation can restrict females from the pursuit of education.

In an interview with journalist for *The Jordan Times* and human rights activist Rana Husseini, Lorna Tychostup discusses how Husseini has brought international attention to the phenomenon of honor killings. The interviews details the journey of Husseini in reporting on these killings and her motivation for doing so. The interview provides readers with an inside look into the work of a noted scholar from inside the Middle East.

Any discussion on health issues must inevitably look at the legal regime surrounding the right to health. Rena Kokalari looks at the efficacy of laws addressing sexual violence in *Can International Law Effectively Address Sexual Violence Against Women in Armed Conflict?* She studies the progressive nature of these laws and suggests a plan to strengthen the protection of women from acts of sexual violence. Dr. Maya Sabatello also takes a legal perspective examining access to medication. In her piece, *The Needy and the Greedy: Access to Medication and Patent Law in Light of the Novartis Case*, she analyzes a recent court decision in India that overruled intellectual property laws, providing patients access to affordable medication. As she recognizes, this case "marks a defining moment in [the] global debate" on patent laws.

Dr. Seye Abimbola, winner of the Global Forum for Health Research/The Lancet Essay Competition, looks at the development of global health priorities. In his essay *Rethinking Global Health Priorities*, he critiques economist Emily Oster's lecture on HIV/AIDS in Africa. He points out that solutions to global health issues should also focus on the lack of basic health services and poverty instead of centralizing funding for diseases like HIV/AIDS. He argues that without the focus on development and healthcare at the most basic level, our global health priorities will be permanently skewed, moving, as he says, "one step forward, two steps back."

Never far from any discussion on health is the practice of female genital cutting. J. Steven Svoboda provides a review of scholar Hanny Lightfoot-Klein's most recent publication, *Children's Genitals Under the Knife*. He praises the author for her unique perspective on the issue and lauds the activist efforts she recognizes in her book.

Our issue closes with a special commentary from Leif Waller, a Peace Corps Volunteer serving in Mongolia. In his piece, *Health Perspective: Mongolia*, he examines global health issues in Mongolia from the perspectives of a practitioner.

This edition of *Perspectives on Global Issues* addresses questions about the global impact of health. We want to thank the contributing authors for their insights on health and human rights, the legal regime around the right to health, and the pieces examining unique health topics. We hope this issue helps stimulate a discussion about overarching global health issues and provides content for further discussions aimed at resolving these issues.

Thank you,

Kristy Crabtree Jennifer Dunham Monika Maslikowski Paul Challan

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The Intersection of Health and Human Rights: Interview with Dr. Chris Beyrer

Kristy Crabtree
Center for Global Affairs, New York University

Dr. Chris Beyrer is a professor at Johns Hopkins University and Director of the Fogarty AIDS International Training and Research Program. In addition to these positions, Dr. Beyrer is also Director of the Johns Hopkins Center for Public Health and Human Rights. He has published widely about the connection between public health and human rights and has greatly contributed to research on HIV/AIDS. He has experience working with governments to implement public policy in prevention and treatment. Throughout his research he has focused on issues of AIDS in Asia primarily focusing on: India, Thailand, China, Malaysia and Laos.

Recently, he sat down with Kristy Crabtree, Managing Editor of *Perspectives on Global Issues*, to discuss public health issues and their connection to global affairs and human rights.

Kristy Crabtree: I want to begin by asking you about your background. Could you briefly describe how your experiences living in New York City in the 1980's have shaped and guided your work?

Chris Beyrer: I started medical school in early 1980's and walked on to the wards as the AIDS epidemic was unfolding in New York City. I think it's fair to say that that really was a defining reality of my career and I have worked in international HIV/AIDS prevention and research epidemiology and vaccine research ever since.

KC: Our next question pertains to your book on *Public Health Aspects of HIV/AIDS in Developing Countries*. In the book you discuss the relationship between human rights and public health. Could you explain this connection and how the two reinforce each other?

CB: Unfortunately, what we've seen in the last decade is that human rights violations increasingly target populations, for example, you have ethnic cleaning, you have the attacks against ethnic minority people in Burma on the part of the junta, and rights violations include: outright violence against civilian populations but also forced displacement and forced labor. What we've seen is that there are health implications to those rights violations. Public health comes into play when you move out of the level of the individuals, so the individual democracy activist, or labor activist or women's rights activist who is targeted by a repressive state- when you move to the level of the population like an ethnic group, like Africans in Darfur, like the southern Sudanese Dinka people, then to look at the impacts of health or rights violations on the health of populations, you really need population-based methods. You really need epidemiology, you really need public health tools, and what we've tried to do in this book was to bring some of the powerful new technology and approaches of modern public health science to bear on these settings in which the human rights abrogations are occurring at a population level.

KC: How do global inequities between groups of people impact public health issues?

CB: They do in enormous and complex ways and there's no question unfortunately that when we look for example at where tropical diseases are still an important part of life, that those [countries] tend to be highly correlated with poverty and with mis-governance. I think it's really important to understand that even when the poorest governments invest in public health you really do see benefits. But what we so often see are situations like Burma, like Sudan, [and] many others where the state really does not invest in the health and wellbeing of the populations and the outcomes there are terrible. These are the places where we see things like: tuberculosis and other epidemics really out of control because public health systems are so inadequately funded and supported. All this is true in clinical arenas as well, but what you have to keep in mind and remember is that there are public health functions that really are the functions of the state: immunization, water, maternal and child healthcare, sanitation, infectious disease and outbreak control. These are the public health functions of the state; if the state is not functioning or not engaged in them, then the health outcomes are very grave indeed.

KC: How are you working with governments to implement prevention and treatment programs, and what have been some successes and challenges?

CB: There are a number of successes out there and some of them I've been involved in and some of them not. Certainly when you look at, for example, the work we were doing in Thailand in the 1990's, you have a government that was very open to scientific evidence, that wanted to see data. So, for example, I worked with others on the HIV prevention program for the Royal Thai army. We found data that suggested a small but significant proportion of men were engaging in same sex behavior, and that therefore we should put prevention messages of outcome and use and safe sex for men who have sex with men into the military program. We showed the data to the Surgeon General in Thailand and they said 'yes, we agree that the data does support this.' We found that about six percent of men reported ever having sex with another man but they accounted for about 12-13 percent of the men with HIV infection. So they were a relatively small proportion, but they had an elevated risk. I think this is a good example of scientific, epidemiological evidence affecting public policy. Now in contrast, we've been working for a number of years in the Russian Federation and pushing hard for substitution therapy for the treatment of heroin addiction, which is *so* related to their HIV epidemic. There we made no headway at all. The Russians remain very resistant to the whole concept of substitution therapy and really modern evidence-based structuring that remains unavailable across the Russian Federation.

KC: Do you have certain methods for working with governments that aren't open to policy suggestions or collaboration?

CB: The first and most fundamental reality here is that as somebody (and this certainly goes for working with the U.S. government too, we've had a very difficult administration in terms of HIV prevention policy with the Bush administration), the critical thing is partnerships. You have to build partnerships with advocacy groups, with non-governmental organizations (NGO), with sympathetic people within the ministries of health, what you usually find is that the technical people in countries and in ministries of health, public health officials, and physicians are very decent people who want to do the right thing. The challenge rarely comes from that sector; it almost always comes from legislative or executive bodies or top leadership, administrators that are political, that do not want to implement progressive policies because of the political problems involved. So it's very important to partner with and support the local groups that are working to make change - and to work with advocacy groups where they exist. It's very difficult to do when

you have a truly repressive state like Burma where the military junta has really shut down independent advocacy groups, where there are not independent NGOs, where there's no independent media. In those kinds of situations, it's very important to partner with the democratic forces, with the ethnic groups, with leaders of the ethnic organizations themselves that are taking on these repressive states. But that's really the key. Change rarely comes from outside, and certainly not because some American epidemiologist thinks a government policy is a bad one. It comes from pressure within - that's why I think our role is really working with local partners, supporting them, empowering them, and helping them both generate and use the data they need to make their case. We're always trying in these kinds of settings to stick to the best available scientific evidence, and to advocate from a position of good science driving good public policy.

KC: What role or what kind of impact do patent laws and access to medicine play in global health issues?

CB: There's a very clear position, which is the legal position internationally with the World Trade Organization (WTO) that patent laws for specific medication can and should be waived, legally waived, in the case of health emergencies. That is the law and of course many groups have opposed it or fought against it in particular situations, but in my view, since that mechanism already exists within the WTO, it's called Compulsory Licensure, then it should be implemented wherever there is situation of public health emergency. In many countries, unfortunately, the public health situation is one of chronic emergency. India is a good example. India's tuberculosis epidemic remains an enormous problem. India should be able to access, manufacture and use the cheapest and best available tuberculosis drugs. To hold developing countries' markets hostage over intellectual property rights is a position that it untenable. Africa represents less than two percent of the global pharmaceutical market – the real concern on the part of the drug companies is that if generic and low-cost drugs are available in developing countries and then circle back through internet purchases and other ways to first world markets and undermine patent protection in those markets. That is a legitimate concern, and it has to be addressed. However, that is a very separate issue from developing countries being able to access generic drugs, which they should be and which they are legally allowed to be as long as they are members of the WTO and seek compulsory licensure, and I think that that really needs to be for things like malaria, HIV, and tuberculosis, but certainly also for neglected tropical diseases.

KC: What policy changes do you think are the most fundamental for improving global health?

CB: I think we're living in a golden era of global health – it's never been paid attention to at the level that it has. We've had very high-level bodies like the UN Security Council and the G-8, the groups of eight industrialized nations, really embracing the idea of global health. I think what we've seen unfortunately is that we're still stuck in a mindset of technical solutions, of magic bullet kind of fixes, and again and again those kinds of approaches to improving global health fall down when it comes to implementation through the very weak and shaky health infrastructures of the poorest countries. I think that what we need to do is move out of the era of disease-specific approaches and really start to engage in building or rebuilding public health infrastructure. Now to do that, we need to relieve the debt burden of many of these countries, but we also need to hold governments accountable. We're doing a very bad job of encouraging or even pushing aggressively for developing countries to invest in health. Unfortunately what we've seen is that places like Burma, Zimbabwe, and Sudan are good examples of places that have divested in health and the outcomes there are very grave. We need to think more about systems and really need to be putting both carrots and sticks in place to ensure that the kind of investments in health that need to be made, are made.

KC: My last question relates to the Copenhagen Conference were economists and Nobel Prize winners were asked what they would do with $50 billion. They placed many public health issues as the highest priority and the best return on investment. I'm wondering if you were in a similar situation what would advocate spending the $50 billion dollars on?

CB: I think first things first, so the things we know work and that really save lives include child immunizations, maternal child health, clean water, responding to infectious diseases, like tuberculosis, HIV/AIDS, and malaria, and I think that all of those require further investments in basic developing country health infrastructure and in health manpower. I would put a significant proportion of that money into supporting and expanding medical schools, nursing schools, pharmaceutical programs - building health capacity and health infrastructure, which includes the health capacity and human infrastructure in developing countries.

KC: I want to thank you so much for your time - is there anything else you want to share with our readers?

CB: The history of medicine often is that changes in our field are often driven by student interest and student demand so I'm delighted that you all are engaged in global health and I think it's been an absolutely thrilling and exciting career and I'm very pleased that it seems more and more opportunities are opening up in this field.

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A Methodology for Iraqi Refugee Health

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Caritas Lebanon Migration Center

ABSTRACT
The two million refugees who have fled Iraq in recent years have presented non-governmental organizations with several health care challenges. Many international NGOs have had little experience working in the Middle East, and their core competencies in refugee health care are more geared for camp situations in Africa and Afghanistan than for Iraqi refugees in urban settings who suffer from chronic diseases.

Caritas Lebanon Migrant Center (CLMC), perhaps the preeminent NGO in the Middle East servicing refugees and migrants, has been at the forefront of pioneering a social work methodology to deliver services. This methodology not only dramatically increases efficiency but also has several major benefits: peacebuilding, host community relations, and programming agility to reduce waste. This article examines the methodology employed by the CLMC to draw programming recommendations for NGOs serving refugees in non-traditional contexts.

BACKGROUND

Aid agencies have developed core competencies and best practices around refugee health as they pertain to camp situations, mostly in places like sub-Saharan Africa and Afghanistan. There is not a body of literature on best practices for refugee situations in urbanized, semi-industrial, or middle-income countries. However, as conflicts and the threat of conflicts emerge in the Middle East, there is now a call for such best practices to be developed.

The cornerstone of refugee health programming is the Sphere Handbook,[1] which establishes minimum standards for a variety of services and support. However, when it looks to chronic diseases, those which are most commonly found in urban refugee crises, the guide admittedly underscores the lack of guidance:

> No generally accepted guidance on the management of chronic diseases during disasters has previously been established. During recent complex emergencies in countries where patients had previously had access to ongoing treatment for chronic diseases, priority was given to those conditions for which an acute cessation of therapy was likely to result in death, including dialysis-dependent chronic renal failure, insulin-dependent diabetes and certain childhood cancers. These were not new programmes, but a continuation of ongoing life-saving therapy. In future disasters, programmes for other chronic diseases may also be relevant.

United Nations agencies and aid agencies show a dearth of information about managing chronic diseases. In fact, they similarly show a dearth of information for refugee crises in urban environments and in the Middle East in general. The World Health Organization (WHO) and

[1] Sphere Project. The Sphere Handbook: Humanitarian Charter and Minimum Standards in Disaster Response. New York, The Sphere Project: 2004. http://www.sphereproject.org/content/view/27/84.

U.N. High Commissioner for Refugees (UNHCR) are usually the two agencies at the front lines for health care for refugees, but both show almost no best practices on refugee health care in an urban setting.

Practical guides, while perhaps focused on urban health care, do not capture the situation of Iraqi refugees in the Middle East. This is perhaps because many urban health care designs are focused on slum conditions rather than middle-income countries which have now become hosts to refugee populations. For example, "Urban Health & Development: A Practical Manual for Use in Developing Countries"[2] does not address chronic illnesses nor middle income cities. Other practical guides such as Medecins sans Frontieres' "Refugee Health: An Approach to Emergency Situations"[3] does not cover chronic illnesses nor urban refugee environments.

Most recently, the military conflict between Israel and Hizbollah in July 2006 pointed to the lack of standards for health care in an urban, Middle East refugee crisis context. The swiftness of local Lebanese NGOs and their institutional memory of the Lebanese civil war were perhaps the biggest assets in avoiding a large scale health crisis. Fortunately, the internally displaced persons (IDP) crisis did not last long enough for those with chronic illnesses to be severely affected. In some cases, dialysis patients and others with heart medication needs were simply moved to areas or hospitals were services where still functioning. Aid agencies had only to ensure access to services, but did not have to confront chronic illnesses on a large scale.

Although U.N. Relief and Works Agency (UNRWA) established a practice in health care for Palestinian refugees in Lebanon, these refugees cannot be compared one-to-one with Iraqi refugees or other refugees in Lebanon. Palestinian refugees, despite their legal status, are resident to Lebanon. In fact, many "refugees" have been born in Lebanon or have resided in the Palestinian refugee camps since 1948. Therefore, the health care practices do not exactly meet the needs of recently arrived refugees. However, UNRWA does provide assistance to Palestinian refugees for secondary health care. This assistance is usually in the form of hospital referrals and assistance with payment subsidies.

Similarly, CLMC has implemented a home-based program focused on the health care of elderly Palestinian refugees. This Humanitarian Aid Department of the European Commission (ECHO)-funded project developed a curriculum on specialized health topics, such as diabetes and heart disease, and trained home-based care workers to animate the elderly. Social animation focused on nutrition and lifestyle changes that can positively impact the progression of those chronic illnesses in the elderly. Nurses from CLMC also made regular visits to diabetes patients for blood sugar monitoring.

These two projects have been developed not out of a best practice guidance, but rather an ad hoc program of meeting needs with existing resources. However, the accomplishments and challenges of such projects have not been widely documented and disseminated. As such, this article seeks to do so in a more systematic manner.

HEALTH AS A PUSH FACTOR AMONG REFUGEE POPULATIONS

As the violence increased and the government decreased services in Iraq, many residents were forced by the illness of one family member to leave Iraq. Those with chronic illnesses could no

[2] Booth, Beverly and Kirian Martin, Ted Lankester. Urban Health & Development: A Practical Manual for Use in Developing Countries. New York, Macmillan Education: 2001.
[3] Medecins sans Frontieres. Refugee Health: An Approach to Emergency Situations. New York, Macmillan Education: 1999.

longer travel to doctors, hospitals, and pharmacies in safety. Furthermore, as government services began to break down in Iraq, many with chronic illnesses left Iraq to seek more regular, reliable treatment in neighboring countries. Social workers have noted that most of those leaving Iraq for health care reasons are heart and cancer patients. They often cannot safely travel for regular health care visits, the providers they are used to visiting have declined in standards, or both. Especially for those with cancer, they left because chemotherapy drug supplies have run out.

COMPONENTS OF THE CURRENT SERVICES

CLMC currently offers a wide range of services to Iraqis which it classifies as "extremely vulnerable." CLMC has established criteria for this classification, including:

- Female headed households
- Households with more than 6 members
- Households in which one member has a chronic illness
- Households in which one member has a disability

Social workers verify the extremely vulnerable status through home visits in which the criteria are verified. Once the classification has been established, social workers then determine the needs of the family and can offer services based on a menu of programming options. The menu includes humanitarian assistance, food coupons, schooling, and health care.

Health care services currently revolve around the treatment of one of the following chronic illnesses: heart disease, diabetes, cancer, and high blood pressure. In these cases, CLMC social workers provide access to the regular health care services of accredited providers in the country. In all cases, it is under the medical direction of doctors that services are offered and treatments are followed. CLMC provides the funding, but the treatment is prescribed by doctors.

In addition, the project includes discussion groups for various health topics. Though refugees in Lebanon do not often face problems associated with lack of potable water or no access to clinics, many from Iraq may face gaps in their health care knowledge. For example, the discussions include reproductive health, HIV/AIDS, and health care related to children.

METHODOLOGY

The social work model has led to a dramatic increase in agility to respond to individual needs, reduces waste, and is well-adapted to the needs of an urban refugee population. Iraqi refugees in Lebanon are first targeted through both word of mouth referrals as well as field offices that are established in neighborhoods where Iraqi refugees live. Up until a January 2008 amnesty, Iraqi refugees without regularized immigration papers were subject to immediate arrest. Given their fear of travel within Beirut as well as the need to establish a known presence in the neighborhood, the CLMC established two field offices in which social workers receive Iraqi refugees requesting assistance, as well as to conduct follow up with each of the cases.

In most cases of chronic illness, Iraqi refugees have already been diagnosed and usually seek assistance in paying for treatments and medications that are already known to them. However, the CLMC begins all requests for assistance with a standardized form, which serves several purposes: understanding the need of the refugee, gathering necessary data for collection and analysis, and providing a format for structured follow up. Once this request is received, the social worker will verify the extremely vulnerable individual status of the requesting refugee. In cases whereby the refugee has received documentation from UNHCR, the Agency will also cover medical costs even if the refugee does not meet the EVI criteria.

For cases of chronic illnesses, CLMC will issue a "prise en charge" document for the health care provider. This document guarantees payment for health services of the named refugee from CLMC. Some Iraqi refugees request to be treated at a certain health care facility while others are referred to facilities if they do not already have a preference. The project allows Iraqis to seek treatment at the facility of their choice as long as it is accredited by the Lebanese Ministry of Health and has a license to operate.

CLMC social workers also schedule a home visit. In this way, the entire situation of the family can be assessed and suggested assistance can be offered. For instance, some families may focus on the health care needs of the sickest member but do not request educational assistance for children. Likewise, the home visit is an opportunity for the social worker to offer coaching to the refugee family on re-establishing their lives in Lebanon, or detect areas in their lifestyle that could be negatively impacting their health, i.e. insalubrious housing leading to the worsening of an asthmatic individual. (CLMC medico-social workers are qualified for doing this as they have earned a university degree in community health.)

In cases of chronic illness, the doctor treating the Iraqi refugee establishes the treatment and provides a prescription for needed medications. CLMC purchases the medications from an accredited pharmacy and distributes no more than a one month supply of the medicine to the chronically ill patient. This is done for a number of reasons: to prevent the sale of the medication by the patient, to ensure that medications do not expire, and to ensure that the treatment regime is followed according to the doctor's instructions. In addition, when the prescription runs out the patient is obliged to meet again with the social worker and thus a regular schedule of follow-up visits is established.

These follow up visits provide the means for social workers to monitor the health status of patients and make referrals to doctors where necessary. Social workers can also ensure that the patient attends regular follow up consultations with the doctor and/or laboratory to monitor the patient's health.

HEALTH CARE ASSISTANCE

Many Iraqis currently in Lebanon, as established above, suffer from chronic illnesses. As Lebanon is generally a high cost country and without the governmental infrastructure to offer free health care, many Iraqis are quickly depleting their savings to pay for treatment. This problem becomes more complex in the current environment: until the recent amnesty for Iraqis, many Iraqis were afraid of arrest and thus did not leave their homes, even to find a job in the informal sector. In other cases, culture prevents many women from finding jobs as well. When chronic illness is present in the family, a combination of these factors mean that families quickly fall into poverty. In most families, the extended family structure means that sacrifices for other vital services like school are made to pay for medicines and treatment of the family member with chronic illness.

The health programming is based on two methodologies: social work and referral systems. Social workers follow the case of each person with a chronic illness, conferring with physicians and other health care providers. Doing so greatly increases the effectiveness of treatment because social workers are able to monitor the progress of treatment and ensure that the patient is following the treatment properly. This individualized approach has the side effect of greatly reducing waste.

The referral system is also a well-adapted methodology to the urbanized nature of the refugee population. In this way, the NGO has no fixed costs in establishing a health care provider service; rather, the NGO--after verifying the needs and inability to pay--makes a referral to existing services whereby the NGO pays for the treatment and medicines. This has several benefits to both the refugee as well as the host country:

- The refugee accesses existing, high quality care. In this way, the stigma of being a refugee or the marginalization that can happen when separate services are offered is greatly reduced.
- The refugee interacts with host country nationals accessing the same services and service providers. This has a conflict mitigation effect whereby both refugee and host country nationals have the opportunity to meet, interact, and put real faces onto a social issue.
- Service providers often are negotiated with to accept lower prices or pro bono work for serving refugees. In this way, there is a solidarity built between service providers in the host country and the refugees. The host country providers, not only international aid agencies, then become connected to the problem and embrace the responsibility of caring for refugees. This builds the connections between the host country and the refugees.

PROGRAMMING RECOMMENDATIONS

As explained above, the urbanized and segmented nature of the Iraqi refugee crisis has presented many challenges to aid agencies. Programming recommendations include:

- **Better targeting.** The nature of this crisis requires aid agencies to better find, target, and attract refugees for services. Options include: word-of-mouth referrals, targeting in places of worship, or having field offices in neighborhoods known to be hosts of refugees.
- **Integrated services.** As long as Arab governments maintain strict immigration policies, refugee issues in the Middle East will most certainly contain a protection and legal aspect. Health care must be offered in ways that do not jeopardize refugees by forcing them to travel long distances or otherwise expose them to protection difficulties.
- **Individualized care.** The individual needs of families will vary greatly even among homogenous groups when chronic illnesses are present. As such, a methodology, such as social work, must be employed. Whereas when primary illnesses are the main health threat, blanket interventions such as vaccination campaigns, latrines, and potable water can make a meaningful impact on a large population, the situation of chronic illnesses requires an individualized approach.
- **Donor acceptance of higher costs per beneficiary.** Chronic illnesses are by definition more expensive to treat because they require more sophisticated treatments but also require more treatments in a series rather than a one-off action. This translates directly to higher cost-to-beneficiary ratios. Donors need to be well educated on this issue and be persuaded to accept it.
- **Case management.** Whereas primary illnesses require only short-term treatments to bring the patient back to health, chronic illnesses require long-term management. Service providers must, at least temporarily while the patient is a refugee without a durable solution, take on the role of case manager. This need not be in a professional medical sense, but social workers must accompany the patient through the illness, liaising with doctors, when necessary.
- **High involvement of local service providers.** Whereas aid agencies are accustomed to providing less sophisticated interventions by themselves, chronic illnesses require more sophisticated treatments. In urbanized settings, existing services providers are better placed to offer those services than are the aid agencies themselves. For the effectiveness of programming, it is better to refer patients rather than try to offer the services by the aid agency itself. This has many side benefits as have been noted above.

- **Better training for front-line employees.** Most NGOs employ social workers or other similarly-trained employees to register refugees and refer them to services. These front-line employees often perform triage or referrals for health care requests by the refugees themselves even though they are not trained to make these decisions. NGOs must provide guidelines for which symptoms could be potentially life-threatening and thus enable front-line employees to make more accurate assessments.
- **Surveillance.** Either within the service-providing NGO or within a coordinating body such as UNHCR, there must be an accurate database that tracks treatments to monitor trends and enable policies to be informed by accurate, real-time data. In cases in chronic illnesses, surveillance should be used more for policy decisions rather than disease spread.
- **Sensitivity to conflict and tension.** In many urbanized, yet still poor countries, the influx of refugees can place pressures on the social fabric. On the one hand, in countries where ethnic or group tensions already run high, the presence of refugees can exacerbate existing tensions or be co-opted by groups needing more members (i.e., Lebanese Shia wanting to co-opt Iraqi refugee Shia). Similarly, the influx of refugees, even with their meager resources, can cause inflation in local economies. For example, rents can increase in certain neighborhoods. Thus, programming must take care to not contribute to those tensions. For example, the use of existing services can provide opportunities for refugees and host country nationals to interact. It also can reduce marginalization whereby refugees are quarantined into services at a certain location and thus creating stigma and differences.
- **Sensitivity to culture.** In Middle East culture, the roles of women, family, and the home are quite ingrained. In order to serve this population, careful respect to culture must be incorporated into the entire methodology of the project, including the staffing.

CHALLENGES

Despite overcoming the challenges associated with treating chronic illnesses of refugee populations in an urban and highly complex social context, aid agencies face one large challenge: the issue of cost. Currently, a normal average for refugee health care is about $10-$25 per beneficiary, whereas care for chronically ill refugees in a Middle East context can range from $50-$600 per beneficiary. Donors are not accustomed to these high ratios, and it is also unsustainable to offer this high an amount to a large group of refugees for an extended period. As chronic illnesses require sustained treatments, projects to address their need will demand high costs over the long-term.

Although service-provider discounts can reduce the overall costs by up to 20%, still much work is needed to find sustainable solutions for health care for chronically ill refugees. Aid agencies must find innovative ways to do so, combining donor interest with the private sector and government bodies from both the sending and host countries.

Through his affiliation with Catholic Relief Services, Mr. Varady supports the Caritas Lebanon Migrant Center on programming and strategic matters. The Caritas Lebanon Migrant Center serves migrants and refugees with legal, medical, social, and humanitarian assistance. It likewise provides training and technical support to other partners throughout the Middle East.

Mrs. Najla Chahda is the Director of the Caritas Lebanon Migrant Center. Under her thirteen years of leadership, the Center has grown into the pre-eminent service provider to migrants and refugees in the Middle East. The Center is supported by multilateral and bilateral donors as well as several European Catholic organizations. The Center maintains a collaborative and unprecedented relationship with the Lebanese Governmental authorities responsible for migrants and refugees.

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Lack of Sanitation = Lack of Education: Creating "Girl-Friendly" Schools in Sub-Saharan Africa

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According to the British government's Department for International Development, "Investing in basic education for girls and women has a positive impact on wider society by boosting family incomes, reducing fertility rates, and contributing to better health and nutrition. Having more girls in school leads to greater economic growth and less poverty.[1] Studies reveal that women who have received even a few years of basic education typically have smaller, healthier families and are more likely to send their own children to school.[2] In spite of these findings, the United Nations Children's Fund (UNICEF) estimates that enrollment of primary school-aged girls is 8% lower than among boys of the same age. Additionally, of the girls who enroll in school, 9% more girls than boys drop out before the end of the sixth grade. There are numerous reasons to explain why adolescent girls drop out of school at a higher rate than boys in much of the developing world, particularly in sub-Saharan Africa. Sometimes girls leave school because their families need them to help with chores or work outside the home for extra income. Other times, girls' education stops when they are determined to be ready for marriage.[3]

UNICEF's studies highlight an often overlooked factor behind the tendency of girls to drop out of school during adolescence. This factor is the onset of menstruation coupled with a lack of sanitary facilities at school. UNICEF estimates that "one in 10 school-age African girls either skips school during menstruation or drops out entirely because of the lack of sanitation."[4] BBC News approximates that "an average girl loses more than a full month of classes in a school year."[5] A *New York Times* article includes statements from two sixth grade girls in Ethiopia who both said that they sometimes avoided school during their periods and stressed that missing classes "really bothered them."[6] In addition to schoolgirls, it has been found that their female teachers oftentimes do not come to teach during their periods.[7]

More than half of students in many sub-Saharan African countries, such as Kenya and Uganda, live on less than a dollar a day. It is not possible for the families of these female students to buy pads or tampons because such products are too expensive. Often in rural areas, pads and tampons are simply not sold. Women and girls who cannot afford sanitary supplies "resort to diverse methods, ranging from old pieces of cloth or used blankets to tissue paper or just remaining indoors to contain the menstrual flow."[8] Schoolgirls who use rags to absorb the blood flow worry

[1] "Millennium Development Goals" from the Department for International Development.
[2] "Women and Water Issue Sheet."
[3] LaFraniere, Sharon. "Another School Barrier for African Girls: No Toilet." *The New York Times*, 23 December 2005.
[4] "The State of the World's Children 2004- Girls, Education and Development." UNICEF, December 2003.
[5] Mawathe, Anne. "Period Misery for Kenya Schoolgirls." BBC News, 17 March 2006.
[6] LaFraniere, op. cit.
[7] Ibid.
[8] Mawathe, op. cit.

about bad odors and leakage because they often do not have access to water to wash themselves and the rags they use.[9] For these girls, not only is being in school during their periods uncomfortable and embarrassing, but it is also a potential hazard to their health as the lack of hygiene can lead to urinary tract and vaginal infections.

Since it is clear that educating girls is necessary for both poverty reduction and social development in sub-Saharan Africa, a more effective and comprehensive approach to encourage African girls to stay in the classroom is needed. Schools must be made more "girl friendly." While non-governmental organizations (NGOs) such as WaterAid and Water 1st International as well as foundations like Ryan's Well focus on bringing water and sanitation facilities to developing countries, they do not have a particular emphasis on improving sanitation in schools. Western corporations donate sanitary supplies to African girls, but questions of the long-term sustainability of these donations have yet to be addressed. Moreover, programs have not been implemented to discuss basic issues of menstruation, health, and hygiene since these topics are seen as taboo in many sub-Saharan African societies.

The purpose of this paper is to outline the necessary components of "girl friendly" schools in order to improve girls' health and educational prospects. There are four components of the "girl friendly" approach to education: the first is the building of private and hygienic toilets at schools; the second entails supplying clean water for washing; the third involves providing sanitary pads and tampons to schoolgirls at little to no cost; and the fourth concerns educating students and teachers about puberty and hygiene so as to improve girls' health, promote dialogue, and dispel menstrual taboos.

The construction of separate and sanitary toilet facilities is the first step towards a more "girl friendly" educational program. These facilities need not be fancy- a simple pit latrine or squat toilet will suffice. It is necessary, however, for toilets to have a door in order for girls to have a private place to change their sanitary supplies. Moreover, toilets for girls must be separated from boys' toilets. UNICEF recommends that girls be included in determining the location of the toilets in order to make sure that the facilities will be used.[10] Additionally, a water supply is essential for good hygiene so that girls can clean themselves and wash their hands. With water, the girls who use rags and other reusable methods of protection can wash out their sanitary supplies.

FemCare, the unit of the Western manufacturer Procter & Gamble that produces sanitary products like Always pads and Tampax tampons, began in March 2007 to donate these items to schoolgirls in sub-Saharan Africa through a campaign entitled "Protecting Futures."[11] This unique campaign combines distributing free pads with building bathrooms and educating teachers in hopes of creating an environment more conducive to girls' learning. However, while Procter & Gamble appears to have the best of intentions in its campaign, it is not clear whether or not its donations will continue indefinitely. If there are no more donated imported pads and tampons, how will African girls procure sanitary supplies? In Kenya, tariffs on imported sanitary supplies have been reduced so that they are supposedly more affordable, but they are still not cheap enough to be

[9] Kayiggwa, Paulus. "Adolescents Missing School During Menstruation Call for Sanitary Pads." *The New Times* (Kigali), 11 October 2007.
[10] "The State of the World's Children 2004- Girls, Education and Development." UNICEF, December 2003.
[11] Deutsch, Claudia H. "A Not-So-Simple Plan to Keep African Girls in School." *The New York Times*, 12 November 2007.

accessible to the general population.[12] Regional manufacturers have provided a possible solution. A Ugandan organization, Maka Pads, was developed in 2004 by Dr. Moses Kizza Musaazi, who wanted to decrease the cost of sanitary pads for his female students.[13] Maka Pads uses locally sourced materials like elephant grass, papyrus, maize leaves, and paper to make cheaper pads.[14] In fact, Maka Pads are one-half to one-third of the cost of imported sanitary products, like Always and Tampax.[15]

The disposal of pads and tampons presents an additional challenge to the "girl friendly" schools campaign. Cooke (2006) maintains that "menstrual materials must be compatible with sanitation facilities."[16] The disposal of imported pads in pit latrines would cause them to fill up quickly, leading to unsanitary conditions. Moreover, Protecting Futures has come across cultural issues in pad disposal. Deutsch (2007) writes, "In some parts of Africa, people believe that one's blood can be used to cast a spell, so girls would fear leaving bloodied pads exposed."[17] To overcome this cultural taboo, Deutsch suggests that Procter & Gamble should provide small, sealed incinerators near bathrooms and instruct teachers in their use.[18] While there is no data available at present about the disposal of Maka Pads, the use and discarding of these supposedly biodegradable pads will present an interesting case for the future.

The final component of "girl friendly" schools is an educational campaign to address the "unmentionable" topics of menstruation, health, and hygiene. Cooke (2006) asserts: "The taboo nature of menstruation in society means girls have not articulated their needs and the problems of poor menstrual hygiene have been ignored or misunderstood."[19] In Uganda, for example, Cooke found that girls had not been prepared, either by their parents or by their teachers, for puberty.[20] A newspaper article from Kigali, Rwanda, states, "Many girls in Rwanda are still unaware even of the existence of menstruation until they have their first period."[21] Faith Macharia, of the Forum for African Women Educationalists, insists that "Discussions about sexual maturation are just not commonplace in African society."[22] Because puberty is not talked about, Macharia explains, "the girls wind up thinking that menstruation is associated with doing something wrong."[23] Moreover, many cultures in sub-Saharan Africa have myths associated with menstruation, such as the belief that menstruating women are "unclean."[24] In parts of Ethiopia, for example, girls are not allowed to cook during their periods, and some are even sent away to the countryside.[25] These myths discourage any discussion of menstruation and reinforce upon schoolgirls the idea that the topic is off-limits.

Educational campaigns hope to overcome the taboo nature of menstruation through fostering an open dialogue between schoolgirls, female teachers, and female health workers. Schools are an

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[12] Mawathe, op. cit.
[13] MakaPads, http://www.theworldchallenge.co.uk/hygiene.php (last accessed 11/11/2007).
[14] http://www.questafrica.org/musaazi/ (last accessed 3/14/2008).
[15] Ibid.
[16] Cooke, Jeanette. "Practical Interventions to Meet the Menstrual Hygiene Needs of Schoolgirls; A Case Study from Katakwi, Uganda." Diss. Cranfield University, Silsoe, August 2006: 46.
[17] Mawathe, op. cit.
[18] Ibid.
[19] Cooke, op. cit, 12.
[20] Ibid., 16.
[21] Kayiggwa, op. cit.
[22] Deutsch, op. cit.
[23] Ibid.
[24] "Menstruation Taboos" from http://www.yale.edu/hraf/reproductive_health.htm (last accessed 3/1/2008).
[25] LaFraniere, op. cit.

important venue in open discussions because they bring schoolgirls together as a group, thereby providing an inclusive forum where the girls can feel less shy about asking questions on menstruation, hygiene, and health.[26] The hope is that through this dialogue, schoolgirls will feel empowered and will discuss issues of hygiene at home with their parents and siblings. Cooke also emphasized the need to educate boys about the effects of puberty on their bodies and to sensitize them to the changes affecting girls.

In addition to discussions about menstruation, Mercy Musomi, executive director of the Girl Child Network, a Kenyan NGO providing free pads to schoolgirls, stressed the importance of instructing schoolgirls in the use of imported sanitary products, as many of the girls had not seen a pad before.[27] Musomi explained that in one Rift Valley community in Kenya, "some girls folded them [pads] and inserted them like tampons." Girls must also be taught how to dispose of used sanitary products in ways that are appropriate for the sanitation system in place.[28] Along with demonstrations on how to use and dispose of sanitary products, schoolgirls also need to be educated about how often to change pad and tampons, as they need to be changed regularly to prevent urinary tract and vaginal infections as well as more serious disorders like Toxic Shock Syndrome.

By addressing a not-often-discussed element of why girls drop out of or do not attend school in sub-Saharan Africa, the "girl friendly" approach to education can make a difference in the lives of young women across the continent. Girls' attendance in school, as well as their overall health, will increase in the short term, and there will be many additional positive long-term effects on sub-Saharan African society. It has been stated that "lack of education means fewer women in developing countries are decision makers."[29] The incorporation of "girl friendly" schools in sub-Saharan Africa might allow more girls to continue their education, enabling their voices as women to be heard.

Claire is an MS candidate in Global Affairs, concentrating in international law and human rights. A Chicago native, Claire completed her undergraduate work at the University of Chicago and also studied at the Université de Paris X, Nanterre. While a student in the Global Affairs program, Claire interned for the Coalition for the International Criminal Court in the Africa Outreach Department; at the Global Justice Center, where she researched international and domestic implications for women's rights treaties; and the International Center for Transitional Justice, where her project focused on the relationship between conflict, natural resources and the environment. Claire expects to receive her MS this May and will be attending New York Law School in autumn 2008.

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[26] Mawathe, op. cit.
[27] Ibid.
[28] Cooke, op. cit., 46.
[29] "Women and Water Issue Sheet"

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No Honor in Killing: Interview with Rana Husseini

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"A woman is like an olive tree.
When its branch catches woodworm, it has to be chopped off
So that the society remains clean and pure."
The words of an Islamic tribal leader

It is a consummate and compelling love story that takes place in the conservative societal arena of modern-day Amman, Jordan. The couple's secret, albeit, chaperoned meetings, admissions of love amid hand holding and two kisses, when discovered, bring – as per cultural traditions - dishonor to the young woman's entire family. The only prescribed way to remove this stain is to kill her. Her father and brother comply by stabbing her repeatedly in the family home, allowing her to bleed out before an ambulance is called.

Published in 2003, the time was ripe for the telling and selling of such a tale. The war in Iraq was on and all eyes were suddenly turned to the Middle East - especially Western eyes - hungry for such an inner glimpse into the 'realities' of the region. However, an 18-month investigation revealed that what originally sold as a personal memoir - Norma Khouri's *New York Times* best-selling "Honor Lost" recounting her childhood friend's murder at the hands of the girl's father - was absolute fiction. Born in Jordan, at age 3 Khouri moved to Chicago with her family, married and birthed two children, and in 1999 fled for Australia with the FBI reportedly at her heels regarding a series of possible criminal property transactions.

Contrasting Khouri's fiction is the large body of investigative work on the issues surrounding honor killings by Jordan Times news reporter and human rights activist, Rana Husseini, over the last 15 years. Ironically, a parting note in Khouri's book heralded Husseini as an important force who helped shed light on Jordan's honor killings and reprinted – without her permission – Husseini's email address. Receiving emails from concerned people worldwide, Husseini read Khouri's book and immediately flagged numerous inaccuracies and falsehoods. Taking her findings to the Jordanian National Committee for Women's (JNCW), Husseini was asked to spearhead a page-by-page investigation that eventually uncovered dozens of serious errors with Khouri's book. These revelations came to light after Khouri's book sold over 200,000 copies in Australia alone and was translated into 17 languages by major publishers such as Random House (in Australia) and Simon & Schuster (in the US).

The JNCW sent the results of the investigation to Khouri's publishers in the US and Australia. According to the Sydney Morning Herald, Random House Australia replied: "Following our discussions with Norma we are satisfied that, while some names and places have been changed to protect individuals' identities ... {Khouri's book] is a true and honest account of her experiences." Husseini's own fact-based book (*Murder in the Name of Honor*, to be released later this year),

submitted to the same publishers *before* Khouri completed her fictional memoir, was flatly rejected.

In *Murder*, Husseini tells of returning to Jordan from the US in 1993, where she had received both her undergraduate and graduate degrees, landing a job at the English-language daily newspaper, going on to break taboo and report on the instances and circumstances of honor killings, and eventually becoming an inspiring force behind both the Jordanian and International movements to bring attention to, and eliminate such killings.

Her very first article about an honor killing appeared on Oct. 6, 1994 under the headline that today titles her book, "Murder in the Name of Honour." In it, Husseini wrote about the story of a young 16 year-old murdered by her 36 year-old brother. She had been raped and impregnated by a younger brother, then forced to marry a man who divorced her 6 months later and sent her home. Greeted by her brother, he tied her to a chair in the family kitchen where he repeatedly stabbed her according to a cultural tradition that says blood must be shed in order to cleanse the family name.

Investigating the murder, Husseini interviewed the girl's uncles – the actual plotters of her murder – who claimed the that the girl had seduced her brother. When questioned as to why the girl would have done such a thing, the uncles attacked Husseini's western attire, her college education in America, and accused her of clouding the issue with her Western beliefs. That didn't stop Husseini. Disturbed by the honor killings, their exceptionally violent nature, their underlying stories, and incensed to learn that the killers were consistently given lenient sentences, if any at all, and the fact that women who survived honor-related attacks were put in Jordan's Women's Correctional and Rehabilitation Center - a prison - for their protection, she turned her focus to Jordan's judicial system.

In Jordan, a country of approximately six million people with a relatively low murder rate to begin with, one-third of all homicides are perpetrated on females in order to cleanse a family's honor. According to the United Nations, 5000 women -13 per day - are killed for this reason yearly worldwide.

Over the last 15 years, with the support of her editors at the Jordan Times, Husseini has continued to break the self-imposed censorship of Jordan's media regarding honor crimes, reporting on each one she uncovered and later writing follow-up articles alerting readers to the leniency of the courts toward the killers. Husseini was the only reporter in Jordan to cover honor crimes before the story reached the international stage, and since has won several national and international awards including the 1995 MEDNEWS prize award for best article "Murder in the name of honor," the Reebok Human Rights Award in 1998, the Human Right's Watch Award in 2000 for being part of the National Jordanian Committee to Eliminate so-called Crimes of Honour, The Ida B. Wells award in 2003 for Bravery in Journalism (*WomensENews*), *Marie Claire's* Magazine Top Ten Woman of the World Award in 2004, and the Spanish Ciutat de L'Hospitalet Award for the Defense of Human Rights and Peaceful Coexistence in 2005.

Perhaps more importantly, stories that had been previously reported simply as 'murders' are now appropriately defined and reported on as 'honor killings.'

Lorna Tychostup: **Due to your reporting, you have become one of the most reliable sources of information on honor crimes in Jordan, and have helped to bring international attention to the debate on honor killings and how Jordanian law supports the killers. What made you decide to write the book?**

Rana Husseini: I am working to produce something accurate, objective, and comprehensive. In the book I talk about the problem in Jordan, about the problem worldwide, about the roots of these crimes, the social factors behind them, about the issue from all its aspects – religious, social, legal. I am hoping it will be the most comprehensive reference book on the topic, putting the problem into perspective with recommendations as to what can be done both locally and internationally to minimize the cause of the problem.

LT: Can you define honor killings?

RH: A so-called honor crime occurs when the family of a female decides to kill the female relative because, in their point of view, she has tarnished her family's reputation or honor. The tarnishing can be represented by many actions. One is that the female becomes pregnant out of wedlock, she is a victim of rumor, incest, rape, or she wants to marry a man of her own choice. Sometimes she is killed for financial reasons. The woman has assets and the family member or members want her to give it up or get it as inheritance. Sometimes she is killed just for talking to a strange man, or being caught in a brothel, or engaging in a relationship. Many times she is found to be a virgin.

LT: One of the first stories you covered was that of an honor killing. This event seems to have directed your life ever since.

RH: Exactly. That story was very horrifying to me because the girl was only 16 years old. At that time I had no idea about these crimes or thought that I would be covering these crimes. I wanted to work for women, but I never thought I'd be working on honor crimes. The story was really shocking. A 16-year old school girl was killed by one of her brothers after another brother had raped her. A victim maybe 6 times, she was raped, her [rapist] brother tried to kill her, she survived, then they married her off to a man 35 years her senior, she had a secret abortion and then her family killed her. Look how many times she was a victim and she was only 16. An intellectual Jordanian woman who worked in a high position and had studied abroad called the newspaper screaming that they should stop me from reporting on these crimes because I was tarnishing the image of Jordan. I became even more enraged. I went to talk to the girl's uncles and they blamed the girl for the rape. I felt that society blames the woman for everything. I wanted to be 'her' voice because at that time nobody was reporting about these crimes. When there were reports, they were so very small you could barely find them in the newspapers.

LT: It was taboo to write about these killings in the 1990s. How did you get permission to write about them?

RH: *The Jordan Times* was different. Published in English, their readership is not as large [as other newspapers] but at the same time we are much more liberal in terms of what we write. We have more liberty. All the editors-in-chief at the paper have always been pro human rights and want to promote anything that could be considered a violation of human rights in Jordan. I have had 5 editors-in-chief since I began working at *The Jordan Times* more than 15 years ago in 1993, and they have all been supportive. None of them have ever tried to stop me from reporting or tried to change my interests. On the contrary.

LT: Have there been threats made to you?

RH: I have received many emails sent to me from people living abroad, Arab men living specifically in the US. There are a lot of people in Jordan who are very supportive and there are people who are against me. They want to keep the issue under the covers, they want to keep women under control, they think what I am doing tarnishes the image and reputation of Jordan. We have our culture and traditions and these people live in the past.

LT: You began writing about honor killings in 1994 and almost immediately brought attention to the issue, not just in Jordan but internationally – long before Norma Khouri's book came out. A movement began to come together in Jordan to address honor crimes.

RH: Yes, it was called "The Jordanian National Committee to Eliminate the So-called Crimes of Honour." Changing the laws in Jordan was one of many issues we addressed. We understood that changing the law alone was not going to help. We had to work on changing people's attitudes, improving services for abused women, finding solutions for women whose lives are under threat - not just to put them in prison. The law is very important but it is not the only solution. Religious figures should openly speak against these crimes, the education system needs to be worked on, and the media needs to work to portray the women in Jordan in a much more balanced manner. We were working to bring awareness, traveling from one governorate to the other talking about the issue, we held lectures, distributed flyers and going to talk to people in person. It was a very important and interesting experience, for us, and the movement. We also broke another taboo. People in the past were scared to sign any petitions. We managed to get 15,400 signatures on a petition that demanded that Article 340 of the Jordanian Penal Code, "*which reduces penalties and exempts those who kill or injure in the name of honour,"* be immediately cancelled.

However, it was not enough. But we were able to raise awareness, the media covered us extensively both in Jordan and abroad, people started to understand more what is a honor crime, that innocent women were in prison, and what the laws are. So it has become a very known topic now among people who did not know it existed before. Attitudes are changing. I did a public lecture last year. Several men stood up at the end of the lecture and told me, "We know that killing our sister is wrong, but sometimes we are forced. How can we avoid doing this?" In the past, when I would give a lecture, men would raise their hands and say, "I would kill my sister, so what." But now the average person is becoming more aware about this issue. Things are moving. Of course they will not change overnight.

LT: Especially since honor killing is so embedded in tradition.

RH: Exactly.

LT: In the parliamentary debate regarding changing the laws, critics say, "We don't want any Western interference. These are Western ideals interfering in Jordanian law and our traditions." But isn't the tradition of this law itself Western?

RH: Yes. It was a Western law that was imposed. Legislators took it from the Ottoman and Napoleonic Code. This Article 340 exists in almost all the penal codes all over the world. One part of the law addresses adultery. When a man walks in and finds his wife with another man and kills her – a wife in the rest of the world but not in Jordan where *any* female relative is subject to being killed – it is called temporary insanity. My argument with the Jordanian women's movement is that female lawyers are still insisting Article 340 be abolished even though it is rarely used. But another law, Article 98 is very elastic and could be attached to all the cases I

mentioned earlier allowing killers to walk free. A man can say, "I had an argument with my sister because she dated a man, so I killed her." He can claim he killed her in a "fit of fury" as allowed under Article 98. Article 340 is very specific – if a man walks in and finds his wife with another man – which is almost impossible to actually happen.

LT: Ferris Nesheiwat has written that, "Jordanian society has demonstrated wilful ignorance of the true principles that govern crime and punishment under Islamic law. If true principles of Islamic law were followed, not a single woman would lose her life because of fornication and no woman would be extra-judicially killed."

RH: That's my point! Article 340 is very specific and is never used. Article 98 is what needs to be addressed. Also, these crimes happen in Christian societies in this part of the world as well. So it is not exclusively an Islamic crime.

LT: **There is also the issue of the time frame. If the husband walks in and sees his wife with another man and kills her, this can be claimed to be a moment of insanity. But in the cases in Jordan, the family actually comes together and plots to kill the female family member. It is a premeditated murder.**

RH: Exactly.

LT: You have written about how the fabric of family life is being destroyed.

RH: Yes. I believe killing is not the solution. Many families will suffer the consequences even if they don't think they will or are. One mother told me her son is so depressed he won't talk to anyone after killing his sister. He is always alone. The killers are victims as well. I don't think anyone really wants to kill their sister or beloved, or mother. I think many of the killers are victims of the wrongful cultures and belief. There is nothing in our culture that says to kill. The problem is people are hypnotized. When you try to discuss this issue people say, "This is my culture, my tradition." But when you look into culture and tradition, it doesn't say you have to kill.

LT: In the places where the law has been changed to keep the stricter punishments in place, for example the northern Iraq Kurdistan governorates, honor killings are not as prevalent anymore, but suicides among females have risen. In Kurdistan, many women are suddenly suspiciously dying from their bathroom heaters igniting and burning them to death. This adds to your argument that you can't just address the laws.

RH: Listen, I want to tell you something. All over the world, there are laws. People break these laws. You have executions. You have death penalties. But people still commit crimes. Here in Jordan, if you change the laws, if you make them harsh, it will minimize the problem. But it is not going to end it. People will always find other ways. For me, as an activist and as a journalist who has devoted all my professional life to this topic, the reason I want to change the laws is because I want to reserve the dignity of the lives of women in Jordan. A woman's life should not be worth 3 or 6 months in jail. You can write a bad check a get a much longer sentence than if you kill a woman.

LT: What is the average sentence a killer – a male member of a family who kills a female member of his family - gets for this so-called honor killing?

RH: Honor killers still get three- orsix-month prison sentences, but judges are tending to give them longer sentences averaging between three months and 10 years, but ten years for an honor crime in not usual. The court may decide that the man has lied and give him the death sentence, but in 99.9999 percent of the cases the family drops the charges so the court immediately drops the sentence to 10 years.

LT: There is the question of females who escape death at the hands of their families but remain under threat of death. Are there any shelters for these women?

RH: There is only one shelter. It opened recently and is run by the government for women who have suffered domestic violence. It does not help women who are being hunted by their families who want to kill them. The shelter has helped some women under threat of death but mostly women who have been abused are sheltered. The shelter is a story on its own. It took them forever to open it. The government first planned to open it in 1997 and its name was finally changed from a shelter to the Family Reconciliation Centre. It can house between 35 to 50 women and 36 children.

Women whose families want to kill them are put in prison by the government for their own safety and are not allowed to leave. They must be released into the custody of a male relative who must pay money as a guarantee he will not allow her to be killed. But this is only on paper. They can be legally bailed out but in the majority of the cases it is because the family wants to kill them. In reality, even if they pay it doesn't matter. A lot of times, the father will write a guarantee he is not going to harm his daughter and then somebody else kills her. I write about this because they are kept in prison when it should be the other way around.

LT: How long do these women stay in prison?

RH: I have seen women who have been there for over fifteen years. This is unfair. The majority of them have been in prison since they were teenagers. They have wasted their lives, their youth in prison. Some of them say they are already dead. Some think that if they leave they will start a new life that their family has forgiven them. But of course, this is not the case. There have been between 20 and 40 women in the prison at one time. Half of them have been there long-term.

LT: There is no international organization working to help get these women out of the country?

RH: One thing about this point. I think if this would be just a temporary solution it could be considered. There were cases of women who were helped by NGOs and were gotten abroad. But for me this is only a temporary solution. We need to solve this problem internally. If Jordan sends women abroad it means it is avoiding the problem. It's not okay for a woman to travel safely outside but to die inside her own country.

LT: I agree. But given the choice of spending 15 years in a prison cell, and I assuming they are among real criminals, or getting an international organization to put together a system that gets these women out and into college abroad, get educated and eventually go back when it is safe for them to do so. And perhaps even be able to fight with others to change this system themselves. It is such a waste of life – that the victim should be imprisoned.

RH: Exactly. That is something I have also been fighting for and advocating against. I try to highlight the lives of these women because for a long time, *people did not know these women even existed.*

LT: There is a recent case in Israel where seven women from the same Arab family were killed because of co-called honor crimes. The girl's mother and sister testified against the son/brother.

RH: This is a precedent. It is very rare to have something like this happen.

LT: Do you think your work had something to do with giving women such courage?

RH: The media attention and the work I think it really paid off. I have been very consistent with how I report on these crimes, reporting on each case I hear about, each court verdict. I've written about the women who are put in prison for their own safety. I've been doing the same work for 15 years. As far as the women's movement, the problem all over the world is that the work is seasonal. At one point there is excitement and they want to address honor crimes. Then other issues come up and they decide to talk about something else. The priorities here shifted, unfortunately, for many people since 2000, when the second Intifada started. Our group stopped working on honor crimes, got more involved in politics and what was going on in Palestine. Then there was 9/11, and after 9/11 the war on Iraq. But overall, I think the work has produced a lot of awareness.

LT: Is there any movement today in Jordan - besides your work - to address honor killings?

RH: There are 3 groups on Facebook. They called for a march but it did not happen. I might start an NGO after the book comes out because there are a lot of young Jordanian people who send me emails and are excited to do something, but they don't know where to go or what to do. For a long time I did not want to open an NGO because I thought I was more effective with the way I was reporting, the activism and the lecturing. But I think I will have to open an NGO because there are so many people who want to do something and there is no one uniting them. I don't know what to do either but the only way to begin to deal with this is to open an NGO that specializes in dealing in this issue.

LT: Beat reporters usually don't get paid very much. What makes you keep doing this work?

RH: Listen, in addition to all the rewards I have received from doing this work, I know I have saved people's lives. I know that for sure. Knowing this helps me to sleep at night. All my work, my activism, my lecturing has saved someone's life and this means the world to me.

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Can International Law Effectively Address Sexual Violence against Women in Armed Conflict?

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INTRODUCTION

In recent decades, there has been worldwide recognition of the rise in the calculated use of rape as a means of exclusion and destruction during armed conflict.[1] Given its pervasiveness, sexual violence against women has become an endemic global health problem. The nexus of war and sexual violence against women is often compounded by the simultaneous breakdown of health systems. This is particularly devastating given the critical demand for health services to stem the impact of sexually transmitted diseases, HIV/AIDS[2] and other physical ailments arising from sexual violence.

Sexual violence also shatters women's psychological health. Women who do not receive psychological support can be more profoundly affected by the emotional impact of sexual violence.[3] These psychological health problems have a ripple effect on the vitality of families, communities, and future generations who are seriously crippled by the magnitude of pain inflicted by sexual violence against women. Addressing the psychological and other health issues that arise from sexual violence against women during armed conflict requires a "multi-sectoral approach"[4] that significantly encompasses the legal system.

In parallel to the increased sexual violence against women and its corollary implications on health, international law has gone through an evolutionary process, forming treaties, conventions and other frameworks to address it. In what ways has the international legal order provided for the prevention of sexual violence during war and supported post-incident justice and reconciliation for victims? How has it fell short in addressing sexual violence against women during armed conflict, and why? The author seeks to address these questions via an analysis of existing international law, leading legal and theoretical perspectives and prominent decisions by the tribunals of the former Yugoslavia, Rwanda and other international cases. The author advances the argument that we must uncover any problematic structural factors inherent in the system of international laws used to prohibit sexual violence against women in armed conflict, in

[1] Her Majesty the Queen in Right of Canada. International Development Research Centre. The Responsibility to Protect: Report of the International Commission on Intervention and State Sovereignty. ON, Canada: 2001: 20. 22 Nov. 2007 <http://www.iciss.ca/pdf/Commission-Report.pdf>
[2] UNICEF. "Sexual Violence as a Weapon of War." The State of the World's Children 1996. 14 Apr. 08 <http://www.unicef.org/sowc96pk/sexviol.htm>
[3] Jeanne Ward and Mendy Marsh. UNFPA. Sexual Violence Against Women and Girls in War and Its Aftermath: Realities, Responses, and Required Resources. *Symposium on Sexual Violence in Conflict and Beyond*, Brussels
21-23 June 2006 : 10. 14 Apr. 08
<http://www.unfpa.org/emergencies/symposium06/docs/finalbrusselsbriefingpaper.pdf>
[4] Ibid, 17.

order to adequately address and eliminate it. Lastly, policy recommendations toward an epistemological and pragmatic praxis are proffered.

I. HISTORICAL CONTEXT: THE PROPAGATION OF SEXUAL VIOLENCE AGAINST WOMEN AS A STRATEGIC TOOL OF WAR

Violence against women,[5] particularly in the form of rape, has been used as a strategic, militaristic tool in armed conflicts throughout history. Rape during wartime was committed in mass scale in Ancient Greece,[6] in Constantinople by the crusaders,[7] in the US during the Civil War and throughout the Vietnam War.[8] Since World War II, ethnic conflicts and civil wars continued to rage and incidents of sexual violence against women have been propagated in staggering numbers by military, tribal and guerrilla fighters. Over 20,000 women were raped in the Balkans between 1992 and 1994, and a staggering 200,000 to 400,000 were sexually brutalized during the Rwandan genocide in 1994.[9]

Women are the primary targets of sexual violence during wartime,[10] and this has varying social, cultural and psycho-political derivations. Women are raped as a means of racial cleansing, sterilized to prevent propagating their own bloodline,[11] forcibly impregnated to destroy their ethnicity[12] and sexually exploited as payment for mercenaries.[13] As an extension of the historic view of females as property, soldiers have used women's bodies in a militarized, political metaphor – penetrating and conquering "enemy territory" with sexually violent acts.

Rape, like other forms of military invasion, has reverberating effects on the victim, her family, the community[14] and the nation. Women often suffer a double victimization in being outcast by their families, unable to marry or have children, or suffering mental and physical scarring. Children born of rape during armed conflict suffer too, in being physically and emotionally outcast from their communities and even legally marginalized by the literature that places them in the dichotomous category of either 'non-victim' or one aligned with the perpetrator.[15] All of this creates profound, long-lasting societal effects.

Historically, rape of women during armed conflict was conceptualized as an inevitable by-product of war, as opposed to a gross violation of international law.[16] Tragically, rather than an

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[5] Women and girls are both the victims of violence during armed conflict. This paper will focus on women.
[6] Michael L. Penn and Rahel Nardos, Overcoming Violence against Women and Girls (Maryland: Rowman & Littlefield, 2003) 52.
[7] Stephanie N. Sackellares, "From Bosnia to Sudan: Sexual Violence in Modern Armed Conflict." Wisconsin Women's Law Journal v. 20 no. 1 (Spring 2005) 137. Wilson Web, NYU.
[8] Penn and Nardos, 52.
[9] Sharon Frederick and The Aware Committee on Rape, Rape: Weapon of Terror. (Global: NJ, 2001) 3.
[10] "The Human Rights Watch Global Report on Women's Human Rights." New York: Human Rights Watch. 1995. 11 Oct. 2007 <http://www.hrw.org/about/projects/womrep/General-21.htm#P422_38354>
[11] Sackellares, 138.
[12] Kelly Dawn Askin, War Crimes Against Women: Prosecution in International War Crimes Tribunals. (The Hague, Kluwer Law International: 1997) 274
[13] "The Human Rights Watch Global Report."
[14] MADRE: Demanding Human Rights for Women and Families Around the World. "Demanding Justice: Rape and Reconciliation in Rwanda." MADRE Speaks Fall 1997. 14 Oct. 2007 <http://www.madre.org/articles/afr/rapereconciliation.html>
[15] R. Charli Carpenter, "Surfacing Children: Limitations of Genocidal Rape Discourse," Human Rights Quarterly. 22 (2000) 458. The Project Muse Collection. New York Univeristy, 22 Nov. 2007 <http://ezproxy.library.nyu.edu:2115/journals/human_rights_quarterly/v022/22.2carpenter.html>
[16] "The Human Rights Watch Global Report."

anomaly, violence against civilian women in armed conflict in modern times remained commonplace.[17] To address this grave phenomenon, international law has progressed, and several legal instruments have been created and refined.

II. INTERNATIONAL LAW RESPONDS: EVOLUTION AND APPLICABILITY TO SEXUAL VIOLENCE AGAINST WOMEN IN ARMED CONFLICT

Though rape has been outlawed for centuries, the earliest document of international humanitarian law (IHL) to address violence against women during armed conflict began with the 1907 Hague Convention.[18] Article 46 states that "family honours and rights" as well as "individual lives . . . must be respected."[19] Beginning with Hague, the idea of protecting women from sexual violence during wartime to preserve their honor and dignity—as opposed to a protection of fundamental, human rights—is one that would philosophically underpin many subsequent international legal documents. During this era, human rights law also advanced with Article 1 of the 1945 Charter establishing the purpose of the United Nations and Article 2 of the 1948 Declaration of Human Rights, which granted to all people the protection of human rights and fundamental freedoms without distinction to one's gender.[20]

In response to the horrors of World War II, the Genocide Convention was created to prohibit and punish perpetrators of genocide and defined it in Article 2(b) as "acts committed with intent to destroy, in whole or in part, a national, ethnical, racial or religious group, as such [c]ausing serious bodily or mental harm to members of the group."[21] This convention would later be invoked to criminalize sexual violence during armed conflict as an act of genocide.

During the post-War period, there was recognition of a need to create boundaries for, and further solidify, frameworks for the laws of war. Thus, the 1949 Geneva Conventions arose as the respected, authoritative legal documents used to govern IHL. The Convention became the first treaty to receive universal acceptance, strengthening its legal reach in protecting victims of armed conflict.[22] Article 27(2) of the Fourth Geneva Convention contains the most explicit prohibition of sexual violence against women during conflict, stating, "[w]omen shall be especially protected against any attack on their honour, in particular against rape, enforced prostitution, or any form of indecent assault."[23] Though the language of the treaty failed to provide protection in non-

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[17] Judith Gardam and Michelle J. Jarvis, Women, Armed Conflict and International Law. (The Hague, Kluwer Law International: 2001) 30.

[18] Thom Shanker. "Sexual Violence." Crimes of War: What the Public Should Know. Ed. Roy Gutman and David Rieff. (New York: Norton & Company, 1999) 323.

[19] Convention with Respect to the Laws and Customs of War on Land (Hague, II) 29 July 1899, entered into force September 4, 1900. Univ. of Minnesota Human Rights Library. 22 Nov. 2007 <http://www1.umn.edu/humanrts/instree/hague-convention-1899.html>

[20] Charter of the United Nations. June 26, 1945, 59 Stat. 1031, T.S. 993, 3 Bevans 1153, entered into force Oct. 24, 1945. Univ. of Minnesota Human Rights Library. 22 Nov. 2007, http://www1.umn.edu/humanrts/instree/aunchart.htm, and Universal Declaration of Human Rights. Adopted and proclaimed by General Assembly resolution 217 A (III) of 10 December 1948, 22 Nov. 2007, < http://www.un.org/Overview/rights.html>

[21] Office of the High Commissioner on Human Rights, Convention on the Prevention and Punishment of the Crime of Genocide, Approved and proposed for signature and ratification or accession by GA res. 260 A (III) of 9 December 1948, entry into force 12 January 1951, in accordance with article XIII, 25 Nov. 2007 <http://www.unhchr.ch/html/menu3/b/p_genoci.htm>

[22] "Geneva Conventions of 1949 achieve Universal Acceptance," ICRC, 21-08-2006, Press Release 6-96, 25 Nov. 2007, < http://www.icrc.org/web/eng/siteeng0.nsf/html/geneva-conventions-news-210806>

[23] Convention (IV) relative to the Protection of Civilian Persons in Time of War. International Humanitarian Law – Treaties and Documents. Geneva, 12 August 1949. 22 Nov. 2007,

international conflicts, it was significant in that it marked the first conventional mention of sexual violence against women.[24]

The historic International Covenant on Civil and Political Rights (ICCPR) was adopted in 1966 and mandates that states protect people from torture.[25] Subsequently, the work of the Commission on the Status of Women led to the 1974 General Assembly Declaration on the Protection of Women and Children in Emergency and Armed Conflict, which affirms that "[a]ll forms of repression and cruel and inhuman treatment of women and children, including . . . torture . . . committed . . . in the course of military operations . . . shall be considered criminal."[26] The fact that this declaration criminalized violence against women during war was significant; however, its non-binding character illustrates the lack of international commitment to prosecute perpetrators of violence against women.[27]

International humanitarian law progressed in 1977 with the adoption of Protocols I and II, which unequivocally prohibit sexual violence against women in both international and internal armed conflicts, respectively. Article 76 of Protocol I stipulates that "[w]omen shall be the object of special respect and shall be protected in particular against rape, forced prostitution and any other form of indecent assault."[28] Protocol II prohibits "outrages upon personal dignity, in particular humiliating and degrading treatment, rape, enforced prostitution and any form of indecent assault."[29] The universally accepted Geneva Convention stands as the authority in IHL, and the 1977 Protocols bolster it.

Momentum toward legal codification of prohibiting sexual violence against women in armed conflict continued to advance through the establishment of other applicable conventions, resolutions, and conferences throughout the 1980s (see Table 1).

<http://www.icrc.org/ihl.nsf/385ec082b509e76c41256739003e636d/6756482d86146898c125641e004aa3c5>

[24] Gardam and Jarvis, 64.

[25] Office of the High Commissioner for Human Rights, International Covenant on Civil and Political Rights. Adopted and opened for signature, ratification and accession by General Assembly resolution 2200A (XXI)
of 16 December 1966, entry into force 23 March 1976, in accordance with Article 49, 26 Nov. 2007 <http://www.ohchr.org/english/law/ccpr.htm>

[26] Office of the High Commissioner for Human Rights, "Declaration on the Protection of Women and Children
in Emergency and Armed Conflict," Proclaimed by General Assembly resolution 3318(XXIX) of 14 December 1974, 25, Nov. <http://www.unhchr.ch/html/menu3/b/24.htm>

[27] Askin, 250.

[28] Office of the High Commissioner for Human Rights, Protocol Additional to the Geneva Conventions of 12 August 1949, and relating to the Protection of Victims of International Armed Conflicts (Protocol 1) Adopted on 8 June 1977 by the Diplomatic Conference on the Reaffirmation and Development of International Humanitarian Law applicable in Armned Conflicts, entry into force 7 December 1979, in accordance with Article 95, 25 Nov. 2007 <http://www.unhchr.ch/html/menu3/b/93.htm>

[29] Protocol Additional to the Geneva Conventions of 12 August 1949, and relating to the Protection of Victims of Non-International Armed Conflicts (Protocol II), 8 June 1977. ICRC, International Humanitarian Law – Treaties and Documents. Art 4(2)(e). 25 Nov. 2007 <http://www.icrc.org/ihl.nsf/FULL/475?OpenDocument>

Table 1
Significant Milestones in the Progression of International Law for the Protection of Women during Armed Conflict[30]

Year	International Document or Event	Purpose or Achievement
1979	**Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), passed by UN GA**	Defined what constitutes discrimination against women and set standards and international recommendations for national action to combat discrimination against women. Described as an "international bill of rights for women."
1982	**Resolution 37/63 on the Participation of Women in Promoting International Peace and Cooperation**	Calls for greater participation and equality of women in national and international affairs to work towards securing peace and security.
1984	**Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment**	Prohibits torture by the state and later used to criminalize sexual violence against women. Article 1 defines torture as "pain or suffering, whether physical or mental, intentionally inflicted on a person for . . . any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity."
1985	**World Conference to Review and Appraise the Achievements of the UN Decade for Women: Equality, Development and Peace**	Known as the Nairobi Conference, acknowledged the prevalence of violence against women.

While the aforementioned frameworks did not directly take on the issue of sexual violence against women in armed conflict, they were instrumental as a whole in shaping world opinion, engaging numerous global state and non-state actors and fortifying the foundation for future law. In contrast, others argue that between the mid-1970s and 1980's, the topic of women and armed conflict virtually vanished as evidenced by its absence as a specific topic on the agenda.[31] Despite these contrasting views, there is consensus that the international legal regime finally began to tackle violence against women as a distinct entity in the 1990s.[32] Legal scholars were able to build on a foundation of evolving international law, traced throughout the twentieth century.

[30] Sources include Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, G.A. res. 39/46, [annex, 39 U.N. GAOR Supp. (No. 51) at 197, U.N. Doc. A/39/51 (1984)], entered into force June 26, 1987. Univ. of Minn, Human Rights Library 25 Nov. 2007, http://www1.umn.edu/humanrts/instree/h2catoc.htm; Division for the Advancement of Women, Overview of the Convention. 24 Nov. 2007 < http://www.un.org/womenwatch/daw/cedaw/>; "Timeline: Women and Peace," 25 Nov. 2007, http://www.globalhealth.harvard.edu/hcpds/books/woundsbook/WoW_51_57.pdf; and United Nations. Report of the World Conference to Review and Appraise the Achievements of the United Nations Decade for Women: Equality, Development, and Peace, Nairobi, 15-26 July 1985, New York, 1986, 24 Nov 2007 <http://www.un.org/womenwatch/confer/nfls/Nairobi1985report.txt>

[31] Gardam and Jarvis, 143.

[32] Karima Bennoune. "Do We Need New International Law to Protect Women in Armed Conflict?" Case Western Reserve Journal of International Law 38.2 (2006): 363-391. ABI/INFORM Global. ProQuest. New York University. 19 Nov. 2007 <http://www.proquest.com/>

III. SUCCESSES: INTERNATIONAL LAW APPLIED

In response to the devastating genocide in the Balkans in the early 1990s and in Rwanda in 1994, the Security Council established the International Criminal Tribunal for the former Yugoslavia (ICTY) and International Criminal Tribunal for Rwanda (ICTR)[33] to criminally prosecute perpetrators of war crimes. The tribunals allowed prosecution of military leaders for rapes committed by their subordinates, if they commanded, aided and/or encouraged the rapes.[34] Several monumental cases were tried and judgments made against rapists and inciters of sexual violence during conflict. In *Prosecutor v. Jean-Paul Akayesu*, the court found that sexual violence was a form of genocide since it was carried out with the purpose of destroying a group. In its remarkable decision, the court reasoned that:

> Indeed rape and sexual violence certainly constitute infliction of serious bodily and mental harm on the victims[.] . . . [R]elating to the law applicable to the crime of genocide. . . [rape is] even, one of the worst ways of inflicting harm on the victim as he or she suffers both bodily and mental harm. These rapes resulted in physical and psychological destruction of Tutsi women, their families and their communities. . . . Consequently, the Chamber finds the Accused individually criminally liable for the said acts . . . and for having through his presence tacitly abetted their commission.[35]

This sent reverberations throughout the international human rights and humanitarian law communities; as it was the first time a court ruled that sexual violence constituted genocide[36] under international law. It marked another step forward in legally institutionalizing the prohibition of violence against women during armed conflict.

Building on *Akayesu*, in another landmark case, *Prosecutor v. Delalic and Others,* known as *Celibici* under the ICTY, the court found that rape and sexual violence could legally qualify as torture.[37] The court's reliance on a sophisticated layering of international legal cases and instruments – several of which have recently come to fruition – is indicative of the development of international humanitarian, human rights and criminal law. The trial chamber referenced three crucial instruments as the basis of its decision: the finding in *Fernando and Raquel Mejia v. Peru*, wherein the Inter-American Commission on Human Rights ruled that the rape of Mejia was torture because it was an intentional act of violence, inflicted on purpose and by a representative of the state;[38] the ruling in *Aydin v. Turkey*, wherein the applicant was brutalized and raped at a police station, an act that the European Court found to be a breach of Article 3 of the European Convention prohibiting torture and defining it as "deliberate inhuman treatment causing very

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[33] Statute of the International Tribunal, adopted by S.C. Res. 827, U.N. SCOR, 48th Sess., 3217th mtg. at 6, U.N. Doc. S/RES/827 (1993), 32 I.L.M. 1203 (1993), Univ. of Minn., Human Rights Library, 24 Nov. 2007 http://www1.umn.edu/humanrts/icty/resolution28.html; Statute of the International Tribunal for Rwanda, adopted by S.C. Res. 955, U.N. SCOR, 49th Sess., 3453d mtg. at 3, U.N. Doc. S/RES/955 (1994), 33 I.L.M. 1598, 1600 (1994). Univ. of Minn., Human Rights Library 25 Nov. 2007 <http://www1.umn.edu/humanrts/instree/rwandatrib-statute1994.html>

[34] Alexandra Stiglmayer, "Sexual Violence: Systematic Rape," in Crimes of War. 327.

[35] United Nations. International Criminal Tribunal for Rwanda. Jean-Paul Akayesu, summary of the Judgement,
no: ICTR-96-4-T Delivered on 2 September 1998, 16 Oct. 2007,
<http://www.amnestyusa.org/events/western/pdf/AmnestyConference_BalthazarSitaCLE.pdf>

[36] Gardam and Jarvis, 192-193.

[37] *Prosecutor v. Delalic,* No. IT-96-21-T, United Nations ICTY. 16 November 1998, 26 Nov. 2007 <http://www.un.org/icty/celebici/trialc2/judgement/cel-tj981116e.pdf>

[38] Ibid, at para 481-483.

serious and cruel suffering";[39] and a report by the U.N. Special Rapporteur on Torture finding that rape and other sexual violence constitutes torture because of its inherent destruction of one's dignity and integrity.[40] The court also codified that torture is a violation of IHL as a grave breach of the Geneva Convention, discussed above. The rationale inspiring the decision in the *Celibici* case is a reflection of the evolving, multifaceted nature of international law. Today, rape as an act of torture is part of the modern understanding of international human rights law.[41]

The tribunal relied on regional and international decisions of law, reports by specialized Rapporteurs within the U.N. and even the work of CEDAW.[42] This illustrates the value and the necessity of comprehensive legal frameworks to address the overwhelming, global dilemma of how to effectively prohibit and punish the rampant acts of sexual violence against women in armed conflict. Undeniably, the jurisprudential development of the international tribunals has facilitated the ability to prosecute rape as "a war crime, crime against humanity and as an act of genocide."[43] It has also enabled hybrid and other international tribunals, composed of both global and local legal and judicial staff, to have authority to adjudicate similar crimes in East Timor, Sierra Leone, Kosovo and Cambodia.[44] Nonetheless, despite these victories for international women's human rights law, systemic challenges pervade.

IV. STRUCTURAL AND CAPACITY ISSUES

The 1990s saw more women physically violated than ever before.[45] While rapes in the Balkans and Rwanda combined were reported in the hundreds of thousands (to say nothing of sexual abuse during numerous other conflicts around the world) only a relatively small number of individuals were criminally prosecuted. The escalation of sexual violence against women, concurrent with an increase in the development of international law instruments to combat this violence seems puzzling and even illogical. The author suggests that the inability of the international legal regime to adequately address chronic sexual brutality against women during armed conflict points to systemic flaws in the legal composition of the international laws, the judicial structures used to provide punishment and redress, and the formation of legal authority.

The Rome Statute establishing the International Criminal Court (ICC), which came into force in 2002,[46] offers the most comprehensive, detailed definitions of sexual violence, its roots in discrimination, and its application towards criminalization.[47] However, women pursuing justice are inclined to rely on the Geneva Convention and not the ICC,[48] especially since over a third of member states are not signatories to it. Geneva law, which places an emphasis on the prohibition of acts of sexual violence against women on the basis of maintaining her "honor," adds

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[39] Ibid, at para 487-489.
[40] Ibid, at para 491-492.
[41] Amnesty International. Broken Bodies, Shattered Minds: Torture and Ill Treatment of Women. 8 Mar. 2001, 26 Nov. 2007, <http://web.amnesty.org/aidoc/ai.nsf/b8977c306ef6ff0380256ef400540ac5/39cb2f2a6c51b8d8802569ed0062a274/$FILE/ATTN5R1N/ACT400012001_intro.pdf>
[42] *Prosecutor v. Delalic,* at para 493.
[43] Bennoune, p. 385.
[44] Kelly Dawn Askin. "The Jurisprudence of International War Crimes Tribunals: Securing Gender Justice for Some Survivors." Listening to the Silences: Women and War. Ed. Helen Durham and Tracey Gurd, (Martinus Nijhoff: Leiden, The Netherlands: 2005) 126.
[45] Frederick 25.
[46] Jeffrey L Dunoff, Steven R. Ratner, and David Wippman, International Law: Norms, Actors, Process. 2nd Ed. (New York, Aspen: 2006) 661.
[47] Coomaraswamy, Radhika. "Sexual Violence during Wartime," in Durham and Gurd, 59.
[48] Bennoune 387.

legitimacy to the idea that if a woman is raped in this context, she is *dishonored*, perpetuating a belief rooted in the very discrimination that gives rise to the assault in the first place.[49] Further, Karen Engle argues that the promotion of the ICTY as the primary legal answer to the problem of the mass rape of women in Bosnia inadvertently devalued women.[50] It defined all Bosnian women as victims of the trauma of rape, stripping them of sexual and political agency, separating "the women from the body politic"[51] and overemphasizing criminal conviction of sexual violence on the international feminist agenda.[52] If the language of international humanitarian law is gender-discriminate, its effectiveness as a tool is weakened. If feminist scholars infantilize women who are raped as a means of "helping" them, all women are devalued in the process by reducing their self-resolve as human beings.

In terms of using international law to prohibit sexual violence against women, admittedly there has been progress, but more needs to be done. In fact, the problem of failing to allow women to possess individual, political agency in the face of sexual violence is mirrored in the construction of international law. On the one hand, sexual violence can now be prosecuted as a war crime, torture, and as genocide, thereby indirectly achieving the status of *jus cogens*,[53] which is a noteworthy development. On the other hand, rape is not categorized and criminalized as an act of violence in and of itself, but rather relies on its extension and connection to other crimes against humanity in order to be legitimately criminal in this context. We must be cognizant that this legal construction requiring a connection between rape and crimes against humanity for the purpose of criminalization can have an impact in viewing "every day rape"[54] (in the private sphere) as a less serious offence, and by extension, normalizing it. This normalization may inadvertently create a cyclical pattern which gives rise to an environment that breeds such destructive behavior against women.

Historically, sexual violence has been viewed by the law as a private, individual crime instead of one resulting from structural, institutionalized discrimination of women. Under the pretext of neutrality, such legal concepts – largely driven by male-dominated authority - marginalized women and prevented adequate legal solutions. Today, women remain the large majority of victims of violence during armed conflict and the reality is that attacks are often perpetrated by male soldiers and backed by the political authority of men.[55] A gender-based response to the health issues arising from this reality is critically needed. However, the failure to recognize violence against women as a major health and human rights matter remains central to the lack of financial and technical resources to address it.[56]

The terms of investigations, reporting rules, fact-finding missions, recommendations, and prosecutions has also been male dominated, sometimes with detrimental effect. In Rwanda, male investigators went from village to village to find out who was raped, lacking female translators and cultural sensitivity.[57] The fact that ad-hoc tribunals were set-up in response to the extreme, genocidal decimation of populations, while hopeful in terms of the progress made, is great cause

[49] Bennoune 384.
[50] Karen Engle. "Feminism and its (Dis)Contents: Criminalizing Wartime Rape in Bosnia and Herzegovina." The American Journal of International Law, Vol. 99 (4), 815. 2005. JSTOR. NYU. 14 Oct 2007.
[51] Ibid 815.
[52] Ibid.
[53] Askin 241-242.
[54] Engle, 783.
[55] Bennoune 382.
[56] Supra note 3, 26.
[57] MADRE: Demanding Human Rights.

for concern in terms of the lack of legal attention to numerous other conflicts around the world, including Sudan and the Congo.

Debate exists around whether we need to improve the mechanisms of international law, or whether the lack of commitment and implementation by states is the real issue. The International Committee of the Red Cross asserts that the tools available within the international humanitarian law regime to protect women from rape during armed conflict are sufficient and that the problem lies with appropriate legal implementation.[58] The author agrees that both the mechanisms and lack of implementation are problematic, and that we must improve these as well as other building blocks of international law.

V. LEGAL AND EPISTEMOLOGICAL PRAXIS: IDEAS FOR THE PRESENT AND FUTURE

International humanitarian, human rights and criminal law have progressed substantially in addressing sexual violence against women during armed conflict in the last 60 years. Several different factors have led to this, ranging from the increased capacity of non-governmental organizations (NGOs) to greater global attention toward the issues faced by women. In order to springboard from these achievements, a holistic approach is imperative. Below is a five-point plan to strengthen the capacity for international law to address sexual violence against women in armed conflict. In so doing, the foundation to prevent and treat the global health issues tied to sexual violence could be strengthened.

- **UN Reform.** Critics argue that the UN does not have adequate representation of women in leadership positions and that it does not provide sufficient political and financial support to the agencies dedicated to women's issues. As Stephen Lewis aptly captured, **"**The world's most important body has yet to recognize the world's most important struggle: the fight for women's rights."[59] As the principal international law-making body, it is imperative that decision-makers and legal minds are reflective of the world's population. One suggestion is for states to make a disciplined effort to ensure two of the four allowable Security Council advisors are women. Another is for the UN to launch a multi-tiered diversity strategy to engage more women in leadership roles. This would include targeted recruitment, mentor programs, training, development, and monitoring. If the roots of international law are not just and equitable, what realistic expectation is there for the laws it churns out to be so?
- **Amend and focus the primary IHL Instruments**. Recognizing the problem of not having a legally binding instrument that specifically focuses on violence against women in war, consideration for a fourth Geneva protocol or an additional treaty is warranted. In this vein, Karima Bennoune suggests creating a standardized, international definition of rape as a category on its own, instead of benchmarking it to other crimes.[60] At the least, enhancement of soft law instruments to influence IHL would be a progressive step. Even if the practical effects of IHL in diminishing sexual violence against women are minimal, the symbolic and transformative effects are powerful.[61]
- **Strengthen implementation, compliance and enforcement vis-a-vis the military**. The primary focus seems to be in prosecuting sex crimes *ex post facto*. Equally, there is frustration derived from states that either do not ratify applicable treaties or do not have the legislative or judicial capacity for appropriate enforcement. Perhaps the approach could be to strengthen training of all military forces on the illegality of violence against

[58] Bennoune, p. 364.
[59] Stephen Lewis, "The Problem: The Second Sex." Foreign Policy, (160), 40-41. 2007. 26 Nov. 2007, Proquest. ABI/INFORM Global database. (Document ID: 1276904671).
[60] Bennoune, 388.
[61] Gardam and Jarvis, 256.

women as a specialized topic. Though IHL and the Geneva principles are commonly taught to troops, this idea calls for a training module solely dedicated to the topic to complement it. The pervasiveness of rape during war justifies the costs of intense preventative training. This could also invert feminists' critique regarding Geneva Law: Rather than residing on IHL, which protects women from sexual violence based on preserving women's "honor," laws and training could more appropriately focus on the soldier or commander maintaining *his* honor, as a representative of the nation.

- **Augment international efforts to provide support, redress and reconciliation.** There is a serious deficit in processes and procedures to support victims of sexual violence in the post-War period.[62] Victims require medical, psychological and social support, and states must make an effort during the initial stages of conflict escalation to put these structures in place. Additionally, compensation should be given priority as both a step toward reconciliation and a "recogni [tion] that compensation, along with other forms of reparation, assists in creating a climate in which the risk of further violations of international law is diminished."[63]
- **Reinvigorate the partnership between international law and civil society.** Unlike the primary mechanisms of international law, NGOs are flexible, knowledgeable, and responsive. Conversely, they can lack authority and funding. Effective, coordinated partnership between the two sectors is vital in alleviating the schisms between sexually violent criminal acts, post-incident health care and support, education and training, justice, legal reform, redress and reconciliation.

National and international law is integral to facilitating changes in health systems, particularly with regard to sexual violence against women in armed conflict. The question begged is whether public awareness, training, lobbying, advocacy and grass roots organizing influences states to accept and incorporate international law, or if international law, in providing authoritative channels applies pressure on states to accept it. The answer may lie somewhere on the spectrum between these two extremes. As such, the practical path toward libratory praxis is to include all stakeholders (or as many as feasible) in each aspect of the five point plan above including UN professionals, scholars, judges, lawyers, military personnel, doctors and other health professionals, victims and even perpetrators. Only facing directly into the eyes of this mammoth challenge can we continue to make strides to heal the global health wounds and eliminate sexual violence against women in armed conflict.

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[62] Bennoune, 385.
[63] Gardam and Jarvis, 247.

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The Needy and the Greedy: Access to Medication and Patent Law in light of the Novartis Case

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On August 6, 2007, the Madras High Court in Chennai, India, delivered its landmark decision in the so-called Novartis case.[1] In its decision, the Court dismissed the legal challenge that a Swiss pharmaceutical company, Novartis AG, filed against section 3(d) of India's 2005 Amendment to its 1970 Patent Act ("2005 Amendment"). The section restricts the types of medical innovations that can be patented, deeming derivatives of a known substance that do not "differ significantly in properties with regard to efficacy" unpatentable. The court upheld the constitutionality of the section and deferred the question of whether it is incompatible with India's commitments under the Trade-Related Aspects of Intellectual Property Rights (TRIPS Agreement)[2] to the international body of the World Trade Organization (WTO).

With that decision, it brought to an end one of the more contested cases revolving around intellectual property rights under international law, on the one hand, and the question of patients' access to affordable medication in developing countries, on the other. While the particular controversy is not likely to die out anytime soon,[3] the ruling marks an important defining moment in this global debate.

This essay aims to shed some light on the Novartis case and to analyze it in view of international law standards. Part II provides the historical and legal background of the case and of India's 2005 Amendment. Part III examines the court's proceeding and the gist of its decision. Part IV explores the short- and long-term implications of the ruling on the accessibility of affordable drugs in developing countries, particularly in light of the TRIPS Agreement and subsequent relevant international regulations. The final part draws some conclusions.

[1] Novartis AG v. Union of India – W.P. No. 24759 of 2006 [2007] INTNHC 2604 (6 August 2007), available at, http://judis.nic.in/chennai/qrydisp.asp?tfnm=11121 (March 22, 2008) (hereinafter: the "Novartis case").
[2] Trade-Related Aspects of Intellectual Property Rights, April 15, 1994, Marrakesh Agreement Establishing the World Trade Organization, Annex 1C, Legal Instruments – Results of the Uruguay Round Vol. 31, 33 I.L.M. 81 (1994).
[3] The patentability of the Glivec drug, which is at the center of the case, is currently under the review of the Intellectual Property Appellate Board (IPAB) in India. There have been some delays in the proceedings due to disagreement about who would be the members of the appeals board. India Glivec patent: case update, available at, http://www.novartis.com/newsroom/india-glivec-patent-case/index.shtml (March 20, 2008)

I. THE NOVARTIS CASE: BACKGROUND

For years, India has been considered the "pharmacy of the developing world."[4] Defying ongoing U.S. pressure, it refrained from legislating patent laws on medicine.[5] At the same time, India is well positioned within the international drugs industry. Unlike most developing countries, it has the capacity to manufacture quality essential medicine on its own.[6] Thus, it has been able to produce cheap generic versions of drugs that were patented in other countries, such as antiretroviral (ARV) medicines to treat HIV/AIDS, and to sell them for much less than their original price to other developing countries. Indeed, India's drugs account for more than 50% of the medicine used for patients in 87 developing countries where UNICEF, the International Dispensary Association, the Global Fund and the Clinton Foundation work,[7] and for more than 80% of AIDS patients who participate in Medecins Sans Frontieres' (MSF's) projects.[8]

The situation changed, however, in 1995, when India joined the WTO. As a member of the organization, India was required to comply with its standards, including the TRIPS Agreement. That also meant that it had to regulate the ownership of medical innovations and drugs, which, according to the Agreement, would have to go into effect on January 1, 2005, at the latest.[9] Thus, between 1995 and 2005, India adopted a few amendments to its 1970 Patent Act, in order to bring its national law in line with its international obligations.[10]

The controversy erupted with the 2005 Amendment to the 1970 Patent Act. This Amendment includes, among other things, a few "safeguards,"[11] such as allowing India's generic corporations

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[4] Drahos, P., "Four Lessons for Developing Countries from the Trade Negotiations over Access to Medicine," Liverpool L. Rev. 28 (2007): 11-39, at 20.

[5] MSF News, "On Patents in India and the Novartis Case," available at http://www.doctorswithoutborders.org/news/access/novartis_qa.htm (March 20, 2008)

[6] Abbott, F. M., "The WTO Medicines Decision: World Pharmaceutical Trade and the Protection of Public Health," Am. J. Int'l L. 99 (2005): 317- 358, at 320; MSF News, "On Patents in India and the Novartis Case," available at http://www.doctorswithoutborders.org/news/access/novartis_qa.htm (March 20, 2008)

[7] Kanaga, R., India: Former Swiss President joins chorus against Novartis' patent challenge, South-North Development Monitor (SUNS) February, 15, 2007, available at http://www.twnside.org.sg/title2/health.info/twninfohealth077.htm (March 20, 2008); Oxfam's response to the statement by Novartis, Feb. 17, 2007, available at http://www.maketradefair.com/en/index.php?file=a2m_novartis_12022007.htm (March 20, 2008)

[8] Medecins Sans Frontieres (MSF), "On Patients in India and the Novartis Case," available at, http://www.doctorswithoutborders.org/news/access/novartis_qa.htm

[9] The TRIPS Agreement allowed for a "transitional period," by which developing states that had not previously patented pharmaceutical products could defer the application of the Agreement until January, 2005, if so they chose (Articles 65(4), 70(8) and 70(9)). India used this period to its maximum (Abbott, F. M., "The WTO Medicines Decision: World Pharmaceutical Trade and the Protection of Public Health," Am. J. Int'l L. 99 (2005): 317- 358, at 320, fn 24.) Paragraph 7 of the Doha Declaration on the TRIPS Agreement and Public Health extended the transition period for "least developing countries" ("LDCs") for implementation of the TRIPS obligations relating to pharmaceutical products to January 1, 2016. See, the Doha Declaration on the TRIPS Agreement and Public Health, WTO Doc. WT/ MIN(01)/DEC/2, available at http://www.worldtradelaw.net/doha/tripshealth.pdf

[10] Colin, J., "Coming Into Compliance with TRIPs: A Discussion of India's New Patent Laws," 25 Cardozo Arts & Ent LJ 25 (2007): 877-912, at 883

[11] The Patents (Amendment) Act, 2005, No. 15 of 2005, New Delhi, the 5th April, 2005/Chaitra 15,1927 (Saka), available at, http://www.patentoffice.nic.in/ipr/patent/patent_2005.pdf For further discussion on

that were active before 2005 to continue manufacturing a drug, even if the application of the pharmaceutical company is later approved as patents. In the spirit of the Doha Declaration on the TRIPS Agreement and Public Health of 2001,[12] the amendment grants a broad permission for the compulsory licensing of drugs, and allows for the export of drugs produced in India to the "least developed countries" that do not have manufacturing capacity on their own.[13] The 2005 Amendment also permits any person the option of opposing an application of a patent prior to the grant of the patent.

The most controversial provision in the 2005 Amendment has been Section 3(d), which was also at the center of the Novartis case. The section reads:[14]

> The mere discovery of a new form of a known substance which does not result in the *enhancement of the known efficacy* of that substance or the mere discovery of

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these safeguards see, Press Information Bureau, Government of India, "Fact Sheet: Important Changes Incorporated in the Patents (Amendments) Bill, 2005, as Compared to the Patents (Amendments) Bill, 2003 (March 23, 2005)," available at http://commerce.nic.in/Mar05_release.htm#h33.

[12] See in particular paragraph 5 of the Declaration. The Doha Declaration was adopted by the WTO members at the WTO Ministerial Conference in Doha on Nov. 14, 2001. The conference was convened following the growing concerns about the impact patent rules might have on the access of populations in developing countries to affordable medicines in the effort to control diseases of public health importance, including HIV, tuberculosis and malaria. The Doha Declaration thus aimed to respond to these concerns stating that "the TRIPS Agreement does not and should not prevent Members from taking measures to protect public health". The Declaration also reaffirms the rights of WTO members to make full use of the safeguard provisions of the TRIPS Agreement, such as compulsory license, parallel export, and others, in order to protect public health and enhance access to medicines for poor countries. Each member state was granted the discretion to determine what constitutes a national emergency and the circumstances of public urgency. The Doha Declaration on the TRIPS Agreement and Public Health, WTO Doc. WT/ MIN(01)/DEC/2, available at http://www.worldtradelaw.net/doha/tripshealth.pdf For more information on the Doha Declaration see, e.g., Abbott, F. M., "The WTO Medicines Decision: World Pharmaceutical Trade and the Protection of Public Health," Am. J. Int'l L. 99 (2005): 317- 358, at 327-349; Correa, C. M., "TRIPS and Access to Drugs: Toward A Solution for Developing Countries Without Manufacturing Capacity?," Emory Int'l L. Rev. 17 (2003): 389-403; Attaran, A., "Assessing and Answering paragraph 6 of the Doha Declaration on the TRIPS Agreement and Public Health: the Case for Greater Flexibility and Non-Justiciability Solution," Emory Int'l L. Rev. 17 (2003): 743-780.

[13] Article 31 of TRIPS allows for compulsory license of drugs (albeit not using these words). This safeguard allows a government, under certain conditions, to manufacture a product without the permission of the patent holder. The flexibility of compulsory license has been a focal point in the debate on access to medicine, particularly as Article 31(f) of the Agreement requires that products made under compulsory license are "predominantly for the supply of the domestic market of the Member authorizing such use." This limitation meant that the least developing countries, which do not generally have the ability to manufacture drugs, could not make actual use is this key flexibility of Article 31. On August 20, 2003, the WTO General Council adopted a decision, providing the least developed countries an interim waiver of this limitation if certain conditions are met. On December 6, 2005, the General Council decided to make this waiver a permanent solution, and submitted a Protocol amending the TRIPS Agreement to the approval of the member states. The Protocol will enter into force once two-thirds of the member states accept it, and so far, 11 states as well as the EU, have done so. See WTO, Implementation of paragraph 6 of the Doha Declaration on the TRIPS Agreement and public health, WT/L/540 and Corr.1 (2003), available at http://www.wto.org/english/tratop_e/trips_e/implem_para6_e.htm, Protocol amending the TRIPS Agreement, available at http://www.wto.org/english/tratop_e/trips_e/wtl641_e.htm; states who accepted the Protocol, available at http://www.wto.org/english/tratop_e/trips_e/amendment_e.htm

[14] The Patents (Amendment) Act, 2005, No. 15 of 2005, New Delhi, the 5th April, 2005/Chaitra 15,1927 (Saka), available at, http://www.patentoffice.nic.in/ipr/patent/patent_2005.pdf

> any new property or new use for a known substance or of the mere use of a known process, machine or apparatus unless such known process results in a new product or employs at least one new reactant.
>
> Explanation - For the purposes of this clause, salts, esters, ethers, polymorphs, metabolites, pure form, particle size isomers, mixtures of isomers, complexes, combinations and other derivatives of known substance shall be considered to be the same substance, unless they *differ significantly in properties with regard to efficacy.*" (emphasis added)

II. THE NOVARTIS CASE

The challenge to Section 3(d) of the 2005 Amendment of India's 1970 Patent Act was brought to court in India in that same year, after Novartis's application for patenting its life-saving cancer drug Glivec (or Gleevec) in India was rejected.[15] Although the drug is patented in nearly 40 countries,[16] the Indian Patent Office found it to be only a minor change from a substance that had already been patented by the company in 1993, the molecule of imatinib,[17] hence unpatentable under section 3(d) of the Amendment.[18] The company subsequently brought the suit to court, requesting that it order the Patent Controller to approve the patent application that the company filed for its drug Glivec, and challenging the legality of section 3(d) on two grounds.[19] First, it argued that section 3(d) was not in compliance with Article 27 of the TRIPS Agreement. The reason being that subject to paragraphs 2 and 3, Article 27 mandated the patentability of all inventions, including "inventive steps," whereas section 3(d) of the 2005 Amendment limited the patent rights only to such inventions that result in the "enhancement of the known efficacy." The right to have an invention guaranteed under Article 27 of the TRIPS Agreement was thus undermined, Novartis argued, hence India was in violation of its commitment under international law.[20] Second, Novartis claimed that the criteria of "enhancement of the

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[15] In accordance with the 2005 Amendment, a group of patients with cancer and generic drug manufacturers opposed Novartis patent application for Glivec on the grounds that the product is a new form of an old drug – and succeeded. see, Mueller, J. M., "Taking TRIPS to India - Novartis, Patent Law, and Access to Medicines," The New England Journal of Medicine 356 (6) (2007): 541-543, at 542; Gopakumar, K M, "The Novartis Case," available at http://www.centad.org/focus_49.asp (March 20, 2008).

[16] Glivec Patent Case in India: FACT vs. FICTION, pg. 1, Available at, http://www.novartis.com/downloads/about-novartis/facts-vs-fiction-india-glivec-patent-case.pdf

[17] Glivec Patent Case in India: FACT vs. FICTION, pg. 1, Available at, http://www.novartis.com/downloads/about-novartis/facts-vs-fiction-india-glivec-patent-case.pdf

[18] There is no "global patent" license, and pharmaceutical corporations have to apply separately to each individual country in which its wants to establish its patent monopoly. Lawyers representing such corporations usually recommend their clients to submit patent applications to as many countries as possible, taking into account considerations such as cost, scope of patent protection given in the particular country, enforcement of patent regulations and others. The decision whether the patent is granted depends on the local Patent Office and the national regulations. Pavento, Lisa C. et al. "International Patent Protection for HIV-Related Therapies: Patent Attorneys' Perspective." Emory International Law Review 17 (2003): 919-931, at 919, 923-924.

[19] Novartis argues that Glivec is an entirely new drug. It argues that while the company received patent rights in 1993 for synthesizing the molecule of imatinib, it could not be administered to patients. Glivec, by contrast, is the result of a couple of other developments that were "built" on this first patent, hence should be regarded as a new innovation. See, Glivec Patent Case in India: FACT vs. FICTION, pg. 1.

[20] The Novartis case, paragraph 3.

known efficacy" stipulated in section 3(d) was vague and arbitrary. As the 2005 Amendment did not provide any clear guideline for the Patent Controller to follow, section 3(d) opened the door for uncontrolled decision-making of the Patent Controller, "based on his whims and fancies."[21] It thus violated Article 14 of the Indian Constitution, which guarantees everyone's "right to equality before the law or the equal protection of the laws within the territory of India."[22]

Whereas the first factual-based request was later deleted from the suit, and so the court did not have to decide on the merit,[23] the High Court of Madras delivered its opinion about the legal claims. With regard to the international challenge, the court stated that it lacked the necessary jurisdiction to test the validity of the 2005 Amendment in light of the TRIPS Agreement.[24] It also refrained from using its discretion under the Constitution to issue declaratory relief that section 3(d) of the 2005 Amendment was incompatible with Article 27 of the TRIPS Agreement.[25] Analogizing and analyzing international treaties as contracts, the court found that the member states to the TRIPs Agreement agreed on a binding and comprehensive body for dispute settlement that is provided under the Agreement itself and which follows its rules of procedures under the WTO.[26] The court thus concluded that it should respect the member states' choice of jurisdiction fixed under the TRIPS Agreement, and that the appropriate forum for Novartis's claim about the incompatibility of section 3(d) with India's commitment under international law was the WTO.[27]

With respect to the constitutional challenge, the court rejected Novartis's argument on three grounds. First, it ruled that it was reasonable for the legislature to adopt a law that provided only the "general principles, broad objectives and fundamental issues," but not the technical or specific intricacies of each provision, without relegating it to the vague and arbitrary, as the company argued.[28] In the particular case, the court stated that section 3(d) of the 2005 Amendment with the Explanation following it prescribed a "test to decide whether the discovery is an innovation or not," and that the burden of proof—essentially a scientific one—was on the patent applicant.[29] "Being a pharmacological giant in the whole world," the court pointed out with regard to Novartis, "[the company] cannot plead that they do not know what is meant by enhancement of a

[21] The Novartis case, paragraphs 1-2.
[22] The Constitution of India, available at http://lawmin.nic.in/legislative/Art1-242%20(1-88).doc
[23] The Novartis case, paragraphs 1. The factual question whether Glivec is a new innovation or a mere minor modification of a known substance is currently still under the consideration of the Indian Intellectual Property Appellate Board (IPAB). India Glivec patent: case update, available at, http://www.novartis.com/newsroom/india-glivec-patent-case/index.shtml (March 20, 2008).
[24] The Novartis case, paragraph 6-7.
[25] The Novartis case, paragraph 7-9.
[26] Part V of the TRIPS Agreement deals with dispute settlement. Article 64 of the TRIPS Agreement refers disagreement to the Dispute Settlement Body and its procedures under the Dispute Settlement Understanding (World Trade Organization, Understanding on Rules and Procedures Governing the Settlement of Disputes, at http://www.worldtradelaw.net/uragreements/dsu.pdf (March 20, 2008)).
[27] Court decision, paragraph 8. Note, that the TRIPS Agreement does not provide private right of action and allows only member states (rather than multinational corporations) to bring a suit to the Dispute Settlement Body of the WTO (DSB). Disputes regarding the interpretation of the Agreement must be brought by WTO member states to this (DSB). However, the Court does not seem to view that as an impediment, as member states can adopt such claims. As it points out: "we see no reason at all as to why the petitioner, which itself is a part of that member state, should not be directed to have the dispute resolved under the dispute settlement mechanism (under the TRIPs)."
[28] The Novartis case, paragraph 14.
[29] The Novartis case, paragraph 13.

known efficacy and [that] they cannot show that the derivatives [of known substance] differ significantly in properties with regard to efficacy."[30]

Second, the court ruled that the interpretation of a law needs to be made not only from its plain language, but also from the social considerations behind it.[31] Referring to Articles 1 and 7 of the TRIPS Agreement, the court remarked that the Agreement itself "provides enough elbow room" for member countries, while fulfilling their commitments under the Agreement, to adopt legislation that was "conducive to social and economic welfare and to a balance of rights and obligations."[32] In the particular context of section 3(d) of the 2005 Amendment, the court pointed out that India was a welfare state and had a constitutional duty to provide its citizens with good health care, including by providing easy access to life saving drugs.[33] It is also clear from the parliamentary debates prior to the adoption of the 2005 Amendment that this concern was in the mind of the parliamentarians.[34] Thus, the Amendment should be viewed as an economic law, in which the judiciary should practice self restraint and allow large latitude for the legislature.[35]

Finally, the court observed that in order to invalidate a law on the basis that it impinged on Article 14 of the Constitution, the plaintiff had to show that, (1) the law was enacted without legislative competence, and (2) that it violated a fundamental right guaranteed under the Constitution. [36] In the context of the 2005 Amendment, however, the court found that neither of the conditions was met. The argument that the Amendment was vague and arbitrary was refuted (see above), and the possibility that the Patent Controller would misuse its powers did not itself merit invalidating the law. [37] Furthermore, the Amendment was not shown to be discriminatory, nor did it violate any fundamental right to carry on the trade, which the company might continue to do.[38] The Court thus upheld the Constitutionality of section 3(d) of the 2005 Amendment to the 1970 Patent Act and dismissed the petition.

VI. DISCUSSION

From Novartis's point of view, the immediate result of the court's decision was that it needed to prove to the Intellectual Property Appellate Body (IPAB) that its drug Glivec was not merely a minor change of its previously patented substance, the molecule of imatinib, but that it was indeed a new substance, or that it "differ[ed] significantly in properties with regard to efficacy" from it. Otherwise, the company would lose its Exclusive Marketing Rights over Glivec,[39] and once its ownership on the patent synthesizing the molecule of imatinib expired,[40] the manufacturing of these drugs would be open to the public.

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[30] The Novartis case, paragraph 13.
[31] The Novartis case, paragraph 14, adopting a ruling of a Court of Appeal in the UK.
[32] The Novartis case, paragraph 15, referring to Articles 1 and 7 of the TRIPs Agreement.
[33] The Novartis case, paragraph 19.
[34] The Novartis case, paragraph 15.
[35] The Novartis case, paragraph 17.
[36] The Novartis case, paragraph 16.
[37] The Novartis case, paragraphs 17-18.
[38] The Novartis case, paragraphs 16.
[39] The availability of Exclusive Marketing Rights (EMR) is part of the arrangements made under the TRIPS Agreement. According to Article 70(9) of the Agreement, if a patent application is filed in a member state during the "transition period," the applicant should be granted EMR if the product received patent rights and marketing approval in another member state. The EMR is for a period of five years after obtaining marketing approval in that Member or until a product patent is granted or rejected in that Member, whichever period is shorter. Glivec was the first pharmaceutical product in India to receive Exclusive Marketing Rights (EMR) during the transition period, in November 2003. Glivec Patent Case in India: FACT vs. FICTION, pg. 1, Available at, http://www.novartis.com/downloads/about-novartis/facts-

The implications of the decision go far beyond Novartis and its drug Glivec, however. First, the court's decision was an important official stamp on a national law that, in light of social and economic rationales, interpreted that limited "patentability" under the TRIPS Agreement was acceptable. It is particularly so considering that the court based its analysis also on the built-in flexibility that is enshrined in the TRIPS Agreement.[41] While Article 27(1) of the TRIPS Agreement requires that patentable inventions and products showing "inventive steps" would be protected, it does not provide a definition of what "inventive steps" actually mean. Article 7 of the TRIPS Agreement on the other hand stipulates that the objectives of the Agreement to protect and enforce intellectual property rights "[should be] in a manner conducive to social and economic welfare, and to a balance of rights and obligations." The decision how to implement the patentability requirement in a manner that is socially and economically responsible, however, was left in the hands of each state. Thus, although the court did not make an explicit determination about the compatibility of section 3(d) with Article 27 of the TRIPS Agreement, and although it is true that the final say about India's compliance with its obligations under the TRIPS Agreement is in the hands of the WTO, for the time being, [42] the court's decision reaffirmed the power and responsibility of each member state to implement the TRIPS Agreement in a way that takes into account its citizens' needs.

From an activist's perspective, the court's decision also sent important symbolic and practical messages. Although previous challenges to national patent laws of developing countries occurred, for example, in the context of Brazil and South Africa, they were dropped following a significant international outcry and before the relevant courts delivered a decision.[43] In fact, when the Novartis case was filed, the company was confronted with no less national and international pressure to withdraw the suit. Ministers from India, Germany and Norway, Archibishop Desmond Tutu, members of the European Parliament and the U.S. Congress, as well as former Swiss President Ruth Dreifuss and others, called on Novartis to withdraw the litigation.[44] Non-governmental organizations (NGOs) such as MSF, Oxfam and CARE, submitted their concerns, and hundreds of advocates from local groups protested Novartis's challenge to the Patent Act.[45] MSF also launched an international petition, which was signed by nearly half a million people

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vs-fiction-india-glivec-patent-case.pdf See also, Gopakumar, K M, "The Novartis Case," available at http://www.centad.org/focus_49.asp (March 20, 2008).

[40] Under the TRIPS Agreement, patent rights are granted for a period of twenty years. If a patent application was filed during the "transition period," the term of the patent would commence on the date of the filing. Abbott, F. M., "The WTO Medicines Decision: World Pharmaceutical Trade and the Protection of Public Health," American Journal of International Law 99 (2005): 317- 358, at 320, fn 24.

[41] See above.

[42] So far, the Swiss government did not submit the issue to the Dispute Settlement Body. Swiss govt won't take Novartis case to WTO, Rediff India Abroad, Business, August 8, 2007, available at http://www.rediff.com///money/2007/aug/08swiss.htm (March 20, 2008)

[43] Bagley, M. A., "Legal Movements in Intellectual Property: TRIPs, Unilateral Action, Bilateral Agreements, and HIV/ AIDS," Emory International Law Review 17 (2003): 781-798, at 784-5.

[44] Press Release, MSF, "Indian court ruling in Novartis case protects India as the 'Pharmacy of the Developing World,'" August 6, 2007, available at http://www.doctorswithoutborders.org/pr/release.cfm?id=2096.

[45] HIV/AIDS Advocates Protest Novartis' Case Challenge India Patent Law, Medical News Today, available at http://www.medicalnewstoday.com/articles/61932.php

worldwide, to drop the case.[46] The pharmaceutical company refused, however, and committed to fight its case all the way through.[47] The fact that the Indian court ultimately rejected the company's arguments is thus significant. It gives the impression that the court is tuned to the social and economic environment in which it functions, a key factor also for its own legitimacy, and that it would not give in to the rising power of multinational corporations that seem to prioritize intellectual property rights over the access of poor people to life-saving drugs.[48]

Moreover, the ruling sent a clear message that the "ever-greening" phenomenon, by which pharmaceutical companies make mere trivial and insignificant modifications to an existing patented drug in order to extend its patent monopoly,[49] is not, and should not, be tolerated. While granting patent rights is important to stimulate further research and development and to enable pharmaceutical companies to recover the associated costs, the prices charged for patented drugs also means that millions of people die each year due to the lack of access to medication.[50] Thus, the "balancing act" in the case of patent applications for drugs that are not new or that do not provide a clear therapeutic benefit over other existing drugs[51] should shift towards the patients in need. Considering the number of patent applications for drugs that are currently under the review of the Patent Controller in India (which stands at about 7,000), and the fact that research has shown that only a small fraction of such applications (less than 4%) are truly innovative,[52] the effect of this message is huge.

In this sense, the court's ruling may have already had a practical impact. According to the *Economic Times*, following the Novartis ruling, GlaxoSmithKline, a pharmaceutical company registered in England, withdrew its patent applications for its antiretroviral drugs Abacavir and Trizivir in India. The stated reason was the company's fear that rejection would have a negative impact on its ability to be granted patent rights on these drugs in other developing countries as

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[46] Press Release, MSF, "Indian court ruling in Novartis case protects India as the 'Pharmacy of the Developing World,'" August 6, 2007, available at http://www.doctorswithoutborders.org/pr/release.cfm?id=2096.

[47] Novartis Media Releases, "Novartis concerned Indian court ruling will discourage investments in innovation needed to bring better medicines to patients," August 6, 2007, available at http://hugin.info/134323/R/1144199/217011.pdf

[48] HIV/AIDS Advocates Protest Novartis' Case Challenge India Patent Law, Medical News Today, available at http://www.medicalnewstoday.com/articles/61932.php

[49] Report of the Technical Expert Group on Patent Law Issues (December 2006), paragraph 5.10, available at http://www.naavi.org/cl_editorial_07/mashelkar_committee_report.pdf The Technical Expert Group was set up to examine the debates arising of the 2005 Amendment by the Government of India, Ministry of Commerce & Industry, Department of Industrial Policy & Promotion *vide* O. M. No. 12/14/2005-IPR-III dated April 5, 2005.

[50] Correa, C. M., "TRIPs and Access to Drugs: Toward A Solution for Developing Countries Without Manufacturing Capacity?," Emory Int'l L. Rev. 17 (2003): 389-403, at 390-391.

[51] According to a study conducted by the US FDA Center for Drug Evaluation and Research, only 22.5% of the drugs that were approved between the years of 1990 and 2004 presented a "significant improvement compared to marketed products in the treatment, diagnosis or prevention of a disease," and only 14.3% of them were classified as new molecular entities. That means that a great number of patents applications that are ultimately only due to the ever-greening phenomenon**.** Love J. and & Tim Hubbard, "The Big Idea: Prizes to Stimulate R&D for New Medicines," Chi.-Kent. L. Rev. 82 (2007): 1519-1554, at 1523.

[52] Oxfam's response to the statement by Novartis, December 12, 2007, available at, http://www.maketradefair.com/en/index.php?file=a2m_novartis_12022007.htm**.**

well.[53] In other words, once the novelty of a patent was challenged and refuted in one country, other countries would be more likely to be skeptical about the originality of the drug. As a result, not only would generic drugs be available in India, but the house of cards effect might prevent their patentability elsewhere.

To be sure, India's interest is not entirely altruistic, and it would be naïve to think so. India has a flourishing generic manufacturing industry that is estimated to bring billions of U.S. dollars to the country each year.[54] The lack of any patent regulations on pharmaceutical products for many years resulted in small incentives for foreign pharmaceutical companies to invest in original research and development in India, but in a significant boost to the Indian competitive generic pharmaceutical industry. As Jeffrey Colin points out, in order for the latter to join the pharmaceutical market, all they had to do was to design a new method or process to an existing drug that was developed and patented by foreign pharmaceutical companies.[55] Consequently, India's pharmaceutical industry is today the fourth-largest market in the world, employing close to half a million people, and still growing.[56]

Furthermore, it is questionable if the court's rhetoric can be genuinely translated into the actual provision of drugs to all in need, including for India's citizens alone. True, India's manufacturers can produce Glivec (and other drugs) at a much lower cost. According to MSF, the price of patented Glivec, for example, is $2,600 per patient per month, whereas India's generic versions of the drug are available for less than $200. Similarly, generic manufacturing of HIV/AIDS treatment reduced their price from $10,000 per patient per year in 2000 to $130 per patient per year by the beginning of 2007.[57] However, it is still a sum that is not affordable for many of the poor population in India and elsewhere,[58] and the Court's decision is not likely, nor does it have the power, to change that. After all, the generic drug industry in India is motivated by financial gain. Indeed, the reality is that also Glivec in India is provided to 99% of the patients who need it

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[53] Global Fund, "Drug Access - GlaxoSmithKline Withdraws Patent Applications for Antiretrovirals Abacavir, Trizivir in India," Summary News, December 10, 2007, available at http://www.theglobalfund.org/programs/news_summary.aspx?newsid=34&countryid=IDA&lang=en

[54] Colin, J., "Coming into Compliance with TRIPS: A Discussion of India's New Patent Laws," Cardozo Arts & Ent LJ 25 (2007): 877-912, at 883. Jeffery Colin points out that the pharmaceutical market growth in India "should push India's total spending on drugs to US$11 billion by 2007." According to the Centre for Trade and Development (Centad), an independent, not-for-profit organization, registered in India that carries out policy research and advocacy on trade and development relevant to South Asia, the revenue in India from Glivec alone in 2005 was $110 million. See Gopakumar, K M, "The Novartis Case," available at http://www.centad.org/focus_49.asp (March 20, 2008).

[55] Colin, J., "Coming into Compliance with TRIPS: A Discussion of India's New Patent Laws," Cardozo Arts & Ent LJ 25 (2007): 877-912, at 882.

[56] Lanjouw, J. O., "The Introduction of Pharmaceutical Product Patents in India: "Heartless Exploitation of the Poor and Suffering,"? NBER Working Paper No. 6366, at pg. 4, available at http://www.oiprc.ox.ac.uk/EJWP0799.pdf; Colin, J., "Coming into Compliance with TRIPS: A Discussion of India's New Patent Laws," Cardozo Arts & Ent LJ 25 (2007): 877-912, at 882-883.

[57] MSF News, "On Patents in India and the Novartis Case," available at http://www.doctorswithoutborders.org/news/access/novartis_qa.htm (March 20, 2008). Though see MSF on-going campaign for access to medication, protesting the costs of second-line therapies, at www.msf.org

[58] See Novartis statements, arguing that also the price of generic Glivec is still four to five times the average annual income in India. It also points out that with regard to treatment for HIV/ AIDS, e.g., while India is a major source for many developing states, only 7% of Indian patients who need antiretroviral therapy receive it. Glivec Patent Case in India: FACT vs. FICTION, pg. 2, Available at, http://www.novartis.com/downloads/about-novartis/facts-vs-fiction-india-glivec-patent-case.pdf

by Novartis itself, on a charitable basis and without charge, rather than by the state and its generic manufacturers.[59] Thus, while as a matter of public policy creating competition to reduce the prices of drugs may be preferable over reliance on the charitable donation of pharmaceutical companies,[60] it does not seem to provide a complete feasible solution for the urgent medical needs today. Further, its success in the long run cannot be guaranteed. After all, also today, 95% of the medicines that are on the World Health Organization's list of essential medicines are **not** patented anywhere in the world, and 99% are not patented in sub-Saharan Africa,[61] and still their availability in places where they are most needed is slim. Other factors, then, such as the state's infrastructure, the availability of appropriate investment, the needed technical knowledge, and perhaps mostly, the political will,[62] play a critical role in the actual availability of drugs to those who need them.

There is also a risk that the court's ruling will lead to a legal and scientific backlash. Ever since the TRIPS Agreement was adopted, both the U.S. and the European Union have pushed for "TRIPS-Plus Agreements," mainly with developing countries.[63] These Agreements raise the bar for national patent laws to higher levels than required under the TRIPS Agreement.[64] They may, for example, extend the patent terms beyond the 20 years granted under the TRIPS Agreement; limit the discretion of national governments to define what constitutes a new innovation and what is patentable, or curb the state's power to use the built-in flexibilities in the TRIPS Agreement, including the option of compulsory license and the parallel importation of generic drugs that were produced off-patent in another country.[65] Furthermore, TRIPS-Plus Agreements often tie the level of patent regulation to bilateral and regional free trade agreements (FTA), allowing trade sanctions against a state that defaults in its commitments under the TRIPS Agreement.[66] In some

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[59] Glivec Patent Case in India: FACT vs. FICTION, pg. 2, Available at, http://www.novartis.com/downloads/about-novartis/facts-vs-fiction-india-glivec-patent-case.pdf

[60] Bagley, M. A., "Legal Movements in Intellectual Property: TRIPs, Unilateral Action, Bilateral Agreements, and HIV/ AIDS," Emory Int'l L. Rev. 17 (2003): 781-798, at 789; Oxfam's response to the statement by Novartis, Feb. 17, 2007, available at http://www.maketradefair.com/en/index.php?file=a2m_novartis_12022007.htm (March 20, 2008)

[61] Colin, J., "Coming Into Compliance with TRIPs: A Discussion of India's New Patent Laws," 25 Cardozo Arts & Ent LJ 25 (2007): 877-912, at 901 (citing the Geneva-based International Federation of Pharmaceutical Manufacturers and Associations ("IFPMA")). See also Sell, S. K., "Trade Issues and HIV/ AIDS," Emory Int'l L. Rev. 17 (2003): 933-954, at 943-944 (discussing the negative impact of marker liberalization and privatization on developing countries and their public health.)

[62] Morgan, M. R., "Medicines for the Developing World: Promoting Access and Innovation in the Post-TRIPS Environment," Univ. Toronto Faculty L. Rev. 64 (2006): 45-111, at 67-70. See also Sell, S. K., Trade Issues and HIV/ AIDS," Emory Int'l L. Rev. 17 (2003): 933-954, at 944-949; Sell, S. K., "TRIPS-Plus Free Trade Agreements and Access to Medicine," Liverpool L. Rev. 28 (2007): 41-75, at 50-57 (discussing the increasing political power of pharmaceutical companies and its negative impact on public health decisions adopted by governments.)

[63] Ho, C. M., "Comment: VII. Access to Essential Medicines: A New World Order for Addressing Patent Rights and Public Health," Chi.-Kent. L. Rev. 82 (2007): 1469-1515, at 1496-1499; Bagley, M. A., "Legal Movements in Intellectual Property: TRIPS, Unilateral Action, Bilateral Agreements, and HIV/ AIDS," Emory Int'l L. Rev. 17 (2003): 781-798, at 791. See also Sell, S. K., "TRIPS-Plus Free Trade Agreements and Access to Medicine," Liverpool L. Rev. 28 (2007): 41-75.

[64] Lucyk, S., "Patents, Politics and Public Health: Access to Essential Medicines Under the TRIPS Agreement," Ottawa L. Rev. 38(2) (2006/7): 191-215, at 205.

[65] Ho, C. M., "Comment: VII. Access to Essential Medicines: A New World Order for Addressing Patent Rights and Public Health," Chi.-Kent. L. Rev. 82 (2007): 1469-1515, at 1495.

[66] Lucyk, S., "Patents, Politics and Public Health: Access to Essential Medicines Under the TRIPS Agreement," Ottawa L. Rev. 38(2) (2006/7): 191-215, at 205. Note that the connection between the protection of intellectual property rights and trade was made under the TRIPS Agreement, whereby trade

cases, developing states were also reluctant to take advantage of generic drugs that were produced by another developing state that defaulted, as they feared they would face similar trade reprisals.[67] Thus, the sanctioning of India's flexible patent law may lead developed states to include further restricting provisions in the TRIPS-Plus Agreements they conclude with other developing countries, while the extent to which developing countries other than India have the power to resist such agreements and to adopt flexible patent national laws is weaker than ever.[68]

Finally, the court's ruling may also be a setback for the scientific development of new drugs. The presumption under the TRIPS Agreement was that protection of intellectual property would lead to greater research and development of necessary drugs.[69] The idea has been that the relationship between intellectual property rights and future scientific development of drugs is circular: higher levels of protection of scientific innovations encourage pharmaceutical companies to carry out further research and development of drugs, which in return allows the state to earn substantial rents from the use of the patents.[70] The difficulties in securing patent rights under the 2005 Amendment, however, may risk the occurrence progress on a few accounts.

First, if India will not provide a sufficient level of patent protection *as determined by Western oriented states and pharmaceutical companies,* the incentive for foreign companies diminishes. Thus, not only will they lose interest in researching and developing new drugs in India for ailments such as cancer, respiratory diseases, etc., but also in particular, for more local diseases, the so-called "diseases of the poor"–malaria, tuberculosis and others—that is already low.[71] Furthermore, if India is perceived as continuing to cultivate primarily only its generic drugs industry, foreign pharmaceutical companies would be concerned about its actual capacity to develop new drugs and to carry out clinical trials even if they considered a partnership.[72]

In the long run, then, if the decision will be taken as mere support of the generic drugs industry, it may slow down India's pharmaceutical industry, first, from advancing its own local research and development capacity, and consequently, second, from becoming a truly independent drug manufacturing country. A focus on imitation of patented drugs inherently lessens the incentive to allocate substantial amounts of time and money for the development of new drugs,[73] and

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sanctions may be laid on a state that failed to comply with the requirements under the TRIPS Agreement following a binding process of dispute settlement. See World Trade Organization, Understanding on Rules and Procedures Governing the Settlement of Disputes, at http://www.worldtradelaw.net/uragreements/dsu.pdf (March 20, 2008).

[67] Bagley, M. A., "Legal Movements in Intellectual Property: TRIPS, Unilateral Action, Bilateral Agreements, and HIV/ AIDS," Emory Int'l L. Rev. 17 (2003): 781-798, at 784, fn 14.

[68] Drahos, P., "Four Lessons for Developing Countries from the Trade Negotiations over Access to Medicine," Liverpool L. Rev. 28 (2007): 11-39, at 33-34.

[69] See, by contrast, Jerome H. Reichman, who challenges the accuracy of this presumption. Reichman, J. H., "Nurturing a Transnational System of Innovation," J. Transnat'l L. & Pol'y 16 (2007): 143-166.

[70] Abbott, F. M., "The WTO Medicines Decision: World Pharmaceutical Trade and the Protection of Public Health," Am. J. Int'l L. 99 (2005): 317- 358, at 324.

[71] Abbott, F. M., "The WTO Medicines Decision: World Pharmaceutical Trade and the Protection of Public Health," Am. J. Int'l L. 99 (2005): 317- 358, at 323, 325; Sell, S. K., "TRIPS-Plus Free Trade Agreements and Access to Medicine," Liverpool L. Rev. 28 (2007): 41-75, at 50-51.

[72] Colin, J., "Coming Into Compliance with TRIPS: A Discussion of India's New Patent Laws," 25 Cardozo Arts & Ent LJ 25 (2007): 877-912, at 893.

[73] There are different quotas for the exact sums of money that are needed to develop new drugs. Pharmaceutical companies claim that the costs associated with research and development of a new drug run between $500 and $800 million. Others contest these sums, also as the pharmaceutical companies do not always bear the entire cost, and in some cases, they may also enjoy taxation and other benefits while carrying out their research. In the context of Novartis, for example, the drug Glivec was considered an

increases dependency on other non-Indian pharmaceutical companies that would be, as pointed out, less interested in such collaboration.

Finally, some have also suggested that India's ability to produce and sell its generic drugs at low costs to other developing countries would also reduce the incentive for these other countries to develop their own manufacturing capacity.[74] That, indeed, would go against the entire "balancing act" that the TRIPS Agreement and the subsequent international regulations aimed to achieve.

VI. CONCLUSION

The court's ruling in the Novarits case displays the tension that exists with ostensibly all international treaties. While the underlying goal of the TRIPs Agreement was the harmonization of intellectual property laws around the world,[75] the implementation of the Agreement was left to domestic laws. Thus, the pluralism in national regulations of patents should come as no surprise. This leads to the question: what are the global implications of harmonization of patent laws without consensus? The Novartis case is exemplary of this quandary.

Needless to say, it is only one small piece of a much broader puzzle that pits globalization, free market, and consequently, patent rights against access to medication. There is no doubt, however, that the Novartis case is a turning point in the debate about how to balance the two. The immediate outcome of the Madras High Court's decision is tangible. India's thriving generic drugs industry can continue manufacturing drugs that were not patented pre-2005, when the TRIPS Agreement entered into full effect in India. It will also be able to legally produce all these drugs that would not pass the threshold of showing a "significant enhancement of efficacy" from existing patented drugs, as the Patent Controller is likely to reject them.

The exact considerations the Patent Controller will take into account are not entirely clear. Surely, what counts as "enhancement of efficacy" will have to be scientifically based. It will also have to be consistent with the requirement of Article 27 of the TRIPS Agreement that not only new drugs are patentable, but also "inventive steps." The meaning of "inventive steps" is not defined in the TRIPS Agreement, however, and the member states of the WTO exhibit an array of criteria on this issue.[76] India's interpretation of the term as including only those innovations that "differ significantly in properties with regard to efficacy" from exiting patented drugs should thus be seen as falling within its sovereign prerogative. Bearing in mind that the implementation of the

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"orphan drug," meaning a drug that concerns rare diseases. Thus, the costs associated with its development were substantially reduced and it enjoyed tax exemptions as well as fast-track marketing approval. Furthermore, pre-clinical research and development of the drug was financed also by other entities such as the Leukaemia and Lymphoma Society, the Oregon Health and Science University and others. See Sell, S. K., "TRIPs-Plus Free Trade Agreements and Access to Medicine," Liverpool L. Rev. 28 (2007): 41-75, at 47; Gopakumar, K M, "The Novartis Case," available at http://www.centad.org/focus_49.asp (March 20, 2008).

[74] Abbott, F. M., "The WTO Medicines Decision: World Pharmaceutical Trade and the Protection of Public Health," Am. J. Int'l L. 99 (2005): 317- 358, at 334.

[75] Fayerman, J. J., "The Spirit of TRIPS and the Importation of Medicines Made under Compulsory License after the August 2003 TRIPS Council Agreement," Nw. J. Int'l L. & Bus. 25 (2004-5): 257-278, at 259.

[76] In the EU, the invention should make a technical contribution to the product, whereas in the U.S. the test is that the invention is "not obvious to a person having ordinary skills in the art, irrespective of whether the non-obviousness is technical or not." Rajasekaran, A.B., "Indian patent law - Needed, proper definition of `inventive step'," Business Line, April 13, 2007, available at http://www.thehindubusinessline.com/2007/04/13/stories/2007041300930800.htm

TRIPS Agreement and its definitions was left in the hands of each individual member state, India has considerable room for maneuvering.

Whether or not social and economic activism should play a critical role in the decision-making, as has been the case with Novartis and other previous legal actions,[77] depends on one's point of view. However, in light of Article 7 of the TRIPS Agreement and the Doha Declaration, the Indian government's decision to take into account economic and social rationales, as well as the global need for access to medication, is in line with the country's international obligations[78] -- that is, if and until the issue is decided otherwise by the Dispute Settlement Body of the WTO. In my view, India's approach is a laudable one.

Still, the impact of the court's ruling goes beyond that and needs consideration. The fact that India is not medically self-sufficient, despite its prospering generic drugs industry, is disquieting. It seems to be at odds with principles of justice, by which if the patentability of drugs is limited for social-economic rationales, then the Indian government and its generic pharmaceutical companies should ensure at least the access of medication to the poor population in India itself. The risk that developing countries will be further pressured to give up their powers under the TRIPS Agreement and to sign intrusive, Western-oriented, TRIPS-Plus Agreements should also be taken into account. Finally, the implications of the decision on the scientific endeavors to invent new drugs should be kept in mind. The upshot may be not only sensed by Western pharmaceutical companies, but also by India's own drugs industry as well as by other developing countries that depend on it. And the sad reality is that although India's 2005 Amendment may pass the legal test under the TRIPS Agreement, the *perception* of India as a country that is not in compliance with its international obligations may have a detrimental effect.

Thus, if India would move beyond its rhetoric to practice, it should first incubate its own innovative pharmaceutical industry. Furthermore, by exemplifying how innovation and access to medication *can* go hand in hand, it would naturally take a leadership position in this debate. Simultaneously, India should regulate its own generic drugs industry so that at least the 350 (out of 500) drugs that are consumed in India and that are produced generically[79] would be supplied to its own citizens who need it. It can also develop its own social entrepreneurship to support its public health objectives rather than rely on the charitable donations of Western pharmaceutical companies. Indeed, the "balancing act" in the global debate between patent rights and access to medication requires social and economic responsibility beyond legal reasoning.

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[77] Bagley, M. A., "Legal Movements in Intellectual Property: TRIPS, Unilateral Action, Bilateral Agreements, and HIV/AIDS," Emory Int'l L. Rev. 17 (2003): 781-798, at 784-5.

[78] See in this regard Brody, B., "Intellectual Property and Biotechnology: the European Debate," Kennedy Institute of Ethics Journal 17 No. 2 (2007): 69-110 (discussing the EU patent system which allows raising moral reasoning in the decisions whether to grant patent rights.)

[79] Lanjouw, J. O., "The Introduction of Pharmaceutical Product Patents in India: "Heartless Exploitation of the Poor and Suffering?" NBER Working Paper No. 6366, at pg. 4, available at http://www.oiprc.ox.ac.uk/EJWP0799.pdf

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PERSPECTIVES ON GLOBAL ISSUES
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Rethinking Global Health Priorities: HIV/AIDS and Basic Health Services

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ABSTRACT
Misconceptions about international health and development abound, the result of which are misguided global health priorities. Some of these, as expressed in Emily Oster's Technology Entertainment Design lecture, can be debunked with research evidence. The author challenges scholar Emily Oster and places an emphasis on poverty and lack of basic health services as the missing link in finding solutions to the myriad of health problems bedevilling the African continent, including HIV/AIDS (whose status as the zeitgeist of the times is also challenged).

INTRODUCTION
Lately, I have inundated myself with a series of incredibly enlightening lectures from the Technology Entertainment Design (TED) Talks. The goal of the TED Talks is to share ideas on a variety of topics, including politics, arts, and global issues.[1] One in particular is worth discussing. Emily Oster, [2] a University of Chicago economist, shared her work and ideas on HIV/AIDS in Africa at last year's TED Talks;[3] however, her argument struck me as particularly, if unwittingly, poorly conceived. Her theoretical abstractions reveal in shameful detail how easily tainted the lens through which the developing world is seen from the outside, and the kind of thinking that underlies the misconceptions that inform the largely skewed global health priorities.

Life expectancy in sub-Saharan Africa today is roughly equivalent to that of Great Britain in the 1840s.[4] Headlines would rather attribute the low life expectancy in Africa to the big killer diseases, with HIV/AIDS topping the list, whereas common, though far less glamorous illnesses like diarrhoea, malnutrition, and respiratory tract infections take many more lives than HIV,

[1] **TED** (**Technology Entertainment Design**) is a conference founded in 1984 and held annually since 1990 in Monterey, California and recently, bi-annually in other cities around the world. It defines its mission as "ideas worth spreading," with lectures covering a broad set of topics including science, arts, politics, global issues, architecture, music et cetera and speakers themselves from a wide variety of communities and disciplines. Over the years, TED speakers have included Bill Gates, Bill Clinton, Al Gore, Billy Graham, James Watson, Richard Dawkins, Quincy Jones, and Bono. The best talks given at TED, presently about 200, are made available to the public for free on its website, and have been viewed over 30 million times to date. (For more information, see: http://www.ted.com/index.php/pages/view/id/5)
[2] **Emily Oster** received her Ph.D. from Harvard in 2006 and she is presently an assistant professor in the department of Economics, University of Chicago. Before now, she was most well known for her controversial Ph.D. dissertation, "Hepatitis B and the Case of the Missing Women," in which she suggests that biology can explain the missing-women puzzle, the higher male-to-female birth ratios in areas with high Hepatitis B prevalence. Ms. Oster's work currently focuses primarily on HIV in Africa. Statistical citations refer to facts represented in Emily Oster's lecture. (For more information, see http://home.uchicago.edu/~eoster)
[3] Oster E. "What do we really know about the spread of AIDS?" http://www.ted.com/talks/view/id/143
[4] Towey R. "Not even a dog's life." BMJ 2007; 334; 638

tuberculosis, and malaria. It is salutary to note that Britain in the early 1900s achieved significant reductions in childhood deaths from diphtheria, scarlet fever, pertussis, measles, tuberculosis and rheumatic heart disease, all equally deadly diseases, long before vaccines and antibiotics became widely available.[5] There is overwhelming evidence that this decline was due to improvements in nutrition, sanitation, water supply, housing, general hygiene and per capita income,[6] the basic essentials of life that are easily taken for granted by an average Westerner. It explains why it is so easy to lose sight of them as we try to solve the big killer diseases in Africa. Without thinking about access to these basic necessities, alongside our concern for conventional healthcare, and pursuing them with as much vigour, the labourers only labour in vain.

Emily Oster based her first argument on a shaky if not completely false premise, justifying a claim, her own claim, that there was no behavioural change in response to the HIV pandemic in Africa by juxtaposing data from two radically different cohorts -- homosexuals in the U.S. and heterosexuals in Africa. High HIV prevalence within a population where there is widespread awareness of heterosexual sex as the predominant mode of transmission will result in increased rate of abstinence from sex or at least a modification of sexual behaviour as an evolutionary compulsion to preserve the species. The logical human weighs the potential benefit of sex against the apparent cost of illness or loss of life. This is especially more so if the sexual act does not hold the promise of procreation, as in homosexual sex, where the benefit of sex might be restricted to immediate gratification. Without an elaborate public health campaign to promote abstinence, HIV prevalence would have reduced on its own. That is what you would expect, but Oster, counterintuitively, says it was not so in Africa. She compares data from gay men in the U.S. in the 1980s, (where the men who had more than one unprotected sexual partner within a month reduced from 85% to 55% in four years) with data from single men having premarital sex and married men having extramarital sex in Africa, which dropped by only 2%.

There are obvious flaws in Oster's argument apart from subject mismatch. Her homosexual subjects had a reduction in the number of *unprotected* sexual partners, whereas there was no specification as to the nature of sex amongst the African subjects: protected or not, homosexual or heterosexual. She did not give any idea of the HIV prevalence amongst the said African population(s), so we cannot possibly estimate the cost of sex among the population, and arrive at any predictable behavioural change based on that. We know that HIV prevalence among gay men was about the highest in America in the early and mid 1980s and since the evolutionary benefit of homosexual sex is low,[7] such a precipitous fall in the number of unprotected sexual partners is easily predictable.

However, even if Emily Oster's subjects were by any chance of logic comparable, and if there was indeed no behavioural change in response to HIV in Africa, her explanation for this -- the cost of abstinence is so high that in the presence of low life expectancy, people would rather not bother to live healthy lifestyles, they would rather prefer to expose themselves to the risk of contracting HIV/AIDS since they are going to die early anyway -- is as unconvincing and implausible. Oster demonstrated that in places and within populations in Africa with high prevalence of malaria and high maternal mortality, there was no positive change in sexual behaviour in response to HIV. She did this, totally ignoring two huge, glaringly obvious

[5] Ibid.
[6] Ibid.
[7] Imre Loefler suggested that the survival value of homosexuality for the human species might be its effect on population growth.[4] For him, it would be a cultural activity par excellence, a natural means of population control, if most people became homosexual and only a small, selected proportion of humans attended to the reproductive needs of the species.

confounding variables, poverty and lack of basic health services -- leading causes of low life expectancy in Africa, together with lack of adequate sanitation and good water supply, which promote the presence and spread of diseases, and in themselves are inextricably linked to poverty.

This is actually where Oster's greatest mistake lies, and unfortunately, it is what forms the main thrust of her thesis. M. Khan and colleagues in Burkina Faso found that even within a developing country, the sex network within rural areas is denser, more closely interlinked than in urban areas, and the percentage of those who receive goods for sex is far greater in the semi-rural border area (45%) and urban area (31%) than in the rural areas (12%).[8] This is easily explained. There is far greater homogeneity in relation to poverty in rural areas compared to urban or semi-rural areas, and so there are fewer people who are prepared to offer money or goods for sex. Poverty too breeds idleness, and it is easy to imagine that an idle man will easily have multiple sexual partners in a community where money is not given in return for sex. This explains why poverty may be associated with high levels of sexual activity. In these settings, there is high maternal mortality both from unsafe abortions, and because maternity care is not available. Where poverty abounds and basic health services are not there, mortality from malaria will be high. Where there is no access to basic health services like sexually transmitted infection prevention and treatment and modern contraception, there will be poor awareness of the presence, reality and prevalence of HIV. Illness and death from HIV is attributed to other diseases, witchcraft, the will of God, et cetera, hence diagnostic, prevention and treatment services, even if available, will suffer low uptake in the absence of these basic health services.

Emily Oster, however, asserts that HIV prevalence rises with increase in economic activity and urbanization. She evokes the oft-quoted high HIV prevalence amongst truck drivers and migrants to support this claim. She also showed that the fall in HIV prevalence in Uganda was closely associated with a fall in the export price of tobacco, Uganda's main export commodity. All of these are true, if only in part, but yet again, she misses the point. It is not wealth as an absolute quantity that encourages increase in sexual activity, hence HIV prevalence; rather, it is the widening of the gap between the rich and the poor, increased contact between the rich and the poor, and the attendant dynamics, the differential power gradient, that characterises the relationships between the two classes. Much of extramarital and premarital sex is facilitated by an economic advantage of one party, often the male, over the other. With a fall in export price of tobacco in Uganda for example, the gap between the rich and the poor is less, there is less money available to maintain multiple sexual partners and visit commercial sex workers, thereby reducing the sexual network, and also, predictably, HIV prevalence, at least in part.

CASES OF BEHAVIOURAL CHANGE

In contrast to Emily Oster's argument, there has been behavioral change. Marjolein Gysels and colleagues at the Medical Research Council Programme on AIDS observed and interviewed truck drivers and commercial sex workers at a roadside town in southwest Uganda.[9] Truck drivers are a high-risk group for HIV due to their sexual networking and long periods away from home. They stop at towns along major routes to eat, sleep, and sell goods, and 94% of those interviewed would regularly have sex when they spent the night at the truck stop.[10] Commercial sex work was found to be common but quite hidden and implicit in this setting, and centered around roadside bars; hence intermediaries are often involved in negotiations between drivers and commercial sex

[8] Khan M, Nagot N, Salouka S, Ganou S, Bidiga J, Weir S, Brown L. "Sex in the city, sex in the country: Urban-rural differences in sexual networking in Burkina Faso." *Int Conf AIDS*. 2002 Jul 7-12; 14

[9] Gysels M, Pool R, Bwanika K. "Truck drivers, middlemen and commercial sex workers: AIDS and the mediation of sex in south west Uganda." AIDS Care (2001) 13

[10] Ibid.

workers. However, in the wake of HIV/AIDS, the middlemen on whom truck drivers rely to find women have had an additional role, which is to identify HIV-negative women, and in spite of this, condom use was reportedly high, at 95%, in marked contrast to local men. HIV prevalence used to be very high among drivers and at truck stops. In the study town it was 40% in 1991;[11] in the surrounding district it was 8% in 2001.[12] The demand for casual sex however appears not to have decreased among truck drivers in the era of HIV, but there is a general awareness that this lifestyle carries the risk of infection.[13] This shows indeed, that there has been behaviour change in response to the HIV pandemic in Africa, contrary to what Emily Oster will have us believe.

Another example of behavioural change came from an intervention with healthcare workers. In 2004, 12% of children with malaria died as inpatients at the national hospital in Guinea-Bissau. Special drug kits for children with severe and complicated malaria were introduced, but this did not reduce mortality. In an award winning BMJ study in 2007, Sidu Biai and colleagues tested in a randomised trial of under-five children admitted with malaria, looking at whether removal of prescription charges, strict monitoring of patients, and financial incentives for doctors and nurses could reduce mortality.[14] Mortality indeed came down to 5% in the intervention group and 10% in controls, reflecting the crucial role of poverty in mortality from malaria.[15] What is particularly interesting about the Guinea-Bissau study was that the only difference between the two groups was that doctors and nurses were given financial incentives in one group and they were not in the other, which alone reduced the mortality by as much as 5%. Given, the drugs were free in both groups, which may explain a fall in mortality from 12% pre-trial to 10% in the control group. Weigh this against the 5% reduction when health workers were given added incentives. From this, it is clear that with just three simple interventions -- if we could make basic health services available, if patients could afford the drugs and other services, and if health workers were well remunerated -- we could cut under-five mortality from malaria by more than half.

It is much the same story with maternal mortality. Obstructed labour and ruptured uterus, eclampsia and other forms of hypertensive disease in pregnancy, obstetric haemorrhage mostly postpartum, puerperal sepsis, and unsafe abortions are still the main causes of maternal mortality. However, in the presence of accessible basic health services, they disappear. In Sri Lanka, the maternal mortality ratio dropped from 550 per 100,000 live births in 1950-55 to 80 per 100,000 live births in 1975-80,[16] and to 58 per 100,000 live births in 2005.[17] This was achieved by introducing a system of health centres all over Sri Lanka, and making quality maternal care services available and accessible to all, including in rural areas. In Sri Lanka, 94%[18] of deliveries in 1993 were assisted by a skilled attendant, compared with 42% in 1999[19] in Nigeria, which had

[11] Ibid.
[12] Ibid.
[13] Ibid.
[14] Biai S, Rodrigues A, Gomes M, Riberio I, Sodemann M, Alves F, Aaby P. "Reduced in-hospital mortality after improved management of children under 5 admitted to hospital with malaria: randomised trial." BMJ 2007; 335: 862-5
[15] Ibid.
[16] Chukwudebelu WO. "Preventing Maternal Mortality in Developing Countries." In Okonofua F, Odunsi K. (Eds). Contemporary Obstetrics and Gynaecology for Developing Countries. (Benin City, Women's Health and Action Research Centre, 2003) pp. 655-6
[17] "Maternal Mortality in 2005: estimates developed by WHO, UNICEF, UNFPA and The World Bank." World Health Organization. 2007. pg 23-27
[18] AbouZahr C, Wardlaw T. "Maternal mortality at the end of a decade: signs of progress?" Bulletin of the World Health Organization. 2001, 79(6)
[19] Ibid.

one of the worst maternal mortality ratios in the world (1,100 per 100,000 live births).[20] This has been replicated in Cuba,[21] where in 1970, the maternal mortality ratio was 73 per 100,000 live births, and in 2000, it had more than halved to 33 per 100,000 live births.[22] In 1999, skilled attendants assisted every delivery in Cuba, after maternity care services were made available and free including accessible referral centres for complications.[23]

GLOBAL HEALTH PRIORITIES

Hospital wards in many developing countries are a heartbreaking, pathetic sight. Things you probably cannot possibly imagine could ever happen,take place everyday without the blink of an eye. No matter how bad a patient is, no matter what the emergency, the family usually has to pay for services and procure materials for treatment at the point of service. Usually, there are no provisions for emergency: drugs, intravenous cannula, needle and syringe, investigations, et cetera. The most basic and commonplace of materials, things you would otherwise take for granted, the most routine of investigations like ultrasound scan and x-rays are often procured at great cost, from private pharmacies and laboratories that have clustered around government-run hospitals over the years owing to the ineptitude of the hospitals to run efficient services. Worse still, these hospitals stock the drugs and have the equipment, but the regular story is that the equipment stopped working after a few months, their models are outdated, there are no staff to man them because they are off moonlighting or do not work during call hours or take weekend shifts, or even the bureaucracy of buying the drugs or getting the investigations done in the hospital is enough to push them outside. These patients are also seen by poorly motivated, low-paid health workers, with many supplementing their income through moonlighting. These factors contribute to the high mortality in the first 24 hours of seeing a patient, and subsequently. The distance from access and the prohibitive costs of hospital treatment and admission keep patients away, contributing heavily to low life expectancy.

In sharp contrast, some new structures are sprouting in or around hospitals in developing countries. They are highly efficient units, dedicated to single disease programs, often HIV/AIDS, provided and funded by external donors. An AIDS orphan who lives with siblings in squalor without access to insecticide-treated nets and artemisinin-based combination therapy for malaria, whose sister and guardian does not have access to specialised obstetric care in pregnancy, gets antiretrovirals for free at these units. Those with more routine diseases receive poor care and still have to pay. Hospital staff who are supposed to be at their duty posts seeing patients that they were trained and being paid salaries and allowances to see are often busy running those units, with extra remuneration often in hard currency, often surpassing their salaries, at great expense of the system. These hospital staff also get lured into full time employment by these donor-funded programmes, further weakening the already fragile healthcare delivery system, and are busy junketing the world from one conference to another, as well as to conventions, forums, meetings, et cetera. Hospital consultants jostle to be the ones to run the HIV clinics. This is the newest brand of internal brain drain sub-Saharan Africa is experiencing.

Single disease priorities generally weaken health systems. They are extremely wasteful; they duplicate efforts and divert funds unnecessarily, starving whole health systems of funds and personnel. Overall, spending on HIV research, treatment and prevention activities is the most

[20] "Maternal Mortality in 2005: estimates developed by WHO, UNICEF, UNFPA and The World Bank." Op. cit.
[21] Chukwudebelu WO. Op. cit.
[22] "Maternal Mortality in 2000: estimates developed by WHO, UNICEF, UNFPA and The World Bank." World Health Organization. 2004. pg 22-26
[23] Chukwudebelu WO. Op. cit.

notorious example of this prodigality. In 2006, although Zambia's entire Ministry of Health budget was only $136 million, the U.S.-funded President's Emergency Plan for AIDS Relief provided the country with an HIV-targeted budget of $150 million.[24] This unbalanced distribution of health funding occurs across sub-Saharan Africa. Raising HIV/AIDS to the status of the zeitgeist of the times has indeed skewed health priorities at both national – in many developing countries – and, most importantly, at global levels. There is only so much we can achieve, with HIV at the centre of our planning and initiatives. We have succeeded in erecting a great vertical programme for HIV, a totem pole of sort, probably the greatest in history, shorn of the system that currently exists for controlling sexual and reproductive health. HIV has managed to employ its own staff, generate its own funding, systems and facilities. Reorganising these structures is at the heart of solving these problems. We cannot move ahead while we ignore so much. What more evidence do we need, than that with all the spending on HIV, much too little is being achieved.

Healthcare and development are so interlinked that it would be grossly wrong to interpret data without due consideration for the whole picture and connections that are not immediately apparent. It is not enough to have epidemiological data, without the insight to interpret them and discern underlying trends. The world has not changed much since mid-19th century Europe. Diseases related to the lack of clean water and adequate sanitation are the second-biggest cause of under-five mortality, with two million dying every year from diarrhoea.[25] Poverty and the lack of basic social and health services is at the centre of what defines developing countries, and that is really where our attention should be focused in trying to find solutions to problems in these countries; any thinking that as much as puts these as second to any other priority is ultimately bound to fail. Until these form the crux of both local and global public health interest and policy, much of our effort will only continue to result in the proverbial one step forward, two steps back.

Seye Abimbola recently obtained an MBChB (MD) from Obafemi Awolowo University, Ile-Ife, Nigeria. He edited his medical school journal, IFEMED from 2005-06 and he has also been international student advisor to another journal, Student BMJ, since 2005. His articles have appeared in both publications, as well as the BMJ, and he has published several short stories online. He was awarded the 2007 BMJ Clegg Scholarship and he won the 2007 Global Forum for Health Research/The Lancet Essay Competition. He is presently a pre-registration house officer at Wesley Guild Hospital, Ilesha, Nigeria, following which he intends to do a PhD in neuroscience with a public health flavour. He is deeply passionate about having research capacity boosted in developing countries.

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PERSPECTIVES ON GLOBAL ISSUES
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Book Review: Children's Genitals Under the Knife

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Children's Genitals Under the Knife. By Hanny Lightfoot-Klein. Charleston, South Carolina: BookSurge Publishing, 2007. www.booksurge.com. 201 pages. $20.00

Hanny Lightfoot-Klein is one of the Seven Wonders of the World. Having previously written two unique, valuable books published by Harrington Park Press, *Prisoners of Ritual* (1989) and *A Woman's Odyssey into Africa: Tracks Across a Life* (1992), she has recently completed her trilogy with the self-published book *Children's Genitals Under the Knife*.

Some readers who do not know Lightfoot-Klein's previous work may be wondering what could be left to say in a third book on the same topic. Yet *Children's Genitals Under the Knife* offers its own uniquely panoramic, idiosyncratic perspective. *Prisoners of Ritual* primarily examined female genital cutting in the Sudan; *A Woman's Odyssey into Africa* both narrowed the focus to the author's voyage of self-discovery and broadened it to encompass gender topics and issues specific to Lightfoot-Klein's personal growth and development. While never departing from being a book about genital cutting, *Children's Genitals Under the Knife* may contain the broadest overview ever presented of the complex larger social context underlying and overlaying the pervasive set of human rights violations represented by genital cutting.

Lightfoot-Klein adroitly points to the parallel between the 150-year history of medicalized male circumcision in the US and our unique belief in simple and direct solutions to problems. She points out (p. 32) that as a country our perverse uniqueness may be even more starkly typified by the fact that clitoridectomy remained in vogue here for over fifty years while only enjoying brief popularity in every other Western country that tried it.

There is plenty here of extreme relevance that I have never heard about before, at least not in such detail. Care for a "vulvular massage" from your physician, ladies? Vibrator-assisted ecstasy was routinely available from select doctors for a period of at least forty years that bracketed the beginning of the 20th Century. Many of us know that popular articles appeared in *Cosmopolitan* magazine favoring "female circumcision" as late as 1976 (and medical articles appeared as recently as 1973 in favor of the same procedure). But Lightfoot-Klein reminds us that no lesser institutions than Boston Children's Hospital and Harvard Medical School were advocating for complete clitoridectomies and simultaneously concealing data not supporting their position as recently as 1966.

One complaint some readers may have is the strength and repetition of the author's conviction that female genital cutting is substantially more damaging relative to male genital cutting. And yet Lightfoot-Klein is also a ferocious, tireless, and longtime opponent of male genital cutting, wryly noting, "In defining the severity of male circumcision, one might liken it to the crushing and ripping away of the eyelids, a procedure for which it would be most unlikely to find many volunteers among those male circumcision proponents wishing to prove its harmlessness."

Her section providing some first-hand accounts of genital cutting are difficult to read but inspire awe at the endurance and understated eloquence of their subjects, not to mention anger that these horrors still blight the face of this earth. A later pair of contributions by intersex speakers also resonates in our minds long after we have turned the page, with Intersex Society of North America founder Cheryl Chase proving particularly indelible. One further unique, utterly unforgettable component of this book is the extended excerpt from a statement *in favor* of female circumcision, concluding with the assurance to the listener: "It will do her good and she will thank you for it."

The author pegs the recent debate over outsiders' attacks on female genital cutting (FGC) just right, emphasizing that first world critics have an important role to play in ending FGC, but "the West must first discard any illusions it may yet harbor that it will lead the Children of Africa out of their wilderness." The author acerbically notes the frequency with which Western critics pick this particular practice to pile onto while overlooking problems viewed by Africans as even more essential such as obtaining safe water, reducing infant mortality, and improving health care. Lightfoot-Klein was an early, outspoken gadfly to those who would overly simplify the sexuality of genitally cut women, showing with her groundbreaking research and activism that even many infibulated women "manage to enjoy a healthy sexual and emotional life." As a result of her objectivity and search for the truth, she was maligned and unsuccessful attempts were made to silence her in order to further certain political agendas.

The author is a woman of passion and careful observation, unafraid to speak the truth yet not particularly seeking the limelight herself. Lightfoot-Klein contextualizes genital cutting within an interrelated skein of perspectives, while at the same time offering hope through her nearly fifty-page section collecting many different examples of positive change evolving due to activism by folks like (and unlike) you and me. You can't afford *not* to accept the author's offer to travel with her on the complicated, at times grim, but ultimately inspiring journey she offers us.

J. Steven Svoboda is founder and Executive Director of Attorneys for the Rights of the Child (ARC). In 2001, Svoboda's submissions to the United Nations became the first document ever accepted by the UN focusing on male circumcision. In 2002, Svoboda received a Human Rights Award for his work with ARC. Svoboda's numerous publications include "A Treatise from the Trenches: Why Are Circumcision Lawsuits So Hard to Win?" (2008), "Gender Equity and Genital Integrity,"(2006); "Prophylactic Interventions on Children: Balancing Human Rights with Public Health," with Hodges and Van Howe, Journal of Medical Ethics (2001); and "Informed Consent for Neonatal Circumcision: An Ethical and Legal Conundrum," with Van Howe and Dwyer, Journal of Contemporary Health Law and Policy (2000). He co-authored Does Feminism Discriminate Against Men: A Debate (OUP, 2007). Penn & Teller shot a full-length feature on male circumcision broadcast in 2005 prominently featuring Svoboda's and ARC's work.

PERSPECTIVES ON GLOBAL ISSUES
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Health Perspective: Mongolia

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It was a somewhat normal winter morning in Bagakhangai, Mongolia. I was sitting in the teacher's room of the school at which I teach, looking over lesson plans and attempting to pick out from the barrage of language around me a word or two I might recognize.
My counterpart, a young English teacher who often throws me a lifeline when I don't know what is happening or being said around me, came into the room.

"There are no children in kindergarten," she announced, slow enough that I could understand. Everyone nodded, a new barrage of words.

"Wait… what?" I asked, slightly surprised.

"No children. All of them became yellow. Except three. My son is ok."

It is a paradox of Mongolia that in a land where people can be so physically separated, with so much space and so few humans (the most recent statistic puts the number at less than two people per square kilometer, an average that becomes more staggering when you factor in that over one-third of the country's population lives in one city), people manage to be, in a lot of ways, far closer and connected than most places in the world.

In many cases this is a good and necessary thing. The ability of Mongolians to retain a sense of unity, culture and identity across such disconnected distances is a positive not all cultures can claim, including my own, and when disasters or countrywide problems occur it can be a help to have a people that are not as disconnected as the landscape might at first appear to dictate. However, in other cases, like when I need to get a ride to the nearest place I can buy food and find myself in an eight-seat car with 20 other people, it can be a painful reality. More seriously, the spread of disease is amplified by the closeness of the people.

The hepatitis, "the yellow disease," that wiped out the kindergarten, and is making its rounds into my own elementary school, is just one example. Prevention is often simple in theory, but more difficult when you start factoring in the reasons it can spread so rapidly.

Our Peace Corps doctor recently sent around a memo with the succinct advice, "DON'T LICK THE CHALK! DON'T EVER, EVER, EVER LICK THE CHALK!" in reference to a common practice among teachers and students of wetting a piece of chalk before writing on the often damaged blackboards. But it is more than just chalk.

Most families live in houses or traditional *gers*, which are felt tents perfect for the nomadic life in that they can be broken down and carried on one horse. These homes are never connected to running water, and often are not next to a source of water at all, forcing families to stock up when they can and then conserve. Something like regular hand washing, thus, becomes less of a priority than, say, staying hydrated.

Bathrooms are the open steppe ("Where is the outhouse?" I asked a herder friend when I was visiting his ger. "Outside," was his answer, with a long sweet of his arm and a sly grin), also used by the herds and the birds, and while this works without much danger for the family that is surrounded by 200 kilometers of nothing and no one, it becomes more complicated when it is brought into communities of several thousand and that open space becomes much more shared.

In schools there *are*, generally, sources of water and bathrooms, a fact the school doctor is currently attempting to utilize: in flyers around the school are instructions for how to wash hands, in addition to general information about hepatitis. However the impact this information has had on the kids, running counter to the tendencies many of them picked up while growing up without the ability to use running water or designated bathrooms, is minimal. The disease continues to spread.

Prevention aside, once diseases hit they tend to hit hard and stay. For a family living on the open steppe, in a location that may change every few months, it can be hard if not impossible to maintain ties with a doctor or other health care provider. When someone gets sick, it is also often a difficult if not impossible task to *find* a doctor or hospital, and given the conditions of the winter it can even be a life threatening task. On a trip into the city one morning in January my van picked up a young girl with a broken arm. She told us, as she warmed up, that she had been flagging down cars in the -30 degree weather for over 6 hours before we stopped. She also, and there was a reluctance to say this, had been traveling from the countryside over the previous two days. These particular problems, I should note, are slowly becoming less common as the nomadic lifestyle fades.

As Mongolia continues to transition to a permanently sedentary population, communities like my own, which are often growing faster than infrastructure and resources can follow, find the local hospital to be an increasingly important place, especially as rising population densities lead to higher rates and the faster spread of disease.

Historically, the health care system has leaned, if not jumped, toward public health, created and maintained until the late 1980s under heavy Soviet influence. For reasons I have yet to fully understand, this has led, especially in rural areas where there are fewer resources and experts that can handle more serious health issues, to the use of the hospital as a type of local health spa, where tired workers can take a week off and receive vitamin injections and a break from the kids. A headache or stress is viewed as a reason to take a bed. Occasionally I will find out a friend has been in the hospital and, worried, ask if they are all right. The answer, accompanied by a confused laugh, is usually like the one my supervisor gave me when she returned from the hospital last year: "Of course! I was there for two weeks. It was very relaxing." Of course one of the results of this type of hospital use is that the hospital is under funded, understaffed and under trained when more serious problems in the community do occur.

These cultural and historical obstacles aside, there are many realities to the country itself, notably the geography and climate, which have drastic and often surprising effects on health. The extreme nature of the winters (nine months in most years, with temperatures that can reach an extreme of -40 degrees in January, -50 for those living in the desert areas) forces people behind doors and away from the sun and outdoor exercise for well over half the year. Vitamin D deficiency, and thus rickets, is a common problem, especially among children, despite the fact that the sun, which would be the population's main source of vitamin D, shines 300 days a year. Being in that sun with such extremely low temperatures is a dangerous game that is often lost, along with chunks of skin or a limb.

Furthermore, the typical Mongolian diet, dictated as I will discuss in a moment by meat and fat, leads to problems of diabetes and heart disease. The somewhat Russian inspired alcohol culture (an unfortunate remnant of the Soviet era), depressed economy and availability of cheap vodka compounds these problems and creates their own.

It is when the culture and the climate collide that the problems become the hardest. In a recent health survey among children in my town, carried out at the start of a children's health project that I will discuss in a moment, it was found that a major problem among children five years old and under was iron deficiency.

This struck me, as it would strike anyone who has spent time here, as extremely odd. I questioned the statistics, even, and asked for a new translation. The Mongolian diet is, quite simply, iron laden red meat. Animals are all that can survive the winters and have become such a major part of life that when harsh winters destroy herds, a natural disaster known as a *zud*, entire towns can die. I started asking other Peace Corps volunteers if they faced a similar health problem and the answer was always *yes*, iron deficiency was huge.

It was in a discussion with a non-governmental organization (NGO) from the capital city that I came to understand what was happening. Mongolians, in addition to eating meat, necessarily consume a lot of milk products. These milk products, "white foods," are considered almost sacred and are often prescribed as folk remedies for any number of common illnesses. They are, thus, an integral part of the culture. At every meal, in addition to eating their half goat, they drink several cups of one such white food: milk tea, made from milk, brick tea and salt. This particular drink is such an important part of the culture that the Mongolian translation of "breakfast" is literally "morning tea."

This tea, however, and similar drinks like coffee, reduces the absorption of iron from foods such as meat when they are consumed together, leading over time to an iron deficiency. If the diet could be more varied, this deficiency would not occur, but when a person's only source of iron, as dictated by the climate, is being cancelled by their main source of hydration, dictated in part by the culture, it becomes difficult to find a way around the resulting problem.

The project being implemented in my town now attempts to do just that: to find a way through these cultural and physical obstacles to better health in an appropriate and sustainable way. In the first stage now, and being implemented with the help of the local government with funding from Khaan Bank, a private bank that often contributes to community based development programs, the project is one of many attempts by many groups across the country to increase the awareness of health issues.

Because of the many problems I have discussed here, in addition to others, it is apparent that a holistic approach is necessary if the community wants to come to terms with some of the more serious and preventable health problems it faces. This approach can not be just a flyer, or just an increase in hospital funds, but has to include more levels of society, especially parents and community leaders who can make small changes in lifestyles to bring about positive change (for example, the introduction of regular hand-washing). Our children's health project aims to bring about this change primarily through education.

As planned, the project consists of three parts: education of community health volunteers, education of parents, and the creation of an information and material "cabinet" or resource center where the community and the hospital can access various tools related to children's health. We

are currently in the first stage of implementation: training local health volunteers on children's health issues. Topics we are covering in our training sessions include food and nutrition, common local health problems, appropriate use of medicine, and mental and physical disabilities. Once we have completed this stage, we will begin to plan parent trainings, hopefully for later this spring, which will be designed and led entirely by those health volunteers with the understanding that in future years the trainings can be repeated. The creation of the resource area will take place next year.

The objective is to provide information to a group of community volunteers who will be able to utilize the knowledge locally and thus increase the capacity of the local health care system without creating a financial burden on the community or country. Because the hospital tends to be overwhelmed with patients, in large part due to its main role as a health spa, having well educated community volunteers that parents can consult should help relieve the pressures the hospital faces and provide more opportunities for parents to be involved with their children's health.

It is vital that the community is the main force behind the project. From idea to implementation, this has been a community driven project, although resources from outside the community, including some small funding and the use of NGOs from the city for the trainings, have been utilized. Because of the focus on community involvement, the project is being implemented within a framework that is culturally appropriate and locally knowledgeable, and, perhaps most importantly, ensures that the community has a vested interest in the project, leading to a greater chance for sustainability in the long term.

It is a very small thing, a local equivalent of that memo from my own doctor, but it is the kind of small thing that needs to occur more often as Mongolia continues to develop as a country and faces ever increasing health issues related to the ongoing transition from a nomadic culture to a sedentary one.

In the end that is what it seems to come down to: small changes at small levels.

Don't lick the chalk.

After growing up in Northern California and attending university in Los Angeles, Leif Waller joined the Peace Corps in 2005 as an English Teacher and Community Development volunteer. He served previously in Bangladesh before his current assignment in Mongolia, which will conclude in August 2008. His host community, Bagakhangai, is a small "enclave" district of the capital city Ulaanbaatar, approximately 150 kilometers outside of the city center.