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**AIDS, Access to Medicines, and the
Different Roles of the
Brazilian and South African Governments in
Global Health Governance**

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AIDS, Access to Medicines, and the Different Roles of the Brazilian and South African Governments in Global Health Governance

Abstract

The present article illustrates how the main actors in global health governance (GHG)—governments, nongovernmental organizations (NGOs), intergovernmental organizations (IOs), and transnational pharmaceutical companies (TNPCs)—have been interacting and, as a result, modifying the global health architecture in general and AIDS treatment in particular. Using the concept of “power types” (Keohane/Martin) and “interfaces” (Norman Long), the authors examine the conflicts among major GHG actors that have arisen surrounding the limited access to medicines for fighting HIV/AIDS basically as a result of the Agreement on Trade Related Intellectual Property Rights (TRIPS), in force since 1995. They then analyze the efforts of Brazil and South Africa to obtain fast and low-cost access to antiretroviral medication against AIDS. They conclude that while policy makers in the two countries have used different approaches to tackle the AIDS problem, they have been able, with the support of NGOs, to modify TRIPS and change some WTO rules at the global level along legal interfaces. At the national level the results of the fight against AIDS have been encouraging for Brazil, but not for South Africa, where authorities denied the challenge for a prolonged period of time. The authors see the different outcomes as a consequence of Brazil’s ability to combine discursive, legal, administrative, and resource-based interfaces.

Keywords: global health governance; HIV/AIDS in Brazil and South Africa; discursive, legal, organizational and resource-based interfaces; WTO; transnational pharmaceutical companies; NGOs

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Zusammenfassung

AIDS, Zugang zu Medikamenten und die unterschiedliche Rolle der brasilianischen und südafrikanischen Regierungen im Rahmen von Global Health Governance

Dieser Aufsatz zeigt, wie die Hauptakteure von *global health governance* – Regierungen, Nichtregierungsorganisationen (NGOs), intergouvernementale Organisationen (IOs) und die transnationalen pharmazeutischen Unternehmen (TNPCs) – durch intensive Interaktionen die globalen Regelungen zum Gesundheitswesen im Allgemeinen und zur Behandlung von AIDS im Besonderen entscheidend modifiziert haben. Ausgehend vom Begriff der verschiedenen Machtformen (Keohane/Martin) und Schnittstellen (*interfaces*, Norman Long), untersuchen die Autoren die Konflikte zwischen den genannten Akteuren, entstanden aus dem beschränkten Zugang zu den teuren antiretroviralen HIV/AIDS-Medikamenten – u.a. eine Folge des 1995 in Kraft getretenen *Agreement on Trade Related Intellectual Property Rights* (TRIPs). Sie gehen sodann auf die unterschiedlichen Politiken der AIDS-Bekämpfung in Brasilien und Südafrika ein und kommen zu dem Schluss, dass diese Länder es zwar gemeinsam mit anderen Ländern und den NGOs geschafft haben, einige WTO-Regeln auf globaler Ebene zu verändern, dass die Ergebnisse auf nationaler Ebene jedoch auseinanderklaffen – enttäuschend für Südafrika, wo das Problem lange Zeit ignoriert wurde, und ermutigend für Brasilien, dank einer gelungenen Kombination der diskursiven, legalen, organisatorischen und ressourcenbezogenen *interfaces*.

AIDS, Access to Medicines, and the Different Roles of the Brazilian and South African Governments in Global Health Governance

Jan Peter Wogart, Gilberto Calcagnotto, Wolfgang Hein, Christian von Soest

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1 Introduction

During the 1990s the number of people dying of HIV/AIDS in developing countries was rapidly increasing; effective medicines to turn the pandemic into a chronic, but not necessarily deadly, disease were increasingly available, yet they were not affordable for the vast majority of affected people in developing countries. Transnational pharmaceutical companies (TNPCs) were in a position to charge high prices for innovative medicines, particularly in the case of AIDS antiretrovirals (ARVs). They were supported by the Agreement on Trade Related Intellectual Property Rights (TRIPS), introduced with the establishment of the World Trade Organization (WTO) in 1995, which demands the harmonization of intellectual property rights (IPRs) in all member countries.

The conflicts between a group of industrialized countries in the “North” and a growing group of emerging economies in the “South” centered around access to ARVs in particular and, eventually, access to medicines for the poor in general. These conflicts provide fascinating insights into the changing pattern of global health governance because they have assumed a multidimensional character and involve—in addition to groups of countries defending and opposing strict IPRs—a large number of civil society organizations (CSOs) networked by the Médecins sans Frontières (MSF) access campaign.¹ When the South succeeded in having the prices of ARVs significantly lowered as a result of negotiations with the TNPCs, the developing countries were also able to reach international agreements to clarify the right to use TRIPS safeguards. These included compulsory licenses² and parallel importation used to “protect public health” and, thus, decrease the risk of trade conflicts related to the stringent patent-right protection.

The course of these conflicts points to the changing character of international relations over the last 20 years. Relations between state actors have been increasingly challenged through a densification of global social relations where private actors (CSOs as well as corporations) have a growing impact on the course of events. States remain important as they conclude binding international agreements, provide the hardware of public health care (Fidler 2007), and thus continue to play a crucial role in pursuing strategies to deal with health issues. Therefore, approaching the issue of access to ARV by analyzing the interaction of public and private actors in global politics as well as in two important developing countries will help us move towards a better understanding of how health problems are tackled in a globalizing society.

We understand global health governance (GHG) as “the totality of collective regulations to deal with international and transnational interdependence problems in health” (Bartsch/Kohlmorgen 2005: 64). These regulations are, simultaneously, the results of conflictive and cooperative processes and the starting points of new conflicts about specific health policies (such as providing universal access to ARVs). These processes imply “interfaces” between actors with conflicting perceptions, values, and interests due to the systemic contexts in which they operate. This essay will focus on the changing nature of those interfaces and the change in power relationships, which came as a big surprise to both the actors and the observers.

The first part of the essay will start with some theoretical observations concerning the four different kinds of interfaces and their impact on the outcome of global negotiations. This will be followed by an analysis of the IPR-related conflicts linked to the TRIPS Agreement and access to medicines, which basically involve the interests of TNPCs and their impact on government policies in the North. The second part of the paper, focusing on Brazil and

¹ The role of global civil society in this conflict is analyzed in more detail in the chapter by Burris et al. in this volume; see also: Sell/Prakash 2004; Hein et al. (2007).

² Under WTO rules, a compulsory license allows governments to produce or to grant a third-party authority to produce a drug without consent of the patent holder in cases of national public health emergency, among other limited circumstances (www.wto.org/English/thewto_e/minist_e/min01_e/mindecl_trips_e.htm).

South Africa, will examine the different types of interfaces which have driven these conflicts and compromises between national health governance (NHG) and GHG in the context of the global fight against HIV/AIDS. A closer look at the health policies of these two countries in general and their fight against AIDS in particular will make it possible to examine both the power relationships between the North and the South and the nature of the interfaces in some detail.

We will maintain that the NHG of the two regional powers Brazil and South Africa has played a crucial role in determining how global challenges are taken up and how the chances to influence GHG are realized. Their sociopolitical settings have allowed both countries to pursue different objectives in fighting HIV/AIDS and interacting with the global level. In the process, the two countries have changed the very economic and social structure of both their own NHG and GHG.

2 Changing Power Relationships and the Role of Interfacing: A Few Theoretical Considerations

“Interfaces” are (following Long 1989) defined as “socio-political spaces of recurrent interactions of collective actors in the handling of transnational and international affairs” (Bartsch et al. 2007: 30). An analytical differentiation is made between four major types of interfaces which are closely related to the different types of power employed, that is, legal, resource-based, organizational, and discursive (ibid.). This differentiation helps to highlight the change in the relative importance of different means of interaction in shaping the financial and economic—as well as the institutional, political, and social—aspects of national and global health governance

Actors in global governance have traditionally dealt in two modes of governance, either involving intergovernmental interaction or, in the private sphere, business negotiations. In recent decades, however, cooperation between actors of different types (public-private partnerships, PPPs) has become more and more frequent, constituting hybrid forms of regulation. Moreover, the actors and their actions have been shaped by structural economic, political, and sociocultural conditions. This implies that actors—by virtue of their structural position and role—have certain features, tasks, and resources that affect their capability to execute power. As global governance is primarily regarded as the sum of interactions between actors, it becomes necessary for the empirical study to follow a corresponding approach which is focused on public-private interactions. While the world markets, with their disparities and the potency of certain actors, should be regarded as the framework of the actors' interactions and as the origin of their power, they have only been considered that in a few research efforts (Barnett/Duvall 2005b; Arts 2003). A study that is focused on power should facilitate a sophisticated analysis that allows for the identification of not only the apparent power of the resource-rich actor but also the potency of “weaker” actors. Based on Bar-

nett/Duvall (2005) and on Bas Arts (2003), who examine the power of non-state actors in global governance, we differentiate between four types of power:

- Decision-making power (refers to the actors' ability to be involved in decision making and in formal norm setting)
- Legal power (the ability to exert power based on legal structures and laws)
- Resource-based power (refers to the actors' material resources (for example, money, funding) and immaterial resources (knowledge, information) and their ability to provide these resources)
- Discursive power (the ability to frame and influence discourses)

We will see that these different types of power are closely related to specific types of interfaces between various actors and levels of global governance. There is, however, also a lack of detailed scientific investigation on the meaning of interests in the realm of the global governance. Most authors presume the existence of collective interests. However, this obscures the fact that the actors' self-interests are highly significant in questions regarding which governance structures have to be used and in which manner, how these structures could be modified and redesigned, the extent to which the process of interaction takes a cooperative or conflictive course, and which policy outcomes are feasible under these circumstances.

Followers of the rational institutionalism school (Keohane/Martin 1999) rightly point out that institutions are more than just short-term entities which emerge because of rapid combinations of power and interests but that at the same time their momentum should not be overestimated. They argue that actors and their interest-oriented and instrumental-rational actions are an essential factor in expounding the emergence and function of international institutions. This creates different combinations of common, complementary, or conflictive interests depending upon the position of actors in global and national societies; we will refer below to the differentiation between market-creation interests and welfare-oriented interests, which is of particular importance in global governance processes.

The extent to which individual interests or overarching goals of social welfare determine the actors' behavior is, last but not least, dependent on their logic of action. March/Olsen (1989) have outlined an orientation that is prevalent in rationalist approaches to actor behavior and called it the "logic of consequentialism." This is characterized by individual utility maximization, strategic action, the rational pursuit of interests, and consistent goal-oriented behavior; it basically relates to a "realistic" pursuance of self-interest which might be based on an actor's position in the economic system and possibly also on the fight for political power.

Social integration, however, depends on more than just complying with rules because of the self-interested desire to avoid punishment. March and Olson confront the logic of consequentialism with a "logic of appropriateness" which assumes that actors behave according to overarching norms and do what they believe is considered appropriate in the eyes of other actors. Risse (2000) supplements these "logics" with the "logic of arguing," implying

that actors exchange arguments on causal and normative contexts through a communicative process and act according to the results of such a process of understanding. This implies that even in the realm of rational action—discarding the emotional/affective binding forces of a community—society depends upon a logic of collective understanding which works independently from a continuous reference to long-term self-interest.

Seen in relation to processes of global governance, these considerations mean that we have to take into account a certain combination of actors primarily following a logic of consequentialism and other actors following the logics of appropriateness and/or arguing. It would be a mistake to relate actors in the economic field and in the social field simply to the first and the second logic, and also to assume that one actor is always following the same type of logic (for example, corporate social responsibility). The formation of a global society implies not only states pursuing their national interests and transnational actors pursuing their collective interest to create global rules—which allow them to pursue their private interests globally (critical interpretations of WTO)—but also the strengthening of advocative actors pushing human rights and supporting “health for all” politics in order to create the necessary confidence for global cooperation.

Analyzing interfaces thus implies describing and examining the actors involved in global governance interactions in their original structural contexts, that is, their sets “of reference points and constraining/enabling properties” (Long 2001: 62). Interfaces represent the intersections of modes of life, worldviews, interests, and strategies in which power relations are important for the emergence of new institutional contexts. As we are particularly interested in the impact different actors have on shaping institutional change and policy outcomes in GHG, we propose a typology of interfaces in relation to the types of power, namely, decision-making, legal, resource-based and discursive power. There is a certain congruence between types of power and specific types of interfaces.

Certainly, it makes sense to talk of *discursive interfaces* when considering not only the role of mass media but also the importance of expert commissions that produce reports intended to shape the perspectives of influential persons on important political issues (thus constituting the use of discursive power). In addition, there are *resource-transfer interfaces* involving the relationships between donors (countries, foundations) and international governmental organizations on the one hand, and the latter type of organization and receiving countries or other actors on the other hand. With respect to decision-making power, it seems useful to distinguish *organizational interfaces*, that is, decision-making structures in relevant organizations and institutions. *Legal interfaces* are created not only by international law (and are a specific outcome of processes at organizational interfaces)—which is exercised by international bodies monitoring compliance with this law (such as the WTO Dispute Settlement Body)—but also by national courts when dealing with international law incorporated into national law (for example, patent law following TRIPS rules). We define discursive, organizational, legal, and resource-transfer interfaces as follows:

- *Discursive interfaces* are communications about a basic understanding of, but also on, strategies to deal with the issues that arise in interactions between different levels of politics and different types of actors. These strategies might involve programmatic elements if longer-ranging concepts of cooperation and problem-solving are developed.
- If these programs are related to existing or newly created organizations, *organizational interfaces* appear, which in the case of international/global organizations typically comprise actors from the international and national levels of politics (partnerships, participation in organization and/or decision-making bodies, operational cooperation, consolidated programmatic cooperation).
- Organizational interfaces, depending on the nature of the organization, might also include *legal interfaces*, which are structured through international and national law (actors attempting to influence legislative processes and negotiations, the implementation of law, legal conflicts, and international agreements).
- *Resource-transfer interfaces* play a particularly important role in the transfer of finances to poor countries, and, of course, in financial transfers from rich countries to multilateral organizations in various fields of social politics. Resource-based interfaces also arise as a strategy to defend specific regulations (or the prevalence of specific political regimes) against irrefutable criticism, for instance, from a human rights perspective. The transfer of resources occurs not only between different levels of politics (typically, national > international > national) but also between different policy areas and types of actors (for example, nation states > CSOs; or IGOs (intergovernmental organizations) > CSOs). Resource-transfer interfaces can relate to both material resources (for example, funding) and immaterial resources (for example, labor force, technical assistance, knowledge). (s. for more details: Hein/Bartsch/Kohlmorgen 2007: 30 ff.)

The “recurrent interactions” between major GHG actors discussed in this essay have manifested themselves in different ways according to the types of interfaces involved. It is asserted here that while closely interconnected, discursive interfaces and their worldwide repercussions have been more important in shaping the conflicts around access to treatment for HIV/AIDS patients than the seemingly powerful resource-based interfaces, and that the emerging legal and organizational interfaces reflect the power of discourses in GHG. Both assertions—if proven correct—should have significant policy implications for present and future global governance in the health sector and beyond.

3 Internationalizing Intellectual Property Rights

The process of globalization has been accompanied by an increased need to base the integration of global markets on international law. The interest of the technologically leading industrialized countries in strengthening international rules on IPRs has to be seen in the context of protecting those IPRs created by advances in computer and information technology, biotechnology, and the patentability of life organisms. Besides a further deepening of GATT in the WTO context, including a strengthening of dispute settlement mechanisms, the North has introduced other agreements which have affected GHG directly and indirectly. They include the General Agreement on Trade in Services (GATS) and the Agreement on Sanitary and Phytosanitary Measures (SPS). While GATS constitutes an extension of trade liberalization for trade in services with far-reaching implications for the national regulation of services—the majority of which was formerly operated by nation states only—TRIPS and SPS are totally new types of agreements in the GATT context, although the internationalizing and institutionalizing of IPRs is a venerable tradition dating back to the nineteenth century.³ With the establishment of the World Intellectual Property Organization (WIPO) in 1967, international protection of IPRs reached a new level of institutionalization. Even then, many of the fully developed countries were not members, and it took another 20 to 30 years before such major industrialized countries as Canada, Austria, Spain, Switzerland, and Norway adopted strong patent protection which reflected the rules and regulations elaborated by WIPO in an international setting. However, WIPO's one country-one vote rule led to stalemates. Furthermore, WIPO did not have any strong mechanism to enforce compliance. Therefore, the US and other developed countries with strong interests in protecting IPRs looked at the enforcement and dispute settlement system which existed within GATT and which was to be further developed in the context of the WTO agreements. Within the context of that institutional setting it was possible to put pressure on advanced developing countries, which were known not only to copy and reengineer innovations, but also to have been successful in exporting those more sophisticated products all over the world. In the pharmaceutical field the increasing competition of international generic producers, which circumvented the strict patent laws of the US and other OECD countries, was increasingly perceived as hurting sales of patented drugs, both at home and abroad.

Moving the focus of implementing international IPR rules from WIPO to TRIPS represented the first round of “forum shifting” in this field, which means an attempt to shift the main thrust of an actor (or a group of actors) fighting for an international agreement serving its (their) objectives to a different international organization or forum (cf. Drahos 2002,

³ After the Paris Convention for the Protection of Industrial Property (1883), and the Berne Convention for the Protection of Literary and Artistic Works (1887), a common international secretariat was established in 1893. During the first half of the twentieth century, the political and economic upheavals of the two World Wars and the economic problems associated with them did not allow any further institutionalization until 1967, when the Stockholm Convention Establishing the World Intellectual Property Organization (WIPO) was signed.

Sell/Prakash 2004). The same strategy was also used by the pharmaceutical companies and the US negotiators in bilateral trade agreements. The early ones, such as the North American Free Trade Agreement (NAFTA), were negotiated either before or at the same time as the TRIPS Agreement. Most of the other ones were signed in the late 1990s and the move towards bilateral agreements has continued during the first five years of the twenty-first century. All of them contained more rigid IPR stipulations, in particular the exclusion of TRIPS flexibilities for pharmaceuticals also. These so-called “TRIPS+” agreements became the rallying points of opposition to the trade agreements in the respective countries. Even respected free-trade advocates such as Jagdish Bhagwati described the WTO's intellectual property protection as a tax that most poor countries paid on their use of knowledge, “constituting an unrequited transfer to the rich producing countries” (Sexton 2001: 10).

In the second half of the 1990s, however, CSOs won growing public support to press TNPCs and developed countries to help improve access to essential medicines, in particular ARVs, using discursive interfaces. Public support also proved decisive in preventing TNPCs full use of their presumably strong legal and resource-based position. In 1997 (and again in 2001) the Pharmaceutical Manufacturer's Association of South Africa went to court to fight against a law that allows domestic production of generics, but in both cases decided to withdraw due to the pressure of global public opinion and CSO action. Negotiations with Brazil on ARVs (delivery and licenses) lead to steep price reductions in 2001, despite calls for the United States Trade Representative (USTR) to threaten legal action at the WTO (discussed in more detail in the latter part of this section). As a consequence of these conflicts, CSOs and developing countries, led by Brazil, took the initiative to press for a clarification of the right to use TRIPS flexibilities in the pursuit of public health. This led to the Doha Ministerial Declaration on the TRIPS Agreement and Public Health in November of 2001.

The Doha Declaration defined the relationship between the protection of patents and its limitation in the context of public health emergencies, making clear that WTO members' right to protect the health of their populations should make it possible to access medication at the lowest possible prices. That unanimous decision was finally reached because of the rapid spread of AIDS in developing countries. It took another two years, however, before a final agreement, stipulated by the famous paragraph 6 of the Doha Declaration, was achieved. This agreement created a system to allow countries which were not able to produce low-cost generic medicines themselves to issue compulsory licenses to have them produced in a foreign country.⁴

⁴ The 2003 Decision actually took the form of a waiver related to the obligations of the Member countries under Articles 31f and 31h of TRIPS. To soothe the fear of TNPCs and their governments in the developed countries, the General Council's Chairperson underlined the fact that the “system that will be established by the Decision should be used in good faith to protect public health and, without prejudice to paragraph 6 of the Decision, not be an instrument to pursue industrial or commercial policy objectives” (WTO News, 2003). For a detailed legal interpretation and a discussion on the relationship between the Decision and the Amendment see, South Centre and CIEL, 2006.

WTO members finally approved these changes to Article 31 of the TRIPS Agreement in December of 2005.⁵ After ten years of the WTO's existence, this was the first time a core agreement of the organization had been amended. To what extent the Doha Declaration and the TRIPS amendment will facilitate compulsory licensing to improve access to medicines remains to be seen. As of 2008, only a few countries of the South, such as Thailand and Brazil, have used compulsory licensing, and only Rwanda has used the new mechanism introduced in Art. 31. Officials of smaller and poorer countries have generally not issued compulsory licenses, either because there were too many cumbersome regulations or because the research-oriented TNPCs were willing to provide low-cost versions of their patented products.⁶

In the meantime, the deadline for the least developed countries to enact and implement patent and other IPRs has been postponed to 2016. The TRIPS Council took that decision during the Hong Kong Meeting in 2005, following the LDCs earlier request for the extension. The developing countries' increasing involvement in the international negotiating process on matters touching on health governance has been a constant feature of negotiations on the "amended" TRIPS Agreement. While we will discuss the latter process referring to the example of legal and organizational interfaces in Brazil and South Africa, it can already be stated that the very process of getting the TRIPS Agreement amended represented a paradigm shift in international negotiations, not only because the "voices of the poor" were heard but also because their requests were legislated.

4 The TNPCs, TRIPS, and AIDS

4.1 Summary Sequence of the TNPCs' Interfaces

The interactions between TNPCs and the other major actors in the global and national health arena have been analyzed in more detail in earlier contributions; Table 1 summarizes only the timeline of events related to IPRs and access to essential medicines.⁷ These events took place between 1994 and 2006.⁸ What was unique in this case was that not only were the TNPCs the major actors in the fight with the government officials of the South over prices of the ARVs against AIDS, but they were also responsible for the introduction and negotiation of TRIPS and TRIPS+ in the US bilateral treaties, even though those were officially governmental interactions. Their involvement was based on the fact that they have vast financial

⁵ As in 2003, the compromise in 2005 was reached as a hopeful overture to the WTO trade negotiations, which followed suit.

⁶ Companies such as GlaxoSmithKline (GSK) and Merck used different packaging and/or bottling and embossing of their tablets for their HIV/AIDS medication than for the same pills sold in rich countries. They also provided a different number of pills per package.

⁷ For the conflict between Brazil and the TNPCs see Wogart/Calcagnotto (2006). For the discussion on TRIPS see Wogart (2007) and Hein (2007).

⁸ See Chapters 2, 3, 7 and 8 in Hein et al. (2007).

resource-based power and that they have also become increasingly involved in the decision making and formal norm-setting of GHG—that is, in using legal interfaces.⁹

Table 1: Timeline of Decisions and Conflicts around IPRs and Access to Medicines

Year	Agreement
1967	WIPO
1994	TRIPS /Uruguay Round
1996	CSO access campaign started Beginning of free-of-charge ARV distribution in Brazil
1996–2001	Brazilian negotiations with TNPCs for lower ARV prices and favorable licenses for local production
1997	1 st South African court case; TNPCs withdraw under pressure from CSOs
2000–	Growing number of bilateral trade agreements with strong IPR provisions (without TRIPS flexibilities, TRIPS+)
2000	TNPCs improve access to ARVs through PPPs and differential pricing
2001	Initiative of South/CSOs: Doha Declaration
2003–05	Paragraph 6 negotiations/ TRIPS amendment/ deadline for TRIPS implementation in LDCs postponed to 2016 (concerning pharmaceuticals).
2006	South introduces Global Framework on Essential Health Research within WHO
2007	Establishment of Intergovernmental Working Group on Public Health, Innovation and Intellectual Property in WHO

Source: Authors' compilation.

As a consequence of that involvement, the TNPCs found themselves in a number of interfaces, ranging from legal ones—encounters with the South African government in the country's courts and the drafting and discussion of the TRIPS legislation with the USTR—to organizational and discursive interfaces. The latter types of interfaces played an important role in the fight over drug pricing with Brazil's government and NGOs as well as in key discussions with public and private partners and opponents. In both cases TNPCs were involved through their major associations at the national and international level (PhRMA and IFFMA) and via the top executives of the major companies. They also used resource-based interfaces, utilizing their vast financial resources on all fronts. Most of the encounters were really a combination of at least two or three types of interfaces. By putting too much emphasis on the legal interfaces at the beginning of the discourse on access to medicine in poor countries, they did not achieve the expected results, as they admitted quite openly afterwards.¹⁰

⁹ For a discussion of the direct involvement of the TNCs in national and global politics, see Sell (2000) and Jawara/Kwa (2003).

¹⁰ *The Economist* (2005b).

4.2 TNPCs' Strategies and the Response from Brazil and South Africa

Analysts within the pharmaceutical industry have long used game theory when providing strategic advice to management. In deciding among alternative research projects, which not only face a significant risk of failure but also the possibility of strong competition, even after many years of successful R&D, management is well advised to use this approach to help choose which projects to sponsor and which to drop or delay.¹¹ In the case of internationalizing IPRs, the TNPCs chose the regime-shifting strategy, which they considered to be secure since it had the backing of the US government. That strategy did seem to work well at the beginning, when the shift of a new legal and enforceable base for IPRs from WIPO to the WTO was accomplished without major opposition.

By simultaneously pressing for the internationalization of IPRs at WIPO (into which the US government introduced the Sustained Patent Treaty (SPT)), attaining the successful introduction and legislation of the TRIPS Agreement at the WTO, and insisting on even tougher IPR regulations (TRIPS+) in various bilateral treaties, the governments of the North in general and the US Trade Representative in particular followed the script designed by the high-tech Transnational Corporations (TNCs), among which the TNPCs played a crucial role.¹²

The TNPCs' success on the national front encouraged Brazil and the NGOs to also play an increasingly more active and demanding role in the international global health arena along legal interfaces, and to mobilize discursive ones. The outcomes of these activities were two initiatives within WIPO and WHO. In 2004, under the leadership of Argentina, Brazil, and Kenya, the developing countries pushed for negotiations on a "development agenda" within WIPO and a medical R&D treaty within WHO; these initiatives were intended to provoke further discussion on the value of and the best timing of IPRs legislation in developing countries (see Figure 1).

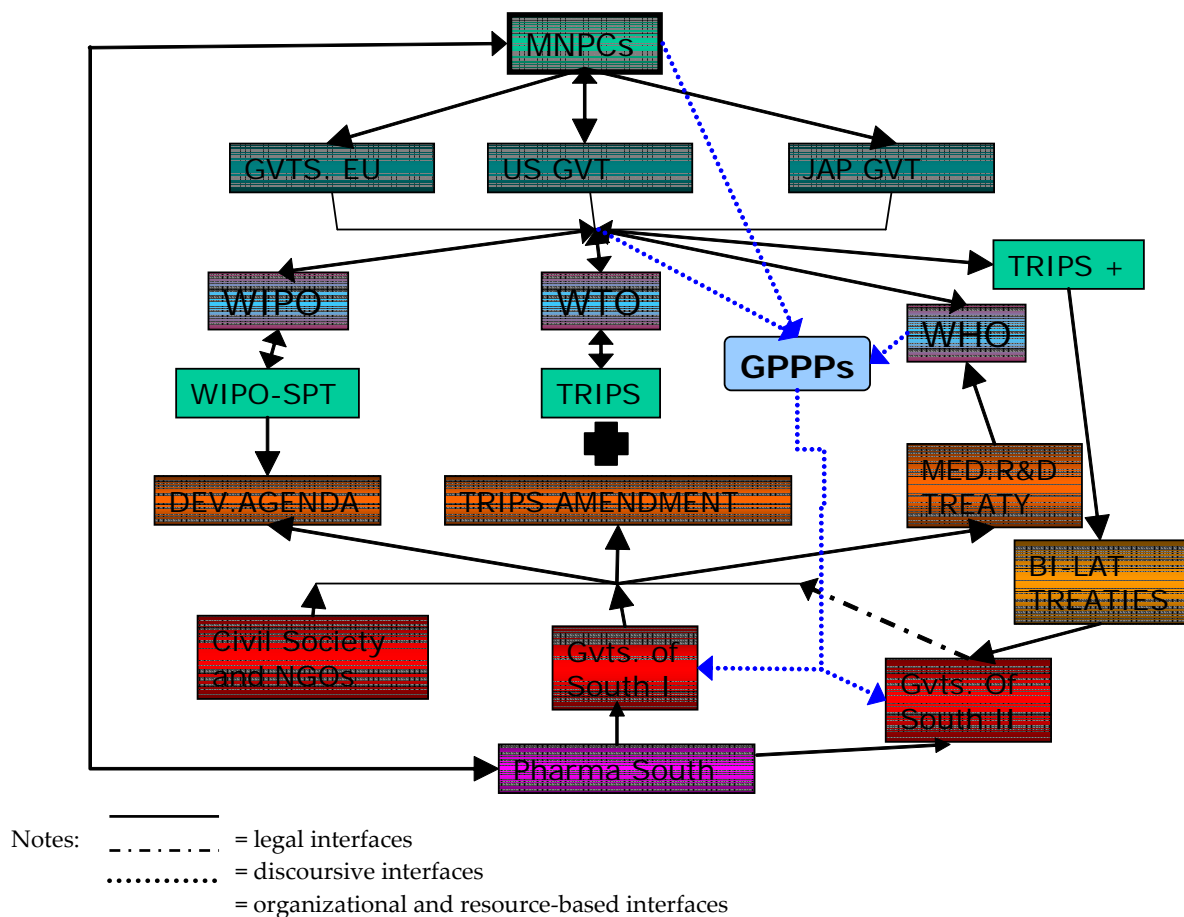
By also using the strategy of forum shifting, the South countered the initiatives of the North with an increasing number of initiatives which transferred the limelight of global health issues from the WTO to the WHO, where it would seem to belong. The scenario depicted in Figure 1 illustrates the multiple interfaces among the major actors in the health arena of today. From earlier discussions regarding the TNPCs' interactions with and influences on the governments of the North, in lobbying for the internationalization of IPRs in various fora, and the response from the developing countries, fighting for an amendment to TRIPS and introducing new initiatives at WIPO and the WHO, it has become clear that the major pillars of the global health architecture are in the process of significant change. They will continue change in the near future. While neither the TNPCs nor the NGOs belong to those "pillars," their actions and interactions have played a major role in bringing about the transformation of such venerable institutions as the WHO, the World Bank, the WIPO, and the WTO, the lat-

¹¹ See for example Senn 1996; 'Game Theory and Business Decisions', <http://faculty.haas.berkeley.edu/xuanming/147/>.

¹² For an extensive discussion of the TNPCs' role in drafting the TRIPS Agreement, see Sell (2000).

ter two of which would previously never have been anticipated to become part of wide-ranging discussions and decisions concerning global health issues in the twenty-first century.

Figure 1: North vs. South Interfacing in an Emerging GHG



Brazil and South Africa have faced major HIV/AIDS crises, with “important aspects of the epidemic following a similar pattern in both countries” (Gauri and Lieberman, 2004: 2). While experts predicted a major expansion of the disease in both countries in the mid-1980s, Brazil has been able to keep the prevalence rate at less than 1 percent of its population (UNAIDS, 2004: 202). The 660,000 estimated HIV cases in Brazil contrast with 5.54 million HIV-infected South Africans, who constitute close to 11 percent of the country’s population (Doherty and Colvin 2004: 196). Table 2 summarizes the major similarities and differences between the two countries concerning their readiness to fight HIV/AIDS.

With national incomes at similar levels and public health expenditures constituting a similar share of public expenditures, the governments of the two countries were equipped with a similar resource base to fight the disease, notwithstanding Brazil’s greater external foreign debt exposure. In short, based on economic and social positioning, South Africa would have seemed to be at least in a similar if not better position to fight the HIV/AIDS pandemic than Brazil; yet the opposite occurred. While the Brazilian government rolled out the ARVs free

of charge in 1996 (AZT as early as 1991), the South African government only started doing this in 2003, and even then reluctantly. The startling difference in behavior can also be observed in the relationship those two countries' actors had with GHG representatives.

Table 2: Brazil's and South Africa's Fight against HIV/AIDS: Similarities and Differences

Item	Brazil	South Africa
Trajectory	HIV-infected people 1992: about 770,000 or prevalence-rate < 1%	HIV-infected people 1990: < 1%
	Actual HIV prevalence 2006: 0.61%; i.e., 620,000 HIV-infected people	HIV prevalence 2006: 11% (5.54 million HIV-infected people)
Per capita income	US\$3000 (2006)	US\$3630 (2004)
Income distribution	Seriously unequal (Gini-Index: 59.3–2005)	Seriously unequal (Gini-Index: 57.8–2005)
Public health expenditures	7.3% of federal budget with additional state and municipal spending	11.5% of total public budget
ARV distribution free of charge (year of implementation)	Since 1988, DST-medication; since 1991, AZT; since 1996, ARV distribution	Since April 2002, legal entitlement for HIV-positive mothers (Nevirapine); since November 2003 for all citizens
HIV/AIDS treatment policy at federal level (year of implementation)	Since 1985: National HIV/ AIDS Program	1994: National AIDS Plan

Note: Gray-colored cells indicate major divergences between Brazil and South Africa.

5 Mutually Reinforcing Interfaces in Confronting the AIDS Challenge

5.1 Resource-based and Discursive Interfaces: Provoking Different Responses in Brazil and South Africa

The Brazilian response to AIDS emerged from the demands of civil society groups and developed through active collaboration between the local government of São Paulo and NGOs and through support from within the official health system, first at the state level, then—after a delay of three years—at the federal level. The civil society organizations had been the most critical opponents of federal government health policies in the 1980s and early 1990s because of governmental reluctance to formulate a comprehensive national HIV/AIDS program. During the first years of the epidemic NGOs remained, together with some local governments, the protagonists of prevention and care (Galvão 1994: 341-352).¹³ In these efforts

¹³ This changed with the new orientation of the Brazilian Sexually Transmitted Diseases and HIV/AIDS Program (BHAP) in 1992, providing a wide range of prevention and care services. The development of a network

they also drew heavily on resources from abroad by interfacing with global actors through the Internet and at international AIDS conferences.

Since the Brazilian public health system had been suffering from continued lack of finance (aggravated by the debt crisis), the gap between the rapidly growing need for AIDS treatment and the scarce financial resources became ever greater in the late 1980s and early 1990s. A 1989 estimate revealed direct treatment costs for each AIDS patient to be approximately US\$15,670/year, with total costs of US\$3.5 billion for all known AIDS patients. One of the arguments for government provision of free treatment was that the treatment was expected to have both a care and a prevention effect.¹⁴

The prevention versus treatment question became a controversial issue in discussions between the Brazilian government and the World Bank during loan negotiations as of 1992. With the reorganization of the National AIDS Program in the Ministry of Health, there was a concerted effort on all sides (governmental programs at every level, NGOs, universities) to work together in seeking to build a national response to the epidemic. This collaborative spirit was reinforced and solidified during the process of elaborating a proposal for the first World Bank AIDS Project (1994–98), in which traditional rivalries and territorial disputes were set aside in favor of cooperation in fighting the disease.¹⁵ While the bank did not finance treatment directly, the national component of the funds did and the funds going from the bank to the NGOs did too, in one way or another. Together with the AIDS II project (1998–2003) and the following AIDS III project, the bank provided US\$435 million, which was supplemented by a government contribution of US\$325 million. There was a special emphasis on prevention services, epidemiological surveillance, capacity building, and the improvement of the quality of life of people living with HIV/AIDS.

The World Bank projects were a watershed—quantitatively and qualitatively—since they induced a high degree of commitment on the part of the government and included decisive financing of NGOs. There was a dramatic expansion of federal government program expenditures for HIV/AIDS/STD¹⁶ treatment, in addition to ARV and other drugs, after the bank had begun to disburse. The World Bank helped not only through financing capacity building and creating facilities at the state and municipal levels, but also through financing prevention projects run by CSOs, thus consolidating one component of the overall Brazilian

of NGOs has since then mainly been financed by the federal government, which has channeled funds from World Bank projects to them.

¹⁴ “The promise of treatment gave an incentive for more at-risk individuals to be tested and gave doctors an incentive to report AIDS cases, thus improving surveillance and prevention programs” (Berkman et al. 2005: 1170). For instance, the implementation of BHAP in 2001 required an investment of US\$232 million, but was estimated to result in total savings of US\$1.1 billion (thanks to the reduction of hospitalization and other costs).

¹⁵ The minister of health, José Serra (1998–2002), maintained somewhat dryly in an interview: “The bank’s participation was positive for it obliged us to do something well organized to make an efficient management and accounting effort” (see J. Biehl, 2004).

¹⁶ STDs: sexually transmitted diseases.

STD and HIV/AIDS program BHAP.¹⁷ Fostered by the joint AIDS I-III projects of the BHAP and the World Bank, the number of CSOs addressing HIV/AIDS grew rapidly from 120 in 1992 to more than 500 in 1998 (Bacon et al. 2004: 45) and 1884 in 2003 (Monitoraids 2004). The increased interfaces between HIV/AIDS CSOs and BHAP seem to have contributed to a better overall relationship between civil society and the state in Brazil.

The fact that the bank agreed to have the operations used for both prevention and treatment would not have been possible without the intense use of discursive interfaces in the form of strong and skilful argumentation related to the country's newly awakening democratic spirit and the willingness for coordination articulated by the national government and critical NGOs such as ABIA¹⁸ and others. These civil society organizations helped to restrict the World Bank's influence to an almost exclusively resource-transfer character; consequently, the Brazilian government could maintain its comprehensive prevention-treatment approach (cf. Calcagnotto 2007: 193 and Parker et al. 2001: 110). In short, Brazil has jointly used resource-based and discursive interfaces, both within the country and internationally.

Other external donors have supported HIV/AIDS programs in Brazil, but their financial contributions have been relatively small. Among others, there has been bilateral support from the major aid agencies of the OECD countries: USAID, CDC, DPID, GTZ, and ANRS. The discursive interfacing has in some cases reached crisis proportions. For instance, in 2005 and 2006 it led to the refusal of an offered USAID credit of US\$40 million because of the USAID insistence on the ABC approach (*"Abstinence, Be faithful, and Condoms"*, in this order of priority), which is rejected by Brazilian authorities especially in relation to sexual workers and abstinence. But despite dissent along discursive interfaces, the cooperation related to resource-based interfaces between BHAP and USAID goes on in other SDT/HIV related activities.¹⁹

Particularly in the foundation period (1985–1992), CSOs working on HIV/AIDS relied heavily on sources from abroad, such as the Ford Foundation, Misereor, Brot für die Welt, and they worked actively along discursive interfaces with international CSOs.

The financial and discursive interfaces have also been intense between the Brazilian business sector, government, and civil society. As part of the BHAP the Brazilian National AIDS Council (CEN) has not only been active in supporting workplace programs within its membership, but it has also played an important global diffusion function in disseminating the best practices of those programs on the shop floor. It was in that context that multinational

¹⁷ The relevance of this qualitative contribution is reflected in the prevention component, for which the bank lent US\$253m in the period 1994–2003. The federal government alone spent a total of US\$290m in 2000 for ARV drugs purchasing, which was 69 percent of total federal spending on AIDS in 2000 (Beyrer et al. 2005: 28). It would have been difficult for the Brazilian government to spend so much for treatment over all the years if the World Bank had not covered the prevention component so massively.

¹⁸ The Brazilian Interdisciplinary AIDS Association, founded in 1986.

¹⁹ S. "Nota Técnica do Programa Nacional de DST e AIDS" in: www.aids.gov.br/main.asp?View={E77B47C8-3436-41E0-AC19-E1B215447EB9} of 13.03.2006 and www.reduc.org.br/news.php?recid=125, accessed 8.1.2008; also: <http://brazil.usaid.gov/noticialNT.php?id=90>, from 10.12.2007.

business and private foundations began to view NGOs and labor unions as partners fighting HIV/AIDS (cf. Terto 1997: 154).

South Africa's encounter with the HIV/AIDS challenge was—on the governmental level— influenced neither by financial contributions nor by discursive interfaces with global actors for a considerable time period. According to Schneider and Gilson (1999: 266), total international aid to the health sector was just over 1 percent of the South African annual government health budget in the period 1994–1999. As a middle-income country with relatively low external debt,²⁰ South Africa was not willing to rely on conditional donor aid. Throughout the 1990s the ANC government thus refused external offers of financial or technical assistance, which it did not see as fitting into its policy framework, particularly with respect to treating HIV/AIDS.

This contested approach came into the open in 2002, when the ANC government blocked the disbursement of US\$72 million granted by the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) to the Enhancing Care Initiative (ECI) of the province KwaZulu-Natal. Its HIV/AIDS program included—among other activities—the financing of schemes to reduce the risk of mother-to-child-transmission (MTCT) of the virus and to provide anti-retroviral treatment to infected persons (Pawinski/Lalloo 2002). Despite the fact that the South African National AIDS Council (SANAC) was not functioning at that time, the minister of health argued that only the national government could apply to the Global Fund (Weinel 2005: 45). It took another two years before the funds were transferred to KwaZulu-Natal's ECI.

Other official inflows of foreign financial support to fight HIV/AIDS were accepted by the national government only in 2004, more than a decade after Brazil initiated its large program requesting external assistance. The American organization President's Emergency Fund for AIDS Relief (PEPFAR) provided US\$221.5 million in 2004/5 for treatment, prevention, care of orphans, and palliative care (United States Global AIDS Coordinator 2005: 115). As stated by the US embassy in South Africa, 60 percent of the funds were allocated to the South African government and 40 percent to civil society organizations working in the field of HIV/AIDS (United States 2006). Thus, the ANC government integrated PEPFAR funds into its changed strategies to fight HIV/AIDS.

In contrast to the government's approach of stressing autonomy, many of South Africa's civil society actors have been partially or fully funded by external actors such as aid agencies, international organizations, or private foundations. Recipients have included the Treatment Action Campaign (TAC), the Health System Trust, the AIDS Foundation, and the research institute IDASA. The most prominent has been TAC, which—since its foundation in December 1998—has quickly emerged as the most vocal civil society actor in the area of

²⁰ In 1996, shortly after the democratic transition, South Africa's total external debt amounted to US\$23.6 billion (World Bank 1998: 249), against a total debt of US\$83.3 billion for Brazil (only medium- and long-term; Central Bank of Brazil 1983: 93).

South Africa's HIV/AIDS policy. Almost the complete organization's budget of R23.5 million for the financial year ending in February 2005 came from foreign donors.²¹

Like official resource transfers, discursive interfaces have been hampered by internal conflicts in South Africa and international misunderstandings. Global actors operating in the country have only gradually been able to shape discourses on HIV/AIDS in general and on antiretroviral treatment in particular. Contradicting government positions, they have been able to demonstrate that antiretroviral treatment of HIV/AIDS is an effective and feasible option for the country. Several examples highlight the difficulty of overcoming South African policy makers' unwillingness to engage in a dialogue on treatment of HIV/AIDS.

One of the most prominent HIV/AIDS antiretroviral projects emerged in Western Cape Province, the only province which, besides KwaZulu-Natal, was not governed by the ANC until 2004. In January 1999, MSF started—with the support of the Western Cape provincial government—an ARV-based program to reduce the risk of MTCT in Khayelitsha, a large township in Cape Town (Médecins Sans Frontières 2003: 14). In May 2001, the organization established the first public-sector service to provide antiretroviral treatment to people living with HIV/AIDS in South Africa. Although the national government disapproved of this action, the political constellation in Western Cape Province permitted the engagement of MSF. The Khayelitsha project set a publicly visible example that ARVs could be successfully administered, even in a poor township setting. This is reflected in the 2003 report from TAC (2003), a close ally of MSF.

While public-private partnerships developed in Brazil in order to prevent and treat AIDS in business and industry, the private sector was on its own in South Africa. Without entering into the discussion of whether businesses' reaction has been adequate to the magnitude of the HIV/AIDS problem, it can be safely said that the highly publicized workplace programs of such important enterprises as the Anglo-American mining company, the parastatal power utility Eskom, and the multinational car manufacturers DaimlerChrysler, BMW, and Volkswagen—beyond a having a very specific impact among the firms' employees and their families—set a publicly visible example and thereby influenced South Africa's HIV/AIDS policy.²² Civil society was less constrained and interacted significantly with other actors, at both the national and the international level. TAC most actively forged networks with international nongovernmental organizations (INGOS) and international organizations which had a significant impact on GHG. In cooperation with its partners, TAC organized international protests supporting South Africa's government in the court case of the Pharmaceutical Manu-

²¹ The main sources were Bread for the World, the Open Society Foundation, the Swedish International Development Agency, Oxfam, and the Ford Foundation. Only one donor, the AIDS Foundation of South Africa, is based in the country (TAC 2005). The full list of donors along with a detailed analysis can be found in Mballi (2005: 22-23).

²² For case studies on workplace programs in two large South African companies, see Stevens (2004). On workplace programs in South Africa, see also Marais (2000: 30) and Butler (2005: 11). Further empirical sources consist of the interviews conducted during field research in May 2005.

facturers Association challenging the Medicines and Related Substances Amendment Act (Gumede 2005: 157, see also above). INGOs later also conducted solidarity protests during TAC's civil disobedience campaign against the government, which included demonstrations in front of South African embassies around the world (Mwali 2005: 36).²³

5.2 Legal and Organizational Interfaces: Disputes with Repercussions on the Global Level

Legal interfaces are a key area which broadens or narrows people's access to the public health system. The legal recognition of universal access to health as "a right of all and a duty of the State" by the 1988 Brazilian Constitution (Republic of Brazil 1988, Art. 196 in: Senado Federal 2003: 119) served as an important base in the negotiations with the World Bank, since the constitutional recognition implies the right of all citizens to health care, including treatment (Parker et al. 2001: 110). On the global level, Brazil's fight for the designation of access antiretroviral treatment as a human right succeeded with the April 2001 Resolution of the UN Commission on Human Rights dealing with the "Access to medication in the context of pandemics such as HIV/AIDS."²⁴ In the run up to the decision, Brazil lobbied intensely for this resolution, beginning with its efforts to put free technology transfer and ARV price reductions on the international agenda. Brazilian representatives secured the inclusion of the issue of ARV treatment and generics on the agendas of several international and multilateral organizations such as the Okinawa G8 Summit in July 2000, the Executive Committee of the WHO in January 2001, the UNCHR in February 2001, and the UNAIDS Board in April/May 2001. As a consequence, the terrain was prepared for the great battle against the WTO panel moved in 2001 by the US government against Brazil's patent law, as well as for the Doha Declaration in November 2001.

The legal battle between Brazil and the United States over pharmaceutical patent rights had strong repercussions for both GHG and NHG. The association of the US pharmaceutical industry (PhRMA) had started to lobby against the Brazilian patent law, which excluded medical products from patent protection, as early as 1988 (Marques 2002: 43, Tachinardi 1993: 67). Only after severe commercial sanctions had been undertaken in 1990, through punitive customs duties on selected Brazilian export products (Silva 2005: 131), did the Brazilian government, in 1996, issue a revised patent law which included the protection of pharmaceutical products.

²³ In its campaign tactics, TAC has learnt from the US-based NGO AIDS Coalition to Unleash Power (ACT-UP) (Schneider 2001: 18). This provides further evidence of the strong interaction of NGO actors from the national and the global level through discursive interfaces.

²⁴ The resolution was passed by a 52-0 vote with only one abstention (Wogart & Calcagnotto 2006: 96; Galvão 2002: 219). One month later, the WHO World Health Assembly, following a Brazilian proposal, also confirmed "the right to health and that the progressive realisation of that right in the context of HIV/AIDS involves access to treatment" (ISHR 2001).

However, the new Brazilian patent law still limited the scope of pharmaceutical patent rights. Paragraph 68 forced TNPCs to produce their drugs locally within three years of patent approval, with noncompliance allowing the government to issue compulsory licenses. The United States filed a complaint regarding this paragraph with the WTO in 2001 (Galvão 2002: 216; Marques 2002: 44, 46). The dispute was only resolved when Brazil restricted the possibility of compulsory licensing to cases of a national health emergency. On June 25, 2001, the United States withdrew its complaint. Brazil in turn agreed to notify the US government in advance if it found it necessary to issue a compulsory license. This solution also came as a result of open pressure from NGOs, simultaneously articulated through discursive interfaces in the US and Brazil (Cepaluni 2005: 80-81; Ashraf 2001: 2112; Galvão 2002: 215-216; Wogart/Calcagnotto 2006: 95-96). In short, through legal interfaces the United States were not able to strengthen the position of TNPCs, which would have blocked Brazil's policies of providing universal access to treatment, producing generic ARVs, and negotiating prices for patented drugs—policies which have been referred to as the “Brazilian model” for AIDS treatment. In May 2007, Brazil issued its first compulsory license for an ARV. Under its terms, Brazil imports generic Efavirenz from drug companies other than the patent holder Merck (Nunn et al.: 12-13).

Legal interfaces also led to significant confrontations in the South African context. The country came into the international limelight when the Pharmaceutical Manufacturers Association of South Africa (PMA), backed by the American PhRMA, sued the South African government before South Africa's High Court in 1997 for violating their IPRs.²⁵ The lawsuit, which was based on the legal provisions of the TRIPS Agreement, was supported by the United States government, which threatened to impose trade restrictions on South Africa (Lanoszka 2003: 191-192). It targeted the Medicines and Related Substances Control Amendment Act, signed by President Mandela in December 1997, which gave the South African minister of health the power to allow both compulsory licensing and parallel importation²⁶ of patented medicines in general and of antiretroviral drugs in particular (Kühl 2002: 76). Responding to intense national and international public pressure and with only a slim chance of winning the case, the 39 TNPCs represented by the PMA backtracked from the case in late 1998 (Weissman 2001).

In January 2001 the lawsuit was reinstated. The chances for a victory on the part of the pharmaceutical manufacturers were now considerably better, because South Africa was now obliged to fully comply with the requirements of the TRIPS Agreement (Kühl 2002: 76). The TNPCs maintained that the case was not directed against South Africa's efforts to seek price reductions for antiretroviral medicine. That, however, was exactly the impression that AIDS

²⁵ Extensive documentation of the case can be found on the web page of the American NGO CPtech, www.cptech.org/ip/health/sa/.

²⁶ “Parallel importation refers to the import of goods purchased in a foreign market by an independent third party and later resold in the domestic market where much lower prices compete with the prices charged by authorized distributors” (Kühl 2002: 18).

activists and NGOs in South Africa and around the world tried to create. Internationally recognized NGOs such as Médecins Sans Frontières, Oxfam, CPtech or ACT-UP pressured TNPCs to withdraw the case. Even the Bush administration now refrained from openly supporting the pharmaceutical industry (Weissman 2001). Demonstrations were organized not only in South Africa, but also in front of several TNPCs' headquarters in Europe and North America. The pharmaceutical industry, fearing another public relations nightmare, withdrew the lawsuit in mid-April 2001 (Lanoszka 2003: 192) and agreed to "a settlement almost on the government of South Africa's terms. The only concession made by the government was to comply with decisions made by the World Trade Organization on TRIPS" (Kühl 2002: 78).²⁷ On balance, the legal interfaces developed through the High Court case have been an important route for interaction between South African actors and the global level. The court case strengthened the South African government's case for blaming the TNPCs and augmented the international pressure to reduce the prices of antiretroviral drugs. It is in the case of legal interfaces that the strategies of the Brazilian and the South African governments have shown the greatest similarity. Both governments fought against TNPCs as being responsible for high ARV prices and promoted the human right to access to essential medicines. According to Gauri and Lieberman (2004: 27), both countries "have styled themselves as emboldened leaders of the developing countries in this regard."

Closely related to the legal interfaces are the organizational interfaces, the use of which acts as a crucial indicator for the degree of cooperation between the national and the global level of health governance. Once more, while Brazilian policy makers had made extensive use of those opportunities even before the threat of AIDS required some degree of organizational interface, South Africa's use of organizational links had been much more restrained, an approach which became even more isolationist during the AIDS crisis in the 1990s.

Since the 1970s, the WHO has developed multiple initiatives with Brazilian health authorities and academic institutions through its regional representative, the Pan American Health Organization (PAHO). These joint activities laid the conceptual basis for the reform of the Brazilian health system in the 1980s and 1990s. That in turn shaped the Brazilian BHAP (Lima 2002: 92-93; Fontes 1999: 113-114). With respect to the BHAP, the nature of these organizational interfaces was not always without conflicts. There were at times divergent conceptions about the mode of resource-transfer interfaces ("authoritatively" earmarked resource allocations) and global and national policies and strategies in the field of HIV/AIDS, particularly prevention programs such as harm reduction and public campaigns. In the early 1990s, this dissent led to a cessation of resource transfers (mainly knowledge) from WHO to Brazil and other countries such as Chile, Mexico, and Paraguay. Disagreement about the

²⁷ As a consequence the Medicines and Related Substances Control Amendment Act from 1997 remained largely unchanged. While the Doha Declaration explicitly permits countries to issue compulsory licenses in the case of national health emergencies, the government rejected proposals from civil society to declare the HIV/AIDS epidemic a national emergency (Gauri & Lieberman 2004: 26).

fundamentals of the Brazilian response widened dramatically in 1991, when the government began the free distribution of AZT, and more so in 1992, with the initial negotiations for a strategic loan from the World Bank. At that point, the dissent had turned mainly towards the WHO headquarters in Geneva, an adversary which “opposed the Brazilian strategy in all international fora.” In the interaction between the Brazilian government and the WHO, the dissent along discursive lines also decisively hindered the development of positive synergies along organizational interfaces. This dissent only lessened in 2002/3, as the WHO—with some influence from the Brazilian government—redirected its focus to an integrated treatment-prevention approach and underlined the significance of BHAP as a model for emerging and developing countries (Teixeira 2005: 8-9). In 2003/4, Paulo Teixeira, formerly director of the Brazilian STD/AIDS Programme, was appointed director of the HIV/AIDS Department of the WHO, which also indicates the rising Brazilian influence on that particular organization.

The UNAIDS Theme Group on HIV/AIDS, established in Brazil in 1997, includes seven UN system agencies and, in its “expanded group,” also two Brazilian ministries (Health/BHAP and Foreign Affairs); three international organizations (FAO, ILO, and UNIFEM); two bilateral donor organizations (GTZ and USAID); the global NGO Family Health International; and two representatives from civil society (UNAIDS 2001: 3). With this multilateral composition, the Theme Group has been able to articulate the activities of international organizations in the country with national actors and so to mobilize organizational and, since 2001, programmatic support for the Brazilian HIV/AIDS policy. According to Paulo Teixeira, the UNAIDS Theme Group in Brazil brought about “positive synergic effects” at federal, state and municipal levels of government (Interview, Teixeira, 24.8.2004), mainly through its support for implementation of the “Three Ones Principles”: one national AIDS coordinating authority, one agreed AIDS action framework, and one agreed country-level monitoring and evaluation system. It has decisively influenced the organization of the Brazilian HIV/AIDS prevention campaigns, for instance, by motivating local mayors to actively participate and inform their communities about the epidemic during the Red Ribbon Campaign and others (Interview, Milhomem, 15.9.2004).

Conversely, Brazilian actors have also effectively used organizational interfaces to influence GHG. In 2004, Brazil's representative was unanimously elected vice-president of the UNAIDS Program coordinating board, and in 2005 he assumed the presidency of the body (CNAIDS 2004). This exemplifies the government's general policy of actively working on HIV/AIDS in international organizations. There is also evidence that Brazil's civil society has exerted some influence on GHG. ABIA, for instance, was actively involved in the 5th International AIDS Conference in Montreal in 1989 (Galvão 2000: 87). On that occasion, the International Council of AIDS Service Organizations (ICASO) was established with the main aim of strengthening the global response of civil society organizations. Acting as the ICASO Secretariat for Latin America, ABIA also spearheaded the creation of the Latin American and

Caribbean Council of AIDS Service Organizations (LACCASO) as a further organizational interface (Galvão 2000: 87).²⁸

While the South African government has rarely engaged in organizational interfaces concerning the treatment of HIV/AIDS, there have been several organizational interfaces in the prevention area. One of those has been the LoveLife public-private partnership, an organization working in the field of HIV/AIDS prevention. Co-financed by the US-based Kaiser Family Foundation and other donors together with the South African government, which provided 34 percent of the overall budget, LoveLife has also received substantial resources from the Global Fund.²⁹ Running South Africa's biggest HIV/AIDS prevention program for teenagers, it has designed accessible and youth friendly clinics and advertising campaigns and has sponsored various events (Interview, O'Connor, 11.05.2005). LoveLife enjoys a cordial and collaborative relationship with the government and even has the minister of health on its advisory board. In short, it has acted as a "government service-provider" (Mbali 2005: 18).

There is also some evidence that experts from the Clinton Foundation were involved in the Joint Health and Treasury Task Team (JHTTT), which was set up to investigate the feasibility and the costs of universal access to treatment for HIV/AIDS in South Africa in 2002 (Ijumba et al. 2004: 333). The US foundation was thus linked to the national level through an organizational interface. Yet, although the Clinton Foundation was—on the global level—very influential in reducing prices for antiretroviral drugs, their experts were later denied further access to South African institutions, with the government stopping any further cooperation with the foundation.

Table 3 provides a synopsis of the comparison between the Brazilian and the South African cases, focusing on the different types of interfaces involved. Resource-based interfaces regarding material (service and financial) exchanges turned out to be powerful as expected and favored the early development of the Brazilian treatment program. The intensive links between resource-based and discursive interfaces, however, are highly important for explaining the role of Brazil as a forerunner in the access politics of developing countries and as a state ally of the CSOs' access campaign.

²⁸ In Galvão (2000), further examples of Brazilian NGOs entering into organizational interfaces can be found.

²⁹ It is thus also an example of the resource-based interface. The organization's annual budget for 2005 was approximately R200 million (Mail & Guardian 2005a). In 2005, the Global Fund abruptly ceased financial support to the prevention program, citing LoveLife's missing performance indicators as the prime reason (Mail & Guardian 2005b).

Table 3: Fighting HIV/Aids: Major Interfaces of Brazilian and South African NHG

Interfaces	Brazil	South Africa
Resource-based	Civil society and public health sector substantially supported by global institutions and NGOs since 1980s.	Civil society supported by global institutions and NGOs since 1980s, but decisively only since 1990s.
	Heavy reliance on foreign financing for public health in 1980s and 1990s (debt crisis; public health free of charge), incl. state and federal HIV/AIDS programs (since 1983).	Government's health budget not constrained by high indebtedness. Significant global financing for government programs only since 2000, treatment programs since 2003.
Discursive	Since the 1980s civil society's human rights discourse for integrated prevention-treatment approach (dialogue between national and global NGOs and all levels of government).	Since the 1980s civil society's human rights discourse for integrated prevention-treatment approach has been developed through dialogue between national and global NGOs.
	Early responsiveness of states (since 1983) and, progressively, federal government (since 1985, except 1990–1992) to civil society pressure for the integrated prevention-treatment approach.	Late (since 2003) responsiveness of most provincial governments and of national government to civil society pressure for integrated prevention-treatment approach.
Legal	Constitutional provisions (1988) for universal public health system as foundation for the Brazilian HIV/AIDS program BHAP. Government has resisted US pressure against patent policy (since late 1980s) and pressed TNPCs on pricing of ARVs in Brazil (2001–2007) based on Act 9313/Nov. 1996, for free-of-charge ARV distribution, and Patent Act Nr. 9279/14.5.1996, allowing compulsory licensing in certain cases.	Medicines and Related Substances Control Amendment Act of Dec. 1997 (allowing compulsory licensing and parallel importation of patented drugs, based on TRIPS). Was the main issue of TNPCs' lawsuit of 1998/ 2001. Explicit government commitment to comply with WTO rules as compromise in legal conflict with TNPCs (2001). Despite its provisions, the act has not been used for compulsory licensing and parallel importation of drugs.
Organizational	Brazilian government fought successfully for recognition of AIDS treatment as a human right at UNCHR and WHO (2001). Spearheading of developing countries' fight for the safety of using TRIPS flexibilities (WTO/Doha negotiations 2001) and generally to facilitate compulsory licensing and parallel imports of essential medicines.	Government fought to use TRIPS flexibilities in WTO/Doha negotiations 2001 together with Brazil and 50 other developing countries.
	Cooperation with WHO since 1970 on health reform and the unified public health system, but dissent over HIV/AIDS-treatment approach since the 1980s; cooperation (government/NGOs) with UNAIDS Theme Group in prevention campaigns since 1997. Intense use of global organizational channels by government to influence UNAIDS approach to HIV/AIDS treatment. Active participation of Brazilian NGOs in developing international and Latin American cooperation among HIV/AIDS NGOs.	Little organizational cooperation by South African government concerning treatment of HIV/AIDS, at least until 2003. Refusal of national government to cooperate with Clinton Foundation for universal access to HIV/AIDS treatment after preliminary studies in 2002. Organizational interface hardly used by government to influence global level. Until recently, PPP cooperation only concerning HIV/AIDS prevention (e.g., LoveLife).

Source: Authors' compilation.

6 Conclusions

The examination of the fight against AIDS and the confrontation over ARV prices between Brazilian and South African government representatives, supported by local and global civil society groups, and the TNPCs and government agencies of the North reveals a number of points which could be important for future policy decisions.

- First, the seemingly all-powerful transnational corporations were forced to negotiate and retreat vis-à-vis two developing countries in view of a global health crisis. While the importance of the NGOs' involvement is undeniable and has been cited here and elsewhere, the emergence of strong national health governance in Brazil and the successful opposition of both Brazil and South Africa to a narrow, TNPC-oriented interpretation of the TRIPS Agreement were crucial examples for other developing countries to also defend their own interests in GHG in a more self-assertive manner. At the same time, the successful stance of CSOs against the South African government points to the strength of global civil society in the case of health issues and to the fact that conflicts on access to medicines are not fought along ideologically hardened North-South lines alone.³⁰
- Second, these accomplishments were achieved through the artful use of different interfaces, the combination of which made the change possible. Important as it was as a first step, defending presumed "national interests" along legal interfaces was a necessary but not sufficient condition for changing the rules and regulations of GHG; change was ultimately accomplished by using opportunities and reacting to challenges along resource-based, organizational, and especially discursive interfaces in the multilevel global polity. As a consequence, future developments in NHG and GHG will require policy makers to consider using the multiplicity of interfaces in order to achieve comprehensive solutions to global health issues.
- Third, it is impossible to clearly separate the various interfaces utilized during the protracted conflict, but each played a prominent part at some stage of the multiple negotiations between 1995 and 2008.
 - TRIPS, the *legal* interfaces in the South African courts, and the agreements negotiated in Geneva played a crucial role in supporting Brazil's legal battles and its claims for access to low-cost medicines.
 - The increasing global involvement in the fight against HIV/AIDS permitted Brazil to fully engage in a number of *organizational* interfaces, which helped not only that country but also other emerging economies sort out their concerns and push the countries of the North to reconsider their positions concerning global health issues.
 - *Resource-based* interfaces played a different role in each country. Once convinced to make the fight against the pandemic a top priority, the Brazilian federal government

³⁰ In that context it is interesting to note the substantial amount of US financial support for AIDS programs (PEPFAR) and the meetings President Bush had with Brazilian president Lula to help fight AIDS in Africa.

was in a position to negotiate the terms of cooperation with major financial donors and creditors. In contrast, South Africa's financial independence and the government's specific stance with respect to the treatment of HIV/AIDS helped it to determine its health policies independently—alas, at a high price.

- Accomplishments at the negotiating tables were strongly supported by *discursive* power, which was first used successfully by civil society at all levels but which government representatives and the TNPCs also increasingly engaged in. The number of papers and reports issued by the industry's national and international associations, some of them written by international think tanks, signaled an increased willingness to enter into discursive interfaces on a quasi-academic level.
- Fourth, the rapid response of the TNPCs represents a move into a new round of confrontation which will challenge the participants to further engage in multiple interfaces. Renewed “forum shifting” by major Northern countries away from the multilateral stage and increased attention to bilateral trade treaties containing TRIPs+ clauses has been answered by the South's introduction of a “development agenda” within WIPO and its proposal for a “Global Framework on Essential Health Research and Development” at the World Health Assembly of May 2006. This, in turn, has led to the establishment of the Intergovernmental Working Group on Public Health, Innovation and Intellectual Property, which aims to develop an international agreement on these questions.

This new round of negotiations on concepts for the funding of health research on the one hand and the evolving norm of “universal access to essential medicines” on the other indicates the emergence of new institutional forms in GHG. Certainly, intergovernmental agreements continue to play an important role in the establishment of binding rules. Nevertheless, state actors are also becoming part of a more open field of global politics in which various types of non-state actors (CSOs, TNCs, PPPs, philanthropic foundations) are strengthening their positions and creating a complex field of interfaces. Private companies and CSOs are now playing a more apparent role in pushing for legal agreements, amendments, or authoritative interpretations of existing rules, as has been analyzed with respect to the conflicts around TRIPS. In some GHG institutions, such as GFATM and PPPs, private actors have voting rights and are playing an important role as experts—as well as strong advocative actors and lobbyists for their own interests.

Eventually, a new and enlarged set of legal norms should emerge from the organizational, financial, and discursive interfaces described above. That in itself should simplify and clarify the roles of the various actors in the changing field of global health. As described earlier in this paper, the first steps in that direction have been undertaken; they are waiting to be supplemented and coordinated through further agreements on the emergence of an improved GHG.

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