Chapter III – HIV/AIDS and the Human Right to Health – On a Collision Course with Global Capitalism

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Rosalind P. Petchesky, "HIV/AIDS and the Human Right to Health – On a Collision Course with Global Capitalism," in Rosalind P. Petchesky, *Global Prescriptions: Gendering Health and Human Rights*, London: Zed Books, in press, pp. 92 – 159.

> . . . [T]he debate on AIDS is increasingly becoming a debate on what kind of world we want to have: a world that nurtures our common humanity or a system that protects and promotes global minority rule. (Booker and Minter 2001:12)

Many recent commentators have remarked that, with all its profoundly tragic and socially disruptive dimensions, the HIV/AIDS crisis has revolutionized how we think and what we know about sexuality and gender relations.[1] AIDS also has a "silver lining," according to Malcolm Molloch Brown, the director of UNDP, insofar as "it is forcing the West to engage with Africa." (Crossette 2001b) Analyzing the global politics of HIV/AIDS is far beyond the scope of this book, yet rethinking transnational women's health movement strategies to implement reproductive and sexual rights is impossible without putting HIV/AIDS squarely into the picture.

As we saw earlier, the pandemic has probably had a much greater impact in opening up a space within UN politics for talking about sexuality, sexual health and sexual rights than anything feminist health activists might have accomplished on their own. In this chapter I argue that the impact of the crisis has even wider ramifications, exploding the boundaries separating such previously distinct categories as health, gender, sexuality, trade, property rights and human rights, and affecting the future shape of global governance regimes. I attempt to document how that explosion began to reverberate during 2000-2001, both within UN meetings on development and HIV/AIDS and beyond, in the global politics of trade. And I examine the "silver lining" in the epidemic, insofar as it has brought the principle of health as a human right into debates about corporate global power.

"People's Health before Patents and Profits"[2]: The Global Campaign for Access to Medicines

By the close of the 1990s conferences and their five-year reviews, the idea of health as a human right had started down a collision course with globalization. As the previous chapter showed, important elements of this contradiction were already in evidence at the WSSD+5 meetings in New York and Geneva. During 2000-2001, the issue of access to essential medicines that had been such a bone of contention in those meetings became a central unifying cause not only for anti-globalization coalitions but also for WTO member states from the South seeking to challenge Northern dominance over trade regimes. In a drama that pitted such groupings against the presumably invincible might of transnational pharmaceutical companies and their Northern government patrons, the forces of global civil society and social justice won a number of surprising victories. Before examining the chronology and political dynamics of these victories in more detail, I should back up and explain why seemingly technical debates over intellectual property rights and trade rules are symptomatic of much deeper fissures within global capitalism. Out of these fissures, I argue, come openings for change.

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[1] See Altman 1995 and 2001; Parker, Barbosa and Aggleton 2000; Cáceres 2000; and Klugman 2000. This chapter focuses on health care as a human right; for a broader discussion of human rights issues affecting people with AIDS, see Altman 1998 & 2001; Bayer 2002; Heywood and Cornell 1998; and the outstanding journal, *Health and Human Rights*, published by the Francois-Xavier Bagnoud Center for Health and Human Rights at Harvard University.

[2] This phrase is from DAWN Suppl. 2001:1—an excellent source that this chapter relies on extensively.

The TRIPs (Trade Related Intellectual Property Rights) Agreement originated in 1994 at the instigation of a group of US-based multinational corporations lobbying the Uruguay Round of GATT, which also created the WTO.[3] Its ostensible purpose was to harmonize the variations in patent laws and their enforcement across countries. But, according to Argentine economist Carlos Correa, the main objective of these corporations was to combat the growth of Asian competitors (whom they accused of imitation and "piracy") and "to freeze the comparative advantages that had so far ensured US technological supremacy." Their "policy of 'technological protectionism' aimed at *consolidating an international division of labour whereunder Northern countries generate innovations and Southern countries constitute the market for the resulting products and services.*" (Correa 2000:4-5, my italics) TRIPS would lock in this division by establishing a minimum global standard of patent, copyright and other protections like those already in existence in major industrialized countries, especially the US. The infotech and biotech industries—the most dynamic levers of US economic growth in the 1980s and 90s and those for whom "knowledge as property" was most vital to profits—and their US government patrons had a particular stake in this globalized patent regime.[4]

In both its origins and its potential consequences, the TRIPS agreement thus favors the economic and technological hegemony of the North. Its regime of patent protections also shuns cultural perspectives at odds with the spread of capitalist markets everywhere—such as the view of animal life, "seeds, plants, and other living resources necessary for food and health" as part of the "commons" belonging to all peoples, rather than bounty for private expropriation and commodification. (Barker and Mander 1999:32; Shiva 2001) As Vandana Shiva and others have warned for years, patents protecting corporate monopolies over such life forms (for agribusiness, genetic engineering and "modern" medicines) are covers for "bioimperialism," or "biopiracy." Slightly altering or merely converting to commercial purposes a seed or rice variety or a healing herb known to indigenous populations for centuries can constitute an "invention," legally entitling TNCs to appropriate local and indigenous knowledges—those belonging to women farmers and healers in much of the Third World. (Shiva 2001:49; Barker and Mander 1999:32) In other words, such knowledges, like whole inhabited lands in the past, are regarded as *terrae nulliae*, their communal owners and inventors rendered invisible since only private (corporate) forms of property count. Cheah calls this "a legalized form of late-capitalist theft" (1997:251); Shiva calls it "recolonization" and likens it to Columbus' "discovery" of America. (2001:12-13)

The defense of TRIPS and IPRs generally by Northern governments and corporations has from the beginning been riddled by contradictions, if not outright hypocrisy. In mobilizing that defense, US corporations—especially "Big PhRMA"—continually make two conflicting arguments.[5] On the one hand, they insist that IPRs are indispensable to sustain their own

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[3] Barker and Mander (1999) list the members of the corporate Intellectual Property Committee as consisting of three major pharmaceutical companies—Bristol Myers, Merck and Pfizer—along with DuPont, General Electric, General Motors, Hewlett Packard, IBM, Johnson & Johnson, Monsanto, Rockwell and Warner—i.e., the largest biotech and infotech conglomerates. Carlos Correa contends that the US pharmaceutical industry was the strongest advocate for the patent provisions of TRIPS and "a major beneficiary of the outcome of the Uruguay Round." (2000:15)

[4] Vandana Shiva puts this initiative in a larger historical frame, reminding us that patents have, from their debut in the 15th-16th century European monarchies, been "associated with colonization," discovery and conquest; from the time of Locke, their underlying ideology was always to ratify "the enclosure of the commons." (2001:11-13, 16-18)

[5] PhRMA stands for the Pharmaceutical Research and Manufacturers of America, the powerful lobbying group for big US pharmaceutical companies, who were also principal campaign contributors to Bill Clinton and Al Gore (see Ireland 1999).

motivation to engage in research and technology development (R & D), implying that, without this incentive, no research for new medicines would take place. On the other hand, they claim that a globalized patent system will ultimately benefit developing countries, since it will bring them new technology, investment flows, and patent protections of their own. Yet, while the long-term consequences for developing countries have still to be understood, certainly in the short term this promise remains unfulfilled. Nearly all (97 percent) of current patents are held by companies in industrialized countries; between 1977 and 1996, 95 percent of all patents granted in the United States were conferred on applicants from only ten industrialized countries. What this means is that something like $20 billion a year in fees for technology use flow from the South to the North. (UNDP 2000; Correa 2000; Abbott/DND Conference 2002)

Meanwhile, TRIPS and the WTO have done nothing to facilitate technology transfer or development of any kind in poorer countries. On the contrary, their main effect for many countries (especially the small-island and sub-Saharan African regions) seems to have been to impede exports, inflate the prices of imported goods and medicines, thus exacerbate trade deficits and inhibit growth—in other words, to *constrict* development. (Correa 2000)[6] This has extremely negative implications for poor people's access to life-prolonging medicines. Studies done in the 1990s in India, Egypt and Argentina indicate that the introduction of patent protection for medicines increases prices by a multiple ranging from three to forty-one times while resulting in greatly reduced local use of (modern, or non-traditional) medicines. (Correa 2000, Box 1) And under TRIPS, the patents last for 20 years. As Shiva puts it, "the patent system 'regulates' competition. It does not necessarily stimulate technology generation, much less diffusion" since its main purpose is to ensure exclusive markets. (2001:4)

What of the mantra that patents provide drug companies in the US and Europe (those with the resources and capacity) the necessary incentive to engage in "innovation"? To make the case that patents serve not only corporate profits but also the public good, industry spokesmen often cite gross figures reflecting the huge sums ($27 billion, $500 million per new product) they invest per year in R & D. What they fail to specify is the large part of this investment that goes to marketing research and the development of products aimed primarily at the North American, Japanese and West European markets—products to cure the endemic plagues of late capitalism, including not only heart disease and stress but also baldness, sexual dysfunction (Pfizer's Viagra) and body fat. Developing countries as a whole comprise 72 percent of the world's population but only 13 percent of the world's drug market. Since Africa accounts for only 1 percent of world drug sales, it is not surprising that a Médecins sans Frontières (MSF) study found that, of the 1400 new drugs patented between 1975 and 1997, only 1 percent were for the tropical diseases that ruthlessly kill millions of Africans each year. As one spokesman for a French-German company conceded, "We can't deny that we try to focus on top markets. . . . But we're an industry in a competitive environment—we have a commitment to deliver performance for shareholders." (McNeil 2000b:6; Rosenberg 2001) The bottom line is the bottom line.

Nor do corporate representatives acknowledge that most of the pre-clinical research for many of the medicines they market and profit from (especially those for HIV/AIDS and

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[6] Correa (2000:34) suggests that the TRIPS agreement would actually have to be amended to allow for technology transfers (for example, environmentally sound technologies), and, presumably, the same would be true for the protection of local and indigenous knowledges. The application of compulsory licensing by developing country governments (see below) does not, he says, require a patent holder to share technologies or methods of production.

tuberculosis) is conducted at public expense by universities and government agencies.[7] These institutions hold the original patents but often license them to private corporations.[8] In a study submitted as an affidavit in the 2001 South Africa case (see below), James Love, Executive Director of the Consumer Project on Technology, convincingly argues that markets are *inherently* unreliable as generators of "scientific and technological research and development (R & D) to meet health care needs." There are many reasons for this besides venal motives: the risks involved; the inability to recover all the benefits (many of which are non-excludable); the aversion of profit-oriented companies to doing research on "adverse effects"; the disinterest of such companies in poor people and their (unprofitable, hence neglected) diseases. Moreover, the patent system itself "undermines scientific progress," since it encourages secrecy, competition and the hording of information; whereas scientific inquiry—contrary to the myths of capitalist entrepreneurship—requires openness, collaboration and information-sharing. (Love 2001:177-78) Indeed, this is precisely why corporate IPR claims must inevitably rest on a bottomless but hidden reservoir of public sector and third world intellectual labor; why, like corporate audits, patents conceal more than they reveal.[9]

On the whole, then, the "advantages" of TRIPS seem overwhelmingly one-sided in favor of existing power imbalances in the global capitalist economy—profits, not people, and certainly not people's health. Patents are a market-based system whose aim is to protect profits and property, not to stimulate R and D. At the same time, Amy Kapczynski observes that "TRIPS is a baseline" rather than a set of rigid, clearly enforceable rules. (2002) In other words, its meanings will be determined by political realities more than by lawyers. Within the TRIPS regime itself, certain flexible provisions leave developing countries a "margin of maneuver"—provisions that no doubt were won through hard negotiation. These include references in Article 7 to the "transfer and dissemination of technology" as one of the treaty's "objectives"; and in Article 8 ("Principles") to the right of member states to "adopt measures necessary to protect public health and nutrition and to promote the public interest in sectors of vital importance to their socio-economic and technological development. . . ." Critical for the issue of access to medicines, they also include (1) the admissibility, under the doctrine of the international exhaustion of IPRs, of **parallel imports**—e.g., imports of cheaper versions of patented drugs from third countries (Article 6); (2) allowable **exceptions to patentability** in the case of "diagnostic, therapeutic and surgical methods of treatment for humans or animals" in order "to protect human, animal or plant life or health or . . . the environment" (Article 27)[10]; and (3) provisions for granting **compulsory licenses** (e.g., to domestic companies to manufacture generic versions of patented drugs), for example "in the case of a national emergency" such as an epidemic. (Article 31 and Correa 2000:7-8, 17, 81-83, 89) Moreover, the agreement's arrangements contain a transitional period pertinent to pharmaceutical products that allows

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[7] Heywood (2001:11) gives the examples of Yale University and the University of Minnesota, where "compounds for two important anti-retroviral drugs. . . were discovered and developed with public funds."

[8] Prof. Harold Edgar notes that the third stage of medical research—large-scale clinical trials—is by far the most costly, and probably only giant corporations have the funds to support it. (personal conversation) This fact, however, does not obviate the *social* dimensions of such research, that corporate profits rely on public inputs to the research process; and that lack of public funds to support clinical trials (rather than, say, missile defense) is a political choice.

[9] Shiva likewise argues that the myth of patents as necessary to stimulate innovation is based on a faulty (and, by implication, Eurocentric) epistemology, one that conceives of science and technology as individual and isolated acts and ignores their indebtedness to diverse generations and cultures. (2001:21-23, 50; also Shohat and Stam 1999)

[10] This was a clear concession to India's 1970 Patent Act, which contains these exceptions; see Shiva, Appendix.

developing countries to postpone the costly and difficult process of implementation for up to nine years (extended until 2016 in the Doha Declaration—see below).[11]

Southern countries such as Brazil, India, Thailand, and South Africa have used these soft spots in the TRIPS armor to defend policies that authorize the manufacture and/or importation of affordable generic drugs to treat HIV/AIDS—the antiretroviral and combination therapies that have transformed AIDS into a manageable chronic disease in the North. In the cases of Brazil and South Africa, they have done so in defiance of a continual barrage of threats by successive US governments and by cartels of multinational drug companies to bring lawsuits or economic sanctions against those countries for violating patent rights.[12] In fact, these threats themselves could be construed as violations of the TRIPS regime, insofar as they abrogate the multilateral dispute settlement process intended to avoid the kind of unilateral actions and intimidation tactics that the US executive and trade representative have deployed with such fervor on behalf of Big PhRMA. Here as elsewhere, the US applies international law selectively to suit its own interests—even when the rules are ones it and its corporate clients initiated! In countries that are particularly dependent on US trade, such threats can have undeniable "chilling effects" on the production or importation of life-saving generic drugs. (Barker and Mander 1999:35)

Nonetheless, for all its muscle, the corporate agenda for TRIPS and iron-clad patent protection has met extraordinary resistance—especially in regard to the issue of access to life-prolonging medicines for poor people with HIV/AIDS. By early 2001, the global campaign against "Big PhRMA" on behalf of lower prices and Southern governments' right to procure affordable generic or patented drugs would become the most dynamic catalyst of efforts to fight AIDS in poor countries. A review of the chronology of events from early 1998 through the fall of 2001 **(see Box 3-1)** shows a spiral of resistance, counter-offense and renewed resistance, in which transnational health and human rights NGOs play a pivotal role in putting global capital on the defensive.[13] With drums, photogenic banners ("AIDS PROFITEER—DEADLIER THAN THE VIRUS," "STOP MEDICAL APARTHEID!"), and a sharp sense of timing, activists from TAC, ACT UP, and other groups used the streets to indict the greed and inhumanity of drug companies—publicly naming them and their CEOs. Meanwhile, TAC, MSF, Oxfam and CPT simultaneously utilized lobbying and legal strategies, in the media eye and behind the scenes, to

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[11] Developing countries paid a heavy price for this postponement, however, since the trade-off was that the US and other industrialized countries secured a long transitional period as well to continue protecting their agricultural and textile markets from developing country competition. (Correa 2000)

[12] Besides the legal actions brought by the Pharmaceutical Manufacturers' Association (PMA) against South Africa and by the US against Brazil (see below), these tactics have included not so veiled threats by the US Trade Representative (USTR) and companies to engage in trade sanctions against countries that even consider undertaking parallel imports or compulsory licensing of drugs. In response to South Africa's Medicines Act in 1997 (see **Box 3-1**), the PMA "closed factories, canceled investments and took out scare ads suggesting that babies could be hurt by counterfeit generic drugs. Its chief lobbyist. . . threatened to cut off all new drug discoveries to South Africa if the law passed, including AIDS drugs, cancer drugs and antibiotics. Asked in a March 1998 interview if she was literally threatening to let thousands of South Africans die, she reluctantly conceded: 'In so many words, yes.'" (McNeil 2000b) Rosenberg (2001:52) notes that just appearing on the US Trade Representative's "Watch List," an official precursor to sanctions, "is a form of sanction because it discourages investment." There is little doubt that the USTR in the late 1990s became "a virtual appendage of the drug industry." (Silverstein 1999:16)

[13] Most important among these groups have been Médecins sans Frontières (Doctors without Borders); TAC (Treatment Action Campaign) in South Africa; ACT UP (AIDS Coalition to Unleash Power, especially branches in Philadelphia, New York and Paris); Oxfam in the UK; the Health Gap Coalition (a network of AIDS and trade activists formed in 1999); GTAC (Global Treatment Action Campaign—a coalition of Health Gap and TAC); and the Consumer Project on Technology (CPT), based in Washington, DC. See Kim 2001, Gevisser 2001, Heywood 2001, TAC 2001, McNeil 2001, Richardson 2001, www.CPTech.org, www.msf.org and www.tac.org. [CHECK]

expose government-corporate collusion and secure agreements for lower prices, bulk purchasing, and access to generics. This combination of strategies and their application at multiple levels—grassroots, national and international—has had a powerful and irreversible effect on global health politics.

Box 3-1 – Chronology of the Global Campaign for Access to Essential Medicines

1994 – **TRIPS agreement adopted** as part of Uruguay Round of GATT.

1997 – **South Africa passes Medicines and Related Substances Control Amendment Act**, containing measures to make medicines more affordable and accessible.

Feb. 1998 – **Pharmaceutical Manufacturers' Association (PMA) of South Africa and 39 drug companies file lawsuit against South African government** to interdict sections of the Act.

1998-early 1999 – Clinton administration, US Congress and USTR pressure South Africa to drop law, threatening aid and trade sanctions.

Dec. 1998 – **Treatment Action Campaign (TAC) forms in South Africa.**

Jan. 1999 – **MSF announces global campaign for access to essential medicines for poor countries** (joined by ACT UP and CPT).

July 1999 – ACT UP-New York and Philadelphia stage protests at kickoff of Vice-President Gore's presidential campaign: "Gore lets Africans die for pharmaceuticals' profits!"

Sept. 1999 – PMA suspends suit against South Africa; USTR announces cessation of sanctions.

Nov. 1999 – UN Committee on Economic, Social and Cultural Rights issues statement on human rights obligations of WTO and trade liberalization.

Dec. 1999 – **WTO meeting in Seattle; tens of thousands of protestors shut down the meeting.** Clinton administration ends opposition to third world government policies regarding access to medicines providing they abide by WTO rules.

Jan. 2000 – Vice-Pres. Gore presides over special session of UN Security Council to declare AIDS a global "security threat."

April 2000 – Women's Caucus introduces language on TRIPS, medicines and human rights at Prep Com for WSSD+5, United Nations-New York.
World Bank pledges "unlimited money" to combat AIDS in poor countries.
TAC/ACT UP demonstrate and sit in at Pfizer headquarters in New York.

May 2000 – Clinton issues executive order saying the US executive will no longer threaten trade sanctions against African countries seeking to procure cheaper AIDS drugs.
5 major US and European drug companies (in conjunction with WHO, UNAIDS, World Bank, UNICEF and UNFPA) offer to cut prices for AIDS drugs in South Africa by 80%.
Brazil reintroduces amendment before World Health Assembly in Geneva asking WHO to establish a database listing prices for all anti-AIDs drugs, including generics.

June 2000 – **WSSD+5 UNGASS in Geneva adopts final document with Para. 80 on health as a human right, IPRs and "access to life-saving, essential medicines."**

July 2000 – **13th International AIDS Conference in Durban, South Africa**; TAC organizes first global march for treatment access; Behringer offers to supply nevirapine free to developing countries for 5 years to prevent mother-to-child transmission (MTCT).
US Export-Import Bank offers sub-Saharan African nations $1 billion a year in loans (at commercial interest rates) to finance purchase of AIDS drugs.
After closing of Durban conference, PMA reopens its lawsuit.

Aug. 2000 - African governments reject loans in favor of "making drugs affordable."

Oct. 2000 – TAC launches campaign against Pfizer to lower price for fluconazole, transports generic version from Thailand into South Africa, holds press conference.

Jan. 2001 – TAC announces intention to file *amicus curiae* brief in PMA case.

Feb. 2001 – Cipla, generic drug manufacturer in India, offers to supply AIDS "cocktail" drugs to MSF for $350 a year per patient and to Southern governments for $600.
TAC leads march of 1000 people in Capetown and produces "AIDS profiteer" poster.
CPT's James Love lobbies new Bush administration to continue Clinton policy on access to medicines and no sanctions; Bush agrees.
Secretary of State Powell calls AIDS "an economic and national security problem."
Oxfam announces it will join global campaign for access and take it to Wall Street.

Mar. 2001 – **PMA case against South African law comes to trial in Pretoria High Court; thousands demonstrate in 30 cities worldwide**; TAC, MSF, Oxfam and COSATU call international press conference; TAC and COSATU hold all-night vigil and picket outside court.
MSF initiates worldwide petition campaign that gets 250,000 signatures in support of South Africa; persuades EU and Dutch government to support campaign.
Cipla asks South African government for license to sell 8 generic AIDS drugs.
Bristol-Myers Squibb says it will no longer challenge companies that want to sell generic versions of its AIDS drugs in Africa.
Brazilian government threatens to utilize compulsory licensing on AIDS medications produced by Merck & Hoffmann-La Roche; Merck agrees to cut prices on 2 drugs.
US files formal complaint with WTO against Brazil for violating TRIPS.

Apr. 2001 – WHO, EU, French National AIDS Council, Kofi Annan and Nelson Mandela call on PMA to withdraw its suit.
UN Commission on Human Rights issues resolution on "Access to Medication in the Context of Pandemics such as HIV/AIDS."
PMA announces it is unconditionally withdrawing the suit (4/19).
2-day summit of 53 African governments adopt pledge to aim for 15% budgetary expenditure on health, with large amount going to AIDS prevention and treatment.

May 2001 – Kofi Annan goes to Washington to seek commitment for $7-10 billion annual AIDS Fund; Bush pledges $200 million.
Novartis, Swiss drug company, agrees to lower price of malaria drug in Africa.
Pfizer offers anti-fungal drug for AIDS treatment free to 50 poorest countries.

June 2001 – **UNGASS on AIDS at UN**; General Assembly agrees on Declaration of Commitment with targets, timetables, and gender-sensitive human rights approach.

Secretary-General promotes Global Fund for AIDS, Malaria and TB, urges governments to raise $7-10 billion.
US drops WTO complaint against Brazil, agrees on settlement.

July 2001 – MSF brokers deal with major drug companies and WHO to cut prices of 5 anti-tuberculosis drugs for resistant strains by 90%.
G-8 Summit in Genoa; thousands of demonstrators are back in the streets, 1 killed by police.

Aug. 2001 – Brazil moves to grant compulsory license for generic version of patented AIDS drug; La Roche agrees to cut price another 40%. Brazilian government withdraws threat.

Nov. 2001 – **WTO Ministerial Meeting in Doha, Qatar; adopts Declaration on TRIPS, public health, and "access to medicines for all."**

I want to stress here once again the mutual reinforcement of activists working inside mainstream power arenas and institutions and those working outside, in the streets (see Chapter 2). There is no doubt about the effective role that demonstrations and other forms of direct action have played in pressuring the US government and transnational drug companies to make significant concessions and in creating a broad public awareness of access to treatment as a human rights issue. Here are just a few examples that leap out of the chronology:

• July 1999: ACT UP (Philadelphia and New York branches) pickets Gore's 2000 presidential campaign kickoff in Tennessee, shouting "GORE'S GREED KILLS"; while back in Washington CPT and Health Gap Coalition [? – CHECK] lobby the Clinton administration on the issue of access to treatment. Within a month, the Clinton-Gore administration has reversed its policy on HIV/AIDS drugs and patents.

• April 2000: AIDS activists from TAC and ACT UP, along with labor and religious groups, conduct a demonstration and sit-in against Pfizer in New York, denouncing the company as an "AIDS profiteer." October 2000: TAC chairperson Zackie Achmat returns from Thailand to South Africa carrying 5000 tablets of generic fluconazole and conducts a press conference announcing TAC's "patent abuse defiance campaign."[14] By May of the next year, Pfizer—the world's largest drug company—announces it will provide its patented drug free to any South African who cannot afford it. (Heywood 2001; McNeil 2000c)

• Mar.-April 2001: As the PMA case against South Africa opens in the Pretoria High Court, thousands march in the streets of Pretoria, Johannesburg, Capetown and cities around the world, capturing wide media attention; Nelson Mandela and Kofi Annan speak out; and MSF collects 250,000 signatures and endorsements from the EU and Dutch governments as well as world-famous pop musicians in support of South Africa and against the drug companies. PMA suddenly decides to withdraw the suit.

Yet there is no simple linear trajectory in this story, nor is local direct action successful in the long run except when it is conjoined with legal, political and media strategies involving meticulous in-depth research and transnational coordination. To understand the complex power relations in the campaign for access to treatment—relations that foreshadow future struggles of civil society groups against corporate globalization—we need to look more closely at three

[14] Fluconazole is the generic name of an anti-fungal medicine that can cure one of the deadliest complications of AIDS; its patented form is produced by Pfizer as Diflucan.

signifying moments in the chronology: the South African case, the Brazilian case, and the Declaration on TRIPS from the 2001 WTO meeting in Doha. Then we need to ask, what do these cases tell us about how gender and race figure in the politics of global health and how health in turn complicates the relations of global capitalism and trade?

South Africa. The racialized/gendered vital statistics on HIV/AIDS in Africa are the familiar, sobering drumbeat behind the chronology of events in Box 3-1.[15] Of the 40 million people estimated to be living with HIV/AIDS in the world in 2001, 95 percent were in developing countries and close to 70 percent (or 28 million adults and children) in sub-Saharan Africa. Of the 3 million who died worldwide that year, 2.3 million were in that region. Ninety percent of all children worldwide born HIV+ are born in sub-Saharan Africa, where HIV prevalence among pregnant women can be as high as 36 percent. And a recent World Bank report warns that the epidemic is undermining efforts to improve African children's access to education because of the very high rate of infections among school teachers as well as the children themselves. (Schemo 2002) This is what Ronald Bayer (2002) calls "the two worlds of AIDS," but it is really three worlds. Although HIV/AIDS may have been a gender-neutral killer in its earlier phases, particularly in the North, in more recent years it is becoming increasingly gender-biased. This is especially true in sub-Saharan Africa, where infection spreads mainly through heterosexual sex and mother-to-child transmission (MTCT). Fifty-five percent of infected adults in the region (as opposed to 48 percent globally) are women; women are a higher proportion than men of those who die each year; and infection rates among women are growing more rapidly. The differentials are even worse for young women and girls (ages 15-24), who in some countries (e.g., Zambia) have rates of infection three times higher than those of young men.

This gender-differentiated pattern is only partly the result of biology (higher "viral load" of male secretions, larger surface area of female genitalia exposed, lesions caused by STDs and FGM). As numerous feminist analyses have revealed, it is even more the result of age-old social and cultural practices of gender subordination that intersect with the legacies of colonialism and apartheid. We have to reinterpret the frequently cited patterns of men's migration, working in mines, having sex with commercial sex workers and infecting wives and partners in the light of cultural norms dictating that women must comply with sexual demands of husbands or partners and that men must "show their masculinity by having sex at a young age and with many women" (Klugman 2000:166); or myths that having sex with a virgin will cure AIDS or avert infection. Such cultural myths and norms result in greater vulnerability of women and girls to sexual violence, shame, ostracism, loss of livelihood, prostitution—and hence infection. Barbara Klugman writes of the "complex interaction of economic subordination and cultural subordination" in Southern Africa that results in women's and girls' compliance with men's sexual demands as well as the common practice of "transactional," or "survival sex"—sex in exchange for money, clothing, food, or other essential needs that women are unable to provide for themselves or their children. (Klugman 2000:146-47)[16] She also calls attention to another

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[15] Statistics in this and the following paragraphs come from UNAIDS 2001, CMH/WHO 2001:47-48; UN/The World's Women 2000:67-69; Altman 2000; McNeil 2001b; and Cauvin 2001. I am relying on statistics from UN sources with the caution that vital statistics from Africa may be rough approximations due to the problems of data-gathering in poor countries as well as the issue of co-morbidities that complicates mortality statistics anywhere.

[16] For a sobering in-depth study of "survival sex" in Durban, see Preston-Whyte et al. 2000. For further analysis of the gender and sexual dimensions of HIV/AIDS, especially in Asia and sub-Saharan Africa, see also Aka-Dago-Akribi et al. 1999; Heywood and Cornell 1998; Rao Gupta and Weiss 1995; Weiss, Whelan and Rao Gupta 1996; Ray and Maposhere 1997; Elias and Coggins 1996; and WHP 1999.

cultural practice common in the region: that of vaginal drying agents used to increase men's sexual pleasure but in the process causing women not only pain during sex but abrasions that (like FGM) increase their vulnerability to HIV and other STIs. In other words, "sexual power relations" take many forms, both intimate and structural, all of which contribute to women's higher rate of death and illness from AIDS. (Klugman 2000:166)

Later in this chapter I will look more broadly at HIV/AIDS as one form of bodily mapping of "global apartheid" and gender injustice. My concern here is to situate South Africa within the larger demographic picture of HIV/AIDS in the region in order to evaluate the importance of the legal and political victory there in April 2001. While South Africa does not have the highest rates of infection in sub-Saharan Africa (Botswana and Zimbabwe take the lead), it has the *greatest number* of people infected of any country in the world—an estimated 4.6 million, or 20 percent of all adults and nearly 25 percent of all pregnant women in 2000. In that same year, 250,000 people died of the epidemic in South Africa alone. The stunning photograph by João Silva [COVER PHOTO?], of a woman in KwaZulu-Natal walking resolutely down the road past a row of caskets on display, illustrates how death overtakes daily life in today's South Africa. (Swarns/NY Times 2001a & b)

So when the PMA lawsuit against the South African government finally came to trial in the spring of 2001,[17] it naturally became the high point of the global campaign for access to essential medicines launched two years before. Initially PMA's suit contended that South Africa's 1997 Medicines Act (see Box 3-1), authorizing parallel imports or compulsory licensing to obtain affordable generic drugs, violated the sanctity of patent rights inscribed in TRIPS. Mark Heywood, head of the AIDS Law Project (ALP) and National Secretary of TAC in South Africa, describes the aims of this corporate action as an attempt "to annex additional powers and safeguards for intellectual property that are not part of TRIPS; to fill in some of the ambiguities in TRIPS, particularly its vagueness around 'parallel importation'; and to warn other developing countries off a similar path." (2001:4) But the drug conglomerates did not count on facing an alignment of forces that included not only the South African government but also high-profile humanitarian NGOs like MSF and Oxfam and world leaders like Kofi Annan and Nelson Mandela; all the UN agencies responsible for HIV/AIDS and health, and even the WTO; and an array of demonstrators outside the courtroom and in cities throughout South Africa, Europe and North America representing trade unionists, women's groups, religious groups, and people with AIDS as well as the major groups of AIDS activists. They did not anticipate that this trial would cast them in a media spotlight and become a truly globalized event.[18] Above all, they did not expect to encounter a powerful, highly knowledgeable adversary *inside* the courtroom in the person of TAC as an *amicus curiae* intervenor.

Heywood's assessment of TAC's role and purposes in intervening as a "friend of the court" is worth reviewing in some detail because it exemplifies a model for organizing around health as a human right that can be applied to many other human rights campaigns.[19] The heart

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[17] See the chronology in Box 3-1 for the odd zig-zags of this suit. Kapczynski (2002) notes "the cynicism" of the PMA and affiliated 39 companies party to the suit, illustrated in their suspending the suit under public pressure in 1999 and then reinstating it only two days after the July 2001 AIDS conference in Durban had closed—"once the press [and global activists] had left town." After realizing the weakness of their position concerning TRIPS, PMA's lawyers shifted their arguments to focus on the South African constitution.

[18] See Heywood 2001, TAC 2001a and b, COSATU 2001a, Gevisser 2001, Swarns 2001a, and Thom 2001.

[19] The following summary is based on Heywood's Dec. 2001 Article, "Debunking 'Conglomo-talk': A Case Study of the *Amicus Curiae* as an Instrument for Advocacy, Investigation and Mobilisation." Many thanks to Jonathan Berger of ALP for sending me this invaluable source in its final draft.

of this model, taken from the anti-apartheid struggles of the 1960s-80s, is a symbiosis between law and direct action, in which litigation becomes "an instrument for progressive and people-driven advocacy and mobilization." (2001:1) Indeed, one is struck in Heywood's account by the extent to which TAC played a leadership role in a two-pronged strategy that was simultaneously aimed at the court and at global public opinion. This "pro-active use of law" was grounded in a number of conceptual and strategic elements along with the traditions of anti-apartheid organizing. Conceptually, it never drifted from a solid human rights framework, one that exposes the subterfuges of conservative groups (e.g., TNCs) attempting to coopt human rights discourse for their own ends (e.g., claims based on intellectual property rights)—what Heywood calls "dressing rights-incursions in the language of rights protection." (2001:2) On the contrary, in its amicus brief TAC argued "*that access to health is a human right that trumps rights to private property*" (my italics) and that the South African Government had "a positive duty," under both its own Constitution and its international obligations,

> to 'progressively realize' rights of access to health care services and to protect rights such as dignity, life, equality and the duty to act in the best interests of the child—rights which are dependent on measures to improve socioeconomic conditions. (2001:6, 8)

Second, and absolutely pivotal to the TAC model, are close collaborations in every strategic action and aspect of the case with all the key players among civil society groups, both international and local. Throughout the treatment access campaign, and specifically in regard to the PMA lawsuit, these included not only MSF, Oxfam, CPT and the Health-Gap Coalition but also COSATU (the Congress of South African Trade Unions), whose leaders TAC briefed on the key legal and political issues in the case during a jointly sponsored all-night vigil. This is just one example of TAC's efforts throughout the case to carefully articulate its legal strategies inside the courtroom with the coalition activities outside, in which its own members and many other groups were engaged—marches, picketing, media outreach, MSF's petition campaign, and enlisting support from celebrities like the Rolling Stones [CHECK] and John Le Carre. Another striking example is TAC's use of the *amicus curiae* process itself as both an organizing and an advocacy tool. It did this by directly involving grassroots people from COSATU and doctors from MSF in affidavits (personal testimony) about how the issues in the case impacted their own lives and work—a method, again, that followed the example of anti-apartheid lawyers. In this way, allied organizations were given "a sense of ownership in the Court battle," which in turn helped to motivate their efforts as picketers and advocates outside the court. (2001:7-8)

Finally, TAC's attitude toward the ANC government during the trial remained one of distance and clear independence, even though technically—and in many respects substantively—TAC's arguments as *amicus curiae* supported the government and probably were pivotal in provoking PMA to withdraw its case. This was necessitated by Mbeki's stubborn opposition to anti-retroviral therapy, which meant that "the *amicus* intervention was but a stage in TAC's campaign for treatment access that would lay the foundations for intensified criticism of the government's policy concerning access to treatments for HIV." (2001:6 and below) Moreover, among the most important facts to be revealed in the trial was a series of offers by the drug companies to the government to lower their prices on triple-combination antiretroviral medicines in South Africa and what those offers were—facts the government had kept hidden. This paved the way for a post-trial advocacy campaign led by TAC resulting in further price reductions of around 50 percent; though still at levels unaffordable to the masses of poor, these reductions nonetheless opened a wedge toward "significant expansion of drug access in South Africa."

(2001:11) Whether the drug companies were "shamed and humiliated" over the loss of moral cover for property, as *The Guardian* in England announced, or retreated out of fear that a public trial would bare the deeper mysteries of property is uncertain. Thanks to the prodding of the TAC brief, however, "the companies faced having to reveal some of their most closely guarded business secrets, including pricing policies, profit levels and the source of funding for research into key anti-AIDS drugs." They chose to back out of the suit instead, but the advocates of corporate accountability had already won a significant victory. (McGreal 2001)

From a strictly legal standpoint, because PMA dropped the suit, no decision, thus "no binding legal precedent," emerged from the South Africa case. Yet, as Heywood's summing-up stresses, the political achievements of TAC's multi-layered strategy were tremendous. They no doubt helped to secure the Declaration on TRIPS adopted in Doha the following November (see below) and, above all, contributed immeasurably toward strengthening the transnational movement for health as a human right:

> Internationally, the intense focus on medicines, prices, patents and rights to health greatly broadened the support-base of an incipient movement that seeks to treat health as a human right and to promote the idea that commodities such as medicines, that are essential for health, should be treated differently under patent law to [sic] commodities that do not have any intrinsic link to human dignity and well-being. . . . On another level, it provided proof that the world's most powerful multinational companies are not invincible and can be brought to account by well researched, well argued mobilizations. This lesson will undoubtedly inspire other social struggles. (2001:13)

It is important to note what is being challenged in this statement, as in TAC's legal arguments throughout the case: neither TRIPS nor the existence of patents but rather their *distorted interpretation* to aggrandize capital at the expense of human rights. Issuing a compulsory license is not the same as "patent breaking" but rather "part of the patent system itself," a way of defining its lawful limits and one explicitly provided in Article 31 of TRIPS. In fact, compulsory licensing, rather than "a concession made to developing countries," is a common mechanism used routinely by the US, Canada, and other developed countries. (Kapczynski 2002; 't Hoen and Chirac 2002) Even though the pharmaceutical giants had initiated and embraced TRIPS as the embodiment of "corporate rights"—an interpretation that some opponents of global capital all too readily join—the outcome of the South African case shows that TRIPS has become a contested terrain in the struggle to define and redirect globalization. As with any international or legal document, its meanings are nowhere written in stone; they evolve in the wake of political struggle. From the spring of 1999 to the spring of 2001, steadily mounting support for the idea that access to life-saving medicines is a human right and denial of such access to the poorest, most affected countries a gross injustice cast the "exceptions" clauses of TRIPS in a new light. Then, after three years of strenuous objections that the South African law violated the sanctity of patents inscribed in TRIPS, the PMA retracted this argument even before the trial opened, resting its case on constitutional arguments instead. By this time even WTO officials had informally conceded the South African law was valid within the framework of international trade agreements. From a bastion of property rights, TRIPS had morphed into a potential enabler of national sovereignty over public health.

But subsequent events would raise serious questions about how much or what kind of a victory social justice forces won in the South African case. Already, during the year preceding the trial, the Mbeki government had cast doubts on its willingness to exert leadership in the

matter of access to medicines for treating HIV/AIDS or even to take the epidemic seriously. First there were Mbeki's baffling public statements agreeing with a fringe group of AIDS "dissidents" that HIV does not cause AIDS and that the cause of the African epidemic is poverty alone—a view thoroughly discredited by most researchers, including those in Africa. This controversy surrounded the 13th World AIDS Conference, held in Durban in July 2000, where local AIDS groups protested government policies more vociferously than those of the giant pharmaceuticals. Then there was the government's questioning of antiretroviral treatment (ARV) on "safety" grounds and its foot-dragging on the drugs' distribution—even after Behringer-Ingelheim had offered nevirapine free for five years to reduce MTCT.[20] (Schoofs 2000; Swarns 2000a & b; Swarns and Altman 2000)

In the months following the trial, controversy over the government's refusal to make ARV available throughout the country built to a crescendo. As COSATU put it, "the prevarication by the Minister of Health amounts to snatching defeat from the jaws of victory." (COSATU 2001b) By the fall of 2001 the Health Ministry was only offering nevirapine to pregnant HIV+ women in 18 pilot sites and had only just accepted Behringer's offer of free supplies—well over a year after it was made. (Swarns 2001c; "Round-Up"/RHM 2001) Frustrated and angry at what it considered an irrational and arbitrary denial of life-saving treatment, TAC sued the government; and in mid-December the Pretoria High Court ruled that the state had "an ineluctable obligation" to expand access to nevirapine to all pregnant HIV+ women under its care. As he left the courtroom surrounded by jubilant activists after the High Court's decision, Mark Heywood declared, "We've made history today." But in the same breath he offered a more sobering comment: "This judgment . . .doesn't solve the problem of AIDS in South Africa by any means." (Cauvin 2001)

Heywood's double-edged statement after the December ruling could be applied to the outcome in the PMA lawsuit as well and points to the limits of both victories. First, ARV for pregnant HIV+ women does not address longer-term treatment for the women themselves or for non-pregnant women and men with AIDS.[21] Moreover, treatment is just one response to a much larger, more complex set of conditions the epidemic both reflects and exacerbates. On some level, Mbeki is right that poverty—intertwined with gender subordination, which he fails to acknowledge—is the ultimate culprit that allows the virus to thrive. From the beginning of the debate over access to medicines for HIV/AIDS, there have been those who argue that too much focus on treatment in a resource-poor environment draws resources from prevention as well as palliative care for those who are already dying and their families. Others urge that more study is needed to cope with the problem of viral resistance; that prioritizing HIV/AIDS will sap the ability of public health budgets to tackle other health crises, such as malaria, TB, and lack of

[20] Nevirapine has been found to lower the risk of MTCT to 13 percent by age 14-16 weeks with only one oral dose given to the mother during labor and another to the infant within 72 hours after birth. However, the very characteristics that make it so effective also create the risk that HIV+ women who receive this treatment will subsequently develop nevirapine-resistant forms of the virus. (Hankins 2000) Thus, the South African government's decision to go slowly and study the drug's effects may have had some medical basis.

[21] It is disturbing that advocates as well as researchers and drug companies are more willing to take a strong stand on this issue when it comes to "saving babies" than prolonging the lives of women. Research on effects of ARV in preventing MTCT has virtually ignored the effects on pregnant women themselves of short-term ARV without other treatment. Behringer-Ingelheim's offer of free nevirapine to LDCs was designated "only for MTCT and not to be used for combination therapy to suppress the replication of HIV." (UNICEF/UNAIDS/WHO 2000:11). Although TAC's long-term political program clearly embraces the reproductive and sexual rights of all women—"Give Women a Choice, Give Children a Chance," proclaim the TAC t-shirts—its lawsuit against the government was confined to provision of ARV in obstetric settings only.

clean water; and that, even if the drugs for ARV are free of cost, South Africa lacks a health infrastructure adequate to deliver them on a large scale along with the necessary monitoring, laboratory tests, counseling and follow-up. (Houston 2001; Flanders 2000) Beyond all these complexities, a *gender-sensitive* program of ARV for pregnant women should take into account the kinds of cultural constraints many women face that I alluded to earlier. "Learning their HIV positive status" may involve serious problems for pregnant women, including "stigma and discrimination, violence against women blamed for infecting partners, shame, anxiety and other psychological sequelae." (Hankins 2000:59) In other words, without serious educational and political interventions to change the old gender-biased attitudes of shame and stigma, some women may reject ARV and the testing it requires.

Other health and AIDS activists, however, argue more persuasively that providing ARV "would put strong pressure on improving primary health care services" and "could be an entry point for a radical reversal in the world's prioritization of resources for health." (Jackson 2001) From an ethical standpoint, they insist it is wrong to let people die when an effective, life-prolonging treatment is available. From a practical standpoint, they note the success with which the South African Department of Health has managed and monitored on a national scale such treatments as those for cholera and high blood pressure; and point to the impressive record that countries with even weaker health systems and poorer resources than South Africa—especially Uganda and Senegal—have had in containing or reducing HIV infection rates.[22] Above all, they look at the example of Brazil, with its commitment to provide ARV and other AIDS drugs free to all who need them and its widely praised success in cutting the AIDS death rate in half in just a few years (see below). The message here is clearly that *political will*, even more than resources or an advanced health infrastructure, is the solution to AIDS in South Africa. (COSATU 2001; Altman 2000) But political will can rarely overcome the cultural climate in which it operates; it makes a tremendous difference whether that climate is one that affirms gender equality, sexual plurality and sexual pleasure or one that cloaks sexuality in punishment and shame.[23]

In the early years of the epidemic in South Africa—that is, prior to liberation and the 1994 elections—the Department of National Health and Population Development (DNHPD) as well as the ANC and a wide range of civil society organizations made strong commitments of principle to a National AIDS Strategy that would be "holistic and multisectoral . . . , including education and prevention, counseling, health care, welfare, and research." (Heywood and Cornell 1998:66) Then, following elections and in the welter of the challenges facing the new ANC government, both popular opinion and national leaders retreated into silence, denial, or worse—a cruel stigmatization of people living with HIV and AIDS. AIDS was dismissed, even by progressive organizations like COSATU, as an "imperialist plot" designed to reduce African population growth, or associated with gay, white, wealthy men and prostitutes.

Mark Heywood and Morna Cornell, writing in the late 1990s, offer a number of reasons (though not justifications) for this retreat. In part these were political, the ironic underside of democratic victory. First, the very climate of euphoria as well as high expectations from the new

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[22] Senegal's infection rate has remained below 2 percent, thanks mainly to the aggressive, outspoken policy of its president to educate people about AIDS, legalize prostitution, and set up free clinics to treat STDs. (Altman 2000)

[23] Displaying its lack of political will, the Mbecki government refused for months to comply with the High Court's ruling (upheld in July 2002 by the Constitutional Court). Meanwhile, leaders in Gauteng and Kwa-Zulu began to defy the national government's policy, ordering that nevirapine be provided to pregnant women in public hospitals in their provinces. Finally in April 2002, after "gentle arm-twisting" by Nelson Mandela, Mbecki reversed his AIDS policy, announcing that the government would provide universal access to nevirapine in public hospitals, not only for all pregnant HIV+ women, but also for rape victims. (Swarns 2002; Lamont and Innocenti 2002)

ANC government meant that concerns like HIV/AIDS got swept into the wings as drafting a new constitution, establishing new institutions, and addressing poverty and development took center stage. In addition, "political enfranchisement has been accompanied by a weakening—even paralysis—of many of the popular organizations that had started to consider AIDS as an urgent issue in the early 1990s," as many of their leaders became part of, or ceded power to, the new administration. (1998:68) The TAC-led campaign against the PMA and for treatment access as a human right has revitalized this movement, though the government continues to prevaricate.

But to understand the deeper roots of silence and shame we have to look at history and culture. Recalling the liberalism of the new South African Constitution and the early National AIDS Strategy endorsed by the ANC, Heywood and Cornell soberly observe that "principles are not always sufficient" and "cultural practices that deny fundamental human rights cannot be wiped away by a constitution created by lawyers, academics, and politicians." (1998:70-71) Like Klugman, they invoke the complex weave of social conditions with local cultural prejudices and practices involving the subordination of women, the sexual privileging of men, and, above all, a deep-seated homophobia that has infected even some ANC leaders and generated at best a silence on the subject of gay sexuality.[24] In turn, we should put these attitudes into the context of 100 years of colonialism and apartheid; centuries of European stigmatization of black Africans as sexually promiscuous, deviant and carriers of disease; and documented scandals of western and corporate medicine using Africans as "guinea pigs." [Jordan, Schiebinger, Gilman, Lurie & Wolfe, Shah (Nation), Le Carre] While this racist history surely does not excuse denial in the face of the epidemic or the evasive policies of Mbeki, it does place in a context and make more understandable the fears surrounding a sexually transmitted and deadly virus in South Africa.

Brazil. On 18 June 2001, at the beginning of the United Nations Special Session on AIDS, the Brazilian Ministry of Health (MoH), along with six Brazilian and Latin American AIDS-related NGOs, sponsored a half-page ad in *The New York Times* that read:

> **AIDS is not a business**. The Brazilian Ministry of Health distributes the anti-AIDS cocktail free in Brazil to anyone who needs it. The United Nations has called this the best AIDS prevention programme in the developing world. . . .
> Local manufacturing of many of the drugs used in the anti-AIDS cocktail is not a declaration of war against the drugs industry. It is simply a fight for life.

As South Africa's government wavered in its AIDS treatment policies, Brazil assumed the undisputed leadership among Southern countries in the campaign to assert public health needs and human rights over intellectual property claims and corporate profits. This leadership manifests itself in multiple arenas—in negotiations with the US government and corporations; in UN forums such as the 2001 UNGASS on HIV/AIDS and the World Health Assembly (where Brazil successfully urged the publication of a WHO price index for AIDS drugs); in the global campaign against corporate biopiracy of the medicinal knowledge of indigenous groups; and above all in the national realm, in its creation of a model HIV/AIDS program based in part on a viable domestic industry for producing ARV drugs that is predominantly public and non-profit.[25]

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[24] They note, "The ANC has always had an ambiguous position on the question of gay rights, adopting a politically correct position in its resolutions, but doing nothing to counter homophobia that has been encouraged by leaders like Winnie Madikizela-Mandela who have argued that homosexuality is 'unAfrican'." (1998:79, n. 7) Compare Klugman, who states that "South African HIV/AIDS [educational] materials make no effort to explicitly address gay people or to promote acceptance of gay relations." (2000:159-60)

[25] It is disheartening to contrast Brazil's policies on access to AIDS drugs with those of India, which was able to develop a vigorous generic pharmaceutical industry (though private rather than public) because of a 1970 law

The success of Brazil's program for preventing and treating HIV/AIDS is evidenced first and foremost in its outcomes: "It has halved the death rate from AIDS, prevented hundreds of thousands of new hospitalizations, cut the transmission rate, helped to stabilize the epidemic and improved the overall state of public health in Brazil." (Rosenberg 2001:28) According to the national Ministry of Health (MoH), the overall 50 percent reduction in AIDS-related mortality in Brazil since 1995 is exceeded in the large urban centers, which account for nearly one-third of all AIDS cases and where AIDS deaths have been reduced by nearly 75 percent. (Brazil MoH 2002; Teixeira 2002) Although the country's AIDS program began in 1985, these exemplary outcomes date mainly from the mid-1990s, when it matched large World Bank loans with significant national budget allocations to create a $250 million AIDS funding package. It was also in 1996 that Brazil passed its law mandating universal access to drugs for treatment of AIDS—not, however, due to any encouragement from the World Bank. On the contrary, Vera Paiva suggests that the Bank's restrictions on using its funds for anything but "educational and prevention activities (since we were a 'developing country')" may have served as a kind of negative incentive to Brazil's independent drug policy and its resistance to the US and Big PhRMa.[26]

Without question, the drugs component of this program—relying heavily on the manufacture of generic versions of essential ARV drugs by the government's own research laboratory and factory, Far-Manguinhos—has been critical in making the program cost-effective as well as in saving lives. Rather than exacting trade-offs from other segments of the health system, the policy of treatment provision "pays for itself" by having reduced hospitalizations by 85 percent, decreased opportunistic infections and increased productivity among people with AIDS.[27] (Brazil MoH 2002; Teixeira 2002; Brazil MoH 1999; Rosenberg 2001:28) Moreover, through a combination of strategies—manufacturing its own drugs through the public sector being the most important but also negotiating with multinational manufacturers to reduce prices in the private market—Brazil has managed to reduce its budgetary expenditures on drugs for AIDS since 1999, both in total dollars spent and as a percentage of its overall health budget. And it has done this *even as the total number of patients served by the universal access program and the complexity of their regimens have increased annually.*[28] According to a MoH study, by increasing the proportion of its ARV drugs obtained from domestic (mainly public) producers of generics rather than multinational producers of brand-name drugs (63% and 37% respectively in 2001), the government saved an estimated $80 million in 2000—or $540 million if compared to

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exempting drugs from patentability. Companies like Cipla in Bombay produce good quality, generic antiretroviral drugs for $350-700 per patient per year, cheap enough for the Indian government feasibly to provide universal free ARV for all those who need it within the country, as does Brazil. Yet, succumbing to "overt and covert resistance" from the transnational and local drug industry, the Indian government has systematically deregulated prices on nearly all drugs and refused to adopt a policy of public support for new drug research and generic provision. (Sen et al. 2002:428-29) For a summary of the numerous exceptions to patentability for food, medicine and drugs in India's 1970 Patent Act, see Shiva 2001:Appendix. Presumably to assure compliance with TRIPS, however, a 1999 amendment to this Act annuls most of these exceptions, ignoring even the TRIPS safeguards.

[26] "Prevention is the only feasible action because we are banned from dreaming about accessible treatment . . . [even though] that treatment is available in plenty for the elites. . . ." (Paiva 2002:4, 13)

[27] Rosenberg (2001:29) notes that while Brazil spent $444 million on AIDS drugs in 2000, including purchasing raw materials as well as manufacturing and distribution, it saved $422 million on hospitalizations averted in 1997-99; and to this one must add the amount saved from drugs to treat opportunistic infections and from increased productivity among AIDS patients. Among other things, "the incidence of tuberculosis in HIV+ patients has dropped by half" in Brazil. See also Oxfam and Galvão, in DAWN Suppl. 2001.

[28] In 2001 there were 113,000 HIV+ Brazilians receiving ARV treatment (95% adults and adolescents, 5% children), compared with 23,000 in 1997. (Brazil MoH 2002:13)

the cost of comparable drugs in the US! (Brazil MoH 2002) And it has created an efficient as well as effective system of R & D to promote new drugs through a system of cost-sharing during expensive later-stage trials between the public and private sectors.[29] (Macedo 2002)

Combining universal treatment access with innovative outreach and education methods, Brazil's AIDS/STD program disproves the view of pharmaceutical and medical elites that poor, illiterate people in developing countries are incompetent to handle the complex regimens of triple-therapy drugs. As sterile debates persist about whether treatment or prevention is more critical to combating the epidemic in the long run, Brazil's program demonstrates conclusively that treatment and prevention, far from being in competition, are interdependent. In fact, the principle of their integral linkage is built into Brazil's 1988 Constitution. (Paiva 2002:3) When people know treatment is available, they are more likely to submit to testing and thus to be exposed to counseling on preventive and safer sex behavior. In Brazil as in the US and Europe, availability of treatment has meant a decline not only in AIDS mortality but also in its prevalence; in the one year from 2001 to 2002, new infections dropped from 20,000 to 15,000, or by 25 percent. (CMH/WHO 2001; Bayer 2002; Siecus 2002) At the same time, the Brazilian government's commitment to making AIDS a number one public health priority has helped to upgrade and expand the country's primary health care system generally by creating a national network of AIDS clinics, trained health workers, counseling and diagnostic services, preventive outreach—including free condoms and clean needles—and epidemiological surveillance along with treatment access. (MoH 1999; Rosenberg 2001) It has thus contributed to strengthening Brazil's public health infrastructure rather than depleting it.

Of course, Brazil's resources and capacity are enormous relative to most other Southern countries, especially in sub-Saharan Africa, giving it the ranking of a middle-income country.[30] But its success in developing a domestic pharmaceutical industry for ARV drugs and an effective HIV/AIDS program is due not only to size and relative GNP but also to a constellation of mutually reinforcing political assets that have intersected with the AIDS epidemic. These include the historical context of democratization since 1984, with its strong emphasis on citizen participation; political commitment to a comprehensive national public health system (SUS) based on principles of social solidarity, multisectoral integration, decentralization and civil society involvement; and vibrant, well organized gay and women's rights movements that have played a critical role in pushing for the broadest possible access to services and treatment without discrimination. (Galvão 2001; Paiva 2000 and 2002; Terto 2000; and Ch. 5, below)

Yet all of these political ingredients are to a large degree present in South Africa as well. South Africa has also undergone a profound political transformation and democratization process with the historic defeat of apartheid and election of a non-racialist ANC government in 1994. Its urban-based civil society organizations—including for women's health and HIV/AIDS—are likewise dynamic, skilled and well mobilized. And its new constitution is one of the most liberal in the world, the only national constitution explicitly to outlaw discrimination based on sexual orientation. In order to understand the differences between the two country contexts and their consequences for public policy, we have to consider differences in *sexual cultures*; for the

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[29] Maria Fernanda Macedo, who is director of Brazil's publicly owned Far-Maguinhos plant, explains that in this arrangement the government remains the primary patent holder and the private company a non-exclusive licensee.

[30] According to the Commission on Macroeconomics and Health, only one-third of developing countries have the capacity to produce medicines, while another one-third "import 100 percent of the medicines they consume." (CMH/WHO 2001:127, n. 122.)

HIV/AIDS pandemic is always and inescapably as much about sexuality as it is about health and social condition.

When I speak of sexual cultures here I am not referring to the enormous variety of sexual practices and sub-cultures that exist in many if not all societies.[31] Rather, I am concerned with the hegemonic cultural discourses of sexuality that capture policymakers and inform or constrain their public speech and action, especially regarding HIV/AIDS. Numerous studies suggest that Brazilian society is more open about sexuality than many, therefore lessening the stigma and denial surrounding AIDS and easing cultural receptivity to such projects as condom distribution, sexual education of youth, and discussion of diverse sexual practices. (Parker 1991; Parker and Barbosa 1996; Paiva 2000 and 2002; Rosenberg 2001; Diniz et al. 1998) But this openness is apparently selective and complex. As embracing as the hegemonic, "Brazilianized" sexual culture may be of a strong STD/HIV/AIDS program, it is equally hostile to the legalization of abortion—a struggle in which Brazilian feminists remain engaged to this day. Nor is it exempt from the sexual and gender subordination of women and a high degree of male sexual violence, especially against wives and partners.[32] And, as Veriano Terto Jr. (2000) reminds us, Brazilian society is certainly no stranger to homophobia. So what makes the difference?

Through his ethnographic studies of sexualities in Brazil, Richard Parker offers us rich insight into the specificities of its cultural landscape. Parker's unraveling of the myth of a separate and freer, more passionate, less sin-tainted sexual world "beneath the equator" reminds us that such mappings of sexual "worlds" are not merely the fantasies of western travelers but also become the prevailing images and stories that societies re-enact about themselves. For Brazilians, *carnaval*—with all its erotic and extravagant pageantry and its bacchanalian revelry—becomes a kind of utopia embodying "the sensual nature of Brazilian life, . . . the chaotic mixture of races and cultures that has given rise to a new world in the tropics." In its re-enactment for a brief time every year, *carnaval* offers "a metaphor for Brazil itself—or, at the very least, for those qualities that are taken as most essentially Brazilian," including affirmation of the body and the erotic. (Parker 1999a:363, 375-76) Within this cultural-sexual panorama, the widespread practice and acceptance of men having sex with men is alive and well. This traditional homoerotic model, though typically structured by rigid gender roles, cuts across all classes and sectors. Above all, the celebration of desire and eroticism as an essential part of the national ethos means that a public health program affirming sexual differences and rights becomes not only possible but in some sense "natural." (Parker 1999b; Paiva 2002)[33]

At the level of social institutions, the onset of the epidemic in the early 1980s in Brazil coincided, in a critical historical conjuncture, with the end of dictatorship and the flurry of civil society and democratization movements: "The emerging Homosexual Movement (*Movimento Homossexual*) grew parallel to, and attempted to form alliances with, other minority organizations and movements of the period (the women's movement, Afro-Brazilian movement, and ecology movement, among others) that shared a concern with democracy, acceptance, and social justice." Thus the epidemic itself was transformative in helping to galvanize segments of a preexisting homoerotic culture into gay rights organizations and a self-defined gay community.

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[31] For a sampling of the enormous recent literature documenting this variety, see Altman 1995 and 2001; Blasius 2001; Lancaster and Di Leonardo 1999; Parker and Gagnon 1995; and Parker, Barbosa and Aggleton 2000.

[32] Thanks to Sonia Correa for reminding me of these realities. For vivid examples of pervasive male violence against women in everyday Brazilian life, especially in the rural Northeast, see Diniz et al. 1998.

[33] Paiva (2002) describes how this open and festive sexual culture translates into AIDS and STD prevention programs—for example, the one in Amazon State, training female sex workers, men who have sex with men and transvestites as peer educators and utilizing street theater, festivals and an International Women's Day march.

(Terto 2000:62) AIDS NGOs such as ABIA (Brazilian Interdisciplinary AIDS Association), which has targeted men having sex with men, became focal points for homosexual Brazilian men. Such groups, with their strong civil and human rights perspective, "opened a new field of activism, mobilized decisive community responses to the epidemic, and gave new dimensions to the visibility of homosexuality." (Terto 2000:67-68; Parker 1999b)

Brazil's successful HIV/AIDS program is thus the product of a unique enabling environment formed out of the intersection between a prevailing sexual culture celebrating freedom and pleasure (including homoeroticism) and a strong political culture of active civil society mobilization empowering many social movements simultaneously. The gay movement has played a crucial part in advocating for services and prevention since the beginning of the epidemic, when it was predominantly a homosexually (MSM) transmitted disease. As the male:female ratio in seroprevalence rates shifted rapidly in the late 1980s and 1990s, with women in poverty and heterosexual transmission accounting for the majority of all new cases,[34] the feminist, lesbian and popular health movements also became involved in activism around the disease. Quoting a former head of the national AIDS program, Rosenberg notes the effect of AIDS activism on health care advocacy more broadly: "There are now 600 nongovernmental groups that work on AIDS. They demonstrated in the street for a higher budget for all diseases, not just for AIDS, and these protests were covered in the press." (2001:29)

What also makes the Brazilian context unique, however, is the responsiveness of government officials, particularly in the national, state and municipal health departments, to popular and NGO demands. This is not an accident, since many of these officials, especially at middle-bureaucratic and municipal levels, have come out of the gay, lesbian and feminist movements.[35] The 1999 official MoH report to the 12th World AIDS Conference is entitled, significantly, *AIDS in Brazil: A Joint Government and Society Endeavour*. The report recognizes that current government policies concerning HIV/AIDS would not exist without the "initiative from civil society" and social movements, particularly of people with AIDS. And it repeatedly and expressly links those policies to human rights: "The most important fact in this period [early 1990s] was that the people living with AIDS started to get organized for their legal and human rights, questioning the epidemic not only as a technical challenge in the health arena but also as a political issue involving the whole of Brazilian society." (MoH 1999:28-29)

In contrast to the economistic discourse of many UN and government advocates for access of the poor to life-prolonging medicines, official Brazilian policy firmly situates this issue in a human rights framework (see discussion of health sector reforms in Ch. 4, below). *AIDS in Brazil* proudly describes Brazil's law instituting universal access to AIDS drugs as "one of the principal achievements in human rights in the recent history of the epidemic." (MoH 1999:43) This strong human rights perspective, and the pivotal role in Brazilian politics of the social movements and sexual cultures that reinforce it, are key to understanding Brazil's outspoken stand on behalf of people's right to treatment and against the sanctity of patent monopolies.

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[34] According to MoH figures, the male:female ratio in reported AIDS cases nation-wide dropped sharply from 28:1 in 1985 to 7:1 in 1988, and then to only 2:1 in 1998. In 1996, there were 284,000 HIV infected men compared with 200,000 infected women, and women accounted for 70 percent of all new cases in the country's Southeast region, where most HIV prevalence is concentrated. (MoH 1999:14, 16-17)

[35] Two examples are Richard Parker, who served for a brief time as chief of the Prevention Unit for the Brazilian MoH's National AIDS Program; and Maria José Araújo, who has directed the Women's Health Program of the municipality of São Paulo. In the national MoH, three senior staff in the Women's Health Program come from the National Feminist Network on Health and Reproductive Rights. (Thanks to Simone Diniz for this information.)

Among all Southern countries, Brazil has been the most defiant in response to pressures from the US government and the multinational pharmaceutical lobby to uphold patents and accede to a narrow interpretation of TRIPS. During 2001 the temperature of the dispute rose considerably, as the MoH engaged in a series of threats and parries with two pharmaceutical giants, Merck and Hoffmann-La Roche, over the prices and availability of their ARV drugs. Under its own patent law, Brazil can manufacture generic forms of most of the drugs it needs to treat AIDS, including nevirapine and several of the protease inhibitors, because these either are not patented in Brazil or were commercialized before the law went into effect.[36] With regard to drugs patented since 1996, the law requires the patent-owning companies either to manufacture the drug in Brazil (to avoid expensive foreign exchange and importing costs) or to issue a license to a local company to do so within three years of securing the patent. In March of 2001—just as the South African case was coming to trial—Brazil's health minister, José Serra, threatened to produce cheaper copies of two patented drugs produced by Merck and one by Hoffmann-La Roche in order to meet the country's AIDS crisis. In other words, he threatened to utilize the compulsory licensing exception of TRIPS. The USTR immediately filed a formal complaint against Brazil with the WTO, culminating expressions of "serious concern" by the US Commerce Department Secretary and imposition of heavy tariff duties on Brazilian exports to the US during the previous year. (Bermudez et al. 2002)[37]

In his statement resisting pressures from the USTR and protesting its WTO action, Serra accused the US of hypocrisy, citing US protectionist policies that "obstruct Latin American exports from entering its markets." "It is of course well known," he remarked, "that the USTR specializes in the defense of the interests of the American economy and not in global free trade." And he warned, "There is no way that the Brazilian Government will retreat on this issue." (DAWN Suppl. 2001:8) Two months later Dr. Paulo Roberto Teixeira, head of Brazil's STD/AIDS program, took a similarly tough stand against US policies at a press conference in New York. All efforts to combat the AIDS crisis would "be lost," he suggested, "if at the global level or in talking about international relations, the USTR [is allowed to dictate] what is good and what is not good for AIDS prevention and control." (Crossette 2001) Signifying the importance of health on Brazil's national agenda, President Fernando Henrique Cardoso used the occasion of a visit to Washington in March 2001 to back up his health minister and Brazilian civil society in their commitment to access to life-saving medicines for all:

> Brazil has raised this banner because it is a cause that has to do with the very survival of some countries, especially the poor ones in Africa. . . . This is a political and moral issue, a truly dramatic situation that has to be viewed realistically and *can't be solved just by the market.* (Quoted in Petersen and Rohter 2001, my italics)

In June, on the eve of the UN Special Session (UNGASS) on HIV/AIDS, the US dropped its WTO complaint against Brazil.

One way to look at this story is to see compulsory licensing, and Brazil's deployment of it, simply as an effective "negotiating tool to pressure companies to reduce the high price of

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[36] Bermudez et al. relate that this law was submitted in 1991, in the shadow of the GATT negotiation process, but only passed in the Brazilian Congress in 1996, after a period of intense controversy and opposition by those who protested that it would have severe effects on the national economy and compromise Brazil's constitutional commitment to health care as a right for all. (2002:212)

[37] For more detailed accounts of this negotiating process, see Rosenberg 2001; Oxfam and Galvão in DAWN Suppl. 2001; and Crossette 2001.

imported medicines." (Oxfam 2001:17) Both companies, first Merck and several months later Hoffmann-La Roche, ultimately agreed to lower their prices substantially, and in both instances the Brazilian government accepted the offer and backed down from its threats. [38] Yet the discourse through which this tense negotiation took place makes it clear that the real stakes are not so much the level of prices, or even equity in pricing, but *who shall have the power to establish prices of a life-saving good and on what ethical grounds.* The stakes are also whether Southern countries will be able to own the processes of research and development that directly affect their people's lives. For in the long run, as even a *New York Times* editorial admitted, importing cheap generic versions of essential medicines or, better still, getting the necessary technology transfers so they can manufacture their own is "a more sustainable solution" for countries in Africa, Asia and Latin America than depending on corporate or donor largesse or shrewd negotiating tactics. (NY Times 2000:20; 't Hoen and Moon 2002) But this puts the right to treatment on a collision course with corporate globalization, and at this point in time it appears that no governments in the South, including Brazil, are willing to entertain such a collision.

In August of 2001, many anticipated that Brazil would be the first actually to issue a compulsory license on AIDS drugs and thus test the limits of TRIPS with regard to life-prolonging medicines. But in the end that did not happen; instead the Brazilian government entered an informal agreement with the US to notify officials in the USTR beforehand whenever it contemplated challenging a patent. "In other words," as Sonia Correa remarks, "we remain somehow hostage of the US." (personal communication) Other Brazilian activists have made similar comments indicating that the country's laws and policies regarding patents fall short of the ideal "model" some would wish. It should be remembered that only in the area of drugs for AIDS has Brazil developed a semi-autonomous, state-sponsored pharmaceutical industry. With regard to many other drugs, it remains reliant on patented imports from multinationals, with which its own very small private manufacturing sector can hardly compete. Thus the multinationals benefit the most from the patent protections that Brazil's 1996 law introduced, maintaining the monopolies and high prices that abound everywhere. (Bermudez et al. 2002)[39]

Transnational AIDS and health NGOs were initially elated at Brazil's apparent defiance of the US over patents, seeing it "as a moratorium on TRIPS in areas related to public health" and a model for third world countries. (DAWN Suppl. 2001:6) Their disappointment at the retreat on compulsory licensing was compounded when the MoH issued a statement in January of 2002 clarifying that it "definitely had no policy of exporting generic AIDS drugs" to other countries.[40] NGOs were alarmed at this announcement, complaining that Brazil, with its unique capacity and political example in the global South, was now "turning its back on its Latin American neighbors" and Africa. (Stern/Health GAP 2002) The government's position,

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[38] Merck agreed to lower the Brazilian price of its brands of efavirenz and indinavir to 20 percent and 17 percent of their US price, respectively; Hoffmann-La Roche ultimately reduced its price for Viracept (nelfinavir) to around 30 percent of the US market price. (Petersen and Rohter 2001; Rich 2001)

[39] Even with regard to production of ARV drugs, Brazilian researchers indicate the system has serious problems—e.g., dependence on other countries for its raw materials; time lags between when new drugs are licensed and their availability to public health providers; and lack of incentives to research new combinations of drugs that are under patent by different laboratories. (Bermudez et al. 2002; Terto Jr. 2002)

[40] The incident provoking this statement was an action by members of MSF and TAC, who had transported to South Africa quantities of generic drugs manufactured in Brazil and obtained by MSF through an agreement with the Oswaldo Cruz Foundation (the MoH's research branch). The NGOs' purpose was to begin testing the limits of the Doha Declaration (see below).

however, seems to be that its first responsibility is to provide AIDS drugs free to the hundreds of thousands of Brazilians who need them; and that its solidarity with Latin America and Africa should take the form, not of commercial exports, but of cooperative agreements for technology transfers (technical support and training in all aspects of production) to countries with potential capacity (such as Chile, South Africa, Uganda, and Barbados); as well as donations or exchanges of government-produced generic drugs to countries in need. (MoH 2002; NY Times 7/9/02; M. F. Macedo, interview) Behind this policy, however, lurks the global politics of trade: the Brazilian government's fear of being perceived as using the TRIPS exemptions to compete in the global drug market, at least before such activity receives the imprimatur of the WTO (see discussion of Doha below). (S. Correa, personal communication)

Despite these complexities, I would still argue that the terms in which the conflict over drugs and patents evolved between Brazil and the US government/Big PhRMA suggest a significant and irrevocable shift in power. By June 2001 the US no longer felt it had sufficient support in the court of world opinion to sustain an action in the WTO based on TRIPS—although the WTO and TRIPS were supposedly created to protect its interests. By August the world's leading pharmaceutical companies had shown their inability to control prices for their AIDS drugs, even in a middle-income country like Brazil. And by December of that year, Brazil had initiated an offensive against corporate biopiracy of medicinal plants in the Amazon. In its most recent action, the Brazilian government has joined with indigenous groups to build toward a domestic biotechnology industry that will protect biodiversity and the intellectual property of Brazil's indigenous peoples. Seeking royalties for their traditional knowledge and a system of equitable sharing, representatives of Amazon tribal groups assert: "We want to be part of the whole process, from research to the economic results." (Rohter 2001) With this statement, indigenous Brazilians challenge the underlying imperialist presumption that inspired TRIPS: that countries of the North have all the "knowers" and "innovators" while countries of the South remain forever the suppliers of raw goods and markets.[41]

Whatever Brazil's achievements in building an effective and sustainable AIDS/STDs treatment and prevention program, Paiva insists that it is a mistake to hold them up as a "best practices" model to be imitated by others. To do so, she implies, is to fatally ignore differences in context-specific conditions and cultures: "We may *inspire* other context based initiatives, we may share common values and an idea of human rights," but there is no one-size-fits-all solution to the plague. (Paiva 2002:2, 16) One might make a similar observation with regard to the more particular issue of procuring affordable medicines and the potential for good or harm of patents. As Bermudez and his colleagues observe,

> . . . *patents are economic policy tools*, adapted to particular circumstances at given moments in each society's stage of development, within their particular social and economic context. Thus, depending on the country, they may or may not be beneficial. (2002:213, my italics)

Many potential strategies exist short of abolishing patent regimes altogether whereby governments can implement the principle that even the poorest people have a human right to life-saving and life-prolonging medicines, and even the poorest countries a duty to provide "the highest available standard" of public health. These include not only compulsory licensing and

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[41] It is important to note that South African researchers with the University of Capetown's Medical Research Council have already implemented such a benefit-sharing arrangement with traditional healers in indigenous communities. The goal is to ensure that these healers and communities are "equal partners" in both the material and the non-material benefits of biotechnology research on traditional medicines. (Matsabisa/DND Conference 2002)

parallel importation but also technology transfer to improve production capacity, rational drug use and use of generics, creating government-controlled funds for investment in R & D in which private donors would have a share, and "patent pools" or public licensing systems that would require patent holders to freely share scientific and technological information and not horde these as "business secrets." (Bermudez et al. 2002:217; Love 2002a & b) All are mechanisms that respect the concept of "intellectual property rights" yet see such rights not only as subordinate to the right to health but also as entailing definite obligations of sharing and public access. So where does such an expansive approach to IPRs and patents leave the meanings of TRIPS?

Doha. The success of Brazil and South Africa in challenging US and corporate rigidities on patents, along with persistent encouragement from transnational health and human rights NGOs, gave a green light to developing country coalitions to move aggressively on the matter of access to essential medicines. In June of 2001, the WTO's TRIPS Council convened a special meeting on TRIPS and Public Health to address mounting concerns over the conflict between patent monopolies and health rights. There, a group of 47 developing countries submitted a joint paper asking that the upcoming WTO Ministerial Conference, to be held in Doha, Qatar in November, "take steps to ensure that 'the TRIPS Agreement does not in any way undermine the legitimate right of WTO Members to formulate their own public health policies and implement them by adopting measures to protect public health.'" (DAWN Suppl. 2001:20) The same language was used in the "Kochi Declaration" on "Facilitating Access to Essential Health Commodities through South-to-South Collaboration," issued a week before the Council meeting by 16 African, Asian and Latin American countries who make up Partners in Population and Development.[42] The Kochi Declaration urged "the importance of appropriate Southern representation in the governance of global health funds and initiatives"; and an interpretation or amendment of TRIPS consistent with "[increasing] self-reliance among developing countries on an equitable basis, with respect to availability, production, affordability, accessibility, use of essential health commodities, research and development," all of which it categorized as "intrinsic components of [the] human right to health." (Kochi/RHM 18:176-77)

The WTO's conference in Qatar—an inaccessible and tightly secure Middle Eastern potentate chosen expressly to avoid the massive demonstrations that shut down the 1999 conference in Seattle—was mostly a great disappointment, from the standpoint of advancing trade equity, gender justice or democratic processes within the WTO. Occurring in the shadow of September 11 and the US "war on terrorism," there was little room for dissent or creative debate. (Williams and Francisco/DAWN 2002; Williams 2001a) Yet the conference did adopt a Declaration on the TRIPS Agreement and Public Health that has greatly helped to reinforce and clarify TRIPS' safeguard provisions (for full text, see http://www.wto.org). Though not a binding treaty under international law, the Declaration nonetheless has considerable political importance and could carry weight in any future controversy over access to essential medicines. Its crucial Paragraph 4 adopts the language of the previous statements by Southern countries:

> We agree that the TRIPS Agreement does not and should not prevent Members from taking measures to protect public health. Accordingly, . . . we affirm that the Agreement can and should be interpreted and implemented in a manner supportive of WTO Members' right to protect public health and, in particular, to promote access to medicines for all. In this connection, we reaffirm the right of

[42] The 16 countries are Bangladesh, China, Colombia, Egypt, Gambia, India, Indonesia, Kenya, Mali, Mexico, Morocco, Pakistan, Thailand, Tunisia, Uganda and Zimbabwe.

> WTO Members to use, to the full, the provisions in the TRIPS Agreement, which provide flexibility for this purpose.

These flexibilities are defined more precisely than in Article 31 of TRIPS and include:

> 5(b) Each Member has the right to grant compulsory licenses and the freedom to determine the grounds upon which such licenses are granted.
>
> 5(c) Each Member has the right to determine what constitutes a national emergency or other circumstances of extreme urgency, it being understood that public health crises, including those relating to HIV/AIDS, tuberculosis, malaria and other epidemics, can represent a national emergency or other circumstances of extreme urgency.

In addition, for the least developed countries the Declaration extends the transitional period after which the patents section of TRIPS must come into effect for 10 more years, until 2016.

Assessments of the Doha Declaration were divided, including among transnational health and development NGOs. Members of MSF praised it as "an unambiguous road map to all the key flexibilities the TRIPS offers," while Third World Network and International Gender and Trade Network leaders disparaged it as "inadequate" for failing to amend TRIPS itself or to address issues concerning the patenting of life forms. (Williams 2001a; Bello and Mittal 2001) Other commentators pointed out that, while the Declaration affirms TRIPS' compulsory licensing provision, compulsory licensing is only useful for the middle-income countries that "have factories capable of producing these medicines." And with regard to parallel imports of cheaper generic versions, "even the rock-bottom prices charged by generic manufacturers. . . are still far out of reach for most people in African nations ravaged by AIDS." (Dugger 2001)

Nonetheless, seen within the context of the entire global campaign around access to essential medicines, the Doha Declaration has to be understood as a step toward recognition of such access as part of the human right to health. As two MSF activists have written:

> For the first time since its creation, the WTO recognizes a hierarchy of values, the primacy of public health over free trade, and more specifically that medicines are not like any other commercial product. ('t Hoen and Chirac 2002, at www.msf.org)

By the late spring of 2002, only one country in the world—Zimbabwe, where adult HIV infection rates are around 25 percent—had actually utilized Article 31 of TRIPS and the Doha Declaration to declare a "national emergency" in order to import generic substitutes for AIDS drugs patented in that country. In an interview with *The New York Times*, Zimbabwe's deputy health minister felt compelled to state "that the country was committed to complying with its international trade obligations and wanted to work within the intellectual property agreement." (Cauvin 2002) Prior to Doha, this statement might have been read as perfunctory obeisance by a "dependent" African country to multinational corporate and WTO hegemony. After Doha, it is necessary to read it with greater nuance, as the subversion of corporate interpretations of intellectual property rules and their replacement with a more expansive interpretation, one that was crafted by Southern countries themselves and that puts national sovereignty over public health and health as a human right above the inviolability of patents.

At the moment of this writing, critical issues left unresolved by the Doha Declaration were still being negotiated. In particular, when TRIPS comes into force in 2006 (2016 for the least developed countries) it will not be possible to use compulsory licensing to export generic versions of patented drugs, which will severely limit affordable supplies for countries unable to manufacture their own—that is, the countries that need the TRIPS safeguards most desperately.

MSF has proposed an amendment to TRIPS that would allow such exports, but the US and its corporate allies are resisting such a move. (www.accessmed-msf.org; Olson 2002) And so the struggle continues—through a process of negotiation that reveals the relations between global trade and access to health care to be a political terrain whose meanings change with shifts in the balance of forces. Currently the global dynamics of AIDS have made TRIPS a tenuous but potentially enabling field for the right to drug treatment in health crises. But beyond TRIPS looms GATS—the General Agreement on Trade in Services, also adopted in 1994 as part of the Uruguay Round but not yet in force. [CHECK] If, as feminist health care advocates warn, GATS is likely to usher in further privatization, corporate globalization, higher costs and diminished access for the poor in the area of vital health services, then a new and more difficult struggle will complicate the already busy agenda of transnational health advocates. (Williams 2001; WGNRR 2002) Perhaps one day it will become possible to remove essential medicines and health services from the domain of the WTO altogether and secure them as part of the global "commons." But that day seems a long way off.

Surprisingly, the US trade representative supported the Doha Declaration on TRIPS. One reason was that even the wealthy, powerful US had just come face to face with its own potential health "emergency" during the anthrax scare the previous month, prompting the Bush administration to consider issuing a compulsory license for generic forms of the drug Cipro, an antidote to anthrax under patent to Bayer. The whole world was aware of this irony.[43] (Dugger 2001; Dyer and Michael 2001; 't Hoen and Chirac 2002) Another reason was that, in the context of needing international support for its "war on terrorism" and having other controversial priorities in Doha—for example, guarding protective tariffs for US textiles, steel and agriculture—the Bush administration decided to sacrifice the interests of the pharmaceutical industry. The multinational drug companies must have seen this retreat on the sanctity of patents as a blow to their command over the large potential markets in AIDS drugs in countries like Brazil, India and China and a boon to generic competitors. But, as Brazilian health policy recognizes, markets cannot solve the problem of AIDS. The question is, can they solve any health problems anywhere for anyone but the affluent and advantaged?

"Equity Pricing" or the Human Right to Health?

The struggle over access to essential medicines is a case study in the fluidity and porousness of corporate global power structures, as well as their tenacity. I want to understand how and why this issue allowed transnational NGOs to advance the principle of health rights over property rights and thus make some dents in corporate power, and how and why a *human rights* perspective on health still meets formidable obstacles in a market-driven world.

From the perspective of the giant pharmaceuticals, one of the most damaging aspects of the global campaign around medicines and its symbiosis with the global crisis of AIDS has been the public disclosure of alarming disparities in drug prices. Studies by MSF and UNAIDS in 2000 revealed that Pfizer was selling Diflucan for $18(US) per pill in Kenya—a country "that averages $5 per citizen per year" in its national health budget—whereas the generic version of fluconazole produced in Thailand cost 60 cents. Pfizer's wholesale prices for the same drug ranged from $8.52 in Kenya to $9.78 in the US, $11 in France, and $27 in Guatemala—all for a gross yield of around $1 billion a year for the company. The pattern of higher prices in some developing countries than in Europe and North America is not unusual; nevirapine was found in

[43] The US has used compulsory licensing before for a variety of technologies (though not pharmaceuticals), and Canada in the 1970s and 80s developed a thriving generic drug business through a compulsory licensing system, making its drugs far more affordable to Canadians. (Pollack 2001; Abbott 2002)

these studies to cost $430 per 100 units in Norway compared with $874 in Kenya. (McNeil 2000a & b) Alongside these prices—adding up to many thousands of dollars per year per patient for ARV "cocktails"—the cost of generic versions is miniscule. Cipla can sell the active ingredient in combivir, an antiretroviral that GlaxoSmithKline sells wholesale for over $7000, for under $240 and the finished generic version for just $275. Brazil can make its generic zidovudine combination drug for $1.44 a dose, compared with $18.78 for the brand-name version in the US. (Petersen 2001; McNeil 2000a)

Why should there be such enormous and seemingly illogical disparities? Because drug prices are determined not by costs of production but by managerial estimates of market characteristics; or, as the pharmacist who oversaw the MSF study put it, by the logic of "profit maximization." Applying this logic ruthlessly throughout the 1990s, the pharmaceutical industry in the US maintained profit rates three times higher than those of any other corporate sector. (McNeil 2000a; Thom 2001) But differentials in prices and markets and how they are arrived at are part of "business secrets," to be guarded closely and defended along with other corporate privacy rights. When, following Brazil's initiative, WHO, UNAIDS and MSF began to publish comparative price and source lists for safe AIDS drugs, including many from generic manufacturers, they effectively pierced the corporate veil covering pricing mysteries.[44] (McNeil 2002; CMH/WHO 2001; WHO/MSF 2000) The EU governments, who have long regulated drug prices in their countries, supported this move against the vociferous opposition of the US and the drug lobby. But the cat was out of the bag; like discrimination in wages, once disclosed, price discrimination in HIV/AIDS drugs was revealed to the world in all its stark reality, as a manifestation of global apartheid in the dispensation of life and death.

In this context, the giant pharmaceuticals adopted a new defensive maneuver that some of their more pragmatic critics defend as the best approach to AIDS treatment: "preferential pricing lists" for Africa, or "humanitarian" differential pricing. As Rosenberg puts it, "The price cuts the drug companies fought until last year have now become their solution to the world's AIDS crisis." (2001:58) In this strategy, discounts of 80-90 percent on drugs for the poorest countries would show that "we're doing our part" and thus address the industry's PR problem, while still yielding ample corporate profits. For the sale of drugs to poor countries at *any* price above cost is still profitable, since the alternative is no sale or ceding the market to the generic companies.[45] (Stolberg 2001) What Big PhRMA is clearly counting on to offset generic competitors, whose prices are still one-half to one-third of corporate discounted prices, is *the lure of brand names*—the anchor of corporate globalization. The assumption is, who would buy a product made by Aurobindo when they can get the original made by Merck? (like, who would buy Nike knock-offs when they can get the real thing for a little bit more?). Behind this assumption, of course, is the imperialist imaginary's first premise: that technological "know-how" resides in the West; generics produced in the third world can only be flawed, "impure" imitations.[46]

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[44] In March and April 2002, WHO published new lists of ARV drugs, including triple-therapy combinations, certified safe based on the organization's factory inspections and added 12 new ARV drugs to its essential drugs list. These lists include generic manufacturers from India, relative prices, and treatment guidelines for health providers. (McNeil 2002)

[45] Even outright gifts, like Behringer-Ingelheim's donation of nevirapine and Pfizer's of Diflucan, are profitable for large drug companies, since they gain from them not only a kind-hearted public image but, more importantly, lucrative tax write-offs against their US and European sales. (conversation with Prof. Harold Edgar)

[46] Typifying this prejudice, the International Federation of Pharmaceutical Manufacturers in Geneva, a big PhrMA lobbyist, railed against "the current plague of substandard and counterfeit medicines" when WHO released its new list in March 2002. (McNeil 2002)

But the deepest fear of the giant pharmaceuticals is not about African or third world markets, which generate a tiny fraction of their total profits, but about the potential effects of lower prices on their markets in rich nations: "They worry that publicity about generic prices will fuel the American demand for cheap imports or price controls." (Rosenberg 2001:58) As the US health care system spun more deeply into fiscal crisis in 2002, spurred mainly by escalating drug and hospital costs as well as the diversion of funds to the "war on terrorism," the chickens started coming home to roost.[47] Why should only people living in poverty in sub-Saharan Africa benefit from fairer prices on drugs? many were starting to ask. What about the millions of elderly for whom Medicare does not cover prescription drugs, to say nothing of the 40+ million adults and children in the US who have lost or cannot afford health insurance? By the summer of 2002, access to medicines was looming as a major issue in the upcoming congressional elections. Members of Congress were submitting bills that would prohibit drug companies from securing automatic delays in the expiration of their patents and allow imports of cheaper drugs from Canada, thus expanding access to generic drugs in the US. (Pear 2002b)[48] What if "equity pricing" were "a truly global system" applied in all countries, not just the poorest? ('t Hoen and Moon 2002:222)

The WHO Commission on Macroeconomics and Health (CMH) considers "differential pricing in low-income markets" (which it equates with "equity pricing") "the best solution" to the crisis of HIV/AIDS and other epidemic diseases in Africa.[49] This approach gives drug companies a mantle of legitimacy through the veneer of "public-private partnerships." For example, in the Accelerated Access Initiative of May 2000, five UN agencies (WHO, UNAIDS, World Bank, UNICEF and UNFPA) backed a consortium of five major drug companies in announcing 80 percent price reductions for their AIDS drugs in Africa. The understanding here is that many low-income countries in sub-Saharan Africa and elsewhere cannot afford these drugs even at generic prices, thus "any large-scale access to the medicines by those that need them will require large-scale donor financing." Corporate price differentials will make such financing—by a combination of private foundations, wealthy governments and multilateral institutions—economically feasible, "*while allowing the patent system to continue to play its role of providing incentives for research and development.*" (CHM/WHO 2001:88, 125-126; Sachs 2001) WHO officials laud the value of bringing the private sector (i.e., Big PhRMa) "to the table" with international organizations and are uncritical of the way in which "differential pricing" and "public-private partnership" arrangements work to preserve the system of patents,

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[47] A series of reports by health journalist Robert Pear in *The New York Times* described health care as the "new darling of pork barrel spending" and attributed most of the inflated government spending to (a) the mushrooming of private hospitals, hospital complexes, nursing homes and other medical facilities; and (b) the rise in drug prices and insurance premiums (which of course reflect increases in hospital and drug costs). These increases translate into enormous profits for drug and insurance companies, not necessarily into better or more accessible health care. (Pear 2001 and 2002a and Pear and Toner 2002)

[48] Senator Debbie Stabenow—a feminist, health care expert and leader of this effort in the Congress—told reporter Pear: "We have an industry that is the most profitable in the world. . . . when an industry is allowed to make 18 to 20 percent a year, at the same time it's raising prices three times the rate of inflation, and people who need life-saving medicine cannot afford it, I think it's time to ask where the corporate responsibility is." (Pear 2002c)

[49] CMH, which published its 200-page final report in December 2001, is a WHO-sponsored project chaired by Harvard economist Jeffrey Sachs. The report, *Macroeconomics and Health: Investing in Health for Economic Development*, is the outcome of dozens of preliminary reports, six working groups, and over 100 collaborators.

preempt compulsory licensing, construct price reductions as a voluntary or "charitable" response, and thus protect the entire system of markets and capitalist profits.[50]

In response to WHO's and CMH's conciliatory approach to the industry, members of MSF distinguish the concept of "equity pricing"—"the principle that the poor should pay less for and have access to essential medicines"—from "commercial terms" like "differential" or "tiered" pricing, a marketing strategy whose central aim is profits. This strategy is "dangerous" and "extremely vulnerable . . . on its own," since it relies mainly "on the will of companies." It needs to be supported by a range of other strategies, including the incorporation into national laws of TRIPS safeguards for compulsory licensing and parallel importation; bulk procurement, making it easier for international organizations and NGOs to negotiate prices and providing "patent exceptions for globally procured medicines"; technology transfer; and generic competition. ('t Hoen and Moon 2002:219-20) We need to go deeper, however, to understand the inherent weaknesses of approaches to treatment access that rely principally on humanitarianism and bargaining with the private sector.

Humanitarian gestures by drug companies and donor agencies to create "equitable" responses to health crises are inadequate because they fail to address the systemic roots of those crises or to require reliable mechanisms of enforcement and accountability, much less democratic participation in defining solutions by the people most affected (e.g., pregnant women and all people with AIDS). They continue to treat health as a commodity and to assume that markets—albeit "tiered" and adjusted for the poorest—are sufficient to meet basic health needs.[51] Focusing on AIDS or other epidemic diseases and defining these as "national emergencies" or "security risks" creates an aura of exceptionalism that ultimately serves to normalize the arbitrary pricing of medical goods and services and their unequal distribution in nearly all other areas of preventive and curative health, including reproductive and sexual health. Such exceptionalist approaches—including that of the "global burden of disease" that I shall review in Chapter 4—thus effectively reinforce the preservation of the vast majority of health-related interventions as the domain of "private rights" (those of corporate owners of property) whose only normative underpinning remains profit maximization. Aggressive global campaigns to raise funds and awareness in the fight against HIV/AIDS and other diseases that are decimating poor populations in sub-Saharan Africa may certainly succeed in saving lives. Cooperation among private donor organizations, UN agencies and commercial suppliers have succeeded in the recent past in negotiating bulk procurement and delivery of such medical commodities as vaccines and contraceptives to millions of poor people throughout the world in an efficient, "targeted" fashion. But these ad hoc and voluntarist strategies for solving health crises contain serious limitations that undermine both their ability to address gender and racial injustice and their long-term viability. Let me mention just two.

First, humanitarianism and "public-private partnerships" inherently rely on good will, kindness, or, more likely, appeals to self-interest and public image. They involve no long-term, sustainable *mechanisms of accountability and enforcement*, another way of saying they are not institutionalized in any kind of formal democratic process. Consequently, they must perpetually

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[50] This became evident at a 3-day conference in New York City on "The Crisis of Neglected Diseases" organized by MSF's Drugs for Neglected Diseases Working Group, especially in the remarks of a WHO representative. (DND/MSF 2002; Brandling-Bennet 2002)

[51] Even competition from generic manufacturers, while effective at the moment in challenging the patent and market monopolies of giant multinationals, is an unreliable strategy in the long run. Generic producers are also businesses interested in maximizing profits and may raise their prices in the future.

depend on the kinds of ad hoc campaigns and pressure tactics that brought the issue of access to essential medicines for HIV/AIDS into the global spotlight in the first place. ('t Hoen and Moon 2002) When international organizations like WHO and UNAIDS or NGOs like MSF undertake to negotiate "equity pricing" or bulk purchasing on behalf of low-income countries, they still must do this on an ad hoc, drug-by-drug basis. The bargaining process itself remains a market transaction based on the assumption of corporate prerogatives rather than a legal decision based on corporate responsibility to uphold human rights. At the national level, the result of "differential pricing" is that "each price cut for each drug in each country is negotiated separately," or that countries must defend their right to seek cheaper alternatives in lengthy litigations in the national courts. Meanwhile, months and years go by and millions more die needlessly. (Rosenberg 2001:58; Terto, Jr. 2002)[52]

In the area of research for new drugs, dozens of "public-private partnership" arrangements have been created during the past several years, for example, to develop an AIDS vaccine and non-resistant drugs for malaria and TB. Like bulk procurement and negotiations for equitable prices, these arrangements may result in effective treatments or vaccines in the short term, and are certainly more likely to do so than relying on the market alone. But multinational corporate participants in such "partnerships," while the first to impugn the public sector's competence and efficiency in drug research, are the last to admit the ways they and their shareholders become primary beneficiaries of "public-private partnerships," even acquiring large donor funds that might have gone to government research institutions.[53] It remains to be determined whether the ultimate products of public-private joint research ventures (e.g., an AIDS vaccine) will be patented and, if so, who will own the patent. Will governments or, more appropriately, some international agency (WHO?) or a non-profit NGO like MSF have the authority and the political will to assert control over intellectual property rights—*in the public interest*—for such publicly subsidized and vital medicines? James Orbinski, who chairs MSF's Drugs for Neglected Diseases Initiative, suggests that the concept of "public-private partnership" evades these issues of ownership and accountability, for it blurs the lines of responsibility between the public, private and non-profit/NGO sectors and replaces duty with charity. A more ethically acceptable alternative framework would be one that regards all the parties in such an arrangement as "public institutional actors" and holds them publicly accountable.[54] (MSF/DND 2002) Yes, but accountable to whom?

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[52] James Love (2002:181) points out another reason why differential pricing and bulk procurement are not an adequate answer to the problems the current patent system poses to universal treatment access, since these approaches "deal with the inventions after IP rights are in hand. By not directly funding the pre-discovery R & D, there are no mechanisms [for public agencies] to assert property rights post-invention."

[53] This kind of arrogance was well in display in remarks by the CEO of GlaxoSmithKline-UK at the Conference on the Crisis in Neglected Diseases in March 2002. GlaxoSmithKline, the second-largest drug company globally after Pfizer, apparently received substantial funding from the Gates Foundation, WHO and the UK's DFD to conduct large-scale trials in research on a new malaria drug—a "not-for-profit" joint venture. (DND/MSF 2002)

[54] DNDi's mission is "to lead research and development for new drugs for the *most* neglected diseases" through North-South and South-South collaborations that treat such drugs as global public goods, so that private sector involvement and intellectual property considerations become secondary to the primary aim of "equitable access to new drugs." See "DNDi, the Drugs for Neglected Diseases Initiative, Concept and Preliminary Proposal," at www.accessmed-msf.org. According to some speakers at the DND/MSM conference in 2002, certain public-private partnerships for research—for example, GAVI (the Global AIDS Vaccine Initiative) and the Medicines for Malaria Venture, are based on agreements that exclude private sector partners from rights over drugs for people in developing countries. The issue of whether or not MSF's new Drugs for Neglected Diseases Initiative (DNDi), which will launch its own research projects to find drugs for tropical diseases the corporate sector ignores, might

With regard to global health crises, rights and initiatives, the void in democratic governance is the most serious neglected disease. By using a combination of behind-the-scenes pressures, litigation and militant public action, well-organized NGOs were able to win many tactical victories against the US government and drug cartels in 2000-2001 and to trigger an important shift in the terms of debate and the power dynamics concerning global trade and health priorities. But these efforts have still not culminated in a permanent mechanism that goes beyond negotiated price reductions or charitable donations, whether by the private sector or governments. In other words, transnational health and human rights movements have still not achieved an institutionalized process at the global level—a kind of international civil court comparable to the International Criminal Court—that could enforce the principle of health as a human right superior to corporate property rights over life-saving medicines (or services). Tina Rosenberg says that what is necessary in order to make essential drugs available to all who need them is "an alteration of the basic social contract the pharmaceutical companies have enjoyed until now." (2001:28) But surely this implies a whole new normative and governance system that would enforce corporate obligations and subordinate unlimited profits to health rights and social development—a different social contract altogether.

We have seen how effective voluntarism is in the case of the UN's Global Fund to Fight AIDS, Malaria and TB. Almost a year from the time Kofi Annan announced the fund and said it would require at minimum $7-10 billion a year, countries had pledged less than $2 billion and the US under the Bush administration a paltry $500 million over the next three years. (Stolberg 2002) Yet, in the aftermath of the September 11 attacks, a crisis affecting Americans, Congress was able to come up with an immediate $40 billion for "anti-terrorism" activities and a 20-year contract with Lockheed to produce military aircraft for $200 billion—enough to erase contagious diseases from the face of the earth. Sonia Ehrlich Sachs and Jeffrey Sachs (2002), reporting from the dying fields of a Malawi village, begin to question the utility of "good faith" pledges:

> Why aren't US leaders visiting the hospitals, villages, and health ministries in Africa to ensure that the United States is doing all it can do to stop the deaths? . . . We are spending tens of billions of dollars to fight a war on terrorism that tragically claimed a few thousand American lives. Yet we are spending perhaps one-thousandth of that in a war against AIDS that kills more than 5,000 Africans each day. . . . [A] tiny share of rich-country income—one penny of every $10 of GNP—would translate into 8 million lives saved each year in the poor countries.

Waiting for the US to "do all it can do" recalls the second major defect of the voluntary "equity pricing" approach: like many forms of "foreign aid," it lacks long-term sustainability and is inconsistent with the right to development. After the PMA dropped its lawsuit against South Africa, the South African government stated that "its primary interest is not in copying patented drugs but in importing generics from other countries or manufacturing them." (McGreal 2001) Yet the entire structure of TRIPS, compulsory licensing, and the tango between Southern governments and Northern-based drug companies over prices rests on an assumption I have continually questioned: that countries in the South lack the capacity to develop viable drug manufacturing and research facilities of their own, or at least to rely more on South-South and intra-regional cooperation rather than waiting either for the largesse of donors (especially the US) or the concessions of multinational companies.

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become a patent-holder has been the subject of much debate within the organization. See www.accessmed-msf.org and MSF/DND 2002.

In fact, a growing number of capacity-building and technology-sharing initiatives in Africa, Asia and Latin America belie this racist and imperialist assumption, as well as the assumption that the public sector is inefficient as both a producer and a researcher. Brazil of course stands out as an example of government efficiency in researching, developing, producing and distributing AIDS drugs. But Brazil is also leading initiatives in intra-regional solidarity by, for example, *exchanging* drug "donations" with other Mercosul countries like Argentina, thus bypassing trade rules and TRIPS altogether; and in South-South agreements to transfer technology, thus helping countries in Africa and Asia to develop their own production facilities. (Macedo 2002; MoH 2002) Other countries have begun to develop similar South-South technology-sharing collaborations—for example, networks between Thailand and Malaysia and among Thailand, Zimbabwe and Ghana; while quite a few Southern countries have developed various levels of R and D, and in some cases manufacturing, capability in the pharmaceutical field—including India, China, South Africa, and Algeria along with Malaysia, Thailand and Brazil. (Navaratnam 2002; Olliaro and Navaratnam 2002) Several Northern government research institutions have also embarked on collaborative scientific training and research partnerships with countries in the South. The Malaria Research and Training Center in Bamako, a project of the US National Institutes of Health; and the Multilateral Initiative on Malaria, involving a number of African countries and located in Dakar, are two examples. (Varmus 2002)

Sustainability is not only about infusions of donor funds and affordable drugs but even more about development of infrastructure, organization, and coordination. What stands in the way of self-sufficient generic drug capacity in many countries in the South is not any inherent lack of ability nor even patent rules, but the need for better management systems within countries and better coordination across countries, those that have developed a generic drug industry (such as India and China) as well as those that have not. (Navaratnam 2002; Roberts 2002; Torreele 2002) In addition there is the need for sufficient will and imagination, especially in US and European research centers, to maximize the internet, universalize e-access and make all scientific publications and data electronically available free of cost—i.e., to create a global community of science and information-sharing. (Varmus 2002; Roberts 2002) But these are conditions that depend on an ethic of openness and collaboration. They must seem alien and subversive in the intellectual and philosophical climate that dominates not only western-style capitalism but also western corporatist science: the conviction that knowledge and ideas are private property and greed is the sole force driving the human quest for knowledge. Yet even the "west" is full of models that prove how fallacious is this thinking. A scientist from the Human Genome Project, based in the UK, points out that that immensely successful, complex and large-scale research enterprise is organized entirely in the public and not-for-profit domain, its findings immediately available on the WorldWideWeb. Innovation and even competition (in Nietzsche's agonistic sense) thrive in an open, non-corporate, non-profit-driven culture. (Roberts 2002)

If we took seriously the right to development codified in numerous international documents as well as the principle of "transfer and dissemination of technology" contained in Article 7 of TRIPS, what would this mean for the potential capacity of many Southern countries to provide essential, life-prolonging medicines for their own people? What would it mean for the responsibility of Northern governments and multilateral organizations to tax exorbitant profits, cut military budgets and cancel debt in order to generate development resources for the South? Or to foster an ethic of global sharing rather than private acquisition concerning intellectual property? How would it challenge Southern governments to make good on their promises to reprioritize their budgets and expand national health spending to 15 percent, "including a

significant proportion on AIDS"? ("Africans Unite. . ."/NY Times 2001) The Jamaican economist Mariama Williams (2001) criticizes governments of the South for "trade-offs and deal-making" with Northern governments; and for letting themselves "be trapped into [a] pervasive market access framework that pushes [them] to sacrifice everything for very minor entry into the markets of the North." In the end, *sustainable* solutions to the problems of health and disease that plague Southern countries and poor people everywhere may be ones that go outside capitalist markets altogether and return to old-fashioned concepts of the public domain, or the common good, including essential medicines and health services as a "global public good" (see Chapter 4). But the ability to make individual or group claims based on such concepts would still require a normative framework and a set of procedures grounded in human rights. It would also require much greater attention to the intersections of gender, race and poverty than the "access to medicines" campaign has exhibited until now.

Specifying the Human Right to Health in the Era of HIV/AIDS

"Health is the human right that in practice most visibly marks distinctions of race, [gender], . . . economic and social condition" because health, or its lack, directly inscribes the body and intensifies the race, gender, class and age distinctions that already mark it. Although it may be argued that other infectious diseases as well as non-infectious diseases cause more preventable deaths in today's world, HIV/AIDS figures so prominently in the battle for health as a human right because it most starkly locates the body at the crossroads of gender, race, class, sexuality and geography. (Booker and Minter 2001:12)

It is no accident that human rights agencies grasp this reality more fully than any other global institutions and provide a perspective on solutions to the epidemic that is more encompassing of all its complex social dimensions than do either macroeconomists or public health experts. That is because the UN human rights bodies have increasingly relied on regular consultations with women's human rights and other civil society groups, for the reasons I discussed in Chapter 2, and such groups persistently have pushed these bodies to apply the principles of indivisibility and intersectionality in their interpretive statements. In 1998 a series of joint consultations organized by the UN High Commissioner for Human Rights, Mary Robinson, and UNAIDS, with significant input from civil society groups, produced a set of International Guidelines on HIV/AIDS and Human Rights. These guidelines and their holistic view of human rights aspects of the epidemic were elaborated in a roundtable during the UNGASS on HIV/AIDS in 2001 as follows:

> . . . responses to HIV/AIDS should explicitly take into account such factors as gender relations, religious beliefs, homophobia and racism, which individually or in combination influence the extent to which individuals and communities are protected from discrimination, inequality and exclusion and have the ability to access services and to make and carry out free and informed decisions about their lives. (UNHCHR and UNAIDS 1998 and UN/GA/S-26/RT.2/01)

In addition, the guidelines enumerate a very inclusive list of human rights that directly affect HIV/AIDs risk, vulnerability and impact—rights to education, information in a language one understands, access to health care and preventive services, to travel and freedom of movement, to "an adequate standard of living," and against discrimination. And they point out the documented fact that "where individuals and communities are able to realize their rights, the incidence of HIV infection declines." (UN/GA/S-26/RT.2/01:2-3) In a subsequent article on globalization and human rights in *The Irish Times*, Commissioner Robinson indicated her own

strong commitment to heightening public awareness and action on these linkages. Challenging the assumption that trade is "truly free and fair" in today's global economy, she asked, "Are intellectual property rules conducive to ensuring access to drugs under the World Health Organization essential drug list?" And she linked "a lack of respect for human rights. . . to virtually every aspect of the AIDS epidemic, from the factors that cause or increase vulnerability to HIV infection, to discrimination based on stigma attached to people living with HIV/AIDS, to the factors that limit the ability of individuals and communities to respond effectively to the epidemic." Among these factors, she listed:

> Lack of adequate nutrition, of basic medicines, of clean water, of elementary education, of suitable employment, of equality for women, among a multitude of other privations, increase the vulnerability of . . . poor people to HIV and AIDS. The poverty deprives them in turn of the means of treatment and care which are available to the wealthy. (Robinson 2002)[55]

This comprehensive understanding of the human rights dimensions of HIV/AIDS and appropriate responses to it builds on a 25-year history in which UN bodies and committees have attempted to define the right to health, contained in both the WHO Constitution and the ICESCR, in an inclusive, holistic manner. In the late 1970s, the World Health Assembly launched its "Health for All" strategy (supposed to be achieved by the year 2000!) with a central focus on primary health care. In 1978 the International Conference on Primary Health Care issued what is known as the Alma Ata Declaration, emphasizing "health for all people of the world" and adopting the WHO definition of health as "a fundamental human right" and "a state of complete physical, mental and social well-being, and not merely the absence of infirmity." The Alma Ata Declaration also asserted that primary health care:

> Includes at least: education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs. . . . (quoted in Koivusalo and Ollila 1997:7, 111-113)

As Koivusalo and Ollila remark, these initiatives suffered "right from the beginning from a lack of resources and from competing viewpoints on health policies" (p. 114). Today, as I shall discuss in the next chapter, there is a concerted effort within WHO and the World Bank to repudiate them in favor of narrower, more "cost-effective" approaches to health care. Yet the human rights agencies of the UN persist in asserting a bold and visionary interpretation of the right to health. In May of 2000, the Committee on Economic, Social and Cultural Rights—the treaty body responsible for interpreting and enforcing the ICESCR—issued a General Comment clarifying "the right to the highest attainable standard of health" contained in Article 12 of the Covenant. This right, it said, "is not confined to the right to health care . . . [but] embraces a wide range of socio-economic factors. . . [extending] to the underlying determinants of health, such as food and nutrition, housing, access to safe and potable water and adequate sanitation, safe and healthy working conditions, and a healthy environment." And not only material conditions but also a wide range of civil and political rights, such as "education, human dignity,

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[55] After four [? –CHECK] harried years of trying to use her UN post to implement a broad, global justice approach to human rights and working closely with women's and other human rights NGOs, it is sad but not surprising that Commissioner Robinson has "resigned" in 2002, under relentless pressure from the US government.

life, non-discrimination, equality, the prohibition against torture, privacy, access to information, and the freedoms of association, assembly and movement" are also "integral components of the right to health." (ECOSOC 2000) What this means in practice is that implementation of the right to health requires *multisectoral* approaches like those called for in the old Alma Ata Declaration (those that global health economists today wish to shelve); and that it can only be addressed effectively through a vision of gender equality, anti-racism, and human development.

In its May 2000 Comment, the CESCR also presents a view of the right to health, like human rights generally, as historically situated and evolving over time. Since 1966, it notes, when the International Covenants were originally adopted, the meaning of health has come to embrace such "socially-related concerns" as "resource distribution," "gender differences" and "violence and armed conflict." Also in tune with changing times, a paragraph on "prevention, treatment and control of epidemic, endemic, occupational and other diseases" now "requires

> the establishment of prevention and education programmes for behaviour-related health concerns such as sexually transmitted diseases, in particular HIV/AIDS, and those adversely affecting sexual and reproductive health, and the promotion of social determinants of good health, such as environmental safety, education, economic development and gender equity. The right to treatment includes the creation of a system of urgent medical care in cases of accidents, epidemics and similar health hazards. . . . (ECOSOC 2000:5)

Both the CESCR and the UN Commission on Human Rights have issued statements directly relating "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health" under international law to the obligation of states to ensure the accessibility and affordability "to all without discrimination" of "pharmaceuticals and medical technologies" for treatment of HIV/AIDS and its "most common opportunistic infections." (UN/CHR 2001) In a statement delivered in late 1999 to the historic Seattle WTO Conference, the CESCR made its boldest assertion to date that human rights norms supersede trade rules in international law and that the WTO itself (whose founding instrument post-dates the human rights treaties) must adhere to human rights principles, including respect for the right to health:

> It is the Committee's view that WTO contributes significantly to and is part of the process of global governance reform. This reform must be driven by a concern for the individual and not purely macroeconomic considerations alone. Human rights norms must shape the process of international economic policy formulation so that the benefits for human development of the evolving international trade regime will be shared equitably by all, in particular the most vulnerable sectors.
>
> The Committee recognizes the wealth-generating potential of trade liberalization, but it is also aware that liberalization in trade, investment and finance does not necessarily create and lead to a favourable environment for the realization of economic, social and cultural rights. *Trade liberalization must be understood as a means, not an end. The end which trade liberalization should serve is the objective of human well-being to which the international human rights instruments give legal expression.* (UN/CESCR 1999:2, my italics)

In its only Special Session on HIV/AIDS, the UN General Assembly fully incorporated this human rights perspective, as well as language from the Cairo, Beijing, Cairo+5 and Beijing+5 documents, into its "Declaration of Commitment." The Declaration defines HIV/AIDS as not only a "security risk" (as the Security Council had in January 2000) but also "a global emergency and one of the most formidable challenges to human life and dignity, as well

as to the effective enjoyment of human rights." (Para. 2) It devotes an entire section to the topic "HIV/AIDS and Human Rights," reaffirming the link between "respect for human rights and fundamental freedoms" and reduction of infection rates. Moreover, "three of the four goals that are stated in the section on Human Rights explicitly address the rights of women and girls"; and many of the document's deadlines and targets are gender-related. (UNIFEM/Shaan Online)[56]

Given "that globally women and girls are disproportionately affected by HIV/AIDS," the 2001 Declaration urges that by 2005 countries shall have taken actions to "promote the advancement of women and women's full enjoyment of all human rights" and "shared responsibility of men and women to ensure safe sex"; to "empower women to have control over and decide freely and responsibly on matters related to their sexuality"; "to increase capacities of women and adolescent girls to protect themselves from the risk of HIV infection," among other things by providing sexual and reproductive health services; and to promote women's and girls' empowerment by eliminating all forms of discrimination and violence against them, including harmful traditional practices, "rape and other forms of sexual violence," and sexual trafficking. (Paras. 59-61) With regard to MTCT, the Declaration urges that by 2005 the proportion of HIV+ infants shall have been reduced by 20 percent and by 2010 by 50 percent, and that "80 percent of pregnant women accessing prenatal care" should have access to effective treatment, along with full information and counseling, to reduce prenatal and perinatal transmission. (Para. 54)

The document's section on "Reducing Vulnerability" is particularly attentive to the many forms of longstanding cultural practices and social conditions that make women, girls and boys vulnerable to infection and urges that countries identify and address these and provide accurate sexual health education, counseling and services for adolescents as part of their prevention programs by the year 2003. (Paras. 62-64) By 2005, "at least 90 percent and by 2010 at least 95 percent of young men and women aged 15 to 24 [should] have access to" preventive programs and services.[57] Paragraph 68 recognizes the "impact of HIV/AIDS . . . especially on women and the elderly . . . in their role as caregivers and in families affected by HIV/AIDS" and gives a deadline of 2003 for governments to evaluate and address this impact. Paragraph 70 on prevention urges increased investments in research not only on development of HIV vaccines but on "female controlled methods and microbicides."

The June 2001 UNGASS on HIV/AIDS was the first meeting of the General Assembly ever devoted entirely to an issue of public health and health rights, and, significantly, it was a meeting in which "leaders of Africa" dominated. (Crossette 2001b) Moreover, in sharp contrast to the World AIDS Conference just one year earlier, where gender and "reproductive and sexual health issues [of women] were by and large not visible on the main conference agenda" (Berer 2000b), this Declaration fully recognizes "that gender equality and women's empowerment are a prerequisite to stemming the tide of the epidemic." (Unifem/Shaan Online) This is no accident but rather a testament to the cumulative impact of transnational women's health and rights organizations on the deliberations of the General Assembly and their strong participation in the

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[56] Para. 58 states that by 2003, all countries shall have put into place "appropriate legislation. . . to eliminate all forms of discrimination against and to ensure the full enjoyment of all human rights and fundamental freedoms [including access to health care] by people living with HIV/AIDS and members of vulnerable groups." Unfortunately, the careful attention the Declaration pays to gender as well as adolescence is marred by the refusal of some delegations to allow the specification of gays, lesbians or sex workers in the paragraphs designating "vulnerable groups"; thus the naming of these groups was omitted. (Steinhauer 2001)

[57] These provisions contain the by now standard UN trade-offs in language on adolescent sexuality. Thus "expanded access to essential commodities, including male and female condoms and sterile injecting equipment," is "balanced" with "encouraging responsible sexual behaviour, including abstinence and fidelity." (Paras. 52-53)

HIV/AIDS UNGASS. (Freitas 2001) It also puts in sharp relief the absence of explicit gender analysis in the politics, slogans, and advocacy materials of the transnational movement for access to essential medicines and the vexing fact that this movement and the transnational women's health movement have so far been running along separate but parallel paths.

With regard to access to essential medicines, the Declaration of Commitment adopts intact the human rights language of the CHR and the CESCR, recognizing "access to medication in the context of pandemics such as HIV/AIDS" as "one of the fundamental elements" in achieving the human right to health. (Para. 15) The substantive paragraphs on this issue, however, are disappointingly vague and obfuscating, avoiding specific deadlines and targets for actually making affordable drugs available to all who need them or specific methods and resource-generating strategies for assuring that low-income countries have the capacity to do so. Throwing a bone to every side in the debate over TRIPS and patents, they incoherently patch together language calculated to offend nobody and therefore to achieve nothing in the way of concrete guidelines for implementing access to treatment in national AIDS programs.[58] This suggests a last-ditch effort by the US delegation to support patent rights and save face at the very moment when the US was dropping its case in the WTO against Brazil. It was a very different moment from what would exist just five months later in Doha, post-September 11 and anthrax.

Nonetheless, the 2001 UNGASS Declaration may be seen as an important step toward the Doha Declaration on TRIPS, insofar as the General Assembly firmly proclaimed access to life-saving medicines as part of the human right to the highest attainable standard of health. When read together, and in light of the CESCR's strong statement about the priority of international human rights and human well-being over "trade liberalization," these documents provide useful weapons for civil society groups to call governments, TNCs and IFIs to account for their health policies and practices. But these formal and still weak mechanisms of global governance—UN conference documents, committee statements, human rights complaints—are only one small tactic in the larger struggle for a massive readjustment of power and resources in the world.

* * *

The story of the struggle for access to HIV/AIDS medicines illuminates the ways in which human rights discourse, as deployed by transnational women's and health movements to fend off corporate globalization, has become a discourse of social and economic justice:

> To date, access to life-saving medicines and care for people living with HIV and AIDS have been largely determined by race, class, gender and geography. AIDS thus points to more fundamental global inequalities than those involving a single disease, illuminating centuries-old patterns of injustice. Indeed, today's international political economy—in which undemocratic institutions systematically generate economic inequality—should be described as "global apartheid." (Booker and Minter 2001:11)

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[58] Para. 55 gives a deadline of 2003 for the development of "national strategies" to "address factors affecting the provision of HIV-related drugs," including "affordability and pricing," "differential pricing," and "health care systems capacity." It urges efforts to provide "the highest attainable standard of treatment for HIV/AIDS" through "strengthening pharmaceutical policies and practices, including those applicable to generic drugs and intellectual property regimes, in order further to promote innovation and the development of domestic industries consistent with international law." Para. 103 blandly proposes, at the global level, to "Explore, with a view to improving equity in access to essential drugs, the feasibility of developing and implementing . . . systems for voluntary monitoring and reporting of global drug prices." This is puzzling, since such a system has already begun under the joint auspices of WHO, UNAIDS and MSF.

The world's resources for HIV/AIDS treatment still evade those who need them most: "of the 25 million HIV-infected Africans and the roughly 4 million each year with advanced HIV-related disease, only around 10,000 to 30,000 Africans receive antiretroviral therapy." (CMH/WHO 2001:51) Likewise with prevention efforts: in 2000, with 95 percent of those infected living in the global South, "95 percent of all the AIDS prevention money [was] being spent in the industrialized countries." (Editorial/NY Times 2000:10) The pledging of a $7-10 billion annual expenditure on combating HIV/AIDS is thus a gesture of implicit reparation toward the immense imbalance in resources and power that both global apartheid and global gender injustice perpetuate.[59] But the failure to realize even this inadequate goal clearly indicates that, to those who command global power, it still represents "an optional charitable response" rather than a fundamental human right and therefore "an obligation." (Booker and Minter 2001:16) None of the health advocates or neo-Keynesian economists who advocate "equity pricing" are saying that colossal corporate greed and massive militarization are wrong in themselves and incompatible with good health for the world's people and the planet. Yet, as I was completing this writing, the US "war on terrorism" was spending over $2 billion a month on military and surveillance activities in Central Asia; the Bush administration was asking Congress for a $27 billion "emergency fund" to fortify "homeland security" and to fight the war in Afghanistan (decimated by two decades of war and untold civilian deaths from continued US bombing "errors"); and the Global Fund against AIDS, TB and Malaria was a tiny blip on the radar screen of global finance. (Dao and Stevenson 2002)[60]

Yet even in this highly militarized context, the campaign for treatment access had opened up a window on global health inequalities that could no longer be shut. The pursuit of global militarization will only, in the long run, make the obscenities[61]—including in the heart of the Empire, as Americans find health care increasingly out of reach—all the more glaring. And the growing injustices will raise awareness that war and global capitalism are themselves contributors to disease. The 2001 UNGASS on HIV/AIDS was steeped in controversy over whether a focus on this epidemic was justified given the huge toll in human life from other infectious diseases, from lack of safe water and from war. (Flanders 2001; Houston 2001; Jackson 2001) But clearly the problem is not one of ranking what is most deadly but of scrutinizing the ways in which all these preventable conditions are "part of an interactive system." (Parker 1999:7) In part this goes back to the issue of sustainability and capacity-building—the need to generate resources not only to provide drugs but to improve systems of health distribution and management. But it also refers to the systemic social and economic inequalities that exacerbate poor health—the patterns of joblessness, anomie, migration, and "survival sex" that in turn are the product of armed conflict, export-oriented economic policies,

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[59] The June 2001 Declaration of Commitment urges countries to "ensure that the resources provided for the global response to address HIV/AIDS are substantial, sustained and geared towards achieving results" (Para. 79). It lays out the goal of reaching "by 2005 . . . an overall target of annual expenditure on the epidemic of between US$7 billion and US$10 billion in low and middle-income countries and those countries experiencing or at risk of experiencing rapid expansion for prevention, care, treatment, support and mitigation of the impact of HIV/AIDS, and take measures to ensure that needed resources are made available, particularly from donor countries and also from national budgets, bearing in mind that resources of the most affected countries are seriously limited."

[60] In the spring of 2002, both the US Congress and the mainstream media were giving greater attention to "the global AIDS crisis," but this did not translate into any significant shrinkage in the vast disproportion between spending on the pursuit of war and a massive "security" machine and spending on vital health needs. See Stolberg 2002a & b.

[61] I borrow the term from Zillah Eisenstein's powerful 1999 book, *Global Obscenities*.

the cannibalization of local markets by multinationals, and, of course, persistent traditions of gender subordination.[62] (Epstein 2001; Preston-Whyte et al. 2000; Klugman 2000)

Examining the social roots of HIV/AIDS brings us to what physician and ethnographer Paul Farmer calls the "political economy of risk," the complex grids through which "social forces . . . come to be embodied as individual pathology." (1999:13) Farmer looks at the intersections of class, poverty and race with gender realities, particularly in the large parts of the world where poor women and girls are the most likely victims of the epidemic. Whether the wife of an I-V drug user in Harlem, a single mother who has sex with a casual laborer in Haiti, or a trader in sex for survival in Durban's informal sexual economy, the women who face the highest risks of HIV infection, says Farmer, cannot be diagnosed in terms of "medical issues narrowly construed." Rather, "their attempts to escape poverty were long bets that failed—and AIDS was the ultimate form their failure took. . . .

> Their sickness is a result of structural violence . . . [which] is visited upon all those whose social status denies them access to the fruits of scientific and social progress. . . . Structural violence means that some women are, from the outset, at high risk of HIV infection, while other women are shielded from risk. (1999:78)

Clearly these social realities have important implications for public health interventions, suggesting that "economic and personal empowerment" of women and girls, as much as "education and peer counseling," must be the object of programs and policies. (Preston-Whyte et al. 2000:168) But they also have sobering political implications: racial and gender equality and health care for all will never flourish in a climate of corporate and military globalization. We need, then, to turn to this larger macroeconomic and political context.

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[62] "Throughout sub-Saharan Africa, HIV infection is most common in places like the mines and plantations and urban squatter camps where these young people live and work, and where the wealth of the globalized economy meets extreme poverty." (Epstein 2001:38)