

## Getting Real About Essential Medicines: The Last Kilometer

Lucie White

Follow this and additional works at: <http://digitalcommons.law.umaryland.edu/mjil>

---

### Recommended Citation

Lucie White, *Getting Real About Essential Medicines: The Last Kilometer*, 31 Md. J. Int'l L. 79 ().  
Available at: <http://digitalcommons.law.umaryland.edu/mjil/vol31/iss1/7>

This Symposium: Articles and Essays is brought to you for free and open access by the Academic Journals at DigitalCommons@UM Carey Law. It has been accepted for inclusion in Maryland Journal of International Law by an authorized editor of DigitalCommons@UM Carey Law. For more information, please contact [smccarty@law.umaryland.edu](mailto:smccarty@law.umaryland.edu).

# Getting Real About Essential Medicines: “The Last Kilometer”

LUCIE WHITE<sup>†</sup>

## I. INTRODUCTION

International law recognizes a person’s right to essential medicines as part of the individual’s overall human right to health. But what does it take to realize this right? What does it take to deliver life-saving medicines that “last kilometer,”<sup>1</sup> from the pharmaceutical conglomerates in rich and emerging nations to the people who need them, often with little bargaining power? At what point in the supply chain has

---

© 2016 Lucie White

<sup>†</sup>B.A., Radcliffe College, J.D., Harvard Law School. Lucie White is the Louis A. Horvitz Professor of Law at Harvard Law School and Executive Committee member of the Harvard Center for African Studies. The author wishes to acknowledge the student editors at the *Maryland Journal of International Law* who helped immeasurably in the research and editing of the article, Peter Danchin and the others on the University of Maryland faculty who organized the symposium, *Clinical Trials and Access to Essential Medicines in African Countries*, in which the article was first presented, and the faculty at Harvard Law School and elsewhere who offered comments on earlier drafts. Most of all, the author would like to acknowledge the people in Ghana’s mental health treatment system and the mental health advocacy communities, particularly those people with mental health issues, whose commitment, vision, and courage have offered a vision of what a rights enhancing mental health system might be.

1. The “last kilometer” problem is often invoked in the global health context to illustrate the challenges of ensuring actual access to essential medicines on the ground to the people who need them, even those who are the hardest to reach or access. *See, e.g.*, Hally Mahler et al., *Covering the Last Kilometer: Using GIS to Scale-Up Voluntary Medical Male Circumcision Services in Iringa and Njombe Regions, Tanzania*, 3 *GLOBAL HEALTH* 503 (2015) (“The global health community frequently invokes the concept of the ‘last mile’ or, in the case of Tanzania, the ‘last kilometer’ to refer to achieving coverage for those clients who are the most difficult to reach.”); Marc Gunther, *Sue Desmond-Hellmann of the Gates Foundation Wants an A-Plus*, *NONPROFIT CHRONICLES* (Nov. 8, 2015), <https://nonprofitchronicles.com/2015/11/08/sue-desmond-hellman-of-the-gates-foundation-wants-an-a-plus> (“For people who are interested in making a difference, the polio journey has a couple of learnings . . . . One is that technical tools aren’t enough. We have the technical tools. We have the vaccine. On the other hand, getting that last kilometer, delivering the vaccine, getting it to people in difficult areas . . . is the journey.”).

enough been done? When the drug has been discovered? Manufactured? Made affordable, or shipped to the nation or region where it is needed? When it has been distributed to clinics or to patients for the first time? Or is it when the medication is given on an ongoing basis? What does it *actually take* to realize the human right to essential medicines, and where should we draw the line? This essay poses this deceptively simple question.

We start with a story set in an almost middle income West African nation with a stably democratic government and a good national health care system.<sup>2</sup> Assume that the right to essential medicines has been both recognized by the nation's law and implemented, at least in the case of some drugs, within the nation's borders.<sup>3</sup> Thus, the government's appropriate agency has composed a list of essential medicines based on the World Health Organization's (WHO) guidelines,<sup>4</sup> deals with pharmaceutical producers and suppliers have been cut, and actual supplies of the drugs have arrived in the nation's ports of entry. Assume further that the drugs in question are either free or inexpensive because they are off-patent, readily available, and often deeply subsidized from international sources. According to a human rights analysis, has the right to essential medicines with respect to this drug been achieved because the drug has been placed on the nation's essential medicines list, shipped inside its borders, and made available to the

---

2. This introductory narrative is a fictional composite that is loosely based on first-hand experience that I have had over several years of work in West Africa as well as extensive personal experience with mental health systems in well-resourced but highly unequal societies like the United States. Subsequent parts of the essay occasionally draw on the specific legal frameworks, policies, social contexts, and ground-level challenges facing Ghana in the context of its dual commitments to universal access to essential medicines on the one hand and the more comprehensive right to health on the other. I use Ghana as an exemplary nation in taking on these dual challenges and in making substantial progress in responding to them. I have been both instructed and inspired by Ghana's global leadership in the mental health domain, in particular, while at the same time, I cannot help but be reminded—from my work in Ghana and the United States—of how long we have to go before we can fully realize these goals.

3. The World Health Organization provides guidance for countries in developing and implementing national drug policies, highlighting “key components” of such policies like the selection of essential drugs, affordability, financing, supply systems, regulations, rational use, research, human resources development, and monitoring and evaluation. See WORLD HEALTH ORGANIZATION [WHO], HOW TO DEVELOP & IMPLEMENT A NATIONAL DRUG POLICY (2d ed. 2001), <http://apps.who.int/medicinedocs/pdf/s2283e/s2283e.pdf>.

4. The WHO Expert Committee on the Selection and Use of Essential Medicines maintains and updates both the WHO Model List of Essential Medicines and WHO Model List of Essential Medicines for Children, recommending “essential medicines” for different disease classes. These recommendations are meant to serve as a guide for countries institutions in forming their own essential medicines lists. See WHO Expert Comm. on the Selection & Use of Essential Meds., *The Selection & Use of Essential Medicines*, 994 WHO TECHNICAL REP. SERIES (2015).

people who need it at an affordable cost?<sup>5</sup>

Yes and no. As the following story will show, to evaluate whether peoples' right to essential medicines has *in fact* been fully realized, we must analyze the issue from where the people who need the drug actually stand.

## II. A STORY

Let's consider the issue from the perspective of an eighteen-year-old girl named "A," an aspiring primary school teacher, who lives in the north of the West African nation, about thirty kilometers west of the nearest village with a cell phone tower and electrical power. Unlike the thriving coastal region, this part of the nation is highly economically deprived. Indeed, families make ends meet by subsistence farming and remittances from family members. They suffer from many health challenges, including undiagnosed cancer; mobility impairments from childhood polio; river blindness; respiratory problems linked to cooking over charcoal fires; cholera and diarrhea from waste-polluted water; malaria; cardiovascular disease and diabetes linked to development-driven lifestyle changes; chronic exhaustion linked to farming in drought-parched soil; chronic severe depression; and other debilitating mental health conditions.

Due to the remoteness of the village, A had walked fifteen kilometers a day for a decade to complete secondary school and planned to travel south to seek work as a porter in the capital city's sprawling central market. However, her plans are interrupted, because over several weeks A becomes more and more agitated. She has racing thoughts and her words start to rush together. She loses sleep. Eventually, her behavior makes no sense at all, and she begins to threaten and strike out at family members who try to calm her down.

Unsure of what to do, A's family takes her to a local "prayer camp" where the pastors use harsh herbs and violent rituals to control her.<sup>6</sup> Her family eventually brings her home and, without other recourse, secures her with a log in a shed behind their compound, as other

---

5. United Nations [U.N.] Econ. & Soc. Council, Comm. on Econ., Soc. & Cultural Rights, General Comment No. 14: The Right to the Highest Attainable Standard of Health (Article 12 of the International Covenant on Economic, Social, and Cultural Rights), ¶ 12, U.N. Doc. E/C.12/2000/4 (Aug. 11, 2000) [hereinafter General Comment No. 14].

6. See generally HUMAN RIGHTS WATCH, LIKE A DEATH SENTENCE 30–36 (2012), <https://www.hrw.org/sites/default/files/reports/ghana1012webwcover.pdf>.

families have done to manage the same situation. Troubled by this “option,” they talk with many people in the area and decide to risk a journey to the government clinic in the district capital—a village just over fifty kilometers away where doctors are said to have “real drugs” that can make their daughter quiet. They borrow a motor bike and, through great effort, confine her in order to make the journey. So what happens when they get there? There are several possibilities:

The clinic could be closed due to a shortage of staff.

The clinic could be open, but, with staff who lack basic mental health training.

Or the clinic could have a visiting nurse on staff with some basic mental health training who visits the clinic once a week.

If A’s family chooses to wait, then the nurse might arrive. She might then tell them to go back to the prayer camp and be patient, or to see a traditional healer in her village. She could also say that A’s condition is “manic depression” and direct them to the psychiatric hospital in the capital city on the coast, some fourteen hours to the south by bus. There, A might become an “inmate,”<sup>7</sup> who at times is confined in a large open space with thirty others who have similar conditions. A might occasionally be cared for by dedicated nurses, but the hard-pressed psychiatrists who work in the nation’s public mental health system, would be far too busy to devote much time to her care.<sup>8</sup>

Alternatively, instead of sending the family to the city, the nurse who occasionally visits the community clinic might agree to help them. She might start by asking for the family’s national health insurance card to pay for the treatment A will receive. The family is not enrolled

---

7. In Ghana, mental health patients are commonly referred to as “inmates” despite the country putting forth reforms meant to address such stigma. Even though the law itself has changed, it takes public education—and time—for such changes to become common parlance across the population, especially in dispersed areas of the country. *See, e.g.*, Masahudu Ankiilu Kunateh, *Inmates of Pantang Hospital Get Free NHIS Cards*, GHANAIAAN CHRON. (Jan. 24, 2013), <http://thechronicle.com.gh/inmates-of-pantang-hospital-get-free-nhis-cards>; *Mental Health Inmates Deserve Dignity - Activists*, GHANA NEWS AGENCY (Oct. 12, 2015), <http://www.ghananewsagency.org/health/mental-health-inmates-deserve-dignity-activists-95606>. *See generally*, IRIN, *Ghana’s New Mental Health Bill Aims to Address Stigma*, GUARDIAN (Aug. 29, 2011), <http://www.theguardian.com/global-development/2011/aug/29/ghana-new-mental-health-bill>.

8. For example, Ghana was reported to be spending only 1.4% of its total health expenditures on mental health in 2011 and that low level of services was found to be concentrated in the urban areas, leaving virtually no resources in more rural areas. Mark Roberts et al., *An Overview of Ghana’s Mental Health System: Results from an Assessment Using the World Health Organization’s Assessment Instrument for Mental Health Systems (WHO-AIMS)*, INT’L J. MENTAL HEALTH SYS. (May 4, 2014), <http://www.ijmhs.com/content/8/1/16>.

in the health insurance scheme, however, because they cannot afford the annual premium. Yet the nurse does not know that she should not have asked for the card at all since mental health services are supposed to be free to everyone, whether or not a person is enrolled in the national health insurance scheme.<sup>9</sup>

Among the essential medicines to which *A* may be legally entitled to<sup>10</sup> for manic depression (or bipolar mania, as the doctors call it) is lithium, a naturally occurring element that is inexpensive for the government to obtain and is readily available—though not always used—in the capital city to the south. Yet even so, in the far northern government clinics where *A* is likely to be taken, the drug is often not there.

Or if the clinic has the drug available, the nurse might not know that it will help *A*. Or if she does know, she may not remember the dosage she should give to avoid a toxic overdose. Alternatively, if the nurse does know how much of the drug to give *A*, she might not be able to let her patient stay in the clinic overnight and thus must send her away with a bottle of pills to take when she gets home. But in either case, neither the clinic nor *A*'s family will have the equipment, or the technical training, to monitor her blood levels on a regular basis so as to protect against toxicity in the future. Thus, without access to follow-up testing, *A* might become very sick. Or she might die.

But before this scenario even happens, it is more likely that her family will stop giving her the drug. They might then take her back to the clinic to have the nurse sort things out, which, without equipment and know how, she won't be able to do. They might take her back to a prayer camp. Or they might secure her in the shed once more, releasing her under their guard to do house chores when they can.

---

9. For example, although people are entitled to free mental health care under the terms of Ghana's Mental Health Act of 2012 § 88 (Act No. 846/2012), the National Health Insurance Act further provides that "a person with mental disorder" is exempted from paying to enroll in the National Health Insurance Scheme (NHIS) and is entitled to the NHIS's health benefits as a member. National Health Insurance Act § 29(c) (Act No. 852/2012) (Ghana).

10. For example, people enrolled in Ghana's National Health Insurance Scheme are entitled to certain essential psychiatric medications under the terms of that program. See National Health Insurance Act § 33(1) (declaring that the National Health Insurance Scheme Medicine List shall be "derived from the Essential Medicines List approved by the Minister," which in turn is based off the WHO's Model List of Essential Medicines); *Benefits Package*, NAT'L HEALTH INS. SCHEME (Ghana), <http://www.nhis.gov.gh/benefits.aspx> (last visited Apr. 12, 2016) (listing NHIS's benefits and excluding medicines not on the NHIS Medicines List). *Compare NHIS Medicines List*, NAT'L HEALTH INS. SCHEME (Ghana), <http://www.nhis.gov.gh/medlist.aspx> (last visit Apr. 12, 2016) (listing medicines covered by the NHIS), with MINISTRY OF HEALTH: GHANA NATIONAL DRUGS PROGRAMME, GHANA ESSENTIAL MEDICINES LIST (6th ed. 2010).

International human rights groups or investigative journalists might then come to A's family home, or the homes of others like them, to expose A's plight as a human rights violation typified by her failure to receive an essential medicine that she should have been entitled to. Those groups might note that, while A was thus deprived of her basic rights, the drug that she needed was in plentiful supply. For it is easier for such commentators, or accusers, to portray the story's end as a human rights wrong than to map out the systemic failures that the chain of "perpetrators" confronts along the way.<sup>11</sup>

### III. HUMAN RIGHTS VIOLATIONS?

The story of A is a story of multiple failings, not in the performance of individuals or corporate entities, but in the *institutions and systems* that failed to deliver the medicine that "last kilometer" to the people who need them. To some degree these failings can be attributed to a shortage of money and the human competencies required to perform needed mental health roles.<sup>12</sup> Yet it is not just a question of money. It is also a question of how the money and people that can reasonably be made available can be woven together into synergistic systems of care.

#### *A. Promoting the Right to Essential Medicines: A Systems Perspective*

The point of this paper is that if we are serious about realizing the right to essential medicines, we must evaluate that right to essential

---

11. This paragraph, as well as the following, suggest not just the need for systemic analysis in order to identify the causes of, and point toward potential remedies for, ostensible "human rights violations." The paragraph also suggests that conventional economic and social rights analyses, when it fails to do a systemic analysis, ends up blaming not so much the victim, but those actors in a complex bureaucracy, like the nurses, psychiatrists, or family, in A's situation, who are doing their very best to respond to her needs with critically limited resources which are themselves only forthcoming within the context of inadequate delivery systems. Such a scenario can be deemed as an example of "structural violence," which has been defined as the following:

The term "structural violence" is one way of describing social arrangements that put individuals and populations in harm's way. The arrangements are *structural* because they are embedded in the political and economic organization of our social world; they are *violent* because they cause injury to people (typically, not those responsible for perpetuating such inequalities). With few exceptions, clinicians are not trained to understand such social forces, nor are we trained to alter them. Yet it has long been clear that many medical and public health interventions will fail if we are unable to understand the social determinants of disease.

Paul Farmer et al., *Structural Violence and Clinical Medicine*, 3 PLOS MED. 1686, 1686–87 (2006).

12. WHO, MENTAL HEALTH LEGISLATION & HUMAN RIGHTS 6 (2003), [http://www.who.int/mental\\_health/resources/en/Legislation.pdf](http://www.who.int/mental_health/resources/en/Legislation.pdf).

medicines from rights *holders'* perspectives. We must not just count the sale price of pills on the shelves. Rather, we must do the much harder work of keeping an eye on the pills as we contrast the journeys of rights holders through existing *systems of care* against optimal ones. Did those people end up getting the medicines they were entitled to on an ongoing basis? If not, what didn't they get? And *where did the system break down?* It is at these points of system breakdown, in situ, where the human rights violations lie.

Viewing human rights realization from such a systemic perspective is crucial for many reasons. Among the most important is that a "smart" change in system design can save a lot of money in contexts where money is short<sup>13</sup>; conversely, a very large increase in budget will have little impact without the system's capacity to "absorb" those funds in productive ways.<sup>14</sup>

### B. Why Start with A?: "From Margin to Center"<sup>15</sup>

Why start with A's case in an essay arguing that the right to essential medicines must be understood in *systemic* terms? Isn't her chronic mental illness at the margins of the whole concept of essential medicines? For instance, shouldn't we be starting our analysis with malaria or Ebola, i.e., those infectious diseases that put us at risk of widespread epidemics and for which we need a pharmaceutical cure?

Indeed, what *do* we gain by centering our analysis of essential

---

13. See, e.g., Bella English, *In Rwanda, Visionary Doctor Is Moving Mountains Again*, BOSTON.COM (Apr. 13, 2008), [http://archive.boston.com/news/world/articles/2008/04/13/in\\_rwanda\\_visionary\\_doctor\\_is\\_moving\\_mountains\\_again](http://archive.boston.com/news/world/articles/2008/04/13/in_rwanda_visionary_doctor_is_moving_mountains_again) (discussing Paul Farmer's work in Rwanda, where a primary care system that used community-based paramedics in a thoughtful way both greatly improved quality and saved valuable resources at the same time).

14. In the context of global health aid, Jeffrey Sachs argues against the notion that a health sector's insufficient "absorptive capacity" with respect to lacking infrastructure and capital can render excess aid futile. Rather, keeping those system constraints in mind, such aid can be used to address those constraints or channeled in alternative ways to further the provision of health care. JEFFREY SACHS, *THE END OF POVERTY* 274 (2005).

15. BELL HOOKS, *FEMINIST THEORY: FROM MARGIN TO CENTER* (1984). We have used A's case as a lens similar to the lens adopted by noted radical feminist Bell Hooks (also known as Gloria Watkins), using her experiences living in black America, in order to assess central, systemic issues in the eyes of one who experiences the negative effects of those issues at the outskirts of the system. As Hooks wrote in the preface to her book *Feminist Theory*:

To be in the margin is to be part of the whole but outside the main body . . . Living as we did—on the edge—we developed a particular way of seeing reality. We looked from both the outside in and the inside out. We focused our attention on the center as well as the margin. We understood both. This mode of seeing reminded us of the existence of a whole universe, a main body made up of both margin and center.

*Id.* at ix.

medicines on A's situation? The answer is simply this: expanding the concept of essential medicines to respond to A's *treatment* needs will help us expand our understanding of what kinds of "medicines," in its holistic meaning, are required for *all* health conditions, even those that are wrongly perceived to respond to one-time chemical treatment alone.

So what are the features of mental health conditions that challenge our limited conception of "medicine" for all health conditions?<sup>16</sup> Four of these features stand out. First, since its origins, the policy of listing essential medicines has focused on infectious diseases generally occurring in previously colonized regions. Such diseases were believed to cause widespread epidemics if the infected person was not either isolated from others or cured through chemical intervention. Mental health conditions, in contrast, often benefit from drugs, but only in the context of ongoing practices of family and community-embedded care. Second, though our core concept of essential medicines has finally begun to expand to include drugs for noncommunicable diseases (NCDs) like diabetes, arteriosclerosis, and cancer, those diseases are too often considered treatable by "miracle" drugs like insulin, rather than through drugs in the context of comprehensive care. We have seen that mental health conditions, without exception, require treatment in the context of networks of ongoing care. Third, unlike both infectious diseases and NCDs, mental health conditions are not yet perceived to be somatic. Yet since they are, in fact, *both* somatic and more, they challenge the rigid division between that part of the person that can be treated with "medicines" and that part which is outside their scope. Fourth, mental health conditions are highly stigmatized across many cultures. Indeed, many mental health conditions are widely believed to be afflictions of character or spirit rather than body. They thus impose stigma on caretakers, taxing their courage, as well as patience, in profound ways. Though this feature of mental health conditions may be viewed as unique, this shadow of stigma has and continues to affect the experience and concept of illness itself, and the caretakers who respond to afflicted people's needs.

In conclusion, let us imagine bringing these four features of mental health conditions from the "margin to center" in our analysis of the "medicine" required to treat all health conditions, even those which at first glance appear to fit most tightly into the predominant paradigm. Consider Ebola. A vaccine and effective antiviral medications will

---

16. The following stereotypes are based on my own practical experience with mental health advocacy and broad knowledge of both stereotypes and realities surrounding it.

help, but the disease afflicts more than the body of the infected person alone. It also affects the wellbeing and resilience of the patient and her family and community in comprehensive ways. It cannot be either contained or effectively treated unless there are longer term drug treatments; community-based preventative and responsive practices; education and awareness to combat stigma; and both patience and courage among the many affected people.

*C. The Right to Drugs / The Right to Care: A Call for Pragmatic Action*

Thus, I take the hard case of A's bipolar condition to challenge and contribute to the reframing of the right to essential medicines *from rights holders' perspectives* in the following way. Let us start by reframing human rights and "economic and social rights," like the right to essential medicines in particular, as something other than lists of discrete pharmaceutical products. Let us understand that right not as a tangible thing, but as a call to action. Let us understand that right not just as a call to action but as a call for *pragmatic* action—a call for specific, feasible steps that people can take together in various ways. Let us understand pragmatic action as action that addresses the treatment challenge from the bottom up and top down, so as to connect people with what they need to maintain wellbeing, even while sick, not through drugs alone, but through *drugs within systems of care*.

I will contribute to this reframing in the following way. First, I will show how the concept of essential medicines since its origins has been constrained within a formalistic frame. Second, I will show how the dominant frame for understanding human rights has been similarly formalistic. Thus, rather than nudging our understanding of health rights *toward* pragmatic action, the convergence of human rights doctrine and essential medicines policy has undermined that goal. Third, I will show how the movement for HIV/AIDS treatment, specifically in the context of antiretroviral (ARV) drugs, finally reframed the right to essential medicines from a formalistic conception into a call for social movement and pragmatic action for change. Next, I will discuss the limits and potential of the HIV treatment access movement from the perspective of both HIV-affected individuals and people like A affected by other health conditions. Finally, I will show how a public health movement that embeds within it the right to essential medicines can transform the demand for "access to essential medicines" into a call—and a movement—for holistic systems of care.

### 1. On Essential Medicines

The concept of essential medicines has, from its origins, been constrained within a formalistic frame. It had its modern origins in the aftermath of World War I, when the WHO was founded.<sup>17</sup> Since then, the WHO has developed the concept in a more and more detailed way. This effort reached a turning point in 1977, when the WHO first issued an annual list of recommended essential medicines, along with the recommendation that individual nations draw from this list to create their own lists of essential medicines to respond to their own contexts.<sup>18</sup> Each nation was then to use its list to inform a range of specific health policy decisions, from determining which drugs would be available free of charge in public hospitals and clinics, to which drugs would be reimbursed by public insurance and subsidy programs, to similar policies. Over 150 nations have now opted into this essential medicines scheme.<sup>19</sup>

The WHO compiles its official essential medicines list on the basis of a cost/benefit calculus that takes account of factors that include cost; comparative effectiveness; safety; ease of dispensing and use; and the like.<sup>20</sup> The list is revised every two years as new drugs reach the market, older drugs become less expensive, the disease burden shifts, and the calculus's bottom line therefore changes.<sup>21</sup> The WHO's most recent list was issued in April 2015.<sup>22</sup> Its listed drugs cover the full range of common medical conditions for both infectious and non-communicable diseases and major mental health conditions. It would be a remarkable global health accomplishment for all of the drugs on the WHO list to be actually available and effectively administered on

---

17. John Charles, *Origins, History, and Achievements of the World Health Organization*, 2 BRIT. MED. J. 293, 294 (1968).

18. Richard Laing et al., *25 Years of the WHO Essential Medicines Lists: Progress and Challenges*, 361 LANCET 1723, 1723 (2003). WHO's conception of essential medicines has evolved over time, initially defined as those medicines that were "of utmost importance, basic, indispensable and necessary for the health and needs of the population." *Id.* Today, essential medicines are recognized as "those that satisfy the priority health care needs of the population and "are selected with due regard to public health relevance, evidence on efficacy and safety, and comparative cost-effectiveness." *Essential Medicines*, WHO, [http://www.who.int/topics/essential\\_medicines/en/](http://www.who.int/topics/essential_medicines/en/) (last visited Apr. 29, 2016).

19. Laing, *supra* note 18.

20. WHO, WHO Medicines Strategy: Revised Procedure for Updating WHO's Model List of Essential Drugs, annex, WHO Doc. EB109/8 (Dec. 7, 2001), <http://apps.who.int/medicinedocs/documents/s22165en/s22165en.pdf>.

21. See, e.g., *WHO Moves to Improve Access to Lifesaving Medicines for Hepatitis C, Drug-Resistant TB and Cancers*, WHO (May 8, 2015), <http://www.who.int/mediacentre/news/releases/2015/new-essential-medicines-list/en>.

22. WHO Expert Comm. on the Selection & Use of Essential Meds., *supra* note 4, annex I.

a regular basis to all people in need of them, in rural as well as urban areas, low income as well as affluent regions, powerful as well as less powerful enclaves, all over the globe. Needless to say, this is not the case, nor do WHO's health policy strategists expect that such a high-level intervention, taken alone, ought to be sufficient to produce that result.<sup>23</sup>

## 2. On Human Rights

This history might also be traced back to the World War I era, but its defining moment came at the close of World War II, when, under the guidance of Eleanor Roosevelt and others, the Universal Declaration of Human Rights<sup>24</sup> was drafted.<sup>25</sup> In this defining moment, the idea of a right to health was not treated at length. Nonetheless, the document created the foundational text—the constitutional framework—on which the International Covenant of Economic, Social, and Cultural Rights (ICESCR) subsequently codified a formal right to health in greater detail in its Article 12.<sup>26</sup> The Covenant placed the legal burden on nation states to take steps to “progressively realize” the right to health to the degree that they are able to under the circumstances.<sup>27</sup>

The ICESCR was itself explicated in great detail in the highly

---

23. See generally WHO, *supra* note 3. As the WHO has recognized:

These problems [of lack of access to essential drugs, poor quality, and irrational use] have persisted despite all the work done to improve access to essential drugs, to ensure drug quality and to promote rational drug use. The reasons are complex and go beyond simple financial constraints. To understand them it is necessary to look at the characteristics of the drug market, and to study the attitudes and behavior of governments, prescribers, dispensers, consumers and the drug industry. Health sector development, economic reform, structural adjustment policies, trends towards liberalization, and new global trade agreements all have a potential impact on the pharmaceutical situation in many countries. They may also affect the ultimate goal of achieving equity in health.

*Id.* at 4.

24. G.A. Res. 217 (III) A (Dec. 10, 1948).

25. *History of the Document*, U.N., <http://www.un.org/en/sections/universal-declaration/history-document/index.html> (last visited Apr. 13, 2016).

26. G.A. Res. 2200A (XXI), annex, at 51 (Dec. 16, 1966).

27. *Id.* at 49 (“Each State Party to the present Covenant undertakes to take steps, individually and through international assistance and co-operation, especially economic and technical, to the maximum of its available resources, with a view to achieving *progressively the full realization* of the rights recognized in the present Covenant by all appropriate means, including particularly the adoption of legislative measures.” [emphasis added]); Hans V. Hogerzeil & Zafar Mirza, *THE WORLD MEDICINES SITUATION 2011: ACCESS TO ESSENTIAL MEDICINES AS PART OF THE RIGHT TO HEALTH* § 1.1.1–.3, WHO (2011), <http://apps.who.int/medicinedocs/documents/s18772en/s18772en.pdf> (summarizing the bases for the legal enforceability of the right to health in the ICESCR and the right to essential medicines that stem from that).

significant General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12) (Comment No. 14).<sup>28</sup> This document makes clear that accessible, affordable, and high quality medicines required for persons to achieve the highest attainable standard of health, including essential medicines, be made available to all according to the Comment No. 14's and ICESCR's terms.<sup>29</sup> Thus, the promulgation in 2000 of Comment No. 14 marks a convergence of the right to health and essential medicines domains. Embedding the essential medicines *policy* into a broader right to health *movement* might now seem obvious. Yet at the time that the right to health was codified, it was not understood to intersect directly with the WHO's listing of essential medicines. Nor was an intersection between the two domains a focus of advocates' attention. Indeed, as essential medicines has gradually become a key health right for advocates to fight for, as well as a complex inventory for experts to compose, scholars and activists alike have thought hard about the value of this linkage.

Since the promulgation of Comment No. 14, the challenge of "implementation" has too often been deferred.<sup>30</sup> When it hasn't, the most common method for incentivizing implementation has been using checklists of "indicators" that can be feasibly assessed on a national or international scale.<sup>31</sup> Thus, research might assess how many of a sample of a nation's essential medicines it has on hand, and the cost to the government of each. Although one might say that this sort of monitoring is better than nothing, it bears noting that the focus of this monitoring of *implementation* is not from the rights *holders'* perspectives, but from the vantage point of the nation state and international entities that produce and control the supply. Another illustration of this supply-side bias in implementation advocacy is the almost exclusive focus among essential medicine advocates, particularly lawyers, on features of international intellectual property regimes—notably the requirements in international trade agreements for the transnational enforcement of pharmaceutical patents—that have kept the cost of many drugs

---

28. General Comment No. 14, *supra* note 5.

29. *Id.* ¶¶ 4, 12(a).

30. This gap is now widely recognized and a major focus of academic and pragmatic attention. *See generally* KATHARINE G. YOUNG, CONSTITUTING ECONOMIC AND SOCIAL RIGHTS (2012) (elaborating why it is so difficult for courts to adjudicate economic and social rights claims in ways that succeed in "getting the food on the table" and how creative constitutional courts, such as those in South Africa, India, and Colombia, have crafted different kinds of remedies that have overcome this challenge).

31. *See, e.g.,* WHO, USING INDICATORS TO MEASURE COUNTRY PHARMACEUTICAL SITUATIONS: FACT BOOK ON WHO LEVEL I AND LEVEL II MONITORING INDICATORS 1–2 (2006), <http://www.who.int/medicines/publications/WHOTCM2006.2A.pdf>.

on essential medicines lists exorbitantly high.<sup>32</sup>

Although it goes without saying that this work is very important, it must be noted it crowds out other kinds of scholarly and advocacy work. First, this heavy focus on intellectual property issues shifts attention away from other important domains where human rights issues can arise, such as the drugs that are excluded—or included—on a nation’s list, and the law, policy, and politics through which the WHO and national lists are composed. Second, this emphasis on intellectual property issues can narrow the framing of the social movement for essential medicines away from “the last kilometer,” i.e., the daunting issues of law and human rights that must be addressed to get essential drugs—even those that are on all the lists, not covered by patent protections, and already in a nation’s port city—into rights holders’ hands.

Although launching a social movement for essential medicines that is framed by human rights might seem like an unequivocal plus,<sup>33</sup> when the dominant, formalistic understanding of human rights guides the building of the movement, this turn to human rights in the essential medicines context has a few downsides. One cluster of costs has to do with the tactical limits that a human rights framework can impose on an essential medicines movement. For instance, a human rights framework can—but need not—preclude other normative framings, like public health or moral duty. It can narrow the attention of lawyers and other advocates to a limited and sometimes highly technical range of values, laws, and strategies.<sup>34</sup> This framework can also work, perversely, to excuse a failure to get drugs to those who need them: for, some human right advocates might argue, so long as the nation has complied with its duty to endorse the sacred “list” and procure the drugs, then the right has been fulfilled. Furthermore, a human rights framework, in any context, including essential medicines, can demobilize and ramp down what might be a powerful social movement by channeling people’s energy into writing reports, appearing before official commissions, filing lawsuits, and the like, rather than more robust forms of protest.

---

32. See, e.g., Brook K. Baker, *Patents, Pricing, and Access to Essential Medicines in Developing Countries*, 11 VIRTUAL MENTOR 527, 528 (2009).

33. Fran Quigley, *The Trans-Pacific Partnership and Access to Medicines*, HEALTH & HUM. RTS. J. (June 18, 2015), <http://www.hhrjournal.org/2015/06/the-trans-pacific-partnership-and-access-to-medicines>.

34. See generally DAVID KENNEDY, *The International Human Rights Movement: Part of the Problem?*, in THE DARK SIDES OF VIRTUE: REASSESSING INTERNATIONAL HUMANITARIANISM 3–35 (2004).

The second set of costs of a human rights framework for an essential medicines movement has to do with the stylized roles within which the framework confines the actors who are involved. One commentator has described these roles as the savages, victims, and saviors.<sup>35</sup> In this schema, the “victims,” those who need essential medicines, are configured as sickly, weak, passive people who are incapable of feeling anger, not to mention channeling that anger into concerted *political* action. They are thus deemed unable to analyze challenges strategically; identifying overlapping interests, including those that they share with adversaries; mapping the actors’ powers and vulnerabilities; creating politically savvy relationships, linkages, and coalitions; and using human rights rhetoric and strategies deliberately, so as to make use of their power.<sup>36</sup> This formidable array of capacities is suppressed rather than enhanced by the “victim script” in which human rights discourse locks them.<sup>37</sup>

The savages-victims-saviors schema also traps the “saviors,” or the coalitions of doctors, lawyers, and academics, for instance, into a paternalistic, humanitarian stereotype, no matter what their actual intentions might be.<sup>38</sup> This humanitarian script has been trenchantly traced to images of colonial settings, endemic with killer diseases, where soldiers worked hand-in-hand with doctors to save the native peoples to work in the mines.<sup>39</sup>

Finally, the savage-victim-savior schema blocks the capacity and motivation of all in the triad to analyze the complex structural and institutional architecture of the pharmaceutical industry and other actors—from global to local—which are part of the reason that the drugs are not there. This “savage” script that human rights framing<sup>40</sup> can imply does little, in the end, to generate broad and rich ideas. For as noxious as a system that uses money to entice the innovation of drugs for elites while poor people die, even this space offers sites for reform. For instance, incentives for drug innovation need not come exclusively from the rights holders’ own market power. It might come from human

---

35. Makau Mutua, *Savages, Victims, and Saviors: The Metaphor of Human Rights*, 42 HARV. INT’L L.J. 201 (2001).

36. See generally Jeremy Perelman & Lucie White, *Stones of Hope: Experience and Theory in African Economic and Social Rights Activism*, in STONES OF HOPE: HOW AFRICAN ACTIVISTS RECLAIM HUMAN RIGHTS TO CHALLENGE GLOBAL POVERTY 149–71 (Lucie White & Jeremy Perelman eds., 2011).

37. See generally Mutua, *supra* note 35, at 203–204, 228–233.

38. See generally *id.* at 204, 233–242.

39. Jeremy Greene et al., *Colonial Medicine and Its Legacies*, in REIMAGINING GLOBAL HEALTH 38 (Paul Farmer et al. eds., 2013).

40. See generally Mutua, *supra* note 35, at 202–203, 219–227.

rights strategists' shaming; competition from public suppliers; philanthropic grants; global funds; negotiated G8 contributions; consumer and shareholder pressure; or an upsurge of direct social movement for change.<sup>41</sup> As easy, and satisfying, as it feels to just "blame big pharma," the slogan does not always lead to creative political action.

A further problem arises when the concept of essential medicines is changed into a human rights movement because of a foundational tension embedded in the human rights concept itself. This is the tension between first generation "negative" rights, on the one hand, and the much more problematic second generation "positive" rights on the other.<sup>42</sup> For example, it might be considered a clear first generation human rights violation for a nation to discriminate against women or other vulnerable groups in the distribution of a limited supply of essential medicines.<sup>43</sup> Or it might be considered a human rights violation for the government to obstruct the delivery of essential medicines to areas with large communities of ethnic or religious minorities.<sup>44</sup> Or it might be considered a violation for the government to withhold an essential medicine from an imprisoned journalist to inflict extreme pain—or torture—in addition to imprisonment for her opposition of

---

41. See, e.g., William Forbath, *Cultural Transformation, Deep Institutional Reform, and ESR Practice: South Africa's Treatment Action Campaign*, in *STONES OF HOPE: HOW AFRICAN ACTIVISTS RECLAIM HUMAN RIGHTS TO CHALLENGE GLOBAL POVERTY* 51–90 (Lucie White & Jeremy Perelman eds., 2011) (describing the movement in South Africa to require the government to provide free ARVs to pregnant women in order to block HIV transmission to their newborns).

42. Negative rights are those rights also considered to be civil liberties such as the freedom from torture, freedom of speech, freedom of the press, freedom of religion, freedom to assemble, and the like. These are called "negative" because they are believed to require the state to refrain from taking action that harms citizens or limits their fundamental liberties, while positive rights are the "economic and social rights" that are believed to require the state to act affirmatively, generally by spending money, in order to provide people the goods required for their survival, well-being, and thriving as human beings. See *INTERNATIONAL HUMAN RIGHTS IN CONTEXT: LAW, POLITICS, MORALS* 186 (Henry Steiner et al. eds., 3d ed. 2007).

43. See, e.g., Ellen Barry & Celia W. Dugger, *India to Change Its Decades-Old Reliance on Female Sterilization*, N.Y. TIMES (Feb. 20, 2016), <http://www.nytimes.com/2016/02/21/world/asia/india-to-change-its-decades-old-reliance-on-female-sterilization.html> (discussing recent efforts in India to make additional forms of birth control publicly available for women, a shift from its historical reliance on state-sponsored sterilization through tubal ligation).

44. See, e.g., Stephanie Nebehay et al., *U.N. Fears for Hundreds of Thousands if Syria Troops Encircle Aleppo*, REUTERS (Feb. 9, 2016), <http://www.reuters.com/article/us-mideast-crisis-syria-un-idUSKCN0VIOT8> (covering the cutting off of humanitarian aid to citizens by Syrian government-led troops encircling the rebel-held city of Aleppo); Jane Perlez, *Death Stalks Muslims as Myanmar Cuts Off Aid*, N.Y. TIMES (May 2, 2014), <http://www.nytimes.com/2014/05/03/world/asia/death-stalks-muslims-as-myanmar-cuts-off-aid.html> (detailing the cutting off of humanitarian aid and medical care by the Buddhist-led Myanmar government as part of a larger crackdown against the country's Rohingya Muslim minority).

the government.<sup>45</sup> In all of these examples, the state *uses its control over the essential medicines supply* to violate one of a person's clearly established "first generation" human rights. Such exploitation of the essential medicines framework to make it a vehicle for violating the most fundamental human rights of citizens is clearly an outrage, if not also, in some cases at least, an actionable crime.

Yet it is much more difficult for human rights discourse to be deployed to target the background economic and social *conditions*—summed up in poverty—that obstruct the ground-level realization of the "human right" to getting high quality essential medicines in the context of effective essential care. For indeed, efforts of advocates to "stretch" human rights discourse to help deliver discrete commodities like housing or education have been very challenging.<sup>46</sup> Further efforts to deploy human rights tools to secure complex systems of care are unquestionably on the cutting edge of human rights advocacy.<sup>47</sup> But little progress on this front has yet been made.

### 3. On HIV, MSF, and Global Poverty

Public awareness of essential medicines increased in the 1980s and 1990s in the context of the AIDS crisis. Social movement arose, particularly in South Africa and the United States, as ARVs were developed but made unavailable to HIV-positive low income people, particularly in sub-Saharan Africa.<sup>48</sup> Eventually, after intensive organizing by South Africa's Treatment Action Campaign (TAC), the South African Constitutional Court issued a landmark decision, *Minister of Health v. TAC*,<sup>49</sup> which required the South African government to make Nevirapine, an ARV, available to HIV-infected pregnant women

---

45. See, e.g., *China's Ailing Prisoners*, WALL ST. J. (June 29, 2015), <http://www.wsj.com/articles/chinas-ailing-prisoners-1435595053> (reviewing the denial of medical treatment to reporter Gao Yu and other Chinese political prisoners by their government).

46. See, e.g., *Government of the Republic of South Africa v. Grootboom* 2001 (1) SA 46 (CC) (demonstrating the difficulties of the South African Constitutional Court in delivering housing to citizens claiming fundamental rights to housing even though both the Constitution and the Court itself recognized their formal entitlement to that right).

47. See, for instance, the efforts of the Colombian Constitutional Court to use its remedial powers in creative ways to compel the government to reform the entire institutional structure of the nation's health system. See Helena Alviar García, *Distribution of Resources Led By Courts: A Few Words of Caution*, in SOCIAL AND ECONOMIC RIGHTS IN THEORY AND PRACTICE: CRITICAL INQUIRIES 67–81 (Helena Alviar García, Karl Klare, & Lucy A. Williams, eds., 2015). See generally YOUNG, *supra* note 30.

48. Mark Heywood, *South Africa's Treatment Action Campaign: Combining Law and Social Mobilization to Realize the Right to Health*, 1 J. HUM. RTS. PRAC. 14, 17–19 (2009).

49. *Minister of Health v. Treatment Action Campaign* (2002) (5) SA 721 (CC).

to prevent the infection of their newborn children.<sup>50</sup> Energized by this victory, this social movement expanded to address killer infectious diseases in low income nations more broadly. Social movement campaigns promoting drug treatment, universal vaccination, vaccine development, and disease eradication for the major infectious disease drugs emerged across the globe.<sup>51</sup> These campaigns helped to transform WHO's essential medicines policy into a social movement that, for all of their inherent limits, would nonetheless soon become framed in human rights terms. Because of the cost of patented ARV drugs in South Africa and elsewhere, the intellectual property questions became a major, and needed, focus of both legal strategy and social movement action.

A turning point in this HIV-prompted social movement for essential medicines came in 1999, when *Médecins Sans Frontières (MSF)*, or Doctors without Borders, earned a Nobel Prize and then decided to use the funds it was awarded to launch its own essential medicines movement.<sup>52</sup> In the early 2000s, WHO began to issue its own guides to essential medicines advocacy.<sup>53</sup> Since then scholars like Thomas Pogge<sup>54</sup> and Jeffrey Sachs<sup>55</sup> and philanthropists like Bill and Melinda

---

50. *Id.* ¶ 135.

51. *See, e.g., Involving Everyone: Social Mobilization Is Key in an Ebola Outbreak Response in Guinea*, WHO (May 2014), <http://www.who.int/features/2014/social-mobilisation/en> (describing direct community outreach efforts to educate Guineans affected by Ebola outbreaks); STOP TB PARTNERSHIP, ADVOCACY, COMMUNICATION AND SOCIAL MOBILIZATION SUBGROUP AT COUNTRY LEVEL, ADVOCACY, COMMUNICATION AND SOCIAL MOBILIZATION TO STOP TB, WHO Doc. WHO/HTM/STB/2006.37 (2006), <http://www.stoptb.org/assets/documents/resources/publications/acsm/tb-advocacy.pdf> (laying out a ten-year strategic framework for advocacy, communication, and social mobilization to combat the spread of tuberculosis); Maxine A Whittaker et al., *Advocating for Malaria Elimination - Learning from the Successes of Other Infectious Disease Elimination Programmes*, 13 *MALARIA J.* (June 5, 2014), <http://malariajournal.biomedcentral.com/articles/10.1186/1475-2875-13-221> (reviewing the lessons of “globally-coordinated elimination advocacy campaigns” for infectious diseases and how they can be applied towards the elimination of malaria).

52. *About Us*, MEDECINS SANS FRONTIERES ACCESS CAMPAIGN, <http://www.msfaccess.org/the-access-campaign> (last visited Mar. 15, 2016).

53. *See, e.g., WHO, WHO MEDICINES STRATEGY: FRAMEWORK FOR ACTION IN ESSENTIAL DRUGS AND MEDICINES POLICY 2000-2003*, WHO Doc. WHO/EDM/2000.1 (2000), <http://apps.who.int/medicinedocs/pdf/whozip16e/whozip16e.pdf>.

54. *See generally* Thomas W. Pogge, *Eradicating Systemic Poverty: Brief for a Global Resources Dividend*, 2 *J. HUM. DEV.* 59 (2001); Thomas W. Pogge, *Human Rights and Global Health: A Research Program*, 36 *METAPHILOSOPHY* 182 (2005) [hereinafter Pogge, *Human Rights and Global Health*].

55. *See generally Millennium Promise: About Us*, MILLENNIUM VILLAGES PROJECT, <http://millenniumvillages.org/millenniumpromise> (last visited May 5, 2016) (overviewing Millennium Promise, an organization co-founded by Jeff Sachs, which “believe[s] that poverty in all its forms can be eliminated by 2030, even in the most challenging and remote places in the world”).

Gates<sup>56</sup> have launched a comprehensive movement to combat global poverty. The most urgent issue in their campaigns has been the unconscionable mortality rate in less developed nations from the major infectious diseases, notably malaria, tuberculosis, and AIDS.<sup>57</sup> Eventually, the United Nations appointed a Special Rapporteur on Extreme Poverty to consolidate these efforts.<sup>58</sup>

It can be seen that even as HIV and global poverty movements energized the confluence of human rights and essential medicines, the movement's focus remained *upstream*. That focus did not shift from blockages in the *sourcing* of affordable drugs, like intellectual property constraints, to the even more challenging issues that arise along the "last kilometer," between the last links in the supply chains and the rights holders' hands. Rather, and ironically perhaps, even as the HIV movement's demand for universal access to ARV medication went viral, so to speak, its focus remained upstream, instead of on the ground.

One final upshot of the upstream focus of the essential medicines/human rights social movement is that the focus on unblocking sources of costly drugs through international lawyering and geopolitical activism has unintentionally entrenched a magical landscape in which miracle drugs can zap "real" diseases, while noncommunicable, chronic, lifestyle-linked, and especially mental health conditions are less worthy of activists' time. We must redraw that landscape, so that *all* health conditions, from mental illness to malaria to HIV, are *treated* rather than zapped, through networks of care.

---

56. See generally *What We Do*, BILL & MELINDA GATES FOUND., <http://www.gatesfoundation.org/What-We-Do> (last visited May 5, 2016) (describing the work of the Bill & Melinda Gates Foundation's Global Development Division: "Nearly 2.5 billion people worldwide live on less than US\$2 a day, and more than 1 billion suffer from chronic hunger. For these people, the basics of food, water, shelter, and sanitation are in short supply, and healthcare and education can be unaffordable luxuries. Our Global Development Division aims to identify and fund high-impact solutions that can help hundreds of millions of people lift themselves out of poverty and build better lives.").

57. See Pogge, *Human Rights and Global Health*, *supra* note 54, at 182–84; *Global Fund Overview*, GLOBAL FUND, <http://www.theglobalfund.org/en/overview/> (last visited Mar. 15, 2016) (describing the fund as a "partnership organization designed to accelerate the end of AIDS, tuberculosis and malaria as epidemics"). See generally Marcella M. Alsan et al., *Poverty, Global Health and Infectious Disease: Lessons from Haiti and Rwanda*, 25 *INFECTIOUS DISEASE CLINICS N. AM.* 611 (2011) (exploring the association between poverty and communicable disease based on the authors' experiences in Haiti and Rwanda).

58. See *Special Rapporteur on Extreme Poverty and Human Rights*, U.N. OFF. HIGH COMMISSIONER FOR HUMAN RIGHTS. [OHCHR], <http://www.ohchr.org/EN/Issues/Poverty/Pages/SRExtremePovertyIndex.aspx> (last visited Mar. 15, 2016).

### *D. Recalling Alma Ata*

Eventually the HIV crisis brought home to essential medicines/human rights activists that it takes more than unblocking drug supplies at the international and national levels in order to ensure that essential medicines reach the rights holders who need them. When health systems and rights holders are under-resourced, sometimes dispersed across wide areas, and in need of drug regimes embedded in long-term treatment practices—when all of these challenges are there, as they almost always are—then it takes more than formal lists, patent overrides, inspiring court decisions, and global activists' fervor to get those treatments transmuted into ongoing care. South Africa was confronted by this multiplex challenge in implementing the spirit as well as the letter of their Constitutional Court's landmark decision in *Minister of Health v. TAC* in order to get ARVs to all the entitled rights holders in need.<sup>59</sup>

In this context, a separate history of insight and action about public health *system* design has been recovered and mined. This history began at the 1978 International Conference on Primary Health Care held in Alma Ata, in what is now Kazakhstan but was then part of the former Soviet Union.<sup>60</sup> At this path breaking conference, representatives from developing and other nations came together to synthesize insights from a plethora of experimental practices in under-resourced regions. Their goal was to articulate a plural vision of health care delivery systems for multiple under-resourced settings. The common theme in this vision would be three grounding elements. The first was strong state responsibility for the funding and oversight of each nation's primary care-based health system. The second was the integration of all three tiers of the system (i.e., primary, secondary, and tertiary care). The third was the creative design of primary health care institutions, networks, and networks of community engagement on the ground.<sup>61</sup>

The Alma Ata vision thus drew on innovations in primary health

---

59. See Nathaniel Bruhn, *Litigating against an Epidemic: HIV/AIDS and the Promise of Socioeconomic Rights in South Africa*, 17 MICH. J. RACE & L. 181, 201–2, 206–7, 209–10 (2011); Lisa Forman, *Ensuring Reasonable Health: Health Rights, the Judiciary, and South African HIV/AIDS Policy*, 33 J.L. MED. & ETHICS 711, 720 (2005).

60. Joint Report of the Director-General of the WHO and the Director of the UNICEF, *Primary Health Care: Report of the International Conference on Primary Health Care* (Sept. 1978) [hereinafter Joint Report].

61. WHO & U.N. Children's Fund [UNICEF] International Conference on Primary Health Care, *Declaration of Alma-Ata* art. V–VIII (Sept. 1978), [http://www.who.int/publications/almaata\\_declaration\\_en.pdf](http://www.who.int/publications/almaata_declaration_en.pdf) [hereinafter *Declaration of Alma-Ata*].

care from China, Latin America, and other areas over prior decades, in which patients, families, community members, “barefoot” medical workers, trained paraprofessionals, and highly schooled medical professionals were drawn into working together to create virtuous circles of care.<sup>62</sup> The Alma Ata vision was inspired by a politics of both populist participation and social movement activism.<sup>63</sup> It endorsed an expansive interpretation of the United Nations’ formal commitment to a universal right to health.<sup>64</sup> Yet at the same time the conference participants also endorsed key features of “western” health systems, like its conception of professional expertise, its technologies, and its listings of essential medicines medications.<sup>65</sup> Indeed, the Alma Ata Declaration’s section VII, subpart 3, after listing several political and economic essentials of exemplary PHC systems, states that all of these systems must “at least” include the universal “provision of essential drugs.”<sup>66</sup>

The Alma Ata vision for primary health care institutional design has been put into practice in several contemporary settings, with remarkable results. These settings include Partners in Health co-founder Paul Farmer’s community-based primary health care clinics in Haiti, Rwanda, the urban United States, Ebola-affected Sierra Leone, and elsewhere. True to Alma Ata’s call for system integration, all of these clinics were nested in the host nations’ public health systems.<sup>67</sup> Such settings also include South Africa’s “treatment literacy” programs.

---

62. See Fran Baum, *Health for All Now! Reviving the Spirit of Alma Ata in the Twenty-First Century: An Introduction to the Alma Ata Declaration*, 2 SOC. MED. 34, 34 (2007); Marcos Cueto, *The Origins of Primary Health Care and Selective Primary Health Care*, 94 AM. J. PUB. HEALTH 1864, 1864–66 (2004).

63. *Id.*

64. See OHCHR & WHO, THE RIGHT TO HEALTH: FACT SHEET NO. 31 9–10 (2008), <http://www.ohchr.org/Documents/Publications/Factsheet31.pdf>. Compare *Declaration of Alma-Ata*, *supra* note 61 (reiterating and specifying the Conference’s goals of achieving “health for all” or “health care for all” throughout) with G.A. Res. 2200A (XXI), annex, *supra* note 26.

65. See, e.g., Joint Report, *supra* note 60, ¶¶ 73, 130, 133. See generally NITSAN CHOREV, THE WORLD HEALTH ORGANIZATION BETWEEN NORTH AND SOUTH 87–93, 97–98 (2012) (discussing the history of compromise between the aspirational goals of Alma Ata and Western industry prerogatives in the Declaration’s endorsement of “appropriate” technology transfer and essential drugs lists).

66. *Declaration of Alma-Ata*, *supra* note 61, art. VII(3).

67. See generally Betsy McKay, *West Africa Struggles to Rebuild Its Ravaged Health-Care System*, WALL ST. J. (June 4, 2015), <http://www.wsj.com/articles/africa-struggles-to-rebuild-its-ravaged-health-care-system-1433457230>. Dr. Paul Farmer—a Harvard professor and co-founder of the Boston-based charity Partners in Health—has been recently immersed in the challenge of combating the Ebola virus in conjunction with the governments of Liberia, Sierra Leone, and Guinea, which for years have all been racked by civil wars, coups, and unrest. *Id.*

These were grassroots education, peer support, and empowerment programs linked with government primary health care centers, mostly in rural areas, which distributed ARVs. These treatment literacy sites could become catalysts for transforming the primary health centers in which they were situated from within.<sup>68</sup> These programs were created to draw HIV-positive clinic patients into participatory educational programs to enable them to adhere to complex ARV regimes. Yet the programs' protocols were more elaborate, drawing all of the clinics' stakeholders, including all patients, HIV-positive or not, providers, and community members into linked practices of care. In recent years, the WHO, health systems think tanks, university-based public health scholars, and others have explicitly recalled Alma Ata in creating health systems in challenging settings, such as post-conflict nations and stressed urban areas.<sup>69</sup> With regard to essential drugs, it is increasingly becoming accepted that it is in Alma Ata's vision for primary health care *design*, rather than the formal pronouncement, that the right to essential medicines, from rights *holders'* perspectives at least, is likely to come within reach.

#### *E. An Unrealized Potential*

Alma Ata's significance to the essential medicines as human rights movement is increasingly recognized. Yet the Alma Ata vision could have done more. For the essential medicines and human rights convergence has failed to challenge either the skewed priorities of the essential medicines policy concept or the dysfunctions embedded in primary health care institutional design. Instead of either of these two potential priorities, the essential medicines and human rights social movement has focused on universal access to drugs for infectious diseases, especially in sub-Saharan Africa. As we saw above, the first such disease that the movement targeted was AIDS. It then expanded its focus to drugs for two other major infectious diseases, malaria and tuberculosis. Then, in the context of the global poverty movement, the movement has begun to campaign to make treatments for waterborne

---

68. See generally Heywood, *supra* note 48, at 17–19.

69. See, e.g., Baum, *supra* note 62, at 40; Max Cooper et al., *Post-Conflict Healthcare Reconstruction: Yemen and the Window of Opportunity for Primary Care*, J. GLOBAL HEALTH (Apr. 1, 2015), <http://www.ghjournal.org/post-conflict-healthcare-reconstruction-yemen-and-the-window-of-opportunity-for-primary-care> (evoking the Alma Ata Declaration while recommending Yemen focus on primary care as a post-conflict developing state); Nikolaos Oikonomou & Anargiros Mariolis, *How Is Greece Conforming to Alma-Ata's Principles in the Middle of Its Biggest Financial Crisis?*, 60 BRIT. J. GEN. PRAC. 456, 456–57 (2010) (over-viewing the problems of Greek's health system in rural, regional, and urban areas and recommending that it more fully embrace and adhere to the Alma Ata Declaration's emphasis on primary care).

infectious diseases available as well.<sup>70</sup>

At the same time that activists have thus kept drugs for the killer infectious diseases at the *center* of their attention, a number of factors, including widespread unconscious bias, have kept the need for sustained drug treatment for NCDs at the *margins*. For though it is often left unsaid, pernicious and mistaken beliefs that NCDs are linked to negative lifestyle choices and moral flaws pervade public consciousness.<sup>71</sup> Patients with NCDs are sometimes viewed to have less social utility than the “worthy” children, youth, and able-bodied adults often falsely believed to be most vulnerable to infectious diseases.<sup>72</sup> At the same time, treatment for NCDs must often be sustained over time. It is sometimes only partially effective and requires great patience to provide. Over time even the most inexpensive drugs required to treat some of these diseases—such as insulin and the supplies needed to administer it on a daily basis—can become quite expensive, while the drugs for other NCDs such as cancer remain totally out of reach.<sup>73</sup>

Because of this combination of an explicit focus by essential medicines/human rights activists on infectious diseases and a simultaneous *marginalization* in public consciousness of NCDs, the need for Alma Ata-inspired primary care innovations—which would put the features of NCD treatment at its *center*—has been too often overlooked.<sup>74</sup>

---

70. See Alsan et al., *supra* note 57; Joia Mukherjee, *Cholera in Haiti: Another Disease of Poverty in a Traumatized Land*, PARTNERS IN HEALTH (Oct. 22, 2010), <http://www.pih.org/blog/cholera-in-haiti-another-disease-of-poverty-in-a-traumatized-land> (describing cholera’s connections to poverty and Partner In Health’s efforts to combat cholera and waterborne diseases in Haiti).

71. See Jacquineau Az. . .tsop & Tisha R. Joy, *Epistemological and Ethical Assessment of Obesity Bias in Industrialized Countries*, 6 PHIL. ETHICS & HUMAN. MED. (Dec. 16, 2011), <http://www.peh-med.com/content/6/1/16>; Jens Seeberg & Lotte Meinert, *Can Epidemics Be Noncommunicable?: Reflections on the Spread of ‘Noncommunicable’ Diseases*, 2 MED. ANTHROPOLOGY THEORY 54, 56–57, 60 (2015).

72. See WHO First Ministerial Conference on Healthy Lifestyles and Noncommunicable Disease Control, *Conference Proceedings*, at 12 (Apr. 2011), [http://www.who.int/nmh/events/moscow\\_ncds\\_2011/conference\\_documents/conference\\_report.pdf](http://www.who.int/nmh/events/moscow_ncds_2011/conference_documents/conference_report.pdf); Anthony Maher & Devi Sridhar, *Political Priority in the Global Fight against Non-Communicable Diseases*, 2 J. GLOBAL HEALTH (Dec. 2012), at 4, <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3529321/pdf/jogh-02-020403.pdf>.

73. See generally Dele Abegunde, ESSENTIAL MEDICINES FOR NON-COMMUNICABLE DISEASES (NCDs), at 11–19, 23, WHO (2011), <http://apps.who.int/medicinedocs/documents/s19716en/s19716en.pdf> (overviewing the cost burdens and accessibility issues of essential medicines for diabetes, cancer, and other conditions in the developing world and advocating the development of evidence-based clinical guidelines to promote the appropriate use and prescribing of NCD medicines); David J. Hunter & K. Srinath Reddy, *Noncommunicable Diseases*, 369 NEW ENG. J. MED. 1336, 1340–41 (2013).

74. Alessandro R. Demaio et al., *Primary Health Care: A Strategic Framework for the Prevention and Control of Chronic Non-Communicable Disease*, 7 GLOBAL HEALTH ACTION

How would Alma Ata-inspired primary health care work for NCDs? The answer is straightforward. Such a primary health care setting would provide the multi-dimensional systems of ground-level patient education, peer support, professional back-up, and care that would enhance complex drug treatment while empowering patients, family, communities, and providers to work together to share, and enhance, everyone else's care. Without such systems, neither patients nor essential others get the medication, treatments, support, or ecosystems of caring others that they need for both specifically diagnosed conditions and overall well-being.

Thus, if the essential medicines/human rights activists want to catch up, they will have to bring the margin of NCDs and mental health conditions back into the center of essential medicines/human rights concerns, as feminist scholar Bell Hooks advised in the context of black women's feminist movement.<sup>75</sup> Essential medicine human rights advocates will have to join with *treatment system* scholars and activists<sup>76</sup> to create effective networks of care. To face up to these challenges, they will have to work through several tensions in human rights discourse itself. Some of these tensions draw from trends I have already identified above.

The first tension arises when *treatment* is reduced by human rights and essential medicines scholars/activists to the ingestion of a thing, one product, or one pill in a market basket of economic and social goods. Yet, to put it simply, getting pills inside people's bodies, without more, will not necessarily give them the treatment they require. In fact, simply putting pills into people's bodies outside the context of systems of care, risks being perceived as unhelpful, intrusive, or even violent.

The second tension arises around the question of scale of the essential medicines problem. The tendency here is to impose a rigid conceptual separation across different "levels" of political space tasked with addressing this issue based on different governmental jurisdictions, in the terms set by current international and domestic laws. In

---

(Aug. 4, 2014), <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4122819/pdf/GHA-7-24504.pdf> (recognizing the "paucity of guiding frameworks for legislative measures" to address death and disability caused by NCDs and advocating a primary health care approach to the problem).

75. See HOOKS, *supra* note 15.

76. See generally Jim Yong Kim, Paul Farmer, & Michael E. Porter, *Redefining Global Health-Care Delivery*, 382 LANCET 1060 (2013) (discussing the emerging global movement for health rights *realization*, including the right to treatment with essential medicines *and* the right for holistic systems of care, *from rights holders' perspectives*).

this mapping, the first level is the “micro” or local governmental jurisdiction. The second level is the “mid-level” or national, and the third level is the “macro” or international and transnational. The challenge here is to keep all three of these legal/social/cultural domains in view and acknowledging their jurisdictions, while at the same time engaging with the potential synergies among them. This involves ongoing motion and interaction from one to another at the same time. Thus, the vision to the solution must be ecological rather than categorical. Without such a way of seeing it, is all too easy to imagine “solutions” to a multi-dimensional challenge in terms of dichotomies. For example, it becomes too tempting to understand the “right” to essential medicines as a question of inadequate international intellectual property regimes, dysfunctional national delivery systems, corrupt local officials, or greedy pharmaceutical conglomerates, rather than all of the above systems, minus the anthropomorphic adjectives, interacting with one another.

Transcending the micro/mid-level/macro trichotomy is enabled by embedding the implementation of the essential medicines right into primary care systems that are in turn nested in wider ecologies of care, rather than either producing more drugs *full stop*, or improving international law. An image of ecologies of care in turn suggests new points where scholars and advocates can enter into the essential medicines/health rights domain. Asking for more and cheaper drugs from big pharmaceutical companies may *feel* cathartic. The demand might fuel social anger. But it will not help untangle the intricate webs of law that configure both big pharmaceuticals’ power *and* the dynamics through which that power in turn *disempowers* the lowest income people who need health care.

Such webs of law do not just include the WHO’s 2015 essential medicines list. And they do not just include international intellectual property law and the WTO. The webs also include bilateral investment treaties, international tax treaties, global financial arrangements, local organizing activities, and laws that govern antitrust and incorporation that might be used either to facilitate—or to obstruct—the formation of huge health care conglomerates in low income communities as well as wealthy nations.

Further attention must also be paid to the webs of laws, both national and international, that *could* be put in place to enable the emergence of health systems more adequate to offer good care in low income nations. Such laws might include frameworks to incentivize the

adaptation of diagnostic and treatment modalities designed for rich nations' but adaptable for use in less-resourced settings. A final domain that warrants creative attention is the loss of medical workers—both professional and lay—from health sites already depleted of material resources. This drain is taking place across rich and poor regions of developed nations as well as across north/south borders in the global south.<sup>77</sup> How can cross-regional and cross-national partnerships target funding and configure workable laws to address these inequitable geographies in a world where income inequality is everywhere? Once the micro/mid-level/macro blinders are loosened and the map becomes more nuanced, one opportunity suggests another. It will take collaborative work to fill in all of the domains.

#### IV. BACK TO THE CHALLENGE OF MENTAL HEALTH CARE

A capacious vision of health rights/essential medicines is needed in every domain including the epicenter of the essential medicines focus so far, that is the fight against infectious disease. Yet, that said, the need is starkly apparent in the case of mental health care. Indeed, the mental health challenge is a “canary in the coal mine” with respect to the urgent need for a different kind of essential medicines/human rights activism in *every* health domain. For the mental health challenge, both in the United States and in developing nations, exposes the fact that maintaining all people's highest level of well-being is a “chronic” endeavor. For *every* disease, and every person, this task is an ongoing *practice* of care.

Here are just a few features of that challenge. The first is obtaining adequate funding. That should go without saying. For you cannot calm A's agitation on an ongoing basis without the drugs, staff, technologies, and equipment that can help. Indeed, in part because of activist effort, the health financing systems in many developing nations were pushed beyond a scheme that required even people with little or no cash income nonetheless to pay cash before treatment even for urgent health needs. Today, in Ghana for instance, health care is financed by a generous national health insurance scheme.<sup>78</sup> The scheme includes the right to a long list of medications for those who can afford to pay

---

77. See Gamal I. Serour, *Healthcare Workers and the Brain Drain*, 106 INT'L J. GYNECOLOGY & OBSTETRICS 175 (2009).

78. See National Health Insurance Act (Act No. 852/2012) (Ghana); *About Us: Brief Introduction to the NHIS*, NAT'L HEALTH INS. SCHEME, <http://www.nhis.gov.gh/about.aspx> (last visited Mar. 15, 2016).

premiums and registration fees.<sup>79</sup> Yet if they cannot pay, then the national Mental Health Act and National Health Insurance Act provide that mental health patients are entitled to receive free needed medications as well as free care.<sup>80</sup>

The current Mental Health Act<sup>81</sup> was revised from the prior colonial version only in 2012. It authorizes the creation of a special tax-financed fund earmarked for mental health expenditures for multiple types of care.<sup>82</sup> Yet even if this fund becomes large, most of its proceeds are likely to be targeted to national level tertiary services in existing psychiatric hospitals, the training of high-level professionals, and the like. The fund is not nearly as likely to fund Alma Ata-inspired networks of ground-level services embedded in wider fabrics of care.

It is the lack of such networks that could make a great difference in the case of A and the many others who, like her, are challenged by mental—and somatic—health conditions. Let us take her situation as the example and assume that the lithium and backup medications she needs are already available in primary care settings in all geographic regions. She still needs at least three more conditions in place to ensure her right to high quality care. First, she needs access to the *equipment and capacity* to have those drugs administered where she actually *is* on an ongoing basis, on the ground. Thus, in the case of lithium and many other drugs, she needs the clinic, and her home, to have access to clean needles, clean water, skin disinfectants, and trained people to draw the blood and read the results. If all of these capacities cannot be accommodated, then alternative testing methods must be adapted to work in less-resourced settings.

Second, she needs supplemental treatments tailored to the challenges she faces along with the agitation, like therapies for the overwhelming sensory input, social stress, and sleep deprivation, which can spiral into further agitation. These treatments, as well as basic mental health education, are critical for guarding against both stigma, and the *self*-stigma, that can lead to self-doubt, despair, and exploitation. They must be available for her, her family, and her neighbors through local health advocates and community volunteers. For without such practices (although they can arguably be called “medicines”), all the drugs that money can buy are unlikely to cure or even manage either mental

---

79. *See supra* note 10.

80. *See supra* note 9.

81. Mental Health Act of 2012 (Act No. 846/2012).

82. *Id.* §§ 80–85.

health conditions or indeed any other health challenge.

Third, *A* and all others with health conditions need people to *be there* in whatever ways that are feasible under the circumstances. These must include highly trained mental health professionals who design, manage, monitor, and realize whole systems of care and provide its most technologically “high-level” care. I might underscore here that though Ghana, for instance, has too few of these people in numbers, its mental health leadership team has worldwide renown.<sup>83</sup> But such highly trained people are not the *only* caring people that health-challenged people need around them to thrive. They also need people at the primary care and mobile outreach levels, community and family volunteers, peer supporters, spiritual counselors, paralegal advocates, and more. All of these must be trained to work together and drawn together into caring teams. These networks of care must be complemented by networks in civil society, all working together on public education; peer and family activism; policy advocacy; and anti-stigma campaigns. Without this dimension of the work, the political will to maintain robust legal frameworks for health funding, patient crisis management, and front line care will erode. Fearful, exploitive responses to health challenges, be they cancer, epilepsy, polio, or mental health conditions, for instance, will continue, and the work of health providers and family members themselves, as they try to cope, can become a target of human rights chastisement and shaming on a global stage.

These objectives echo the Alma Ata Declaration and the earlier practices it drew from. Furthermore, these objectives are belatedly being “found” to be “evidence-based” and thus drawn upon in primary health care design in rich but unequal nations like the United States. Furthermore, such practices are proving effective in managing other NCDs and even infectious diseases, among all socioeconomic groups in all regions of the globe.<sup>84</sup>

It is incumbent on the essential medicines/health rights movement to keep up with these developments. Chemicals must be re-conceptualized as just one part of the networks of care that are required and must therefore be designed, resourced, and put in place, in order to deliver the treatments consistent with all people’s highest attainable

---

83. For instance, the Chief Psychiatrist of the Ghana Health Service, Dr. Akwasi Osei, has long been a faculty member at the WHO-sponsored global university program on mental health and human rights located each year in Pune, India. See Indian Law Society & WHO, *International Diploma in Mental Health Law and Human Rights 2011–2012*, at 4, 25, <http://enil.eu/wp-content/uploads/2011/06/Prospectus-2011-12.pdf>.

84. See Rebecca Onie, Paul Farmer, & Heidi Behforouz, *Realigning Health with Care*, STAN. SOC. INNOVATION REV., Summer 2012, at 28.

level of mental and physical health. We need to move beyond an obsession with intellectual property reform as the only key to essential medicine rights and toward understanding that decreasing the cost of expensive drugs is but a single part of what it will take to deliver the essentials of rights-based care. For within the “coal mine” of mental health care, unpatented, inexpensive, and widely available medication is both already there and not yet fully accessed, and that is a comprehensive circle. To realize the human rights to essential medicines, we need to draw our work toward it and bring it into reach.