LIRA TOWN COLLEGE
S.4 ENGLISH LANGUAGE P.II

Read the following passage carefully, and then answer the questions that follow:

HOW DRUG COMPANIES EXPLOIT AFRICA

The United Nations agencies seem finally to have found an answer for Africa's pharmaceutical problems. Nearly 90 percent of the world's drug output comes from the developed countries. And within these countries, most of it comes from the giant multinational companies. These firms exploit African countries in every possible way. According to the UN agencies, they indulge in excessive profiteering and tax evasion; they sometimes sell harmful products; when their position is challenged by a budding local industry, they often try to force it out of business or to buy it.

At first sight, the monopoly of the giant multinational drug industry looks virtually indestructible. Yet the UN agencies have made some remarkable progress, without any of the huge and lavishly-funded international projects and conferences for which the UN is now infamous. The now has a workable strategy to help African countries boost their bargaining power against the drug multinationals, and move towards the establishment of their own drug industries.

The initiative came not from within the UN, but from the Guyana government. Acting on behalf of the non-aligned nations, Guyana set up a task force on pharmaceuticals, consisting of experts from the WHO (World Health Organization), the UN industrial development organization (UNIDO), and the UN conference on Trade and Development (UNCTAD). This task force is a unique arrangement within the UN system. A number of UN agencies are working towards a single objective, under the political leadership of the developing countries themselves.

The underlying theme of the UN strategy is simple: drug use within a country must reflect the real health needs of the majority of the population.

There are five main reasons for this theme. First, the number of essential drugs needed to meet the health needs of the population within a country is amazingly small, one or two percent of the thousands of different branded drugs at present marketed in most African countries. WHO has prepared a list of essential drugs for the third world, which consists of only 220 items.

Second, the sources of supply for most of these essential drugs range from large multinationals to small, local manufacturers. By centralizing a country's purchases and making all these companies compete for orders, many essential drugs can be obtained at much cheaper prices. Sri Lanka, which pioneered some of these ideas, bought the tranquiliser diazepam in 1973 at one-seventieth the price charged by its previous multinational supplier.

Third, the technology needed to manufacture many essential drugs is within the reach of even relatively small developing countries. (UNIDO now looks upon pharmaceutical manufacture as a key area for technical co-operation among developing countries.) India

has a large number of small-scale multipurpose plants, each of which produces several chemically related drugs in successive batches. Through UNIDO, India recently supplied Cuba with a single plant to manufacture fifteen drugs (including paracetamol, aspirin, and vitamin B base), for a mere $500,000.

Fourth, the third world can produce drugs for many essential health needs from local medicinal plants. Herbal drugs can be prepared in the village, using local labour and resources, and substantially reducing the demand for imported drugs.

Lastly, as the essential drug lists of neighbouring countries should be quite similar, regional co-operation should become easy. Countries could collaborate in joint drug purchasing, joint research and development, and possibly even joint production of drugs and vaccine which can not be produced economically by small countries.

Many of these ideas are already being adopted by various third world countries. Guyana and Sri Lanka, for instance, now restrict their purchases to a basic drug list. The Caribbean community nations have set up a joint purchasing system. Thirteen Arab countries have already started a joint company to manufacture drugs for the entire Arab region. In the commonwealth a working group has been established at Arusha, Tanzania, to investigate joint drugs purchasing on behalf of Tanzania, Uganda, Kenya, Zambia, Malawi, Botswana, Swaziland, Lesotho, Mauritius, and the Seychelles. Ghana, Nigeria, Tanzania and Zambia and other African states are taking a growing interest in traditional African medicine.

Various elements of the UN pharmaceutical strategy are already under way in Africa and elsewhere in the third world. Could the UN strategy on drugs become a model for similar third world reform of other industries? Other task forces along the drugs model, consisting of UN experts directed by third world governments themselves, could provide immediate action. In this way, the non-aligned countries could use the UN system in a far more coordinated and effective way. Instead of verbose international conferences, it may be fare more useful for the UN to establish practical working strategies in a few key areas.

In a paragraph of not more than 50 words, explain why Guyana thought that it was necessary to set up a task force on pharmaceuticals.

2. In a paragraph of not more than 120 words, describe and explain the strategies adopted by the task force in fighting against the multinationals' monopoly.

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3. In one sentence, explain why the developments outlined in this passage have a wider importance than the pharmaceuticals industry.

Read the following passage carefully, and then answer the questions that follow:

Winged Medical Service

The dispensary at Oltiasika Maasai Rural Training Centre is a simple, concrete two-roomed building. It is situated in the Chyulu Hills near the Tsavo Game Reserve, in full view of Mount Kilimanjaro. Oltiasika is inaccessible by road. The doctor who brings supplies of medicines and vaccines, and does any necessary treatment, flies in, once a month, at the control of a little six-seater light plane belonging to the East African Flying Doctor Service.

The flying doctor service delivers routine medical services on regular basis, and provides emergency medical or ambulance services when needed, to remote areas covering nearly two million square kilometers. Although the service is best known for its romantic rescue missions, the work done in clinics like that at Oltisiaka is mostly routine. The people who live in this area, the still largely nomadic Masaai herds people, are prey to all the ills that poor nutrition and sanitation can bring. Dependent on their herds for their livelihood, they are caught in a vicious circle of drought and over-grazing. Debilitated, they fall an easy prey to disease.

The doctor, Ann Spoerry, is a woman in her sixties who has been in the flying doctor service for about fifteen years. French born and trained, she speaks a mixture of Swahili and colloquial English. On arrival she leaves the controls of her plane for a few hours to embark on the familiar routines of weighing and measuring, history-taking and prescribing. Some of her patients may need medicine against bilharzias, others may need vaccination; others- young mothers, perhaps – may want vitamin pills. Then, her work done, she gets back into her plane and takes off for her next appointment, a clinic in Amboseli. Below her, the land is greenish-brown in colour, dotted with twisted, broken trees.

You wonder how people can survive in this environment. Indeed, most of the cases seen at Oltiasika reflect the attendant difficulties of maintaining standards of hygiene and nutrition. Dr. Spoerry sees this as an important part of medical work in Africa. The difficulties are as much as a matter of lack of facilities as lack of understanding. "A lot of tropical disease can be avoided – TB, malaria, bilhazia, cholera, hundreds of thins – through hygiene, clean water, evacuation of refuse, nutrition and vaccination. Such measures may not be exciting, but they are effective.

"They are all help to keep people healthy. There would be far less sickness if standards in these areas were maintained. But its easier said than done. Even if the means exist, you still have to alert people to their importance at the same time as practicing curative medicine.

"Little by little, though, you get peoples confidence, and they begin to trust you. But you still have a lot of explaining to do, especially about vaccination. To be credible, a vaccination has to be good. Take measles, for example. We got into a lot of trouble because the old vaccine was not stable and needed refrigeration. Anything like a little sunshine would destroy it, and then we might get a nasty epidemic."

Now days the emphasis is on getting people to help themselves as much as possible: "All the talk now is of primary health care where the people give themselves the first care before turning to a doctor. This is really just a new name for something we have been doing for a long time. In many cases it means working with the traditional healers. This can sometimes be difficult if the traditional methods of health care are too different from ours. But some people like the Pokots, are easy to work with because they have herbalists who work like us."

More conventional western type and preventive primary medical care is now promoted by the recruitment of high caliber local people on a voluntary basis to look after specific areas of care in their own communities: "If you want to find and maintain a good water supply, get a young man; find a young woman to promote nutrition, another to look after simple ailments, and so on."

Officially, Dr Spoerry now works for the African medical and research foundation (AMREF). For more than twenty years AMREF has been pioneering new methods of effective health care for rural communities. It has sought to extend the range of knowledge in this field and, by blending new with old, to arrive at more appropriate solutions to the real needs. AMREF is particularly in preventive medicine, and develops projects in East Africa of the kind that Dr Spoerry has described.

The flying doctor service is just one of AMREF's projects. The service now has a radio and air link with many of the most inaccessible parts of Kenya and Tanzania. Acting on behalf of both governments, "the largest practice in Africa" brings both curative and preventive medicine and public health, as well as training, to these remote areas. It operates an extensive high frequency radio network which enables instant contact to be maintained with 100 stations, so that action can be taken immediately if an emergency should arise.

1. Write a paragraph of not more than 65 words summarizing the work of the Flying Doctor Service.

2. According to this article, what are the main diseases afflicting people in rural areas? What are their causes, and how can they best be combated?
   Write your answer in a paragraph of not more than 90 words.