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Bridging the Gap between Corporate and Social Responsibility within the Pharmaceutical Industry in the Sub-Saharan Africa

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Abstract

The article proposes a configuration model of culture in the pharmaceutical sector which explores dynamic relationships between capital performance and consideration of socioeconomic determinants in underprivileged societies. The context includes medication needs and treatment costs within the hostile environment of endemic poverty in Sub-Saharan Africa. It also articulates a call for a new paradigm based on an adjustable framework of patent rights to strike a very important balance between present needs and future research. Discussion is grounded in a cautionary tale that signals the need for corporate responsibility and commitment to the social construct within which pharmaceutical companies operate and grow. Essential drug list and generic drugs policies are *sine qua non* conditions that need to be embraced by responsible governments to combat corruption and improve health indicators. Communication campaigns audited for the purposes of the study unfold along different levels of intervention and interaction, manifesting their centrality in messages related to health behavior and effective drug use. Findings suggest that companies prioritize training, interact with institutions rather than social groups or individuals, and use a mix of online and traditional media to reach out to their target audiences.

Keywords: Health care, Sub-Saharan Africa, Essential Drug List, Generic Drugs, Patent Rights, Pharmaceutical companies, Research, W.T.O., T.R.I.P.S., India Patent Act

1. Introduction

Eradication of diseases is a vision with several components and perspectives that need to synthesize humanitarian and organizational viewpoints. In the era of a global economy and by extension globalized societies, it would be unrealistic to draw strategic lines that ignore the new environment. Amidst financial ambiguity, modern economies are expected to balance sustainable growth with protection of fundamental human rights

Effective disease control programs in poor countries create the dynamic for reduction of treatment costs that can drastically relieve national budgets and make space for allocation of financial resources to other pressing needs of their economies. Development and growth are the driving forces that can initiate virtuous cycles of adequate funding in vital sectors, such as production, infrastructure, safety, education. With these mechanisms in place and full function, reduction of poverty is no longer a distant potential.

Pharmaceutical companies can play a key role in this improvement because they bridge the gap not only between industry and academia, but also between business and technology, rich and poor societies (Reich 2002). Developed economies can afford the drug prices that fund research. Pharma companies grow in such economies but extend their corporate persona to responsible global citizenship with treatment of diseases in underdeveloped countries. Through value-based community programs and accountable ventures they can help minimize overall costs and target major health-related issues.

Nongovernmental organizations and intergovernmental agencies under their current status and dependencies are assigned the task of moderating frictions and tensions, keeping poverty rates under control and not allowing survival, development, or environmental imbalances to assume threatening global dimensions. To claim a more decisive role, it is imperative that their research agendas are advanced radically from the diagnostic, operational level, to include theory, agency, and context.

Contrary to Milton Friedman's view (Friedman, NYT 1970) that organizations should restrict their Corporate Social Responsibility (CSR) programs to increase their profits a 2002 report from the World Economic Forum (WEF 2002) observes that the three key pressures— corporate competitiveness, corporate governance, and corporate citizenship—and their interconnections will play a critical role in shaping the agenda for business leaders in the coming decades.

1.1 Purpose of Study

The purpose of this study is threefold. First, take a diagnostic look at the pharmaceutical industry in developing countries. Second, identify conflicts that raise barriers between corporate sustainability and citizens' right to health. And third, draw the picture of a hybrid model that could bridge the gap between corporate and social responsibility.

The paper also explores the systemic reasons behind persisting shortages of appropriate medication in Sub-Saharan Africa and identifies the strategic direction that would otherwise curb, if not neutralize, the underlying factors that hinder access to healthcare. Alongside corporate decision making, emphasis is placed in human contribution to these conditions, be it voluntary or involuntary, legit or deviant, to help mitigate effects of a hostile environment.

1.2. Background Information on Research and Development in the Pharmaceutical Industry

1.2.1. The Pharma Landscape

Today, the pharmaceutical industry faces radical shifts in buying behaviors, often perceived as threats. According to the report "*Market Effectiveness: The Key Competency for Pharmaceutical Growth*" by the strategy consultant D.Caruso (Caruso 2007) these threats are summarized as:

- Price and market share pressure from generic drugs, the growth of which is not desired by multinational pharmaceuticals who prioritize patented drugs
- New stakeholders, such as health plan providers and governments, taking a stronger role
- Consolidation of pharmacy/provider industry, a trend that shifts power to new players in the value chain (distributors, benefit managers, retailers)
- Increasing scrutiny by regulatory bodies and interest groups that turn expansion of markets into a risk
- Demographic shifts that differentiate market growth dynamics and prioritize the industry's foothold in emerging rather than underdeveloped markets

Response to threats of this caliber suggests a course of strategic direction that is not necessarily aligned with health needs of the underdeveloped world. Despite its size and density, Third World remains a small market which lends itself to image and brand awareness schemes rather than risky business models that fully incorporate social responsibility into action.

In the recent decades, research and development of innovative, affordable medicines has come to a standstill because of an increasing need for sustainability that shifts focus away from markets that do not guarantee massive profits. Industry interests and global agreements have raised significant barriers to access of poor populations to medicines that are critical for their survival. There are two main underlying causes for this stagnation: a) Prices for new medicines and vaccines are high, and b) there is little incentive for pharmaceuticals to invest in new drugs that target relatively small primary markets. South Africa's 1997 Medicines Act states that the government of the Republic of South Africa may pursue parallel importing and compulsory licensing. Pharmaceuticals are particularly concerned and have persistently lobbied governments against such practices that may alert consumers in the West of possibilities for low prices that will reduce profits in the developed world.

However, patent rights are connected to incentives for research. Because research is inextricably tied to the private industry and its profits, ambiguity about protection of rights in the future hinders research on drugs for diseases responsible for millions of deaths each year. Various studies, including a 2010 report by the International Society for Pharmacoeconomics and Outcomes Research Drug Cost Task Force (*Good Research Practices for Measuring Drug Costs in Cost Effectiveness Analyses*), contend that the existing model is built along two extremes:

a) strong patent rights raise prices, increase profits and lead to investments in future products, thus benefiting future generations, or
b) weak patent rights allow for competition, lowering of prices, thus helping present generations gain access to essential medication.

The dilemma here goes far beyond business sustainability or protection of human rights. It's a highly political and moral call for a decision to prioritize one generation over another. Technological advance occurs at high speeds and changes rapidly the way medicine and general well-being are administered, hence future generations may find other ways to benefit from and keep a higher health status. On the other hand, the profitability and sustainability of a corporation that gives thousands of jobs and aids research are significant issues that always should be taken under consideration. Hence, the above issue is a difficult crossword and it can only be addressed at a supranational level of negotiation and agreement.

Facts and figures

1) More than five million people in low and middle income countries cannot access anti-retroviral drugs for HIV and AIDS treatment.
2) Infectious and parasitic diseases account for 30% of the disease burden in low income countries compared to just 3% in high income countries.
3) 15% of the world's population consumes 91% of the pharmaceutical products.
4) Only 10% of the funds for global investment is allocated to finding solutions for 90% of global health problems (the 10/90 problem)
5) Africa accounts for 1% of the pharmaceutical market and even the reduction of prices under parallel importing or compulsory licensing is unlikely to affect their profits.
6) In Sub-Saharan Africa only 38% of essential drugs are publicly available.
7) 95% of Africa's needs in Active Pharmaceutical Ingredients (APIs) are covered by imports. (Generics and Biosimilars Initiative, WHO, ICTSD 2011)

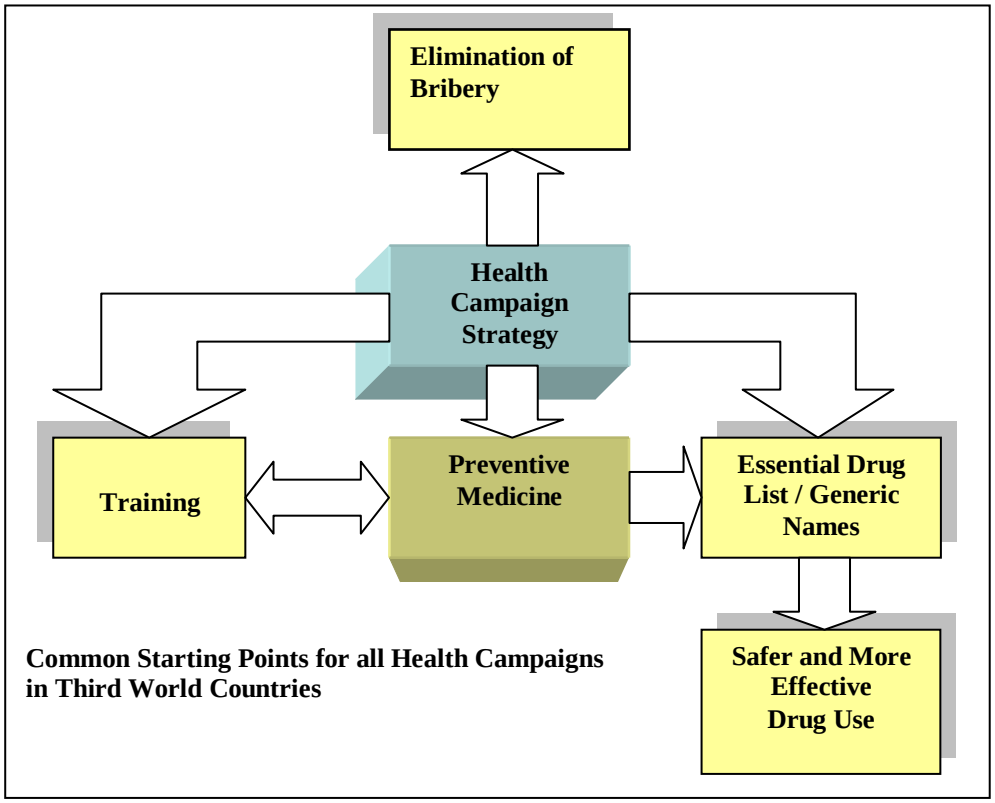
The patent system, globalized by the World Trade Organization (WTO), reduces significantly the dominant incentive framework for development of new drugs in the unprofitable markets of developing countries. Put simply, the system discourages innovation that is necessary to meet health care needs of poor populations, and derails competition by prohibiting low-cost generic medicines. Ideally, these states could establish and implement a legal framework which applies limitations in the exportation process of generic drugs to richer countries in order to avoid creating a black market of bootlegged generics. Despite the Doha Declaration that brings some legal facilitators to a highly regulated environment, the rationale of WTO legislation sustains a framework that does not provide for underdeveloped markets.

Within this context, pharmaceutical organizations manifest their goodwill and responsible corporate citizenship through extension programs under their CSR functions. As such, they are not health campaigns per se; they do not mobilize groups of stakeholders against underlying factors of unhealthy life and poverty, nor do they advocate for behavioral shifts that will challenge the existing power structure. They stretch their corporate persona in a downright

linear, source-to-receiver mode to inform public opinion of their commitment to underprivileged communities. But, is that sufficient?

Since 1970, India's Patent Act permits the country's manufacturing companies to legally produce generic versions of medicines patented in other countries. According to India Patent Act, exports are allowed a) in certain developed countries where international patents expire and b) in least developed countries with no capacity to produce generics (Janodia et al. 2007). Because of its expertise in reverse drug engineering and efficiency of the pharmaceutical manufacturing industry, India has been established as the primary source and leading exporter of generic medicines.

The Novartis lawsuit against the Union of India and Others is a case in point that establishes a judicial precedent in favor of poor nations that cannot afford the cost of patented drugs. In March 2012 the Supreme Court of the country ruled that only true medical innovations and not evergreen versions of the same drugs can be patented according to the Indian Patent Law and consequently extend the company's exclusivity rights for another 20 years. The Pharmaceutical industry is concerned that in India, the top producer of generic drugs worldwide, patents are exceptionally hard to secure. The ruling was hailed by civil society, international aids groups and professional associations as a landmark decision that promotes greater access to health for poor populations. The case was framed as an attempt of the industry to stand up against sovereign states and their obligation to protect their citizens. Global economic integration paved the way for reduction of states and loss of sovereignty. India is a powerful emerging economy and a strong negotiator. Poor countries with weak production and infrastructure do not have the same competitive edge and remain dependent on institutions such as IMF, WB, WTO. The neoliberal paradigm evangelizes consolidation programs based on fiscal restructuring, suffocation of welfare and strangling of budgets for health and education.



1.2.2. Problematic Areas

Challenges in the African pharmaceutical sector can be summarized as follows:

- ✓ Limited local production
- ✓ Defective supply systems
- ✓ Sub-standard and counterfeited drugs
- ✓ Unreliable and expensive utilities
- ✓ Lack of clinical research
- ✓ Unsupportive financial and legal context
- ✓ Lack of specialized skills and market intelligence

Core reasons for problematic access to drugs:

- ✓ Lack of field-based drug research
- ✓ Lack of essential and quality drugs
- ✓ World Trade Organization agreements and regulations

Pharmaceutical Research and Development abandons tropical diseases because of:

- ✓ High costs, low purchasing power
- ✓ Shift to more profitable production
- ✓ Competition and counterfeit of drugs
- ✓ Cost of adhering to quality standards

1.3. Essential Drug List / Generic Names

Several of the major pharmaceutical firms sell the same drug under different brand names, resulting in a situation whereby one drug may be known by as many as 25 different names. Most Third World countries which do not have a national formulary specifying drug purchases have seen a rapid rate of growth in the number of preparations available (Gish et.al. 1979, Lauridsen 1984). There are several thousand brand name drugs in the Third World. In some countries it is not uncommon to find more than 200 brands of antibiotics. Obviously, many of these are duplicate products which force the countries to spend more of their valued health budget. In order to eliminate the problem of excessive drug usage WHO has approved the development of an Essential Drug List, in which only those drugs that are really needed should be included. The selection of essential drugs should depend upon (WHO 1979):

1. the health needs structure
2. the development of health services of each country.

The Essential Drug List and the use of a Generic name policy will not only provide these countries essential and necessary drugs but also will reduce the drug expenditures, which in many countries may reach 40%-50% of the national health budget. Another effort of the Essential Drug List is the elimination of the number of prescription drugs sold as over the counter drugs (OTC). It is also estimated that in the most Third World countries the absence of essential drugs causes people to use more drugs when given the opportunity. Alongside the use of the Essential Drug List, countries need to learn that a generic drug policy will save money for the countries directly and indirectly by providing drugs which regulations and side effects are well known. The application of this policy entails informing and persuading those individuals who can best utilize the relevant data. Therefore, health education (Rubinson & Alles 1984) concerns health care providers and consumers as well.

Communication campaigns with a central message on the efficiency of generic drugs must be developed. It is important for the health planners to remember at this point that different messages must be developed for different target audiences. Informal and formal communication contexts must be developed, in order to influence people in favor of generic drugs. To communicate effectively with their target audience, health planners must first understand who the target audience is, how they feel about the problem and how they need to be communicated with to influence their decision making process. In addition, health planners need to know how different target audiences are likely to respond to various sources of communication and different types of messages. It should be noted here that informal communication plays a significant role in helping establish new practices (Kreps & Thornton 1992). By informal communication it is meant the various channels and networks through which individuals can be reached (popular magazines, television, small communities etc.) Especially in Third World countries where it is difficult to reach mass audiences, the importance of informal health education is indisputable.

1.4. Safer and More Effective Drug Use

In truth, this policy of safer and more effective drug use can exist only in a country with an essential drug list. A better examination of the use of drugs will be helpful for the health workers in all the Third World countries. Providing health workers with pamphlets that include information for only a limited number of the most necessary medicines will increase their flexibility to decide on types of treatment which will improve local health conditions. Therefore, health workers need to be trained on a limited number of drugs enabling them to solve health problems related to their communities.

For reasons previously explained, campaigns launched through the CSR initiatives of the five pharmaceutical companies in this research do not raise the topic of generic drugs. Although availability and affordability of essential drugs are key solutions for poor countries, protection by WTO agreements on Trade-Related Aspects of Intellectual Property Rights (TRIPS) may impede access to essential medicines and low cost substitutes. In developing countries (Watal 2000) where these expenditures account for up to 66% of total health spending, this could be a major cause of impoverishment and dislocation of scarce resources. It is possible, however, that some provisions of TRIPS, such as compulsory licensing (non-commercial government orders to obtain cheaper versions of drugs) and parallel imports (regulatory freedom to allow importation of patented drugs from markets where their prices are lower), can be used to increase access to medicines.

Under this regime, interventions of pharmaceutical companies are critical in engaging key players and building models of responsible health behavior, despite their reasonable limitations in terms of access and outreach. Pfizer's Infectious Diseases Institute (IDI) in Uganda represents a $60-million USD to date and has become a regional Centre of Excellence for prevention, treatment, training and research to strengthen regional capacity in HIV and AIDS, malaria and tuberculosis. The institute has trained over 8,500 healthcare providers from 27 African countries and provided treatment to 40,000 patients throughout Uganda. The Novartis Malaria Initiative provides scientific education and research, e-learning tools for health professionals and access venues for health care. Novartis and Johnson & Johnson also partnered with the *One Million Health Workers* campaign, a United Nations Solutions Initiative under the auspices of the Earth Institute.

The One World Health Project, a non-profit drug development organization initiated in 2000 takes this fragmentary collaborative approach at a higher level. The project incorporates traditional organizational structures, yet it departs radically from the classic pharmaceutical industry model. In the context of public-private partnerships (PPPs), the Institute for One World Health, an affiliate of PATH since 2011, is actively working to build the concept of a non-profit pharmaceutical company along the following features:

a) Pursues a mission in service of global health needs rather than large anticipated returns on investment
b) Follows the model of PPPs in terms of portfolio management approach and coordinated partnerships with major funders, academia and external product developers
c) Possesses an enhanced, in-house research and development team
d) Addresses a wide range of neglected diseases
e) Promotes unrestricted modality of treatment according to needs: drugs, vaccines, diagnostics

f) Ensures recycling of off-patent drugs, and patent licensing or donation of intellectual property rights to lessen costs
g) Partners with for-profit drug companies in a "dual-market" strategy to allow negotiation for no-or low royalty contracts at the same time with public funding for development
h) Distributes products to wealthier markets to subsidize the no-or low cost provision (multi-tier pricing)
i) Assumes financial risk for early and risky drug development stages to attract expertise from the for-profit sector

A different approach adopted by the United Nations Industrial Development Organization (UNIDO, 2010) confirms the predominance of the intergovernmental sector in projects related to availability and affordability of essential drugs against pandemics in poor African countries. The initiative was launched in 2006 and implemented in 14 least developed and developing countries to help strengthen the local production of essential generic drugs. To ensure applicability and sustainability, the project unfolded along three levels:

- The macro-level of policy advice at a global scale
- The meso-level of institutional capacity building at the national scale
- The micro-level with direct support to local enterprises

The value of this model lies in its holistic approach with embedded, synchronized interventions in all three levels and consistent focus on its scope and mission. The project has put in place the essential building blocks required for production of high quality generic medicines and upgraded production plants to become compliant to Good Manufacturing Practices accreditation and WHO prequalification. Throughout the process, four countries have been identified as compliant to this upgrading: Ghana, Kenya, Botswana and Cameroon. Unfortunately, the initial focus on Least Developed Countries revealed extremely weak pharmaceutical capacities and had to be broadened to Developing Countries at large. Based on the understanding that growth lies at the root of sustainable economies, the campaign *"One-Village-One-Product"* initiates a communication plan to boost the local participatory process. The project attempts to bring together UNIDO values and commitments with the key local frameworks for activities that encourage African villages to come up with a unique product. It also identifies and segments target audiences, initiates message guidelines and suggests a pricing model that mimics monopolistic trends in order to maximize profits for local producers.

1.4.1. Access to local communities

However, informing health workers about drugs or training them does not guarantee any change in the way local people behave. In order for one to achieve a safer and more effective drug use one needs to look at the level of understanding between health workers and target audiences. Communication between health practitioners and the public will play a vital role in teaching people how to use more effectively and safely drugs (Kreps & Thorton 1994). Several presupposed factors need to be utilized in order for a message to be delivered accurately, to be understood and ultimately to be adopted. Two of the most important are: the skill and communication strategies that practitioners obtain and the relationship between health care workers and individuals.

Providing any kind of information is not a simple act of making empty statements. Especially health issues should be addressed with accurate, understandable and powerful language that will lead to the adoption of certain practices by the target audience. In order to have mutual sense of what is all about, we need to share communication skills such as reading, writing and language. In many developing countries, such as India or Indonesia, hundreds of different languages are spoken; there may be one official national language, but millions of people do not speak it. Extension of health services throughout such nations is handicapped by elementary problems of communication. Health educational material, for example, must be prepared in several languages, not to mention the difficulties of oral communication. In most African countries, language problems are complicated by tribal differences (e.g. Nigeria and Ethiopia). Tribalism often involves long standing social/structural barriers, which obviously limit cooperation in health care. But it is not only the difference in the morphology of languages that creates problems between health workers and target audiences. Differences between language's structure and the cultural background and value of the speaker can be obstacles to communication. Thus, the stresses between the population speaking different languages are based on deeper cultural distinctions. Third World languages are endowed with small vocabulary, some of them so small that many words' translation depends on such variables as context, tonality and body symbols. Consequently, in order for someone to understand a language (especially a high context one) one needs to be familiar with the culture, the historical background, the values, and the relationship of the local people with their environment (Hall 1976). Thus, without some understanding of local values, we cannot appreciate the meaning of the words as they are used in the specific culture. As Bauwens (1978) contends culture and communication are inexorably linked and one cannot be comprehended without the other.

The other contributing factor to the success of this policy is convincing people to trust and visit their local health care centers and to comply with treatment. Trust, as in any relationship, is built gradually and upon the gratification of expectations (Kreps & Thornton 1994). Those expectations concern the empathetic, caring, responsible and effective reaction from the part of the provider (Rossiter & Pearce 1975, Callahan 1990). When health workers fail to understand and cure patients' problems, the contact will be inevitably impaired. The practice of provision of health services through health care centers in the Third World advocates that a lack of homogenic performance of health staff leads to poor evaluation of health care centers by patients. In other words, the success of primary health workers in their promotive and preventive roles depends to a large extent on their ability to provide credible front line curative service. Dissatisfaction among the local people increased by factors such as lack of medicines, unattractive appearance of physical facilities, and lack of communication skills and courtesy from the health care personnel. Francis (1969) and others (Truax & Carkhuff 1967) report that a mother's compliance with a regimen prescribed for her child is better when she is satisfied with the initial contact, perceives the physician to be friendly, and feels that the doctor understood the complaint; they also found that a lack of warmth in the doctor – patient relationship and a failure of the doctor to provide the patient with information about the disease, were key factors in noncompliance. An excellent conceptualization of this variable is contained in Glasser's (1958) comment that "…*people were failing to take advantage of the vaccine for themselves and*

their children, not because of specific resistance to it, but rather because of lack of definite, positive influences, which might direct them to a clinic or a doctor's office for inoculation".

Thus, it is necessary, for the health planner to initially identify the problem areas, the needs and wants of the people and integrate them into the social, political and cultural factors which influence people's behavior.

1.5. Elimination of Bribery

Corruption poses extra problems in Third World countries (Silverman et.al.1990) not because it occurs more frequently than in Developed countries, but because these countries with their restricted resources and their high needs cannot afford corruption. Pharmaceuticals are scarce in the Third World, and for that reason are sought after by corrupt means. Medicines meant for free distribution in public health institutions pass into private hands. This kind of corruption is related to prevailing customs of gift-giving and to traditional loyalties (mainly relatives) which prevail over obligations to the state. Another factor is the traditional proprietary view of the public office. The most important single force promoting corruption, however, is the overwhelming position of the state as the principle provider of goods, services and employment, coupled with the relative underdevelopment of the private commercial sector. The education gap between office holders and most citizens, moreover, facilitates corrupt practices. Identifying bribery as a fault only of certain individuals will offer a limited perspective on an issue which is embedded in organizational life.

Communication strategies within health care organizations and employees' responsibility and involvement are significant factors that may solve the problem of bribery. The effectiveness with which the organization communicates its goals to employees and the ways that uses to involve them in meeting these goals are variables that have an impact on the quality of the delivered services (Ray, Miller 1993). When employees identify themselves with the organization and feel that they are its representations in its external environment it is highly probable that they will strive for its success (which in the case of health care is the delivery of effective services).

Bribery is and possibly will be an accepted way of life, not only in the Third World but also in many of the Developed countries. Bribery as a phenomenon within a wider sociocultural contextual framework should be seen as an indicator of political corruption in a broader sense. It is absolutely not restricted to the drug industry, but seems to be involved in all aspects of social life. Collectivistic high-context societies where power distance is manifested in tall hierarchies and superior authority is not questioned are vulnerable to the proliferation of corruption and bribery. In the case of drugs with the potential to heal but also to harm, bribery may be a deadly way of life.

1.6. Methodology

To exemplify the communicative value of organizational campaigns as documented on the company websites, the paper focuses on five distinct projects conducted by pharmaceutical organizations across the African continent. Initiatives are audited along the type of action, targeted disease(s), levels of interaction, partnerships, stakeholder groups, communication channels, corporate elements, and intended qualitative interventions. Results are presented in eight distinct checkbox tables, one for each of the above group elements.

Namely they are:

1. GlaxoSmithKline & Access to Malaria Care
2. Bristol-Myers Squibb: Secure the Future
3. Pfizer Commitment to Communities
4. Novartis Improving Health Care in Africa
5. Johnson & Johnson Our Community Work in Africa

Despite the small size of the sample, discussion on indications hopes to provide some insights into the prevailing characteristics of corporate campaigns, how these correspond to pressing health needs of poor nations, and how effectively they transcend from theory to agency. Existing barriers to this process need to be identified and discussed along the search for some consistency between organizational mission and corporate citizenship.

COMPANIES / CAMPAIGN DESCRIPTION	GlaxoSmith Kline	Bristol-Myers Squibb	Pfizer	Novartis	Johnson & Johnson
Training/Education		√	√	√	√
Prevention	√		√		√
Treatment	√	√	√		
Advocacy	√				

COMPANIES / DISEASE FOCUS	GlaxoSmith Kline	Bristol-Myers Squibb	Pfizer	Novartis	Johnson & Johnson
HIV/AIDS		√			
Malaria, Cholera, Hepatitis, Other	√				
Pregnancy, Maternal & Child Health					
Immunization, Sight Disabilities					
Inclusive			√	√	√

COMPANIES / LEVELS OF INTERACTION	GlaxoSmith Kline	Bristol-Myers Squibb	Pfizer	Novartis	Johnson & Johnson
International	√	√	√	√	√
National/Governmental	√	√	√	√	√
Community	√	√	√	√	√
Individual		√			

COMPANIES / PARTNERSHIPS	GlaxoSmith Kline	Bristol-Myers Squibb	Pfizer	Novartis	Johnson & Johnson
Civil Society	√	√			
Academia/Research Cntrs	√	√	√	√	√
Private Funds	√		√		√
Professional Associations	√	√	√		
Health Institutes		√	√	√	√

COMPANIES / TARGET GROUPS	GlaxoSmith Kline	Bristol-Myers Squibb	Pfizer	Novartis	Johnson & Johnson
Governments	√	√		√	
International/Local Agencies	√	√	√	√	√
Community Health Workers	√	√	√		√
Local leaders	√	√			
Affected populations		√	√		√
Donors/fundraisers		√			√
Volunteers					

COMPANIES / COMMUNICATION CHANNELS	GlaxoSmith Kline	Bristol-Myers Squibb	Pfizer	Novartis	Johnson & Johnson
Press		√		√	
Television					
Radio					
Web, Social Media	√	√	√	√	√
Corporate Publications		√	√	√	√
Multimedia		√	√	√	√
Events	√	√	√		

COMPANIES / CORPORATE ELEMENTS	GlaxoSmith Kline	Bristol-Myers Squibb	Pfizer	Novartis	Johnson & Johnson
Mission/Vision					√
Interactivity (donation, log in, contact form)		√			
Credibility/Transparency	√	√	√	√	√
Languages other than English					
Consistency of layout/color	√			√	
Search engine	√			√	
Friendly navigation (menus, buttons, sidebars, sitemap)				√	√
Images of people					
Images of services	√	√			
Symbols/Logos	√	√		√	√
Facts & Figures			√	√	√
FAQs					
Newsletters, Reports	√	√	√	√	√
Animation					

COMPANIES / QUALITATIVE INTERVENTIONS	GlaxoSmith Kline	Bristol-Myers Squibb	Pfizer	Novartis	Johnson & Johnson
Increase knowledge/awareness		√	√	√	
Change attitudes/motivations	√				√
Improve skills		√	√	√	√
Influence social norms	√				√
Impact environmental context (health determinants)	√	√	√	√	√
Prioritize availability/accessibility of health services	√		√		√

2. Findings and Discussion

Training and education seems to be the central focus of campaigns, with prevention and treatment following. Three out of five campaigns are inclusive, targeting HIV/AIDS along with tropical diseases and maternal/child health. While pharmaceuticals interact at multiple levels with their partners (international, national, community), only Bristol Myers Squibb displays outreach potential at the individual level targeting influencers among rural communities.

While widespread partnerships with local and international agencies make sense, campaign emphasis in community programs raises a significant question. According to data from the World Bank and Trading Economics, out of a Sub-Saharan-Africa population of 910 million, more than 500 million are located in rural areas. What is the actual thrust of these projects within this grand total? What is the number of people in need that is being consistently impacted by organizational support to communities?

Academia and research centers are by far the most valued partners of the pharma industry, a rational finding supported by the collaboration and interdependency between the two sectors. Two out of five companies partners with civil society, thus prioritizing access to poor populations through effective distribution frameworks.

For reasons related to safety, cost and reliability, volunteer programs in third world projects of pharmaceutical companies are not the norm unless they involve employee volunteers or specific internships backed by academic institutions. It is understandable that the industry will engage specialized and trained workers to support its community programs, and this calls for a sophisticated screening process rather than a general appeal to available time donors. Under this spectrum it is no surprise that social responsibility programs publicized on corporate websites do not target volunteers as a key audience.

Appeal to local leaders on the other side, requires a cooperative level of interaction that stretches out to communities and individuals. It is the role of local authorities, NGOs and the third sector to mediate for access to these community leaders who can intervene to influence motivations, attitudes and behaviors in culturally relevant and sensitive ways.

Websites and social media take primacy as cost effective communication channels, with corporate publications and use of multimedia also widely used as effective tools bearing witness of source credibility. Events and press releases are also used to raise awareness, whereas electronic mass media are the least preferred promotional vehicles.

Transparency and credibility are standard qualities in the design of organizational campaigns as methods to convey trust and reliability. In the same spirit, newsletters and reports are well integrated, while animation and images are clearly not significant attributes compared to the solid blocks of text addressed to stakeholders and intended to strengthen brand identity, image and reputation.

2.1. In Search of a New Model

Some negotiation theorists dismiss effects of cultural differences as stylistic and superficial. They contend about a universal paradigm, a one-size-fits-all assumption that they believe will yield the desired outcome without time-consuming or costly adjustments.

The Western, low-context problem solving model that puts people away from the problem comes to stark contrast with the holistic, high-context, relationship focused paradigm of collectivistic ethos that prevails in non-Western societies.

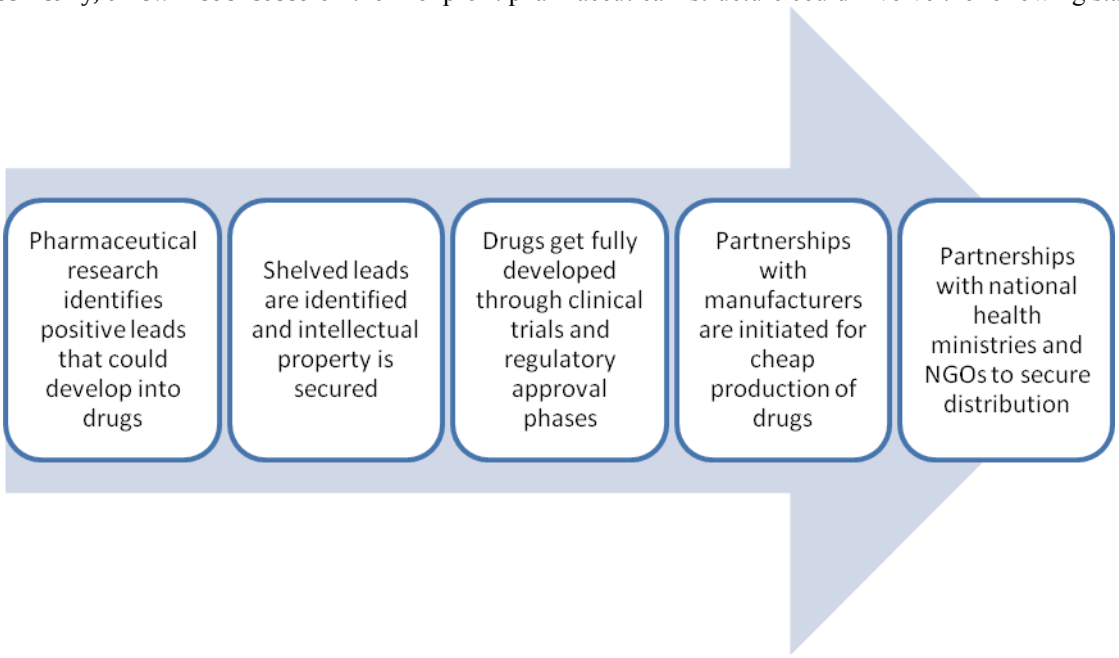
Perhaps there lies the root of at least one evil, Africans' lack of compliance to the "materialistic ego" of Western related societies. These societies do not respect symbols, history, status or face; they position people below numbers and at the same time the individual above the community. The campaign message may be articulated but it's not effectively heard. It may be launched, but it fails to trickle down from top and middle layers to bottom. Messages that are built around frustrating, blunt rules of a totally utilitarian worldview are doomed because of their cultural cacophony (i.e. dissonance). Such cross-cultural asynchronies and communication lapses occur because rarely health campaigns focus on building strong ties with those enablers and facilitators that can make the most impact among rural populations. Alleged data on lack of funds, infrastructure, voluntary time and number of educated health workers usually represent a fraction of actual needs. This inadequacy is sustained by lack of applied fieldwork and recycled by unsanitary living conditions.

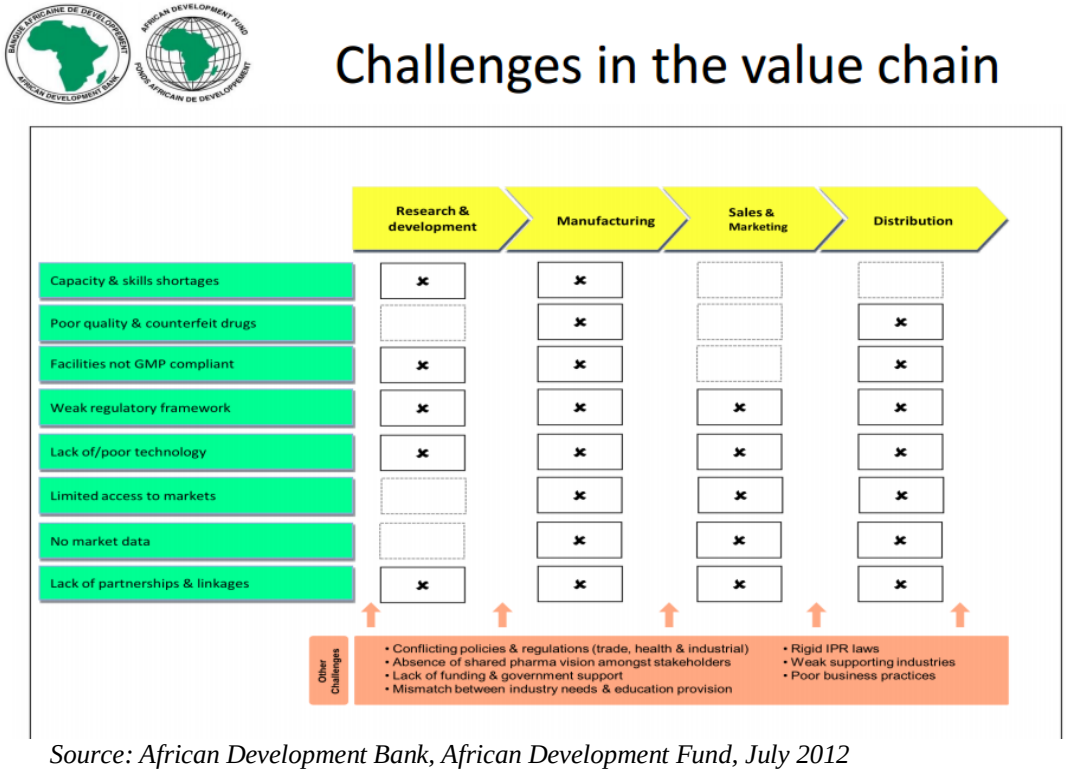
Insofar as people have a choice, they will not alter their behavior unless they are convinced that benefits are far greater than losses.

It is also imperative that international leadership seeks ways to strike a balance between present and future health needs. Because research is essentially halted in low-income countries where profits for pharmaceuticals are insignificant, it is probably time to raise the question whether research that is tied to fundamental human rights should be treated as a fundamental human right in itself rather than a commodity of marketable value. Placing research at the root of health and safety, not just for the underprivileged but also for the developed societies, paves the way for a solution that may be beneficial for mankind as a whole. This is probably where the new model of a nonprofit drug organization can successfully bridge the gap between allocation of scarce resources and daunting growth indicators.

Patents can also be used as price control and innovation agents. Ideally, a patent system can be flexible enough to recognize differences in countries in terms of their market size, GDPs per capita and prevalent diseases, and at the same time encourage the private sector to become involved in the creation of new products. Patent protection can be minimized in the poorest countries and broaden gradually to cover dominant diseases in order to encourage research and innovation. As a poor country becomes wealthier, protection can grow to gradually allow raised prices to result in further investments for new drugs. (Lanjouw 2003)

Specifically, a new model based on the "nonprofit pharmaceutical" structure could involve the following stages:





Source: African Development Bank, African Development Fund, July 2012

This hypothetical model would likely require a corresponding, innovative communication strategy that would bring together all involved actors from governmental, civil society and for-profit sectors, and initiate a strong participatory approach. The campaign can be seen as a multi-branch tree, where the root is a mission that holds everything together, trunk and branches represent strategic goals and objectives carried out by project executors who give substance to the

mission—consultants, experts, health workers, planners, opinion leaders, local authorities and community influencers—and leaves are the final products delivered to the intended target populations.

Pharmaceutical companies are capable of building sophisticated campaigns based on their credibility, status, expertise, know-how and reputation. In the era of globalized thinking, where corporate goodwill is an absolute ingredient of sustainable growth, the drug sector simply needs to embrace the value of collaborative empowerment that works towards the greater good. These are remarkable efforts that renew bonds of trust with institutions, carry modeling value for other industries and reinforce a cycle of virtuous brand awareness among key stakeholders.

3. Conclusion

Experts contend that health campaigns do not attain spectacular results in terms of effects on health behaviors. Sophisticated pharma projects fall under this norm by targeting facilitators and health professionals to help create the dynamics that will produce beneficial interventions and behavioral shifts.

The present study manifests that pharma companies in the third world have the unique opportunity to build a new paradigm of responsible corporate citizenship. There are practical complications and barriers to this process, should we assume that an innovative strategic direction is adopted: budget constraints, perceived costs to stakeholders, poorly designed campaigns or inadequate change management.

A hybrid model that would bring together the nonprofit code of business ethics and the for-profit structural framework presupposes a vision that would encompass profitability inside a larger plan of sustainability and growth, and a mission that puts on top of the agenda a) the systematic disease control among poor populations, therefore access to affordable medication and b) grassroots projects that promote education among carefully diversified and segmented markets.

Patented drugs secure further R&D; cheap generics halt R&D in areas where patented drugs are not affordable. This traditional model is now challenged and is revisited by an innovative, flexible approach where patents rise or lower to adjust to needs for investment and price control.

The ideas that unfold in this paper permit a cautious optimism on the existence of a theoretical basis for the development of business models that facilitate poor populations to reclaim their right to health and dignity. Healthy behaviors climb up the ladder of societal priorities and the improvement of people's well-being leads to shared value imperatives. In the context of business-centric benefits, scholars, scientists and corporate decision makers can jointly explore possibilities that articulate a better understanding of human needs. Campaigns that seek to influence health attitudes and behaviors in the underdeveloped world need to create meaningful messages and deliver them through appropriate channels that are consistently supplemented by interpersonal networks. Evaluation research should be carefully performed to assess the degree of audience receptiveness, resistance barriers and the desired impact versus the outcomes achieved.

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