Politics of Intellectual Property and HIV/AIDS Framings

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Abstract

HIV/AIDS is more than a simple disease; it is a complex phenomenon revolving around a nexus of highly contested issues. TRIPS, a new element of the neoliberal economic order has significant implications for the international partnerships and leadership in response to HIV/AIDS. It provides a particular vision how the pandemics should be administered internationally. Combined with the other frames for understanding it creates immensely complex picture of international partnership. The present debates also view HIV/AIDS as human security, development assistance issue. I explore the impact of TRIPS on the international cooperation in response to HIV/AIDS in the context of these frames.

Introduction

In the beginning of the 21st century it had become common wisdom that HIV/AIDS was much more than a health pandemic threatening the world. HIV/AIDS is not just a medical issue, but rather a complex phenomenon revolving around a nexus of highly contested societal, political, economic and psychological issues. The disease has been socially constructed.

In the scholarly literature there has been a tendency to pinpoint the pivotal role of national governmental organizations as the single most important type of actor in the health policymaking arena in regard to AIDS (Donovan 2001; Theodoulou 1996; Fee, Fox 1998). Others link HIV/AIDS to widening international cooperation and the challenges posed to the ways AIDS is being confronted. They argue in favor of international organizations as the champions in combating disease, stressing their effective role in partnership creation (Mann, Tarantola, Netter 1992; Gordenker, Coate, Jonsson, Soderholm 1994; Soderholm 1997).

Recently it was the *Trade Related Aspects of Intellectual Property* (TRIPS) that creates new rules of transnational partnerships, networking, and communication. By introducing new, Western ideas on intellectual property rights to the world community, TRIPS also shifts the power of international actors and redefines both

national governments and the international institutions' interests. Put differently, TRIPS is effectively shaping a new structure of international partnerships. The implications for the global health are immense: TRIPS regulates the prices of drugs, mechanisms of their redistribution, and sets the means of compliance.

TRIPS is also the double-faced Janus: new rules on intellectual property can be both beneficial and malignant. Advancement technological innovation, transfer of technology, advantages both to producers and consumers can ultimately, stimulate social and economic welfare. Yet the questions of the access to essential drugs by the South, including both the countries with manufacturing capacities and those without them, are reverse the rosy picture of TRIPS portrayed by the WTO and other troubadours of neoliberal economy.

TRIPS rearranges the way leading actors and hard-hit countries will interact and put more constraints on the health leadership. As the process of global recognition of TRIPS is far from being completed, the process and goals of the new health governance are highly contestable. Among political leaders, experts from the international financial institutions some serious disagreements persist on who is most privileged by the TRIPS regime, and whether the process of partnership building and cooperation leads to innovation, strong leadership or impasse in global health governance.

Obviously, the implications of TRIPS go far beyond the technical debate, especially in the context of other evolving HIV/AIDS issue framings. Intellectual property (or political economy) frame is only one in the family. Nowadays, the development assistance frame is reinvigorated by the President Buhs plea of generous monetary contributions. Since the late 1990s this frame was not the focal point of HIV/AIDS issue framing. Both the intellectual property frame and development assistance frame are pivotal in shaping how and what the countries with the high seroprevalence will obtain. It is the Gordian knot of funding that has no one-sided solution. The emerging new human right to health discourse can be very influential in forming these priorities. The influence of the new discourse will largely depend upon its success in attacking the intellectual property normative basis and technical characteristics of TRIPS. It is an essential task to study what effect these intermingling frames have on the creating effective leadership, partnership and their ramifications for the eradication of amplifying pandemic.

Here I can concentrate on a narrower task to explore how and why TRIPS facilitates/impedes international cooperation on global health and what obstacles/assistance do they bring to the global health leadership within the context of other currently predominating HIV/AIDS framings. Put simply, how it affects the international cooperation in response to HIV/AIDS?

My paper is organized in six parts. First, I explore what kind of HIV/AIDS issue framings are dominant today. Second part examines one of the most heated questions of impact of TRIPS on global battle with HIV/AIDS. Here I pay much attention to the technical provisions and their implications. I also argue that contending arguments are generally not sufficient, and are ingrained into ideologies of political economy. In the third section, I look at how TRIPS put more unnecessary constraints on international partnership in response to the pandemic. The forth section investigates the shifting of the political economy frame to the human right to health discourse. This nascent discourse is paramount today. In the fifth section, I start looking at another HIV/AIDS frame—development assistance—and their implication for international partnerships of two major players, the US and the Global Fund. The perplexities of their relations make battle with HIV/AIDS more problematic. The last section offers some observation on the nascent norm of HIV/AIDS funding as reflected in the debates between loosely organized net of global health activists and the primary donors.

HIV/AIDS issue framings

Over the last two decades the HIV/AIDS epidemic was framed in a number of ways by an array of domestic and international, governmental and non-governmental actors, involved into the process of the disease eradication (Jonsson, Soderholm 1996). The disease was perceived and framed respectively as a public health issue, as a human (civic) right problem, as a developmental crisis (especially for African countries), as a security concern, and, lately, became integral part of rapidly emerging intellectual property rights regime. Although all these issue framings have been identified in late 1980s, there was a clear historical evolution of how some frames became domineering in the process of international cooperation, while other became minor. In early 1990s, for instance, HIV/AIDS was predominantly framed in terms of human rights concerns, yet several years later it became to be perceived as a larger developmental/economic problem, and later HIV/AIDS in 2000 (S/RES/1308) and 2004 was put on Security Council agenda as a security problem.

Three of these frames are predominating now, including international political economy (intellectual property rights), human (right to health) and military security and development/assistance frames. The debates on these three issue framings dominated the political discourse since late 1990s. After the basic antiretroviral therapy was invented, intellectual property frame became exceptionally salient. WTO, World Bank, and the leading pharmaceutical companies (big PHARMA), supported by the Bush administration, became champions of the

intellectual property frame, arguing that it was crucial to facilitate the combat with HIV/AIDS. Simultaneously, as the grassroots organizations learned about anti-retroviral therapies, they commenced the political contestation (under the motto to overcome barriers to the existing drugs) with those international actors, which encouraged TRIPS to be globally accepted. Mechanisms and of intellectual property and implications of their acceptance were put in the focus of the debate. Ironically, despite all the discursive battles, he rights of intellectual property on medicines are still largely underexplored in their relation to the emerging global health regime.

Human/national security frame was insistently put on the international agenda by Richard Holbrook, then US ambassador to the UN, and somewhat supported by Kofi Annan and Peter Piot (UNAIDS chief). A number of American political leaders talk about HIV/AIDS in terms of security. Several important international institutions, as Global Fund and global health activist net also link the pandemic with security issues. HIV/AIDS is perceived one of the most powerful factors that are contributing to economic decline, creates vicious cycle that leads to constant poverty, and thus dramatically diminishes human security.

Some global health actor put the unrealistic expectations of the Fund to be as powerful leader. This group includes highly visible activist health groups, such as Oxfam, Consumer Project on Technology, Tavistock Group, International Federation of the Red Cross and Red Crescent, F-X Bagnoud Centre for Health and Human, Doctors without Borders and others. These resonators themselves also play the role of norm entrepreneurs, attempting to bring in their beliefs in global social structures and make them abiding by appealing to the international organizations that have more credibility. They became trapped (and they still are!) by and within their discourse, and cannot provide reasonable framework for partnerships.

Human security frame is supported by those who think about HIV/AIDS in terms of human for health (Yamin 1996; Orbinski 2001; Evans 2002; Cullet 2003). Although the human security twist, proposed within the UN in 2001 was not appealing within bigger security issue frame, now it became impossible to ignore its salience. In the closest future this frame, probably, will take on significance and capture attention by major international players.

The rhetoric of the leaders of the US administration pinpoints HIV/AIDS as security issue as well. Yet it is interpreted as “a threat to national security” stipulated by the borderless virus (CIA Chief Tenet). HIV/AIDS, leading to the absence of the effective control over armed forces and especially the weapons of mass destruction, further separation and conflict of civilian and military parts of society, and HIV becoming a weapon of war— all

these factors are potentially threatening to the US military security. Bush, Powell, Tenet and Kerry seem to converge on the point that HIV/AIDS provides the breeding grounds for terrorism and thus affects the interests of the US.

The US Secretary of State Colin L. Powell since his UN Assembly Address (June 2001) and over the time of his appointment was constantly reaffirming his acknowledgment of HIV/AIDS as the global security issue. On several occasions he accentuated the link between the destiny of democracies in Latin America and Caribbean and the priority of combating the HIV/AIDS[1], and equates the campaign against terrorism with the world's efforts to combat HIV/AIDS. Besides these obvious tributes to military security, Powell also seems to reformulate the possible ramifications of the pandemic. HIV/AIDS is perceived not just a health and humanitarian issue, but rather as a factor that tears the fabrics of societies with unprecedented consequences. Other vigorous champion of the global health aid, Senator Kerry, summarized this argument,

"…how can Africa or others torn apart by AIDS be expected to resist the call to violence, to terror and even trade in weapons of mass destruction if they live in chaos? It's time for all of us to treat AIDS in Africa for what it is—a profound threat to the security of America and the world, because it destroys human infrastructure and leaves a vacuum for terror to fill."[2]

The other predominant strain of discussions lies within the development assistance frame (vocalized by USAID, the President, and Congress) and cuts across all others frames and leaders. As many scholars argue, the most important factors to global health come from the trade and investment policies, debt burden and international development assistance, new practices of socio-economic governance (Dodgson and Lee 2002; Lee, Buse and Fustukian 2002; Sell 1997 and Sell 1999). Indeed, the ways the war on HIV/AIDS is funded very often is linked both to intellectual property rights and perception of threat to [national] security.

Most importantly, as on the ground the epidemic itself is immensely complex, it is often impossible to delineate between different frames (they, of course, are just analytical tools!). The nature of the intermingling of three predominate frames dealing with HIV/AIDS then put different international actors in complex situation. The structure of their relations is far from being clear, and a variety of actors, assuming leading positions within one frame face significant obstacles in the other. Both the academic literature on HIV/AIDS and practitioners throughout the 1990s have called to the strong leadership in response to the pandemics (Gordenker, Jonsson, Coate and Sodelholm 1994; Orbinski 2001).

Since the beginning of the epidemic, both the major international institutions and various international HIV/AIDS organizations and activists became concerned with establishing and maintaining the new set of mechanisms for global health governance to control the HIV/AIDS pandemic. At some junctures in time actors like international conferences on HIV/AIDS, office of Jonathan Mann, Gro Harlem Brundtland became so salient in the global health infrastructure so that they gave the impression the objective of strong leadership has been achieved. Yet, as the epidemics evolved, HIV/AIDS was no more civil rights issue, its medical aspects are more and more confined to the medicines distribution, and the developmental problems in Africa became aggravated, the old kind of leaderships were if not outdate, but not ready to face new challenges.

Yet among political leaders, activists, experts and NGOs workers some serious disagreements persist on a crucial question: who should be an undisputable *leader* in response to the pandemic? It is not by accident that the president of the international council of *Medicins sans Frontieres* James Orbinski in 2001 called fore more prominent and assertive role of WHO, an organization that by definition should have been operating in the center of the global health processes. But as part of his argument goes, recent processes of globalization put significant barriers on the way of controlling the pandemics. This observation not only reiterates almost decade long quarrels about who is most privileged by the existing global HIV/AIDS regime (and can the most privileged be at a flagman role?), but also what frame is the most efficient in response to pandemic. Is TRIPS helpful in reaction to HIV/AIDS, is development assistance provided the right way, and is human security frame able to mobilize resourceful response to the pandemic—these are long enduring questions. In practical terms, there is a growing international demand for better global mechanisms of health that would unite a variety of [contradicting and overlapping] frames. As Dodgson and Lee put it, "[t]here is an acute need for public health to be placed higher on these <economic and developmental> agendas to protect and promote people's health" (Dodgson and Lee 2002: 92).

In this complex context TRIPS become paramount. After the Doha negotiations (Fourth Session of Ministerial Conference in Doha, November 2001) there is no country left that can turn a blind eye this issue frame. As the academic literature suggests, TRIPS is introducing new ideas of property to the world community of actors, and thus it will inevitably lead to the reconfiguration of global structure, and have significant implications of reshaping the traditional North—South divisions and pose new challenges for the LDCs' "sovereignty". Therefore, TRIPS is also a very useful case to understand the globalization dynamic, private authority in world affairs, and shifting centers of decision-making.

Both “academics” and “practitioners” contributed to the studies of TRIPS, interpreting the meaning and significance of the Agreement from the legal, policy alternative and purely academic perspectives. Very often, the observers and commentators are closely associated with some advocacy or interest groups and thus inevitably are involved into the conflict of interests, favoring either the Southern “pessimistic perspective of the TRIPS influence onto the global health governance, or the Northern “optimistic” perspective, unquestionably treating TRIPS as a necessary, even inevitable, mechanism to improve the global health.

The most elaborated model is presented in Susan Sell’s study of multinational corporations as agents of change, where TRIPS is envisioned as a mechanism of power redistribution (Sell 1999). She underscores several factors why the intransigent developing world complied with TRIPS, including external pressures from the USA, optimistic expectations about the future inclusion in the neoliberal economic institutional framework, and historically embedded asymmetries in experience and expertise on the intellectual property issues (Sell 1999: 187). As Sell demonstrates, TRIPS epitomizes the triumph of private pharmaceutical corporations and thus indicates the shift of center of power in global health governance. She made a clear case of TRIPS favoring 12 major corporations, who use the global issue network to facilitate the exercise of their utility-maximizing behavior (Sell 1999: 169). The general thrust of her argument, sounding in unison with Steinberg’s, reduces global governance mechanisms (including health) to the study of coercive mechanisms and power politics.

Several events recently proved this undertaking to be incomplete. As the story evolved the South was able to defend its vision of how TRIPS should be operationalized (WT/GC/W/450), the effort which was conducive to the fractional change of global governance norms, which seem not to be unquestionably related to the pivotal interests of the most powerful actors. The real outcomes of TRIPS negotiations are at odds with Sell’s predictions. Contrary to Sell’s prediction that to put new ideas on the global agenda the power structure of the international relations should be changed first, now we witness the situation when ideas shift more or less fluidly.

These new ideas, in return, can provide a significant feedback to the structure and thus transform it dramatically. The ideas are not disentangled form the structure of governance, primarily because TRIPS, like other WTO agreements, provides just a legal framework, and therefore the ramifications of the agreement are dependant upon the decision of the resolving disputes (Mashelkar 2001: 956). Put simply, the new ideas create new structures. It appears that it was the overlapping framings that defined the nature of political situation.

TRIPS provisions in the battle against HIV/AIDS

Novelties of TRIPS provisions as a mechanism of global health governance are quite clear (Sell 1997). Prior to the Uruguay Round, when the basic intellectual property rules have been agreed upon, countries encompassed dissimilar approaches to drug patents, based on the domestic trade history and recognizing only domestic interests. With the obligatory provision of patents for pharmaceuticals under TRIPS, the intellectual property (IP) politics became homogenized.

The TRIPS Agreement, although supposed to set very clear and straightforward standards of patent protection, is immensely complicated because of its highly technical character, a number of exceptions from general rules, and a variety of possible interpretations to be reconciled by the dispute settlements. TRIPS agreement was even less clear in regard to the global health issues. As the public health impact of TRIPS requirements was not fully assessed yet, this unclearness made TRIPS to be questioned by various international actors, including MSF, the South Center, the Friend World Committee for Consultation, and academics.

WHO proposed one of possible frameworks for TRIPS and global health policy evaluators "Key questions for monitoring the public health impact of TRIPS." Four principles run as follows: (1) are newer essential drugs more expensive than they would have been if not under patent, (2) is introduction of generic drugs being slowed, (3) are more new drugs for neglected disease being developed, (4) are transfer of technology and foreign direct investment in developing countries increasing or decreasing (WHO 2001). As these principles are highly contestable, the questions who benefit and in whose interests remain open. To grasp how the TRIPS influence the global health governance we have to start positive evaluation of the issue.

Political contestation around the TRIPS Agreement reached its peak after the Fourth Session of the Ministerial Conference of the WTO in Doha, Qatar, November 2001, when possible implications of the TRIPS agreement for access to drugs where debated by the Ministers (DESA/DSD/PC3/BP3). MSF perceives that enforcement of WTO rules would have a negative impact on the slowly developing local manufacturing capacities and contribute to stagnation of the drugs production in the LDCs. Is TRIPS dismissing social, public interests by favor only the perspective of intellectual property rights holders, or is it the effective instrument for the anti-pandemic cooperation and leadership? The problem of TRIPS technical "flexibility" lies at the heart of the debate.

The principle of flexibility was set forth by the developed countries in the draft ministerial Declaration "to ensure that medicines for treatment of HIV/AIDS and other pandemics are available to their citizens who need them,

particularly those who are unable to afford basic medical care" (IP/C/W/313). A group of developing countries interprets TRIPS very broadly as allowing to retain the sovereign power of the state in regard to protection and promotion of public health, and withholding the rights to establish own policies and rules regarding the exhaustion of intellectual property rights.

These ideas were adopted in the final ministerial declaration in somewhat milder form. As Article 7 says, the protection and enforcement of intellectual property rights should be implemented in a manner conducive to social and economic welfare, and to a balance of rights and obligations. Article 8 puts the same idea even more bluntly: "…adopt measures necessary to protect public health and nutrition, and to promote the public interest in sectors of vital importance to their socioeconomic and technological development provided such measures are consistent with [the TRIPS] Agreement." Generous privileges to the South include the so-called "safeguards" (Bolar provision, compulsory licensing and parallel import). Thus, to patent holders are supposed to allow larger flexibility to the Third World in their anti-HIV/AIDS drugs policies.

There is growing concern about the cost of the essential drugs production, which envisions the role of patents as hampering production of the typically more affordable generics of patented drugs. There is also concern that if the hard-hit states are forced to purchase brand drugs, then most of the assistance inflows will be redirected to the western pharmaceutical companies. Prices of anti-retrovirals in the Third World are expected to rise because of the increased patent protection.

Other concern is the diminishing access to drugs as a result of complying with TRIPS agreement. Patens are viewed as a significant obstacle to the drugs distribution in the situation when the disbursing or redistributive mechanisms for the poor countries are not faced in the TRIPS, and having the absence of the adequate health governance infrastructure in the LDCs. Even UNAIDS does not advocate provision of the free or cheap drugs for LDCs precisely because the lack of national/local disbursing mechanisms. UNAIDS is strictly against the relaxing the trade rules, believing that the TRIPS "safeguards" can be used only as a measure of last resort and that LDCs should start good manufacturing process themselves (Piot 2003; Roundy 2000).

Indeed, South Africa, Brazil, Jordan, Ecuador, and Sri Lanka have already experienced these pressures. However, the advocates of the right to health framework tend to aggravate situation. Brazil is an example of a country that both produces cheap generic version of the anti-retrovirals basically undermining international standards of intellectual property, skillfully bargains with the pharmaceutical giants and can resist the US complaints

with the WTO (in 2000). In fact, Brazilian government adopted a strategy to threaten compulsory licensing of drugs in case if the patent-holder corporation is not willing both within several years to start production of treatments, and to reduce the price of the exported drug (Galvao 2002: 1862—1864). Brazil's negotiation with Switzerland-based pharmaceutical company Roche on the dramatic reduction of HIV/AIDS drugs (about 60%). Yet health activists perceived the Brazilian success negatively, indicating that the success of one country leads to dilution of principal goals of the anti-AIDS movement (Lurie 2003).

In March 2001 the 39 subsidiaries of the world's pharmaceutical companies were against the South African Medicines and Related Substances Control Act, which was designed by the South African government to facilitate access to cheaper drugs. The major complaint was that the new South African provisions are not following the TRIPS provisions. Yet in April 2001 they dropped the suit under the wave of public protests (Joseph 2003: 443; Block 2001: A12). One by one, some of those 39 major pharmaceutical corporations began offering new discounts (they dropped price threefold) to South Africa and some other poor countries, agreeing to donate life-saving medicines to the public health agencies of African countries (Barnard 2002: 165). These evidences make me say that the corporate profit-driven strategies have been slowly replaced by considerations of global health rights and social justice.

Oxfam and MSF, India and Brazil, on the contrary, say that generic drug manufacturers should produce drugs for export to other countries that due to national health emergency can issue a compulsory license. They advocate exclusive use of the possible cheapest drugs from developing countries as opposed to the pharmaceutical companies' products. Increasing urgent need for drugs aggravates heats up the contentious politics.

The triumph of the developing world in framing as drug issue as right to health is ambiguous. There is no clear understanding what implications for the anti-HIV/AIDS campaign it will have. Generally, it is difficult to state if pharmaceutical companies' compliance with LDCs requirements is spurred by new norm internationalization, or by tactical reasons. Obviously, the corporate policy towards global health is being under construction now, and all the conclusions drawn here are to be viewed as preliminary.

MSF is optimistic about it: it gives primacy to human right to health and set significant limits to the neoliberal economic policy, initially embedded in TRIPS. Yet it is still reasonable to argue, using one captivating formula, that Doha Conference provided the "influential interpretation of imprecise obligations" (Lanjouw 2002: 3), and there are still no clear-cut rules about drugs. Future then will depend on the informal bargaining process

between pharmaceutical companies and hard-hit countries, the intra-state informal relationships, and bilateral diplomacy:

"A large number of countries have come under direct pressure from other countries or from pharmaceutical companies to provide strong patent protection on pharmaceutical products and to refrain from allowing compulsory licensing or parallel imports. African government has been unable to apply this law because of threats from the US government to take trade sanctions over it, and because of legal action by the South African Pharmaceutical Manufacturers Association—coalition of the world's thirty-nine biggest drug companies—aiming to block the law's application" (Dommen 2002: 27).

Reconfiguring HIV/AIDS partnership under TRIPS

TRIPS is reconfiguring those networks and partnerships, which have been more or less efficient in containing the global diseases, such as AIDS, during the 1990s, thus contributing to mapping of the new pattern of anti-AIDS governance. Several TRIPS' implications for the international partnerships are paramount. TRIPS threatens the needed global solidarity and consolidation as a basis for international cooperation in response to the pandemics.

Although recognizing the TRIPS agreements themselves, the world leaders retain immense reservations about their usefulness3. In fact, after the bargaining process within the WTO was over, Third World's representatives started vehemently questioning the soundness, legitimacy and even morality of the adopted regulations. Prime Minister of India Vajpayee interpreted the Doha agreements on pharmaceuticals as a path leading to the dependence upon the imports of these foreign items. 4 Then, the agreement about the intellectual property on drugs are just manifesto of the Third World leaders to obtain more institutional leverage with the WTO and desire to push their interests, values and vision from inside.

Potential "losers" try to reverse the adopted norm within the framework of the post-agreement situation, trying to achieve utility-maximizing goals norm within the Agreement framework. Resistance at the national level of Argentina, India, and South Africa, which do not pass the legislation complying with the language of WTO agreements (Scherer 2000: 2252) is an evidence of decaying incentives for good-will cooperation. TRIPS instead of

a cooperative arena became a competitive, which was perceived by some actors as a springboard, as opposed outside of emerging regime of the intellectual property.

The role of partnerships is decreasing, moving from true multilateralism to unilateralism, which is defined by the decision to invest (or not to do so) in the LDCs pharmaceutical industry. As Lanjouw notes, "the incentive to invest in research rests squarely in developed countries, regardless of the patent regime in poor countries. In fact, the drug industry points out that it often does not patent products in the poorest countries even when the opportunity is available since there is so little prospect of profit" (Lanjouw 2002). In more practical terms, TRIPS provision can either stimulate generic competition or reduce the prices for off-patent drugs, but may also significantly delay the introduction of new generic drugs, depending on the way in which national legislation is designed and implemented.

Indeed, the patent system favors corporate interests over the great social good and narrows the opportunities to challenge the spread of HIV/AIDS. The patent system deters the sound competition and was designed to enable patent holders to set prices higher than those that would be obtained in a competitive market (Correa 2002).

If a limited number of firms (seven) supply a limited number of branded antiretroviral drugs (fifteen) for the all hard-hit countries, then private firms will be in a position to impose prices and rates of return and thus undermine chances of poor countries to cope with epidemic (Kazatchkine, Moatti). The price is voluntary, determined essentially by a small group of the word's major pharmaceutical corporations such as Merck, Glaxo-SmithKline, Pfizer, and Bristol Myers Squibb, aka "Big Pharma." How to balance property protection concerns and the global health issues? The basic recommendation that followed is to combine patent rights with compulsory licensing to guarantee an efficient public disclosure of innovative knowledge (Kazatchkine, Moatti). Yet this can be only a partial solution.

The leadership in the loose HIV/AIDS net in this context switches to new actors. There has been a major shift from 1990, when World Health Organization (WHO) under Mahler and Brundtland, and Mann's Global Program on AIDS (GPA) were widely accepted as leaders in HIV/AIDS eradication. In many respects, the initial global anti-AIDS strategy was changed as TRIPS allow IFIs to influence all the WHO's HIV/AIDS-related policies. As of May 1999, WHO was given a mandate to monitor the public-health consequences of international trade agreements, TRIPS accord vis-à-vis the patent protection, and general compliance to TRIPS' requirements (Pecoul 1999: 1894).

As Northern pharmaceutical companies attack the use of generic drugs as possibly harmful (drug-resistant virus mutations), WHO was used as an instrument to limit Thai's right to compulsory licensing and parallel import. The whole "Revised Drug Strategy" monitoring was assigned to the WHO because of Thai's 1998 effort to produce HIV/AIDS generic of Bristol-Myers original drug. In regard to monitoring TRIPS the WHO's role is mostly "technical," ensuring that generic drugs, produced in LDCs would not cause the virus resistance and its further mutation.

TRIPS also stimulate potential rivalry among the countries of the hard-hit countries, putting them into different compartments of political economy. In the developing world today countries are divided along the lines of pharmaceutical production capacities, by the deadlines for the full compliance with TRIPS. The countries with powerful pharmaceutical sector can initiate local production of generics of those drugs that are not patented or whose patent is expired. Under the "Bolar provision," they are allowed to start research over the existing drugs protected by patents, thus having very serious advantage in creating original product. India, Brazil and Thailand in this respect have a privileged position. States with no or small pharmaceutical sector face difficulties in making effective use of compulsory licensing provisions.

Deadlines for complete implementation of the TRIPS agreement also separate the possible Third World's united front in response to challenges to the global health. TRIPS clusters countries into four groups (a) developed countries, complying with TRIPS as early as 1996, (b) developing countries, 2000, (c) developing countries that did not grant pharmaceutical product patents prior to TRIPS—2005, and (d) least developed poor countries—2016. This, effectively, means that different groups of countries will have dissimilar opportunities in establishing the national health governance, and thus put dissimilar constraints on the anti-AIDS cooperation.

TRIPS declaration fails to create straightforward interpretation of compulsory licensing for the purposes of export in the countries that lack manufacturing base, the role of non-binding provisions and the vision of local authorities increase dramatically. The greater role of non-binding decisions, in fact, removes the international community obligations to respond in the situations of the national epidemics and leave it up to the nation-states leaders. The declaration national health emergency is recognized as crucial factor, which allows significant deviations from TRIPS obligations. However, President of South Africa Thabo Mbeki's reluctance to cooperate and declare the national emergency put more moral obligations on the international health cooperation.

Moreover, by new distribution of obligations and institutional accountability shift, TRIPS lead to the de-globalization of epidemic in terms of international response, esp. when more and more depends upon the private pharmaceutical corporations who are not obliged to act anyway against the epidemic. Poku and Whiteside conclude that "under IMF and World Bank leadership the role of the state has been replaced by a multiplicity of new—and largely unaccountable—actors in the health arena" (Poku, Whiteside 2002: 192).

Emerging human right to health discourse

The broad movement towards new human right to health discourse basically framed as "patient rights vs. patient rights." This frame also can be labeled "human security." The emerging discourse is rigidly linked to the intellectual property frame. It is both a reaction to the new TRIPS regulation and offspring of the earlier (late 1980s—early 1990s) movement to protect human (civic, political) rights.

Historically, at the beginning of one of the most successive campaigns against the HIV/AIDS, under the influence of Jonathan Mann the human rights to health were defined as a comprehensive framework which raises the responsibility for addressing and underlying the causes of HIV/AIDS and other threats to health. Framing HIV/AIDS pandemic in terms of human rights allowed Mann to forge broad international coalition in response to the disease and raise awareness of the national governments and made them to respond actively.

At the same time, Mann recognized that putting health on the political and economic agenda was a tremendously challenging task (Yamin 1996: 406—407). The First international conference on health and human rights, which was held at the Harvard University (1994), which sought to put the equality of access and treatment, and nondiscrimination principles at the center of the human right to health principles.

Yet, the human right concerns at the early stage of the pandemic were rigidly linked to the homosexual movement which aimed at privileging civil (political) rights of HIV-infected people, including fight against stigma and public discrimination of people living with HIV/AIDS (as well as in the workplace). This agenda was not concerned much about socioeconomic or developmental rights, as the AIDS-related human right movement was primarily from the developed world.

TRIPS favor commercialization of global health governance, and ultimately it does not matter who is privileged, for the new structure of the global health governance is dramatically reshaped. As Cahill puts it: "the

commercialization of biotechnology, especially research and development by transnational pharmaceutical companies, is already excessive and increasingly dangerous to distributive justice, human rights, and access of marginal populations to basic human goods" (Cahill 2001: 221). After Doha, human rights concerns became linked to the issue of the free and non-discriminatory access to medications5.

The attack on TRIPS agreements follows the argument that international treaties concerning patent protection interfere with the basic human right to life-saving drugs by reducing the access to health care and the availability of live-saving drugs. Moreover, the human rights concern refers to the accessibility of drugs at affordable prices, provided to all those who need them through viable health delivery structure (Cullet 2003: 143). The global health governance, imagined by the Third World champions, is both encouraging and utopian. Anti-commercialization of live-saving medicines, namely public subsidies, price control measures, support of local pharmaceutical industry, and greater burden on public (state-led) sector of health governance—is at the heart of this strategy.

Big Pharma does not frame the pandemics as human right to health. Advocates of the humane global governance work to impose moral obligations on the pharmaceutical companies. As Joseph puts it: "While it may seem easy to make a moral judgment that rich companies should do more to help poor people, it is a significant extra step to advocate legal liability for failure by those companies to do more… it is difficult to presently identify direct human rights for Big Pharma, in relation to access to drugs" (Joseph 2003: 437).

On a positive side, the global health is more and more defined in terms of human rights, especially by those who tend to contest the currently existing macroeconomic approach to the global health. Following the adoption of TRIPS, human right bodies gave more attention to the problem of TRIPS impact on the human right situation. Tavistock group, International Federation of the Red Cross and Red Crescent, F-X Bagnoud Centre for Health and Human, OXFAM, TAC and some academics, including Amir Attaran, Jeffrey Sachs, and L-G White share the opinion that TRIPS to contradict the basic human rights. The most radical interpretations have been provided by the group of scholars, publishing aggressively in the Third World Quarterly, including Nana Poku, Fantu Chery, Caroline Thomas and Mark Heywood. They have vigorously stimulated an international debate on the morality of the TRIPS Agreement and the patent system (Heywood 2002: 226).

The first international NGOs meetings dedicated particularly to the TRIPS impact on the global health and access to AIDS medicines took place in early 1999 in Geneva and later that year in Amsterdam, co-sponsored by

Consumer Project on Technology, Health National Association and MSF. The result of these meetings culminanted in so-called "Amsterdam Statement," which underscored, among other things, the moral argument of "burden sharing" between developed and developing world and emphasized the importance of the national instruments of health governance ('t Hoen 2002: 34).

Some representatives of epistemic communities still advocate strong moral rules to be applied to the global health governance. Sachs, for instance, is speaking about "the strategic significance of the global inequality" (Sachs 2001), making point that employing higher moral standards ensures of long-term advantages both for the North and the South. On the contrary, ignoring and evading the problem of the global health could be conducive to the spread of deadly pathogens, including multi-drug-resistant strains, across international borders, not being geographically limited to the LDCs (Sachs 2001: 194).

International advocacy groups are not aside in pushing forth the revised health-related human right discourse. One of the most frequently cited examples of advocating the new interpretation of the human rights in relation to public health is OXFAM campaign against Pfizer and Glaxo-Wellcome under the slogan "Patient Rights over the Patents Rights" (Lanjouw 2002: 2), reaffirming that intellectual property rights are not inalienable private rights as opposed to the right to health.

In May 2003 MSF urged G-8 member states to respect the promises and commitments made at previous summits and to take concrete measures to make medicines accessible at affordable prices to patients in poor countries. Among the proposed measures are: (1) ensuring a genuine equity-pricing system, supporting competition from generics and investment in local production, (2) encouraging developing countries to use TRIPS "safeguards," and (3) supporting research and development into neglected diseases.

Under many pressures, provided by international non-profit organizations and advocacy networks, the behaviour of the leading pharmaceutical companies started to change, even though it is contradictory to the goals of the self-maximizing behaviour. The powerful international players gradually began to realize that health products should be treated differently as opposed to the other articles of trade. New international initiatives of paramount importance are: Global fund against HIV/AIDS, TBC and malaria established in 2001 and UNAIDS-led "Accelerating Access" initiative, joined by Big Pharma, initiated two years later TRIPS. These initiatives undoubtedly are of the most visible example of a new corporate behaviour.

Differential North-South pricing began to be perceived as a solution to the conflict of interests of the North, aiming to keep strong intellectual property protection, and the South, desiring cheap medicines for their infected citizens. Differential pricing, as some of WHO officials argue will not diminish major pharmaceutical companies' profits and their will not at the stake here (Scherer 2000: 2245). Several reasons are mentioned. (1) LDCs anyway would not be considered as a market for medicines, so the bulk of profits comes from the first world, and (2) companies' losses on providing drugs to LDCs roughly equal exchange rates fluctuation (Shoell 2003: 177).

Thus, in 2002, after a year of Doha Declaration adoption, it became clear that trade concerns considerably reshape the public health agenda. The international debate on the global health is far from being finished. The most important upcoming event is the discussion of human rights and health-related issue at G-8 meeting in Evian, France (June 1—3). The scope and nature of change is, however, problematic, as after several years of protracted efforts, only Uganda, Senegal and Rwanda got a deal on prices, and the leading industrialized countries are concerned by diseases in LDCs only if they pose a potential threat to their economic interests. The acute USA—Singapore case on TRIPS emerged recently.

However, it is clear that the emerging TRIPS-related human rights discourse is becoming an efficient tool to integrate public health objectives in the global health governance, to bring back the public health practitioners' responsibility to protect and promote the health at the population level. The emphasis is increasingly put on commitment to social justice and popular participation.

Whose leadership: the US vs. the Fund

TRIPS was imagined by many advocacy groups and political observes to become the stable "game" with fixed rules. This was said to provide articulated and stable mechanisms of governance with the leading role of WTO and world biggest pharmaceutical companies. Yet, let me reiterate once again, the political economy HIV/AIDS frame never existed in political vacuum, and was always mixed with other frames and approaches. Recently at the highest political level, the serious doubts about the how HIV/AIDS epidemics should be contained were vocalized. These doubts were linked to the US administration reasserted its role in global health governance by offering a generous financial support to fight HIV/AIDS and the creation of one more important international actors— Global Fund to Fight AIDS, Malaria and Tuberculosis (GFATM). Based on UN General Assembly resolution (A/RES/S-26/2), GFAMT was launched in 2001 by the UN Secretary-General, the US (Bush) and Nigerian Presidents, and

became operational in January 2002. At the heart of the interaction between these two actors are the problems of shifting loci of authority, and the future of global health leadership.

Bush's legislation seemed to be pathbreaking in providing $15bn to sponsor HIV/AIDS eradication. The US President's pledge is indeed historically unprecedented. On May 27, 2003, US President George Bush signed legislation under which America will provide US$15 billion over 5 years to fight HIV/AIDS[6]. This event received a mixed response: hopes, expressed by the health-related NGOs and activists, were diluted with aggressive frustration for a number of advocacy groups and health activists [7]. Trumpeted by the mainstream press, the new legislation spurred a new round of harsh hit on the US leadership role: "Bush clearly intends to use the issue of AIDS funding to impose US policies, granting aid to those who toe the line and denying it to those who fall short of the mark or find themselves out of favor."[8] Although ignited by some ideological motives, this new criticism demonstrates mainstream perceptions of many global health practitioners. Activists are concerned to what extent is the US willing to become an unambiguous and straightforward funder and leader of global health.

The strategic objectives of this pledge remained unclear. This absence of clarity about the [true] intentions of the Bush administration promise of $15bn for African HIV/AIDS raised the global health activists' suspicion and incredulity towards the US action. Confusing normative debates over funding blurred the picture. Bush demonstrated somewhat inconsistent behavior by first pledging substantive inflows of money against HIV/AIDS and then either reducing the amount of the initial inflows or redirecting them. Lion's share of the money was designed to go to the governments of 14 selected countries as opposed to be given to multilateral institutions[9].

In this context, GFATM is often nominated to become the US's strategic partner and alternative (or, parallel) center of global HIV/AIDS leadership (Lee, Buse, and Fustukian, 2000). As A Health Global Access Project (GAP) indicates, GFATM is "the single most effective tool" that has capacities to implement the programs called for by the President[10]. The preconditions for this role are outstanding. As several academics observed, according to the initial plan it was supposed to restore the historical mission of Global Programme on AIDS (GPA), offering new creative multilateral strategies to maintain coordinated health policies on the global level (Jonsson, Soderholm 1996). Recruiting former ministers of health of Uganda and Japan and other high-profile practitioners, CEOs of the pharmaceutical giants, GFATM was supposed to acquire supreme organizational capacities and positive public image. GFATM was designed to "support simplified, rapid, and innovative disbursement mechanisms. Its resources will be complimentary to existing programs and focus on clear and measurable results."[11]

GFATM's objective was also to focus attention on improving global health provisions via creating incentives to the industrialized nations to prioritize global health in their foreign/global aids plans. GFATM's main priority in this respect was, as formulated by its CEO, "to increase the flow of donor resources to the many public and non-governmental health services that are poised to deliver dramatic results measured in lives saved, disease strengthened."[12] Thirdly, and quite traditionally, GFATM was intended to forge robust and durable IGO-INGO relationships and create a system of donor-leader-provider continuum, based not just on some ad hoc inflows of money, but rather to provide

"…an alternative to the traditional isolation of the involvement of civil society, NGOs, faith based organizations and private sector…, ensuring that the public sector and private sector work side by side, enlisting the help of all segments of society to succeed in the challenge of controlling HIV/AIDS."[13]

Soon the ultimate demands on the Fund became clear, namely: (1) fund raising to be based on the "scientific" evidence of need as opposed to the political process, (2) the amount of provided funding to be specified by the GFATM officials as opposed to the donor country, and (3) regular annual contributions to be based on the estimated costs of country proposals. Ideally the inflow was named to about $7—$10bn per year, which is consistent with the WHO's Commission on Macroeconomic and Health calculations and Annan's vision.

Many times, when the crucial decision had to be made, the allegedly simple structure of the Fund led to the organizational deadlock within the Board, and between the Secretariat and the Board. Over the years of the Fund's operation, the significant gap between pledges and real inflows of money and the mismatch between monetarily inflows and necessary local disbursements widened dramatically. As Featchem, GFATM's executive director, noted, none of the Fund's fundamental goals have been achieved since 2002, when after the second round of disbursements the Global Fund became fully unfunded.

The possible decision was to switch to other than the USA and OECD states donors. Yet the overt incredulity towards private sector was conducive to maintaining the old strategy (GF/B5/2/35), that is being not at the leader's position, but rather financial instrument of the donor countries. Feachem's keeps on requesting larger monetary commitments underscoring the increase of countries' capacities to absorb resources, the boost of effective national programs that are ready to be started, and the sharp increase in quantity and quality of grant proposals.

Nobody inside the Fund pushed forward a clear strategy how to practically implement the initial plan. After almost three years of operation, the Fund still faces the same obstacles as at the moment of its creation. Nor the Fund

is vocal about their problems with the largest donors, and it has to rely on a number of advocacy groups from the non-governmental and private sector. They include International AIDS Vaccine Initiative, Campaign to Stop Global AIDS, International AIDS Trust, International HIV/AIDS Alliance, Hope for African Children Initiative, Stop AIDS Campaign, AIDS Education Global Information System, AIDS-Bells, International AIDS Economics Network and others. Often, the Fund executives prepare no public statements and could not be reached for comments. In addition, although GFATM's role was to focus attention on improving global health provisions via creating incentives to the industrialized nations to prioritize global health in their aid programs, it was never strategized how this to be done.

At the same time, several pivotal appointments, made by the US, undermined the Fund's possible leadership and put it under the US control. US Health and Human Services Secretary Tommy Thompson had been chosen as chairman of the board of GFATM (while keeping his appointment at HHS). Chair Thompson has been severely criticized for being more loyal to the US as opposed to the Fund. Recently retired CEO of the US pharmaceutical giant Eli Lilly Randall and a member of the Pharmaceutical Research and Manufacturers of America (PhRMA) Tobias was announced as head of the Bush AIDS program to administer HIV/AIDS relief plan for Africa. These are very illustrative and widely discussed examples.

These appointments revved up initiated the heated discussion whether the appointed officials are the Fund's friends of foes. Tobias is perceived as a controversial figure in terms of his overt opposing to generics in developing countries and committed support to the intellectual property right frame. Being the strong advocate of AIDS eradication through prevention and education as opposed to treatment, he is also believed to lack any experience with AIDS or with Africa. [14]

The general political dynamic, which is not normally mentioned in press, shows that after the Fund became operational, the African and Asian representatives on the Board were replaced by American colleagues, whose role in the Fund became fundamental. The decisive role of the American experts on the Fund's governing board and the constantly increasing donors' role undermine the fund as the node of global HIV/AIDS leadership. Still there is no internal consensus of the Fund leaders whether to comply with the US logic of funding or try to promote other norms in a vigorous and aggressive manner.

Gordian knot of funding

The Gordian knot of funding winds up most of the HIV/AIDS frames together. The development assistance frame, human right to health and political economy frame are undividable as the international public debate about norms of funding became heated up. There are several elements of this norm of funding, on which the US administration and GFATM diverge significantly.

The balance between treatment and prevention in the funded programs is in the focus of the problem. Bush's administration unequivocally stands for the training of the medical personnel and prevention, which is "indispensable to any strategy of controlling the pandemic". The special emphasis on prevention and support of abstinence as the better control mechanism of the pandemic creates some additional and almost unpredictable restrictions in funding. Antiabortion sentiments, for instance, recently resulted into discontinuation of financing of some of the most effective programs in Africa. The funding of Marie Stopes International (MSI) was cut exactly because it was giving abortion advice. The White House also overturned a Congress award of $34mn to the UN Population Fund because it did joint work with MSI. Funding is also withdrawn or refused in cases, when NGOs provide condoms[15]. Yet the activists, on the contrary, consider the treatment to be the most effective in the eradication of HIV/AIDS.

In this context, American-based pharmaceutical companies start playing major role, reinvigorating the ideas of the intellectual property rights as an incentive for vital research and development, but simultaneously downplaying the role of the local, country-based producers. Here the Fund's administrators largely support the pharmaceutical giants' case. Tobias, for example, made clear that the drugs for Africa should be purchased from the US companies at the American price. The funding for the local production of anti-retroviral therapy is basically blocked. Self-sustaining mechanisms of cheap generics production therefore will not be allowed.

Bilateralism in the global HIV/AIDS funding defeated multilateralism. The administration justifies bilateralism in terms of lack of accountability and transparency of the African national health infrastructure, and the need to monitor them. Evertz (HHS) and Peterson (USAID), for instance, clearly express their reluctance to forward health donations too fast as it may impede accountability mechanisms, both in project design and in financial matters. Toni Fauci and O'Neill (HHS and National AIDS Advisory Board, respectively) are more cautious in addressing the issues of bilateralism and underscore the fact that the multilateral donations to the Fund and bi-lateral programs meant to complement each other. The Fund's multilateral disbursement practice although are difficult to

monitor locally. A biggest problem with bilateralism is how effectively the money is spent by the nation-states governments and what real impact on HIV/AIDS it has. The problem of corruption is pivotal too.

The funding norms set significant challenges to the global HIV/AIDS leadership. The Fund's relative financial capabilities in fighting AIDS are much restricted as opposed to the US. Yet both the Fund Secretariat itself and many global health activists claim that the Fund is a global leader in response to HIV/AIDS, TBC and malaria. However, up to date GFATM was not able to prove its advantage over other international agencies whose mission (fully or partially) was to deal with HIV/AIDS crisis. As *only* the Gates fund considers partnership with the Fund seriously, mobilization of resources from the private sector remained minuscule. Ad hoc inflows of money did not transform into the long-term sustainable mechanism of global HIV/AIDS funding. Even in the wide public discussion the Fund failed to offer any convincing reasons that the US administration's logic of funding is flawed.

The Fund was never able to convince the international community that the US health funding is flawed and there is a sound and innovative alternative, represented by the Fund itself. From the very beginning, GFATM assumed a very strange place in the global health network. As a novelty in the global health governance GFATM has no strict and rigid organizational links. Yet monetarily it depends on the US, and symbolically—on the activists net, which vocalizes basic grievances of the Fund (Fund the Fund campaign). GFATM is still at the crossroads facing a difficult choice either to integrate into the heterogeneous health activists' net or to become in effect one of the US institutions.

Here we see not just different contradictory norms with no action taken as a result, but rather nascent norm (still being severely contested) how to deal with global health funding. What we witness now is a symbolic struggle between the US and global health net with GFATM as its centre. Generally, this case shows that disagreements on the norms of funding does not preclude to entities from cooperation against the mutual threat. The situational imperative shows that even then two actors have to collaborate because of the way they put together and the prior affect still has its influence on actors' behavior.

Conclusion

The question persists if the TRIPS set forth the actors that can effectively assume the position of leaders on the global scale. Over the last several years, the eyes of global health activists, scholars concerned with HIV/AIDS

epidemic, and influential policy-makers have turned hopefully, and sometimes desperately, towards those international actors who could perform the role of global leader[s] in response to this devastating pandemic. It is argued that to date no international actor has assumed the role of the global leader in response to HIV/AIDS, while the functions of previous coordinating "nodes" (like GAP, or annual international conferences) are practically exhausted. Obviously, as the interests and visions of a number of domestic and international, governmental and non-governmental actors, involved in the process of disease eradication, diverge quite dramatically, the leadership becomes one of the major problems.

Although it is evident that TRIPS Agreement clearly reshapes how the global health governance is exercised, the nature and role of leadership is not quite clear. The global health governance is clearly moving towards commercialization and disregard of public health perspective. However, many voices appear in support of generous support of LDCs in their fight with the devastating pandemics. However, we are still at the crossroads, because until 2016 the TRIPS is not yet fully implemented, and a number of factors can reverse what seems to be inevitable today.

Paradoxically, the process of global homogenization of the rules on intellectual property vis-à-vis global health was conducive to the greater dissimilarly in how health governance is carried out in various parts of the globe. TRIPS also spurred the divergent approaches how the global health governance has to be carried out. Many pandemics not perceived as global any more because there are variety of drug markets where the capacities to combat the disease vary dramatically.

In terms of mapping the system of global health governance, the effects of TRIPS downplayed the flagman role of WHO and UNAIDS. TRIPS completed the process of the loss of original solidarity under the Mahler's WHO and lead to corporatization of the global health politics, and, ultimately, symbolize the transition from partnerships networks based on the global solidarity to the formal and non-binding health governance, coupled with compulsory health commercialization.

Resistance to TRIPS triggered several important ideational reactions: (1) move from fight against stigma in the workplace to the right to health [delivery], (2) transition from economic rationale to moral and ethic arguments, favoring further redistribution of power and finance within global health governance mechanisms, and in perspective (3) the justification of the transition from the regulatory to the redistributive economic policy in the global health.

These changes can, in return, play a crucial role in modification, adjustment or even revolutionizing global health governance.

There is a stunting paradox: despite all the variety of recent issue framing seem to establish international domination in response to HIV/AIDS, the role of leadership remains dubious. Yet almost all interest groups converge in the recognition of the special role of the US government as an essential fund-raiser and the largest global health donor, dealing with HIV/AIDS. The role of pharmaceutical giants cannot be omitted either. Yet their role provokes correct suspicions.

References

Access To Antiretroviral Drugs In Brazil, The Lancet, 360/9348 (2002):1862-1865.

Altman D. 1999. Globalization, Political Economy, And HIV/AIDS. Theory And Society 28/ 4: 559-584.

Attaran, Amir And Sachs, Jeffrey. Defining And Refining International Donor Support For Combating The AIDS Pandemic, The Lancet, 357/9249 (2001): 57-61.

Bale, H. E. The Conflicts Between Parallel Trade And Product Access And Innovation: The Case Of Pharmaceuticals. Journal Of International Economic Law, Winter 1998, 637-653.

Barnard, David. 2002. In The High Court Of South Africa, Case No. 4138/98: The Global Politics Of Access To Low-Cost AIDS Drugs In Poor Countries. Kennedy Institute Of Ethics Journal 12.2 (2002) 159-174.

Bancroft, Angus. 2001. Globalisation and HIV/AIDS: Inequality and The Boundaries Of A Symbolic Epidemic. Health, Risk & Society 3 /1: 89-98.

Berman, Daniel, and Nathan Ford. 1999. AIDS and Essential Medicines And Compulsory Licensing Summary Of The March 25-27, 1999 Geneva Meeting (Available At: Http://Www.Accessmed-Msf.Org/Prod/Publications.Asp?Scntid=392001830123&Contenttype=PARA&)

Bloche, M.G. 2002. WTO Deterrence To National Health Policy: Toward An Interpretive Principle. Journal Of International Economic Law 5/4: 825-848.

Bond, P. 1999. Globalization, Pharmaceutical Pricing And South African Health Policy. International Journal Of Health Services 29 (4).

Bryan, Charles. 2002. HIV/AIDS and Bioethics: Historical Perspective, Personal Retrospective. Health Care Analysis 10: 5—18.

Cheru, Fantu. 2002. Debt, Adjustment And The Politics Of Effective Response To HIV/AIDS In Africa. Third World Quarterly - Journal Of Emerging Areas 23: 2.

Confronting AIDS: Public Priorities In A Global Epidemic. World Bank Report 1997.

Correa Carlos M., 2002. Implications Of The Doha Declaration On The TRIPS Agreement And Public Health. World Health Organization, 2002.

Cullet P. 2003. Patents And Medicines: The Relationship Between TRIPS And The Human Right To Health. International Affairs 79/1: 139-160.

DESA/DSD/PC3/BP3. Fourth WTO Ministerial Conference—WTO Secretariat Background Note. Background Paper No. 3. (April 2002).

Dodgson, Richard And Lee, Kelley. 2002. Global Health Governance: A Conceptual Review, In Wilkinson And Huges, Global Governance: Critical Perspectives. Palgrave.

Dommen, Caroline. Raising Human Rights Concerns In The World Trade Organization Actors, Processes And Possible Strategies. Human Rights Quarterly - Volume 24, Number 1, February 2002: 1—50.

Evans, Tony. 2002. A Human Right To Health? Third World Quarterly - Journal Of Emerging Areas 23: 2

Gaffeo, Edoardo. 2003. The Economics Of HIV/AIDS: A Survey. Development Policy Review 21/1: 27—49.

Gollin, Michael. 2001. Generic Drugs, Compulsory Licensing, And Other Intellectual Property Tools For Improving Access To Medicine Notes Of A Talk Given At Quaker House, Geneva, 23 May 2001 Occasional Paper 3

Hanefeld J. 2002. Patent Rights Vs. Patient Rights: Intellectual Property, Pharmaceutical Companies And Access To Treatment For People Living With HIV/AIDS In Sub-Saharan Africa. Feminist Review 72/1: 84-92.

Health Action International. Power, Patents And Pills - An Examination Of GATT/WTO Policies And Essential Drug Policies. Seminar Report. Amsterdam: HAI-Europe; 1997.

Henderson E. 1997. TRIPS And The Third World: The Example Of Pharmaceutical Patents In India. European Intellectual Property Review 19(11): 651-663.

Heywood, Mark. 2002. Drug Access, Patents And Global Health: 'Chaffed And Waxed Sufficient.' Third World Quarterly - Journal Of Emerging Areas 23: 2.

Joseph, Sarah. Pharmaceutical Corporations And Access To Drugs: The "Fourth Wave" Of Corporate Human Rights Scrutiny. Human Rights Quarterly 25.2 (2003): 425-452.

Kazatchkine Michel, Moatti Jean-Paul. Antiretroviral Treatment For HIV-Infected Patients In Developing Countries: A Change In Paradigm Is Now Attainable. (Available At: Http://Www.Unaids.Org/Publications/Documents/Care/Acc%5Faccess/Cdrom/Resources.Html#Pharmaceutical).

Kobori S. 2002. TRIPS And The Primacy Of Public Health. Asia-Pacific Review 9/ 1: 10-19.

Kremer, Michael. 2002. “Pharmaceuticals And The Developing World,” Journal Of Economic Perspectives 16(4), Fall 2002.

Kwon H. 1995. Patent Protection And Technology Transfer In The Developing World: The Thailand Experience. George Washington Journal Of International Law And Economics 28:567-606

Labonte R. 1998. World Trade And Investment Agreements: Implications For Public Health. Canadian Journal Of Public Health 89 (1): 10-12.

Lanjouw, Jean O. 2002a. Intellectual Property And The Availability Of Pharmaceuticals In Poor Countries. Center For Global Development, Working Paper No. 5.

Lanjouw, Jean O. 2002b. Beyond TRIPS: A New Global Patent Regime. CDG Brief 1/3.

Marques M B. 1994. Brazil-US Controversy On The Impact Of Patenting In Biotechnology: Some Relevant Questions For Pharmaceuticals. Science And Public Policy June: 165-172.

Mashelkar, R. A. 2001. Intellectual; Property Rights And The Third World. Current Science, 81/8.

MSF. Joint Letter To The TRIPS Council MSF, Oxfam, CPT, Third World Network, Essential Action, Health GAP January 2002.

MSF. Joint Letter To The World Trade Organization's TRIPS Council Regarding Article 30 Consumer Project On Technology, Essential Action, Medecins Sans Frontieres, Oxfam International, Health GAP Coalition, And The Third World Network January 2002.
MSF. A Matter Of Life And Death: The Role Of Patents In Access To Essential Medicines MSF Briefing For The 4th WTO Ministerial Conference In Doha, Qatar November 2001.
Nelson, Samuel. 2002. The West's Moral Obligation To Assist Developing Countries In The Fight Against HIV/AIDS. Health Care Analysis 10: 87—108.
Otten A. The Implications Of The TRIPS Agreement For The Protection Of Pharmaceutical Inventions. WHO Drug Information. 1997(11): 1.
Oxfam. Patent Injustice: How World Trade Rules Threaten The Health Of The Poor. Oxfam, 2001.
Pécoul B, Chirac P, Trouiller P, Pinel J. 1999. Access To Essential Drugs In Poor Countries: A Lost Battle? Journal Of The American Medical Association 281(4): 361-367.
Perez-Casas C, Berman D, Chirac P, Kaper T, Pécoul B, De Vincenzi I, Von Schoen-Angerer T. HIV/AIDS Medicines Pricing Report. Setting Objectives: Is There A Political Will? (Avalable At: Http://Msf.Org/Advocacy/Accessmed//Reports/2000/07/Aidspricing/).
Roundy, Bill. 2000. From Worse To Bad: US AIDS Drug Trade Policy Lamented, Criticized, The Washington Blade, 7 January 2000.
Rozek RP, Berkowitz R. 1998. The Effects Of Patent Protection On The Prices Of Pharmaceutical Products: Is Intellectual Property Protection Raising The Drug Bill In Developing Countries? Journal Of World Intellectual Property 1(2): 179-243.
Rozek RP, Tully N. 1999. The TRIPS Agreement And Access To Health Care. Journal Of World Intellectual Property 2 (5), 813-819.
Sharma, Shalendra D. The World Trade Organization And Implications For Developing Countries. SAIS Review 17.2 (1997): 61-75.
Scherer, F.M. The Pharmaceutical Industry And World Intellectual Property. Vanderbilt Law Review.53:6.
Sell, Susan And May, Christopher. 2000. Moments In Law: Contestation And Settlement In The History Of Intellectual Property, Review Of International Political Economy, 8:3.
Sell, Susan. 1999. Multinational Corporation As Agents Of Change: The Globalization Of Intellectual Property Rights, In A. Cutler Et Al. Private Authority And International Affairs, SUNY.
Sell, Susan. 1997. Power And Ideas: North—South Politics Of Intellectual Property And Antitrust. SUNY.
Shoell, S. Why Can't Poor Access Lifesaving Medicines? An Exploration Of Solving The Patent Solution. Minnesota Intellectual Property Review
Steefland, P.H. 2003. Introduction Of A HIV Vaccine In The Developing Countries: Social And Cultural Dimensions. Vaccine 21: 1304—1309.
Steinberg, Richard H. In The Shadow Of Law Or Power? Consensus-Based Bargaining And Outcomes In The GATT/WTO. International Organization 56.2 (2002): 339-374.
South Centre. The TRIPS Agreement—A Guide For The South. Geneva: South Centre, 1997.
'T Hoen, Ellen. TRIPS, Pharmaceutical Patents, And Access To Essential Medicines: A Long Way From Seattle To Doha. Chicago Journal Of International Law
Thomas, Caroline. 2002. Trade Policy And The Politics Of Access To Drugs. Third World Quarterly - Journal Of Emerging Areas 23: 2
UNCTAD. 1996. The TRIPS Agreement And Developing Countries. United Nations Conference On Trade And Development, (UNCTAD/ITE/1).
UNO. 1998. Implications Of WTO/TRIPS For Technology Transfer In The Pharmaceutical Industry. New York, United Nations.
Vandermoortelle, Jan. Social Policies And Investment In Health. Development 44/1: 44—50.
Velásquez G, Boulet P. 1999. Essential Drugs In The New International Economic Environment. Bulletin Of The World Health Organization; International Journal Of Public Health 77(3): 288-292.
Velásquez G, Boulet P. 1999. Globalization And Access To Drugs: Perspectives On The WTO/TRIPS Agreement. WHO, Health Economics And Drugs, EDM Series No. 7 (Revised).
Waitzkin, Howard. Report Of The WHO Commission On Macroeconomics And Health: A Summary And Critique. The Lancet. Vol. 361. 2003. 523—526.
Whose Interests Does The WTO Serve? The Lancet, 361/9354 (2003).
WHO 2001. Globalization, TRIPS And Access To Pharmaceuticals. WHO Policy Perspective On Medicines, No. 3, March 2001.
WHO 2002. TRIPS, Intellectual Property Rights And Access To Medicines. HIV/AIDS Antiretroviral Newsletter, No. 8, December 2002. [By Karin Timmermans].
WHO/EDM 1999. Globalization, Patents And Drugs – An Annotated Bibliography. Health Economics And Drugs EDM Series No. 9. Geneva: World Health Organization; 1999 (WHO/EDM/PAR/99.6).
WHO/EDM 1999. Globalization And Access To Drugs - Perspectives On The WTO TRIPS Agreement. Health Economics And Drugs EDM Series No.7. Geneva: World Health Organization; 1999 (WHO/EDM/98.9 Revised).
WIPO 2002. WIPO News: A Selection Of "Press Releases" And "Updates" Chosen From The WIPO Website., World Patent Information, 24/1 (2002): 63-64.
WIPO 2001. WIPO Patent Information Services For Developing Countries, World Patent Information, 23/ 3 (2001): 295-308.
WTO 2001. WT/MIN(01)/DEC/2. Declaration On The TRIPS Agreement And Public Health Ministerial Conference, Adopted On 14 November 2001.

Wilson D, Cawthorne P, Ford N, Aongsomwang S. 1999. Global Trade And Access To Medicines: AIDS Treatments In Thailand. The Lancet 354 (9193): 1893-95.
Yusuf AA. 1995. Intellectual Property Protection In The Countries Of Africa. International Journal Of Technology Management (Special Issue On The Management Of International Intellectual Property) 10(2/3): 269-292.
GFATM. Fifth Board Meeting. Report of the Fourth Board Meeting. Geneva, 5—6 June 2003. (GF/B5/5)
GFATM. Fourth Board Meeting. Report of the Third Board Meeting. Geneva, 10—11 October 2002.
GFATM. Report of the First Board Meeting. Geneva, 28—29 January 2002.
GFATM. Report of the Executive Director R.G.A. Feachem.
GFATM. New Global Fund Head Vows To Get More Money Flowing To Effective Programs. GFATM—Press Release, 9 July 2002.
GFATM. Sixth Board Meeting Chiang Mai, 15 – 17 October 2003 Report from the Executive Director Richard G.A. Feachem
GFATM. REPORT OF THE GOVERNANCE AND PARTNERSHIP COMMITTEE GF/B6/7
GFATM. Sixth Board Meeting Chiang Mai, 15 – 17 October 2003.REPORT OF THE FIFTH BOARD MEETING GF/B6/2
Red Cross Condemns Rich Nations for Reneging on Global Fund Promises. *Agence France Presse* (10.13.03) - Tuesday, October 14, 2003
Global Fund to Fight AIDS Neglected by Rich Countries: International Organisations, AIDS activists, Call for Funding for AIDS Treatment and Effective Prevention Programmes from Japan, U.S., Australia, other countries International Federation of Red Cross and Red Cresent Societies - 13 October, 2003
Rachel Emma Zimmerman, Staff Reporter Global AIDS Fund Deals a Setback to Drug Makers in Board Selection Wall Street Journal - January 21, 2002
Lee, K., Buse, K., and Fustukian, S. Health Policy in a Globalising World. Cambridge University press, 2002.
Khabir, Ahmad. Bush Pledges Billions To Fight HIV/AIDS, *The Lancet*, Vol. 3, July 2003. P. 396.
Remarks by Secretary Of The State Colin L. Powell At The Organization Of American States General Assembly. 3 June 2003. Washington File—3 June 2003
Secretary of the State Colin L. Powell upon Receipt of the National Committee on Foreign Policy's Hans Morgenthau Award, 12 September 2002. Http://Usinfo.State.Gov J
Jonsson, Christer, Soderholm, Peter. 1996 IGO—NGO relations and HIV/AIDS: innovation or stalemate? Third World Quarterly, Vol 16, No 3.
Jeffrey Sachs. A Miserly Response to a Global Emergency. .**Financial Times**. July 16, 2003.

[2] Quoted in Ellis, Susan. HIV/AIDS Is "As Much A Crisis As Iraq" Says Powell, Washington File—l11June 2003.
[3] http://www.southcentre.org/info/southbulletin/bulletin19/bulletin19.htm
[4] http://cpim.org/statement/2001/2001_nov_16_wto_doha%20negotiations.htm
[5] To give just one example, according to the Drug Price Report, less than 10% of population in the developing world has access to the anti-retroviral therapy, and in Africa it is as low as 0.1%.
[6] Khabir, Ahmad. Bush Pledges Billions To Fight HIV/AIDS, *The Lancet*, Vol. 3, July 2003. P. 396.
[7] Phillips, M. Zimmerman, R. Health Activists Are Skeptical About Bush's AIDS Proposal, The Wall Street Journal—Jan 30 2003.
[8] Mason, Barry. Bush Uses AIDS Funding As An Instrument Of Foreign Policy. *WSWS*. 18 Feb 2003.
[9] Fox, Maggie. Health Secretary To Head Global AIDS Fund, Reuters Newmedia—30 Jan 2003.
[10] Global AIDS: State Of The Union Backgrounder. The Bush Administration And AIDS Funding: A Health GAP Briefing Paper—Jan 29, 2003.
[11] First Meeting Of The Transnational Working Group To Establish A Global Fund To Fight AIDS, TBC And Malaria. GFATM—Press Release, 13 Oct 2001.
[12] New Global Fund Head Vows To Get More Money Flowing To Effective Programs. GFATM—Press Release, 9 July 2002.
[13] Ibid.
[14] Talbot. Bush's AIDS appointee spells out corporate agenda. 9 October 2003. **www.wsws.org**
[15] Kaiser Daily HIV/AIDS Report Summarizes Editorials Addressing International AIDS, Family Planning /Funding www.thebody.com/kaiser/2003/sep4_03/family_planning.html