b) Brazil's National AIDS Programme

In 2001, Peter Piot, the executive director of UNAIDS between 1995 and 2008, emphasised the destructive dimensions which the AIDS epidemic has reached on this planet since HIV emerged in the 1980s.

> The world has known about AIDS for twenty years. During that time the disease has spread to every continent. In the worst affected countries, it has set back human progress by decades. [...] AIDS is an emergency, but it is a long-term emergency. We are facing the most devastating epidemic humanity has ever known. Our response must therefore be equally unprecedented: the most concerted, sustained, coordinated, full-scale assault on a disease the world has ever known.
>
> (in: UNAIDS 2001: iv)

The Global HIV/AIDS Report of June 2000 documented that in 1999 there were 34.3 million people living with HIV/AIDS, with 5.4 million people newly affected in that year and a total number of 18.8 million deaths and 13.2 million orphans left behind since the beginning of the epidemic in the early 1980s (UNAIDS 2000: 6). The AIDS epidemic (or pandemic) devastates whole families, communities, societies, countries and regions, in particular in developing countries within sub-Saharan Africa (24.5 million people living with HIV/AIDS) as the region worst hit (UNAIDS 2000: 6).

HIV/AIDS is more than just a health crisis; it is also a development and security crisis 'unique in its devastating impact on the social, economic and demographic underpinnings of development' (UNAIDS 2000: 7). The challenges involved are gigantic and manifest when considering the concern of states in the UN Declaration of Commitment on HIV/AIDS in June 2001 'that the continuing spread of HIV/AIDS will constitute a serious obstacle to the realization of the global development goals' (UN 2001: 2). The UN Declaration explicitly refers to the linkages of HIV/AIDS to issues such as development, poverty, hunger, education, gender equality and even climate change, transforming the combat against HIV/AIDS into a formidable foreign policy issue.

When the tempest of HIV/AIDS began to unfold its devastating force in the early 1980s, HIV was regarded as nothing more than a public health issue. And Brazil was one of the developing countries directly in the heart of this tempest. The first cases of HIV/AIDS were diagnosed in São Paulo in the early 1980s (Ministério da Saúde n.d.). In those early years the response to the first cases of HIV/AIDS was limited to

actions within the affected communities, in particular the homosexual community, which did not receive greater attention from the federal government (Parker 1997: 9).

Instead, the authorities of the State of São Paulo reacted very fast and established the first AIDS Programme in the state in July 1983, which included diagnosis, epidemiological vigilance, prevention and treatment as the essential elements to tackle the disease (Do Carmo Sales Monteiro and Da Penha Ramos Oliveira 2007: 10). In addition, the information service *Disque Aids* was launched as the first of its kind in the whole of Latin America to inform Brazilian society about the disease (Do Carmo Sales Monteiro and Da Penha Ramos Oliveira 2007: 10).

Only in 1986 did the Ministry of Health launch the National Programme of STD (sexually transmitted diseases) and AIDS, which was modelled on the São Paulo AIDS Programme (Galvão 2000: 117; Ministério da Saúde n.d.; Teixeira 1997: 47). From that year onwards, the Brazilian response towards AIDS became much more consolidated with its essential elements being reinforced and implemented all over Brazil (Teixeira 1997: 56).

The next pivotal step in Brazil's response to AIDS occurred in 1988, when the new Constitution of Brazil entered into force. The Constitution recognised the right to health as a fundamental social right of the Brazilian citizen, and the Ministry of Health established the National Health System of Brazil (Sistema Único de Saúde – SUS) (Constitution of Brazil 1988: Art. 196; Do Carmo Sales Monteiro and Da Penha Ramos Oliveira 2007: 10–11). These two developments further reinforced the organisation, implementation and expansion of Brazil's response to AIDS (Do Carmo Sales Monteiro and Da Penha Ramos Oliveira 2007: 10).

In the late 1980s, the State of São Paulo, again in a pioneering role, started to offer the antiretroviral drug AZT (Zidovudine) free of charge (Berkman et al. 2005: 1170). In 1991, AZT was finally distributed for free in the whole country (Do Carmo Sales Monteiro and Da Penha Ramos Oliveira 2007: 12). Two loans provided by the World Bank, the first one in 1994 (worth US$ 160 million) and the second one in 1998 (worth US$ 165 million), further strengthened Brazil's administrative capabilities in the fight against the AIDS epidemic (Do Carmo Sales Monteiro and Da Penha Ramos Oliveira 2007: 12–14; World Bank 2001a, 2001b), in particular as far as the free distribution of antiretrovirals (ARVs) is concerned.[3]

Brazil's Ministry of Health supported this integrative strategy of treatment and prevention through heavy investments into Brazil's local

manufacturing capabilities, which increased Brazil's independence from international pharmaceutical companies and reinforced the country's bargaining power in its negotiations for reducing the prices of patent-protected AIDS drugs (Berkman et al. 2005: 1170; Teixeira et al. 2003: 83).[4] In the beginning, Brazil bought AZT from the patent-holder Burroughs Welcome (Hein and Moon 2013: 69). Since AZT was not a patent-protected drug in Brazil, the government also started to produce a generic version of the drug to guarantee its free distribution (Hein and Moon 2013: 69). Even though Brazil's local production of AZT was not illegal, pharmaceutical companies protested against this approach (Hein and Moon 2013: 69).

In 1996, the then Brazilian president Fernando Henrique Cardoso institutionalised the free and universal access to antiretroviral therapy and drugs through a presidential decree (Teixeira et al. 2003: 76). This step legally entrenched the most fundamental pillar of Brazil's fight against AIDS: the right to health of the Brazilian citizen.[5]

Peter Piot stressed that Brazil's decision to guarantee free and universal access to ARV therapy 'led to the quadrupling of the number of Brazilians accessing these drugs [...] [and] sent the signal that people living with HIV/AIDS were valued citizens, whose care was a matter of entitlement, not of privilege' (in: Galvão 2005: 1113). As far as Brazil's innovative treatment and prevention approach is concerned, Peter Piot also remarked that 'Brazil is perhaps the world's leading example of the synergies available between prevention and care' (in: Galvão 2005: 1114).

Apart from the political decision to guarantee free and universal access to AIDS drugs, civil society actors played a fundamental role in Brazil's fight against HIV/AIDS. In fact, the activities undertaken by civil society actors are at the heart of the success of the São Paulo State Programme and the National Programme. In the early 1980s, when the outbreak of the AIDS epidemic was still largely ignored by a majority of government officials, those communities affected most (homosexuals, prostitutes, drug users, etc.) started to get organised very quickly, first through individual activists and small community projects, and later in the form of NGOs (Galvão 2000: 48–59).[6]

The creation of the first NGO in the fight against HIV/AIDS in Brazil and in the whole of Latin America dates from 1985, and is called the Group of Support for the Prevention against AIDS (Grupo de Apoio à Prevenção à AIDS – GAPA, located in São Paulo) (Galvão 1997: 73; Ministério da Saúde n.d.). The creation of GAPA/São Paulo marks both

the beginning of better-coordinated activities in Brazil's civil society and the formation of a new discourse with a focus on the treatment of the victims (Galvão 1997: 73). For instance, GAPA/São Paulo started to offer legal assistance for people living with HIV/AIDS, an unprecedented move which increased the awareness of the civil rights of such groups (Galvão 2000: 69). Also in São Paulo in 1985, the transvestite Brenda Lee opened the House of Support Brenda Lee (Casa de Apoio Brenda Lee) which was to support people living with HIV/AIDS who were very often marginalised by society, including in most cases by their own families (Galvão 2000: 69–70). In 1987, the Brazilian Interdisciplinary AIDS Association was founded in Rio de Janeiro with the main objective of mobilising society on the issues of access to treatment and the defence of the human rights of those people living with HIV/AIDS by means of disseminating information and knowledge (ABIA 2007). In 1989, Herbert Daniel, one of the most prominent Brazilian AIDS activists, founded Pela VIDDA (pela Valorização, Integração e Dignidade do Doente de AIDS – For the Valorisation, Integration and Dignity of people with AIDS) in Rio de Janeiro, the first NGO of people living with HIV/AIDS (Galvão 2000: 168; Galvão 2005: 1112). As was the case with the São Paulo State Programme, GAPA/São Paulo, the House of Support Brenda Lee and Pela VIDDA/Rio de Janeiro were seen as models for the creation of further GAPAs, Houses of Support and Pela VIDDAs in many other Brazilian states (Galvão 1997: 73; Galvão 2000: 62–3, 70).

Through the strong organisation of Brazil's most affected communities and the innovative step of the government to offer antiretrovirals for free, Brazil's approach to fighting HIV/AIDS started to herald a powerful message. The fight against HIV/AIDS is most successful with a strategy that combines prevention and treatment in the form of distributing AIDS drugs for free. The strong participation of Brazilian civil society actors was fundamental in shifting the focus to the human right to health and the right to access to medicines of those people living with HIV/AIDS.[7] By the year 2000, Brazil's National AIDS Programme had turned into a hugely successful approach in how to successfully tackle the AIDS epidemic in a developing country. In fact, Brazil was the first developing country to guarantee the free distribution of AIDS drugs (Hein and Moon 2013: 68). According to the WHO, between 1996 and 2002, 'more than 60 000 HIV/AIDS cases, 90 000 deaths and 358 000 HIV/AIDS-related hospital admissions were averted' in Brazil and the HIV/AIDS morbidity and mortality rates had fallen by 50 per cent to 70 per cent (WHO 2004: 23).

c) The discursive interface

The WTO Trade Dispute on patent rights between Brazil and the US in early 2001 is fundamental in understanding Brazil's emergence as a leading actor in the global access-to-medicines debate. The discursive interface lays out the role of the different actors involved directly and indirectly in this trade dispute. Apart from Brazil and the US, these actors include the pharmaceutical industry, the global AIDS movement and the US media.

The role of the US and the pharmaceutical industry

On 03 December 1999, the Pharmaceutical Research and Manufacturers of America (PhRMA)[8] submitted their annual National Trade Estimate Report on Foreign Trade Barriers to the US Trade Representative (USTR), complaining about inconsistencies between Brazil's Industrial Property Law and the TRIPS Agreement (CPTech 1999). The USTR argued that Article 68 of Brazil's Industrial Property Law violated Article 27 of the TRIPS Agreement:

> Article 68 [...] requires domestic exploitation of the subject matter of a patent. Importation may only satisfy this requirement if local manufacture is not feasible, inconsistent with the terms of TRIPs Article 27. Our industry is increasingly concerned about this provision, as hopes that it could be resolved quickly at the local level have faded, and the threat becomes more immediate. This is further aggravated by the October 6, 1999 issuance of a Presidential Decree regulating the implementation of Article 71 of the law, which governs the grant of compulsory licenses[9] in broadly defined situations of national emergency.
>
> (in: CPTech 1999)

The USTR used this legal and technical language to express his concern about Brazil's practice of either locally producing or importing generic versions of patent-protected AIDS drugs to guarantee the sustainability of its National AIDS Programme, which was based on the innovative and original strategy of providing universal and free access to these drugs. In addition, the USTR was also alarmed about Brazil's potential use of a compulsory licence in situations of national emergency, which the country could use to have patent-protected AIDS drugs produced by someone other than the pharmaceutical company in possession of the patent. Nevertheless, Brazil had never used Article 68 to produce

generic versions of its AIDS drugs, and the government had not issued a compulsory licence on an AIDS drug at that time (Hein and Moon 2013: 71).

Only months later, the USTR put Brazil on the watch list in his 2000 Special 301 Report, repeating his concerns with Article 68 of Brazil's Industrial Property Law and preparing the ground for the initiation of a WTO Trade Dispute:

> Brazil's patent law imposes a 'local working' requirement[10] as a condition for enjoyment of exclusive patent rights. This requirement can only be satisfied by local production, and not importation, of the patented product. This appears inconsistent with Brazil's obligations under Article 27 of the WTO TRIPS Agreement, which requires that patent rights be 'enjoyable without discrimination as to... whether products are imported or locally produced.' Brazil has stated repeatedly that it disagrees with this interpretation of the TRIPS Agreement. In order to resolve this longstanding difference in views over this issue, as well as to address the concern that other countries may cite the Brazilian 'local working' requirement as a justification for proposing similar legislation, the United States is now requesting WTO consultations with Brazil to pursue this single-issue case.
>
> (Knowledge Ecology International 2000)

The annual Special 301 Reports serve 'as an instrument for pushing foreign and American IP [intellectual property] commitments beyond existing obligations without the inconvenience of a strong public comment process (as required in rulemaking) or a structured adversarial process (as required in formal adjudication)' (Karaganis and Flynn 2011: 91). When it comes to preparing the Special 301 Reports, which serve predominantly the interests of US-based industrial companies, the USTR closely collaborates with US-based industry including PhRMA (Karaganis and Flynn 2011: 90–2). James Love of the US-based NGO CPTech (Consumer Project on Technology) stressed that being put on the Special 301 watch list was essentially a question of power and pressure, indicating the power of the US in the global economy and its leverage to pressurise other countries to abide by international intellectual property laws as far as it suits US interests (Love 1999). In the face of losing 'hundreds of millions of dollars annually to patent piracy around the world' (CPTech 1999), US pharmaceutical companies are very keen on assuring that their patents are protected in Brazil, the largest pharmaceutical market in South America (CPTech 1999).

On 08 January 2001, the US government requested the establishment of a panel at the WTO, arguing that Brazil's local working requirement (Article 68 of its Industrial Property Law) and its possible granting of compulsory licences was inconsistent with the TRIPS Agreement (WTO 2001a). Of course, Brazil was not happy with the decision taken by the US and fought back by challenging the US Patent Code on the grounds that several of its provisions were not consistent with international law, including the TRIPS Agreement (WTO 2001b). The WTO-dispute settlement process was officially initiated on 01 February 2001, when the US refuted Brazil's legal allegations and the US government, backed by the pharmaceutical industry, insisted on its accusation that Brazil had infringed international intellectual property rights (WTO 2001c).

The US government framed its approach as a purely legal matter. The US accused Brazil of not complying with the international TRIPS regulations in two cases – the local working requirement and the possible granting of compulsory licences – which entails the discrimination against US patent-owners and as such the market-oriented interests of US-based companies. In the official US statements there is no specific reference to pharmaceutical patents or the discrimination against US-based pharmaceutical companies, even though the leading pharmaceutical companies in the US, represented by PhRMA, regarded their interests on Brazil's pharmaceutical market most at risk in the face of Brazil's local working requirement.

The role of Brazil

While the US and the pharmaceutical industry had already been active in working against Brazil's HIV/AIDS strategy before January 2001, Brazil had been engaged in first efforts to disseminate its own strategy on the international level (Nunn 2009: 122–3, 126–7): (1) At the WHA session in May 2000, Brazil, for the first time, proposed a resolution on a monitoring system of AIDS-drug prices which in the end failed due to opposition from the US and the pharmaceutical industry. (2) In July 2000, at the Durban AIDS conference, Brazil engaged for the first time in discussions with the media, the international civil society movement and other developing countries on how to reduce the prices of generic AIDS drugs. (3) Throughout the whole year, Brazil had threatened to break the patent (issue a compulsory licence) of two AIDS drugs, namely Efavirenz (produced by the US-based pharmaceutical company Merck[11]) and Nelfinavir (produced by the Swiss pharmaceutical company Roche).

As a continuation of these efforts, Brazil's then Minister of Health, José Serra, repeated his threat on 02 February 2001, only one day after the official initiation of the WTO dispute settlement process, that he would break the patents of Efavirenz and Nelfinavir[12] if those companies did not reduce the price of the drugs (Folha Online 2001). At that time, seven of the 12 AIDS drugs,[13] which the government used for its antiretroviral therapy, were produced by Farmanguinhos, a government-owned laboratory which is part of the Oswaldo Cruz Foundation (Oxfam 2001a: 2, 6, 7; Report of the UN High Commissioner for Human Rights 2001).

Merck's strategy followed the very same lines as the actions of the US government against Brazil in the WTO. At the beginning of March 2001, Merck threatened Brazil to file a lawsuit for the violation of Merck's patent rights for Efavirenz (Darlington 2001). Threatened by Brazil that the country was prepared to break the patent of the drug if Merck did not lower the prices, Merck agreed to reduce the price of two AIDS drugs: the price of the drug Indinavir was reduced by 65 per cent and the price of Efavirenz by 59 per cent, which was estimated to save the country around US$39 million out of its US$305 million budget for AIDS drugs (Reuters 2001).[14]

Brazil continued its aggressive strategy and started to directly confront the US in several international organisations. On 28 March 2001, Brazil proposed a resolution to the UN Human Rights Commission entitled 'Access to medication in the context of pandemics such as HIV/AIDS' (Duque Estrada Meyer 2001a). In this resolution, Brazil emphasised 'the need for intensified efforts to ensure universal respect for and observance of human rights and fundamental freedoms for all, including by reducing vulnerability to pandemics such as HIV/AIDS' and called upon states to considerably improve the access to medicines (UN Commission on Human Rights 2001). The Brazilian Delegation explained that the resolution was supposed to specify the range of the International Covenant on Economic, Social and Cultural Rights and the Universal Declaration of Human Rights by guaranteeing the availability of AIDS drugs in sufficient quantities for affordable prices (Statement of the Delegation from Brazil 2001). The resolution was overwhelmingly approved in the UN Human Rights Commission (52–0 vote) with the US as the only member state abstaining from the vote (Duque Estrada Meyer 2001b). The US defended its abstention by claiming that the resolution threatened the protection of intellectual property rights and that health matters ought to be discussed in the WHO (Pruzin 2001).

And indeed, after this successful move against the US in the UN Human Rights Commission, Brazil turned its attention to the WHO, where, in the context of the 54th WHA session in May 2001, Brazil proposed two resolutions (E-Drug 2001; Weissman 2001). The first of these was on a revised drug strategy and the second was on HIV/AIDS. After compromises with the US and the EU on the original language of Brazil's proposals, the following resolutions were adopted by the WHA: (1) 'The WHO Medicines Strategy' and (2) 'Scaling up the response to HIV/AIDS'. Notwithstanding the weakened and at times more ambiguous language which prevailed due to the interference of the developed countries, both resolutions still favoured Brazil's original intentions of building upon the success achieved in the UN Human Rights Commission and strengthening access to medicines as a human right.

The WHO Medicines Strategy recalled 'that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being' (WHO 2001a). Building on the acknowledgment of the non-discriminatory access to medicines as a human right, the resolution urged member states to engage in efforts to improve the universal access to medicines and requested the WHO director general to implement a voluntary monitoring system for drug prices. Only one year before, Brazil had still failed with this request to establish a monitoring system for drug prices.

The second resolution, 'Scaling Up the Response to HIV/AIDS', complemented the strengthening of the access to essential medicines as a human right by recognising the benefits of (1) antiretroviral therapy – as applied in Brazil as essential part of its National AIDS Programme – and (2) the AIDS-drugs price reductions as a successful means to combating HIV/AIDS (WHO 2001b). The resolution called for reinforced efforts in the fight against the HIV/AIDS epidemic, which, apart from guaranteeing an improved availability of drugs at affordable prices and the production of generic drugs, involved the establishment of a global HIV/AIDS and health fund.[15] After the long-lasting drafting process and the huge compromises on Brazil's original text that led to the two final WHA resolutions, Brazil, as in the UN Human Rights Commission, was successful in maintaining the upper hand in the dispute between human rights and patent rights. And yet, several CSOs accused the US – and the EU member states – of consciously obstructing public health efforts by bullying and pressuring Brazil into accepting their weaker language (Health GAP Coalition 2001; Weissman 2001).

On 30 April 2001, the USTR published the Special 301 Report for the year 2001 (CPTech n.d. a). The report rejected the assertions made by the

Brazilian government that the case against Brazil would threaten Brazil's National AIDS Programme and repeated that the US solely focused on Brazil's local working requirement, which was not related to health or the access to AIDS drugs (Knowledge Ecology International 2001: 10). Brazil's then Minister of Health, José Serra, reacted promptly and accused the USTR of merely protecting the interests of the American economy and its pharmaceutical industry instead of trying to protect international regulations. Serra gave two main reasons which explain the USTR's statement (Ministry of Health 2001): (1) The mere threats announced by Brazil to issue a compulsory licence which were responsible for the considerable price reductions for AIDS drugs offered by pharmaceutical companies; and (2) Brazil's production of generic versions of patent-protected AIDS drugs. Serra made clear that Brazil carried out these efforts without breaking any existing patent laws and stressed that Brazil would not back down against the US.

Some weeks later, the debate on the access to medicines also reached the TRIPS Council, when during its regular meeting from 18 to 22 June a Special Session on intellectual property and access to medicines was held.[16] For that session, Brazil had submitted a document[17] which stressed a clear positioning in favour of human rights and public health as opposed to the protection of patent rights (WTO 2001e). The representatives of Médecins Sans Frontières and the Third World Network[18] present in Geneva observed that during the Special Session the US stood alone with its position of upholding the principle of the inviolability of patent rights against the human right to health and the access to essential medicines (Oh 2001a; 'T Hoen 2001a).

Brazil launched a strong defence of its National AIDS Programme by confronting two powerful pharmaceutical companies and engaging in activities at various important sites of global health governance. By threatening both Merck and Roche to break the patents of the two AIDS drugs Efavirenz and Nelfinavir, Brazil pursued an aggressive strategy to defend its National AIDS Programme. Merck actually conceded to the pressure and reduced the price of Efavirenz and Indinavir. In the UN Human Rights Commission, Brazil was successful in strengthening the human right to health through the resolution 'Access to medication in the context of pandemics like HIV/AIDS'. The adoption of the resolution demonstrated that the whole Commission agreed with Brazil's approach, except for the US.

In the WHA, Brazil repeated this success and pushed for two resolutions which formally recognised significant elements of Brazil's National AIDS Programme. The 'WHO Medicines Strategy' recognised the human

right to health and the human right to access to medicines, while the second resolution 'Scaling Up the Response to HIV/AIDS' formally legitimised Brazil's innovative antiretroviral therapy of prevention and treatment, which included the necessity of seeking price reductions for indispensable AIDS drugs. The adoption of these two resolutions also showed that, as in the case of the UN Human Rights Commission, a huge majority of states supported Brazil's approach. In addition, Brazil was successful in putting the debate on the access to medicines on the agenda of the TRIPS Council with a clear emphasis on the human right to health.

The role of the global AIDS movement

Even before the US had decided to push for a WTO dispute settlement process against Brazil, the global AIDS movement had already been in full swing. One particular reason for this intensive activism referred to a similar threat from the pharmaceutical industry against the government of South Africa. Following the South African government's adoption of the Medicines and Related Substances Control Amendment Act in 1997, which allowed parallel imports[19] and the production of generics to make drugs more affordable, 39 pharmaceutical companies filed a lawsuit against the government arguing that this new law violated the TRIPS Agreement (MSF 2001b).[20]

In December 1998, the South Africa-based NGO Treatment Action Campaign (TAC) was founded and became one of the most important campaigners for the access to medicines (Treatment Action Campaign n.d.). In 1999, Médecins Sans Frontières launched its global Campaign for Access to Essential Medicines (MSF n.d.). In early 1999, the Global Access Project 'Health GAP', a US-based NGO, came into being to join in the campaigning efforts for the global access to medicines and to oppose the policies advocated by pharmaceutical companies and the US government (Health GAP n.d.).

All these new forces had been joining efforts to campaign against the lawsuit brought against the South African government, in particular in the weeks prior to the expected court hearing in South Africa's High Court on 05 March 2001 (CPTech n.d. b).The investments made in campaigning for the access to affordable medicines bore fruits not only in relation to the case of South Africa. In February 2001, several investors were concerned about the international image of the newly merged British pharmaceutical company GlaxoSmithKline[21] which was criticised by the social movement for its stance on protecting patent rights of AIDS drugs in Ghana and Uganda and for justifying the lawsuit against

South Africa (*The Financial Times* 2001). The criticism was sparked by an Oxfam Briefing Paper which reviewed the role of GlaxoSmithKline and pointed out 'that pharmaceutical companies face a major reputation risk if they do not do more to promote access to life-saving drugs in the developing world' (Oxfam 2001b: 4). Oxfam, which joined Médecins Sans Frontières, Act-UP (the AIDS Coalition to Unleash Power) and other NGOs in the global access campaign in February 2001, particularly praised Brazil for its efforts in reducing drug prices by relying on locally manufactured generics and imported drugs to fight HIV/AIDS (Oxfam 2001b: 17).

As a result of the social movement's campaigning efforts, several NGOs were quick to react when the US moved to challenge Brazil's Industrial Property Law. On the same day the trade dispute was initiated, Médecins Sans Frontières condemned the steps taken by the US by 'calling upon the United States government to withdraw its request for a WTO dispute settlement procedure on the Brazilian patent law' (MSF 2001d). Médecins Sans Frontières explained that the request represented a threat to the continuing success of Brazil's National AIDS Programme and to people living with HIV/AIDS in other countries, for '[t]he US action will also intimidate countries which would like to take up Brazil's offer to help them produce AIDS medicines' (MSF 2001d). The organisation explicitly stressed that the free distribution of AIDS drugs – and as a prerequisite, the generic production of these drugs – was key to the success of Brazil's National AIDS Programme. Or in other words, Brazil's practice of locally producing its AIDS drugs, which the US indirectly claimed was not consistent with international law, 'has been key to the success of the strategies to offer universal access to HIV/AIDS medication in Brazil' (MSF 2001d). One day later, on 02 February 2001, the NGO Act-UP/Paris condemned the US and requested the key international organisations in global health governance to express their support for the Brazilian position (De Cenival 2001).

Also on 02 February 2001, Gregg Gonsalves, the Director of Treatment Advocacy from the US-based NGO Gay Men's Health Crisis, sent a letter to the then USTR Robert Zoellick in which he sharply criticised the action taken by the US against Brazil at the WTO. Gonsalves urged Zoellick to withdraw the WTO request (Gonsalves 2001). Gonsalves provided the same arguments as Médecins Sans Frontières, referring to Brazil's successful National AIDS Programme, the free distribution of AIDS drugs and their generic production as the key to this success. As Gonsalves made clear, '[t]he price of the patented versions of these drugs would have made their use in Brazil's program unfeasible'

(Gonsalves 2001). Gonsalves further argued that, by proceeding with the WTO dispute settlement process, the US would expose thousands of people living with HIV/AIDS to the risk of death (Gonsalves 2001).

On 09 February 2001, Gonsalves received a response from Joseph Papovich, Assistant USTR for Services, Investment and Intellectual Property Rights, who was eager to deflect attention from the focus on pharmaceutical patents. Papovich argued that the dispute 'is about a measure that discriminates against imported products in favor of locally produced products, regardless of whether these products are health-related or not' (Papovich 2001).

On 05 February 2001, the TAC released a statement no less critical of the US decision. In its statement, TAC 'supports the demand by hundreds of Brazilian organisations that the US government drop its complaint against Brazil at the World Trade Organisation' (Achmat 2001b). TAC accused the US of aiming to 'destroy Brazil's generic pharmaceutical industry', 'intimidate Brazil and other poor countries attempting to break their dependency on multi-national pharmaceutical companies' and threaten 'the lives of millions of people living with HIV/AIDS' (Achmat 2001b). TAC was convinced that '[t]he complaint protects the interests of the multi-national pharmaceutical industry and their exorbitant profits alone' and further concluded that the entire US action 'is not even in the interest of most people in the USA, who pay extremely high prices for pharmaceutical products' (Achmat 2001b).

On 06 February 2001, another influential civil society organisation, the US-based Consumer Project on Technology (CPTech), pointed out three reasons to explain its disagreement with the decision made by the US (CPTech 2001): (1) The success of Brazil's National AIDS Programme; (2) Brazil's ability to manufacture generic versions of AIDS drugs which are cheaper than the patent-protected drugs; and (3) The intention of pharmaceutical companies to undermine the success of Brazil's National AIDS Programme.

The TAC criticised the US by disapproving of its efforts to present the issue 'as a narrow technical challenge to a non-health-related concern' and suggested instead to call the move made by the US 'the continuation of a long history of bullying weaker nations in pursuit of narrowly defined US commercial interests' (Geffen 2001).

In May 2001, Oxfam published a policy paper entitled 'Drug Companies vs. Brazil: The Threat to Public Health', in which Oxfam made clear that Brazil was under assault from the pharmaceutical companies and the US government (Oxfam 2001a: 2). The pharmaceutical companies particularly feared Brazil because 'Brazil has taken a leading role

in the developing world on the issue of access to medicines, and has raised concerns about how WTO patent rules affect AIDS-drug prices' (Oxfam 2001a: 3). Rejecting the technical argument brought forward by the US, Oxfam recommended that the US government drop the lawsuit against Brazil with the argument that '[t]he health needs of the Brazilian people should be the prime determinant [...] and not the commercial interests of international big business' (Oxfam 2001a: 5). Oxfam supported Brazil's position by singling out the country and its efforts in the fight against HIV/AIDS as the prime example in the developing world in resisting the commercial interests of the US government and the pharmaceutical industry. For Oxfam, the trade dispute had become much more than a mere legal issue. As Brazil's internationally praised National AIDS Programme had become a symbol in the fight against HIV/AIDS, a success of Brazil against the US in the trade dispute would prove to be a further symbol both for reinforcing the future fight against HIV/AIDS and the accompanying discourse with a focus on human rights instead of patent rights.

Oxfam also took advantage of the heated debate in the run-up to the TRIPS Council meeting in June by publishing a briefing entitled 'WTO Patent Rules and Access to Medicines: The Pressure Mounts', in which Oxfam was convinced that the TRIPS Special Discussion 'offers the best opportunity yet to shift the balance of global patent rights in the interests of public health' (Oxfam 2001c: 1). By referring particularly to the cases of South Africa and Brazil, Oxfam repeated its calls for 'reducing the length of pharmaceutical patenting in developing countries, or exempting developing countries entirely from the pharmaceutical patenting' (Oxfam 2001c: 5) and thus allow parallel imports and the production of generics, which would significantly contribute to lower prices (Oxfam 2001c: 5–6).

On 21 June 2001, 135 organisations – among them the Third World Network, Médecins Sans Frontières, Oxfam, Act-UP and ActionAid – and 24 individuals signed a Joint NGO Statement on the Special Discussion in the TRIPS Council, which further increased the pressure for WTO member states to finally act in favour of public health (Third World Network 2001).

Meanwhile, the statements and activities of the global AIDS movement were supported by the national NGO movement in Brazil. Significant involvement of local civil society actors was crucial to the success of Brazil's National AIDS Programme so that Brazil's government could also count on a strong and experienced Brazilian social movement in confronting the challenge posed by the US. On 5 March, the day of

the court hearing in the case of South Africa, the Rio de Janeiro State Forum of AIDS NGOs launched an awareness-raising campaign on the issue 'patents vs. public health', while the São Paulo State Forum of AIDS NGOs organised a demonstration with around 60 people in front of the US consulate in São Paulo capital (Santos-Filho 2001a, 2001b). During the 11th National Meeting of AIDS NGOs in May, which took place in Recife, activists organised a demonstration in front of the US Consulate in Recife involving more than 250 organisations (Abong 2001; Galvão 2002: 17). In June, further demonstrations against the US took place in the Brazilian cities of Salvador, Rio de Janeiro and Brasília (Passarelli and Terto Jr 2002: 42).

The immediate reaction of several leading civil society organisations in the global fight against HIV/AIDS was of enormous outrage at the decision taken by the US to request a WTO dispute settlement process against Brazil. The AIDS movement was already highly mobilised and alert because of the South African lawsuit, which also centred on the primacy between human rights or patent rights in the access-to-medicines debate. Many civil society organisations perceived the US strategy of treating the WTO Trade Dispute as a technical violation of patent rights committed by Brazil as an attempt to violate human rights in the particular case of HIV/AIDS. In their statements the most representative organisations of the global AIDS movement, including Médecins Sans Frontières, Oxfam, Global Health GAP, CPTech, Act-UP and the TAC emphasised the risks people living with HIV/AIDS in Brazil and around the world would be exposed to if the US proceeded with its request for a WTO dispute settlement process and were successful in defending US pharmaceutical interests. At the same time, these civil society organisations pointed to the real motive behind the trade dispute, namely commercial interests, and mobilised to exercise considerable pressure on the US government and the pharmaceutical industry. Brazil's National AIDS Programme and its approach of locally producing AIDS drugs, however, was regarded by the AIDS movement as a role model in the fight against HIV/AIDS. On top of that, the AIDS movement even supported Brazil's aggressive strategy of threatening Merck and Roche with breaking the patents of Efavirenz and Nelfinavir.

The role of the US media

Only days before the WTO dispute settlement process was officially initiated, *The New York Times* had published a lengthy editorial on Brazil's National AIDS Programme, entitled 'Look at Brazil' (Rosenberg 2001). The whole article had celebrated Brazil's unique approach to fighting

HIV/AIDS and praised the main pillar of Brazil's National AIDS Programme, the free distribution of AIDS drugs. The article clearly defended Brazil's strategy of challenging the pharmaceutical industry and its sacred cow called patent rights.

> The drug companies are wrong [...] on how to make AIDS drugs affordable. Their solution – limited, negotiated price cuts – is slow, grudging and piecemeal. Brazil, by defying the pharmaceutical companies and threatening to break patents, among other actions, has made drugs available to everyone who needs them. Its experience shows that doing this requires something radical: an alteration of the social contract the pharmaceutical companies have enjoyed until now.
>
> By the term of that contract, manufacturers, in return for the risks of developing new drugs, receive a 20-year monopoly to sell them in some nations at whatever prices they choose. The industry has thrived under this contract. And so have we, the rich. The system has conquered an unimaginable range of diseases. But for billions of people the medicines have remained out of reach. Poor countries, it is now clear, must violate this contract if they are to save their people from AIDS.
>
> (Rosenberg 2001)

The article went on to paint the pharmaceutical industry's behaviour in rather bleak colours by stressing that '[c]ountries that have tried to manufacture generic medicine have fallen under debilitating pressure from pharmaceutical companies and from Washington' (Rosenberg 2001). The article concluded by wholeheartedly justifying the use or the threat to use compulsory licences as the only successful way to pressurise pharmaceutical companies into negotiating with developing countries.

> This is the larger lesson of Brazil: AIDS can become a manageable disease in the third world, but it takes power, in addition to other things. The ability to pull the price of AIDS drugs within reach of those who need them may someday come from the backing of some international organization [...]. But at the moment, it arises only from the threat to make or buy generic drugs.
>
> (Rosenberg 2001)

On 12 February, *Time* magazine published a similar story which described the difficulty of millions of South Africans in accessing

life-saving AIDS drugs and made the pharmaceutical industry responsible for this situation.

> Despite years of evidence of AIDS' genocidal toll on poor countries, no one has brought these drugs within reach of ordinary Africans. In fact, the people who make the drugs – American- and European-owned multinational pharmaceutical corporations – and their home governments, notably Washington, have worked hard to keep prices up by limiting exports to the Third World and vigorously enforcing patent rights.
>
> (McGeary 2001)

Time magazine highlighted the important role of Brazil in manufacturing generics and providing them for free, which negated the long-standing argument of pharmaceutical companies that 'it's not wise to offer cheap AIDS drugs without a proper medical infrastructure – that deadly, drug-resistant strains would emerge' (McGeary 2001).

On the same day, the *Wall Street Journal* identified the commercial interests of pharmaceutical companies and the trade dispute as a threat to the internationally praised success achieved in Brazil's National AIDS Programme. By making an explicit reference to Brazil's threat to break the patent of Efavirenz, the *Wall Street Journal* stressed that '[i]f Brazil does not reduce its reliance on expensive imported drugs, the country's Health Ministry projects spending on AIDS medications will rise fivefold, to $1.7 billion by 2005' (Jordan 2001).

In March 2001, newspapers in the US and all around the world were reporting extensively on the developments in the lawsuit against South Africa (CPTech n.d. b). On 5 March 2001, for example, the first day of the court hearing in the lawsuit, the *Philadelphia Inquirer* published an article on the global access movement and the main activist organisations in the US, the Health GAP Coalition and Act-UP, and their cooperative efforts with Médecins Sans Frontières, Act-UP/Paris, South Africa's TAC and Oxfam. The article pointed out that the efforts of this global movement changed the perspective on the access-to-affordable-AIDS-medicines debate in Africa 'from an economic issue to a moral one' (Collins 2001).

In the three weeks before the US government withdrew from the trade dispute, US newspapers and weeklies continued to report extensively about the fight of the global AIDS movement for more affordable access to AIDS drugs. On 09 June 2001, the *LA Times* reported

that over the last few weeks, pharmaceutical companies had been confronted with lawsuits filed by consumer groups who accused them of blocking price reductions for generic drugs used in the treatment of non-communicable diseases like cancer or heart disease (Gellene 2001). Notwithstanding the power of the pharmaceutical industry in the US and worldwide, the article argued that these legal actions against drug-makers would damage the image of the industry and called for legal changes mandating price reductions.

Two days later, on 11 June 2001, an editorial in *The New York Times* painted a very bleak picture of the US government's approach to the access-to-medicines debate in Africa. The article sharply criticised the head of the US Agency for International Development, Andrew Natsios, who neglected the significance of AIDS treatment in the form of AIDS drugs in sub-Saharan Africa and preferred to concentrate solely on prevention measures, even though the mere focus on prevention had clearly failed[22] (Herbert 2001). This article made it clear that the discourse represented by US government officials and pharmaceutical companies had become more and more disputed, even in their own country.

On 18 June 2001, the *Washington Post* applauded the recent moves of several pharmaceutical companies to offer price reductions on AIDS drugs, and even suggested amending the US patent law to take advantage of the momentum and legally entrench the progress made (Mallaby 2001). In the run-up to the Special Discussion of the TRIPS Council on Intellectual Property and Public Health, the *Financial Times* published an article on 19 June 2001, preparing its readers for a shift in '[t]he battleground between health groups and pharmaceutical giants over the high price of life-saving drugs in poor countries [...] to the World Trade Organisation', where over 100 NGOs pressurised the US and the pharmaceutical industry to back down from their position (Williams 2001).

Influential papers like *The New York Times, Time* magazine, the *Wall Street Journal* and the *Washington Post* supported the position of Brazil in the access-to-medicines debate and took a highly critical stance towards the position of the US. As in the case of the global AIDS movement, US newspapers and weeklies regarded Brazil's National AIDS Programme as an impressive response to the HIV/AIDS epidemic in the country. The local production of AIDS drugs along with Brazil's threats to seek price reductions of patent-protected AIDS drugs from pharmaceutical companies was considered the right solution in the fight against HIV.

Heroes and villains in the access-to-medicines debate

On 25 June 2001, the US withdrew the WTO panel against Brazil, leaving Brazil as the moral winner in a dispute about the prevalence of human rights or patent rights in the access-to-medicines debate. It is no surprise that the reactions from civil society organisations – among them Médecins Sans Frontières, Oxfam, the Third World Network and CPTech – were extremely enthusiastic (Amgott and Smith 2001; Love and Weissman 2001; Raghavan 2001; 'T Hoen 2001b).

The day of the US retreat was also the first day of the UN General Assembly Special Session on HIV/AIDS.[23] The resulting UN Declaration of Commitment on HIV/AIDS, adopted by the UN General Assembly on 27 June 2001, can be seen as a further milestone in the entrenchment of a more rights-based approach in the fight against HIV/AIDS and the recognition of Brazil's position in this matter by the UN General Assembly (UN General Assembly 2001b). It was the first UN Declaration emphasising that the access to medicines was a fundamental human right. In this context, the UN member states recognised 'that there is a need to reduce the cost of these drugs and technologies in close collaboration with the private sector and pharmaceutical companies' (UN General Assembly 2001b: Art. 24). The Declaration also appreciated 'the efforts of countries to promote innovation and the development of domestic industries consistent with international law in order to increase access to medicines' (UN General Assembly 2001b: Art. 26).

Brazil received additional recognition for its approach from the UN High Commissioner for Human Rights, who described the situation of HIV/AIDS treatment in Brazil as an exemplary case of a country to combine its obligations under the TRIPS Agreement with its obligations to guarantee the human right to health and the access to medicines (Report of the UN High Commissioner 2001). In this context, the UN High Commissioner recognised Brazil's strategy of locally producing generic drugs and requesting a compulsory licence for the patent-protected drugs Efavirenz and Nelfinavir if negotiations to reduce the prices were not successful.

By the end of June 2001, Brazil could count among its supporters very influential newspapers and weeklies in the US, the most prominent AIDS NGOs in the US and worldwide, a huge majority of countries in the WHA, the UN Human Rights Commission, the TRIPS Council and last but not least the UN General Assembly. The unintended consequence of Brazil's strategy of defending its own National AIDS Programme was the emergence of a rights-based HIV/AIDS narrative through the intensive involvement of civil society actors and the US media in defending Brazil's position against the US.

Through its response to the challenge posed by the US, Brazil revealed its character as the hero of a story which gained shape over the course of the trade dispute. By acting at various international organisations in favour of its own rights-based approach to HIV/AIDS, and by aggressively confronting several pharmaceutical companies, Brazil made itself known as an advocate of people living with HIV/AIDS from all over the world.

In this sense, the unfolding story bears the essential elements of a romance. Brazil, as the hero with an 'idealistic' objective, found itself on a long journey which started with its own national experience with HIV/AIDS. In its own national fight with this lethal and devastating epidemic, Brazil discovered a highly innovative and original solution by guaranteeing all Brazilians living with HIV/AIDS the free and universal access to life-saving AIDS drugs. This solution was so overwhelmingly successful that Brazil was able to shake itself free from the monstrous claws of this destructive epidemic. At the same time, those who made this destructive force of HIV/AIDS a highly lucrative business through the sale of highly expensive AIDS drugs were getting increasingly nervous. Brazil's solution was criticised by the US and the pharmaceutical industry for obscure legal reasons. They turned into Brazil's enemies in this battle against HIV/AIDS and defied the hero and its innovative solution by posing a challenge in form of the WTO Trade Dispute. Brazil took on the challenge in the knowledge that the WTO Trade Dispute constituted a grave risk to its National AIDS Programme. Like Odysseus, Brazil wrestled down its enemies on the international stage on various occasions, such as at the UN Human Rights Commission, the WHA and during its negotiations with pharmaceutical companies for price reductions.

In this context, Brazil worked hard to enforce the human right to health, the human right to access to medicines and the importance of ARV therapy through two resolutions in the WHA and one in the UN Human Rights Commission. In the TRIPS Council, Brazil also stressed its rights-based position and an interpretation of intellectual property rights in the light of human rights. And in its aggressive confrontations with the pharmaceutical companies Merck and Roche for the reduction of the prices of their AIDS drugs, Brazil strengthened the human right to health and the human right to access to medicines by (1) using or threatening to use compulsory licences and (2) locally producing generic versions of AIDS drugs.

These activities, along with Brazil's National AIDS Programme, were overwhelmingly supported and praised by most of the influential international civil society organisations in the fight for better access to life-saving drugs and a number of US-based civil society organisations. Both civil society organisations and several influential US newspapers and weeklies helped the romance of the glorious hero in shining armour involved in a monumental fight against the evil and wicked enemy gain shape. They portrayed the US action as a threat to Brazil's National AIDS Programme. Similarly, they defined the role of the US as the representative of commercial interests which threatened the lives of millions of people infected with HIV. Or more bluntly, the global AIDS movement defined the US and the pharmaceutical industry in the role of the arch-enemy to millions of people living with HIV/AIDS. In this context of outrage, criticism and disapproval towards the US (and the pharmaceutical companies), the representatives of the global AIDS movement lifted Brazil up on a pedestal to represent the symbol of hope in the fight for human rights.

And like the heroes in the Greek and medieval romances upon their return from the long and adventurous journey, Brazil was greeted and honoured by the international community for its exemplary fight for better access to life-saving medicines and the prevalence of human rights over patent rights. And yet, Brazil's success in the trade dispute did not mean that the US government and the pharmaceutical industry had accepted its position. Brazil's enemies were only licking their wounds in the shadows. For the romance of Brazil's heroic activities in the fight against HIV/AIDS to further develop, its activities on the organisational and resource-transfer interfaces were crucial.

d) The organisational interface

The organisational interface analyses Brazil's activities in the context of various international organisations after the end of the WTO Trade Dispute on patent rights. First, it examines Brazil's role in the adoption of the Doha Declaration on the TRIPS Agreement and Public Health in November 2001. Thereafter, it sheds light on Brazil's further activities and achievements in the WTO, the WHA and the UN Human Rights Council.

The Doha Declaration on the TRIPS Agreement and Public Health[24]

On 25 July 2001, the TRIPS Council held an informal meeting on intellectual property and public health, a follow-up on the Special Discussion which had taken place on 20 June (Oh 2001b). A majority of developing countries, including Brazil, recalled the statement made by Brazil and the African Group during the Special Discussion on 20 June and suggested that elements of this statement, which argued in favour of public health, be included in the Doha Ministerial Declaration[25] (Oh 2001b). The US was opposed to the request of the developing countries and continued to refuse to interpret intellectual property in a perspective which would benefit public health concerns (Oh 2001b).

During the meeting of the Second TRIPS Special Discussion on 19 September 2001, no real progress could be observed in reaching an agreement between the position advocated by Brazil and other developing countries and the position advocated by the developed countries. The African Group[26] actually circulated a lengthy preamble followed by a 14-point declaration as a draft for a possible Ministerial Declaration on Public Health in Doha. This draft, originally proposed by Brazil and India, reiterated the primacy of public health over patent rights by allowing the use of compulsory licences, parallel imports and the production of generic drugs (Teixeira 2003: 55; WTO 2001f). The US, Australia, Canada, Japan and Switzerland proposed a draft of the preambular language of a possible Ministerial Declaration in which they rejected the claims held by the developing countries and continued to support the primacy of patent rights over public health concerns. On the one hand, the developed countries did '*recognize* [italics in the original] that access to medicines for treatment of HIV/AIDS and other pandemics, such as malaria and tuberculosis, [...] is one of the major challenges for the global community and for its sustainable development' (WTO 2001g). On the other hand, they were convinced that the existing TRIPS Agreement and its flexibilities provided for the appropriate framework to deal with HIV/AIDS and other pandemics (WTO 2001g). After several weeks of continuing consultations, the US attempted to block any kind of consensus aimed at increasing the flexibilities of the TRIPS Agreement and started to concentrate its efforts on restricting the scope of the declaration (Oh 2001c).

On 27 October 2001, the Chairman of the General Council presented a draft Ministerial Declaration aiming to conceal the two different positions of the developing and developed countries.[27] For the fourth paragraph he suggested two different options, paying tribute to two different discourses which had been confronting each other:

Option 1:

> [Nothing in the TRIPS Agreement shall prevent Members from taking measures to protect public health. Accordingly, while reiterating our commitment to the TRIPS Agreement, we affirm that the Agreement

> shall be interpreted and implemented in a manner supportive of WTO Members' right to protect public health and, in particular, to ensure access to medicines for all.
>
> In this connection, we reaffirm the right of WTO Members to use, to the full, the provisions in the TRIPS Agreement which provide flexibility for this purpose.]

Option 2:

> We affirm a Member's ability to use, to the full, the provisions in the TRIPS Agreement which provide flexibility to address public health crises such as HIV/AIDS and other pandemics, and to that end, that a Member is able to take measures necessary to address these public health crises, in particular to secure affordable access to medicines. Further, we agree that this Declaration does not add to or diminish the rights and obligations of Members provided in the TRIPS Agreement. With a view to facilitating the use of this flexibility by providing greater certainty, we agree on the following clarifications.
>
> (WTO 2001h)

While the first option, with a strong focus on public health, represents the position advocated by the developing countries, the second option, with a clear focus on the status quo of the TRIPS Agreement and the use of its flexibilities, represents the position advocated by the developed countries. As Ellen 'T Hoen, the main representative of MSF's global access campaign, observed during the negotiation process, a majority of states preferred the first option ('T Hoen 2003: 52).

In the end, it was the leaders of the two main positions, the US on one side and Brazil on the other side, who, as in the first half of the year, came to confront each other to negotiate the final version of the declaration. With Brazil as one of the decisive defenders of the public health position, the negotiations led to the adoption of the Chairman's first option by all the states present (Teixeira 2003: 55). As was the case during the whole of the year, Brazil was once more successful in defending its position. Paragraph 4 of the Doha Declaration on the TRIPS Agreement and Public Health reads as follows:

> We agree that the TRIPS Agreement does not and should not prevent members from taking measures to protect public health. Accordingly, while reiterating our commitment to the TRIPS Agreement, we affirm that the Agreement can and should be interpreted and implemented in a manner supportive of WTO members' right to protect public health and, in particular, to promote access to medicines for all.
>
> (WTO 2001i)

The wording of the final text of the fourth paragraph is almost identical with option 1 proposed by the Chairman of the General Council. The fifth paragraph specified that '[e]ach member has the right to grant compulsory licences and the freedom to determine the grounds upon which such licences are granted'. In addition, the fifth paragraph clarifies that '[e]ach member has the right to determine what constitutes a national emergency or other circumstances of extreme urgency, it being understood that public health crises, including those relating to HIV/AIDS, tuberculosis, malaria and other epidemics, can represent a national emergency or other circumstances of extreme urgency' (WTO 2001i). And as a third important point, the fifth paragraph also allows the use of parallel imports in that '[t]he effect of the provisions in the TRIPS Agreement that are relevant to the exhaustion of intellectual property rights is to leave each member free to establish its own regime for such exhaustion without challenge' (WTO 2001i).

With a broader use of compulsory licences agreed upon, the problem remained that 'WTO members with insufficient or no manufacturing capacities in the pharmaceutical sector could face difficulties in making effective use of compulsory licensing under the TRIPS Agreement' (WTO 2001i: paragraph 6). A solution for this so-called 'paragraph-6-issue' was to be found in the TRIPS Council before the end of 2002.

The paragraph-6-issue

Further developments were unfolding in the WTO with respect to paragraph 6 of the Doha Declaration on the TRIPS Agreement and Public Health (hereafter Doha Declaration) which still remained unresolved and required the TRIPS Council to find a solution before the end of the year 2002. During the TRIPS Council meeting in June 2002, several proposals of how to solve the problem were circulated. Among those proposals was one put forward by Brazil,[28] highlighting several issues that were integral to Brazil's position as an advocate of a solution which favoured a focus on public health concerns without violating the TRIPS Agreement (WTO 2002). The issue of parallel imports and the use of compulsory licences by developing countries in the face of lacking manufacturing capacities was of particular importance for Brazil. Brazil's TRIPS negotiator at that time, Francisco Cannabrava, explained that Brazil depended on the imports of generic drugs from China and

India due to the weakness of the country's own generic drug industry (Nunn 2009: 138). The principal points of the Brazilian proposal were as follows:

> Any WTO Member could face difficulties in making effective use of compulsory licences due to insufficient or no manufacturing capacities in the pharmaceutical sector. Therefore, the solutions envisaged by the TRIPS Council [...] should not exclude specific categories of countries. In any event, developing countries, in particular least-developed countries, should certainly be among the main beneficiaries of possible expeditious solutions.
>
> Difficulties of access to public health-related products are not limited to countries with insufficient or no manufacturing capacities where these products are protected by patents. Therefore, the expeditious solutions envisaged [...] should also address situations where no patents exist in the countries in need of access to public health-related products, or cases where economies of scale make domestic production for a particular product impractical or too costly.
>
> [...] the TRIPS Council should [...] recognize the right of WTO Members to authorize third parties to make, sell and export patented public health-related products without the consent of the patent holder to address public health needs in another country.
>
> (WTO 2002)

At the next TRIPS Council meeting in September, the Brazilian Delegation repeated its position, while at the same time specifying that Brazil was against any attempt to limit the scope of diseases to which paragraph 6 would apply. The Brazilian Delegation held that paragraph 6 should apply to 'public health problems' without limiting the scope to merely those diseases mentioned in paragraph 1 of the Doha Declaration on Intellectual Property and Public Health[29] (TRIPS Council 2002a). The US, however, was pushing hard to limit the scope of diseases by attempting to avoid the notion that paragraph 6 applied to public health problems other than those specified in paragraph 1 of the Doha Declaration (Love 2002). Similarly, the US tried to exclude paragraph 4 of the Doha Declaration,[30] which clearly referred to 'public health', from the solution to paragraph 6 (Love 2002).

After further negotiations, the Chairman of the TRIPS Council, Pérez Motta, presented a compromise text – also called the Motta text – of all the different proposals on the table (TRIPS Council 2002b). Chairman

Motta emphasised that two solutions were possible as far as the most contentious issue – scope of diseases/public health problems – was concerned. Motta summarised the two suggested wordings as follows: It was possible to refer either to 'HIV/AIDS, malaria, tuberculosis or other infectious epidemics of comparable gravity and scale, including those that may arise in the future' or 'the public health problems referred to in the Doha Declaration as a whole' (TRIPS Council 2002b: 1). In the proposed compromise text, Motta suggested in paragraph 1(a) that a pharmaceutical product 'needed to address the public health problems' arising from epidemics such as HIV/AIDS (TRIPS Council 2002b: 3). This interpretation favoured the position of Brazil and other developing countries and generated consensus among the WTO member states, except for the US which, apart from all other parts of the draft text, could not agree on paragraph 1(a) (TRIPS Council 2003). As a consequence, the US blocked the text and the negotiations dragged on until 2003.

At the TRIPS Council meetings in February and June 2003, no consensus was reached on the Motta text (ICTSD/IISD 2003: 2). Any attempts made by the US to further limit the scope of diseases to national emergencies were rejected by the developing countries (Oh 2003a, 2003b). Isolated in its position, the US changed its strategy and moved away from changing paragraph 1(a) and engaged in efforts to limit the number of countries eligible to take advantage of the paragraph-6-decision (Inside US Trade 2003). The Motta text specified in paragraph 1(b) that 'any least-developed country Member, and any other Member that has made a notification to the Council for TRIPS' would be eligible for the paragraph-6-solution 'in the case of a national emergency or other circumstances of extreme urgency or in cases of public non-commercial use' (TRIPS Council 2002b: 3). It was also agreed upon that some WTO members would not be eligible for the paragraph-6-solution except in situations of national or extreme emergency.[31]

The US intended to limit the system only to the least-developed countries as specified in paragraph 1(b) and tried to ignore the fact that the system also applied to countries in the developing world (ICTSD/IISD 2003: 3). Negotiations on this issue remained without result until August, when more intensified talks between the TRIPS Council Chair and the US, Brazil, India, South Africa and Kenya took place (MSF 2003). These talks resulted in a separate statement which was read by the General Council Chairperson at the General Council meeting on 30 August 2003 (WTO 2003). This statement paved the way for the final adoption of the Motta text on 30 August 2003 through further concessions to the US in laying out several key shared understandings which,

in addition to the 23 countries already mentioned in the Motta text, included further countries opting out of the system, or only using it in 'situations of national emergency or circumstances of extreme urgency' (WTO 2003).[32]

Even though the US saved its face with the final statement by increasing the number of countries excluded from the agreed system, Brazil, along with other developing countries, succeeded in preserving the reference to public health problems in the use of compulsory licences instead of limiting it to diseases like HIV/AIDS, tuberculosis and malaria. On 06 December 2005, this decision was finally made permanent by amending Article 31 of the TRIPS Agreement (WTO 2005).[33]

The World Health Assembly sessions

The two WHA resolutions approved during the WHA session in May 2001 on the initiative of Brazil led to unprecedented steps taken by the WHO in the following year. As a direct result of the WHO Medicines Strategy, the WHO announced in April 2002 its first HIV/AIDS-treatment guidelines in poor settings and the inclusion, for the first time, of AIDS medicines[34] in its WHO essential medicines list (WHO 2002a).

These new treatment guidelines built on the WHO resolution 'Scaling up the response to HIV/AIDS' and the UN General Assembly Special Session on HIV/AIDS, which had urged for a combination of HIV care and prevention (WHO 2002b: 21–2). According to the new treatment guidelines '[a]ntiretroviral treatment should be seen in the context of an overall essential care package for HIV-infected persons and as an integral complement to HIV prevention programmes' (WHO 2002b: 22). Both the inclusion of AIDS drugs in the WHO essential medicines list and the new treatment guidelines directed at ARV treatment in developing countries implicitly recognised Brazil's successful efforts in the fight against HIV/AIDS.

The 55th WHA in May 2002 approved a resolution entitled 'Ensuring accessibility to essential medicines'. With this resolution the WHA welcomed the Doha Declaration, reaffirmed the WHO Medicines Strategy of 2001 and urged its member states 'to reaffirm their commitment to increasing access to medicines, and to translate such commitment into specific regulation within countries' (WHO 2002c). Even though this resolution was adopted without Brazil's active involvement, it nevertheless strengthened the country's position on public health.

During the 56th WHA in May 2003, Brazil returned to the stage and once more took the lead in confronting the US (Oh 2003c). Brazil circulated a proposal[35] for a new resolution on intellectual property in order

to counter a proposal put forward by the US (Oh 2003c). The US tried again to strengthen intellectual property rights for the sake of human rights as the most appropriate way to improve the pharmaceutical companies' research and development capacities. The US proposal, however, met huge criticism from CSOs because it failed to even mention the Doha Declaration on the TRIPS Agreement and Public Health. Brazil countered the new US attempt to undermine the achievements made in reinforcing the human right to health by urging countries in its proposal to adapt their national legislation to the provisions of paragraph 6 of the Doha Declaration, so that it would be possible for developing countries to import generic medicines (Oh 2003c). Among WHO member states, the Brazilian proposal received much more support than the US proposal, so that Brazil's ideas became once again the basis for further negotiations, which resulted in the resolution 'Intellectual property rights, innovation and public health' (Oh 2003c).

The resolution underlined the huge divide between developed and developing countries in the access-to-medicines debate by stating that 90 per cent of pharmaceutical sales worldwide occur in the developed world, while 90 per cent of those deaths resulting from infectious disease worldwide occur in the developing world (WHO 2003b). In the same vein, the resolution emphasised that 'research and development in the pharmaceutical sector must address public health needs and not only potential market gains' (WHO 2003b). The resolution established a clear linkage between patent rights and public health problems by 'reaffirm[ing] that public health interests are paramount in both pharmaceutical and health policies' (WHO 2003b). On top of that, the resolution requested the WHO director general to establish a body (the Commission on Intellectual Property Rights, Innovation and Public Health – CIPIH) to analyse the implications of intellectual property rights for the public health situation in developing countries (WHO 2003b). In both its wording and content this new resolution reflected once more Brazil's initial ideas and their approval of WHO member states in opposition to the US position.

In April 2006, CIPIH published its report in which it could observe a new awareness among the actors of global health governance for an interpretation of intellectual property rights in favour of public health concerns (CIPIH 2006: 174). The report found that in a huge part of the developing world 'the monopoly costs associated with patents can limit the affordability of patented healthcare products required by poor people in the absence of other measures to reduce prices or increase funding' (CIPIH 2006: 174). In light of recognising the conflicts

revolving around the issue of intellectual property and public health concerns in developing countries, the report made, among others, the following proposal which clearly supported Brazil's position: Developing countries should consider the use of compulsory licences and parallel imports, whereas companies should facilitate a more affordable access to medicines through imports or local production (CIPIH 2006: 180–1).

For the 59th WHA in May 2006, Brazil and Kenya prepared a proposal for a resolution on a global framework on essential health research and development. In this draft resolution, both countries urged the member states 'to make global health and medicines a strategic sector and take determined action to direct priorities in research and development according to the needs of the patients' (Love 2006). Brazil and Kenya also requested the WHO director general to create a working group which should develop proposals and recommendations for the establishment of the global framework based on the proposals made by CIPIH (Love 2006). The resulting resolution 'Public health, innovation, essential health research and intellectual property rights: towards a global strategy and plan of action' decided to establish the Intergovernmental Working Group on Public Health, Innovation and Intellectual Property which should prepare a plan of action for the global strategy (WHO 2006b).

Building on the findings of CIPIH and through consultations in 2006 and 2007, the Intergovernmental Working Group on Public Health, Innovation and Intellectual Property published its report in May 2008 to be considered at the 61st WHA (WHO 2008b). The report proposed a global strategy and a plan of action on public health, innovation and intellectual property which was later adopted by the 61st WHA and resulted in the resolution 'Global strategy and plan of action on public health, innovation and intellectual property' (WHO 2008c), which aimed to establish a medium-term framework for more needs-driven health research.

Brazil's involvement in the negotiation process which led to the final adoption of the resolution and the global strategy was crucial in that Brazil was adamant on including a reaffirmation of the principles of the Doha Declaration and a recognition of the priority of public health considerations over commercial interests (Ministério da Saúde 2010a: 62). As part of the global strategy, this resolution requested the establishment of a working group 'to examine current financing and coordination of research and development' (WHO 2008b). When the report was published in 2010, many developing countries were not satisfied with the results, criticising in particular the fact that the working group did not

pay sufficient attention to the threat intellectual property rights pose to the access to drugs (Mara and New 2010). In this atmosphere of dissatisfaction among many developing countries, several proposals for a new working group by Thailand, Australia and UNASUL[36] were tabled (New 2010). The new working group on research and development, which was created at the 63rd WHA in 2010, recognised that the costs of research and development should not result in an increase of medicines prices, in particular those needed in developing countries (WHO 2010b).

The UN Human Rights Council[37]

In August 2001, the UN Sub-Commission on Human Rights adopted a resolution which contributed to strengthening Brazil's position in the preparations for the Doha Ministerial Conference in November 2001. In its resolution, the Sub-Commission reminded the member states 'that actual or potential conflict exists between the implementation of the TRIPS Agreement and the realization of economic, social and culture rights, in particular the rights to self-determination, food, housing, work, health and education' (Sub-Commission on Human Rights 2001).

From 2002 to 2005, the UN Human Rights Commission confirmed, updated and extended the 2001 resolution 'Access to medication in the context of pandemics such as HIV/AIDS' to tuberculosis and malaria, all of which in November 2006 were recalled by the newly established UN Human Rights Council (UN Commission on Human Rights 2005).

In September 2009, Brazil, along with other developing countries[38] proposed a resolution in the UN Human Rights Council on the 'Access to medicines in the context of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health' (UN Human Rights Council 2009a). The draft resolution included the following demands: (1) The access to medicines should be fundamental in the progressive realisation of the human right to health. (2) The human right to health should be applied to communicable and non-communicable diseases alike. (3) The Doha Declaration should be interpreted in a way to protect public health and promote access to medicines for all. Brazil and the other developing countries were successful in getting their original language adopted in the UN Human Rights Council in October 2009 with two main exceptions (UN Human Rights Council 2009b): The proposal to extend the human rights perspective of access to medicines to communicable and non-communicable diseases alike was deleted. Instead, the importance of intellectual property protection for the development of new medicines was emphasised, which constituted a clear concession to the position of the developed countries.

Enforcing key elements of the National AIDS Programme

Brazil's activities on the organisational interface tied in with its efforts carried out in the first half of 2001 during the WTO Trade Dispute on patent rights, and further emphasised its role as a hero in the global fight against HIV/AIDS. The battle over the dominance of the two rival positions continued in several international organisations with the US as the main representative of the prevalence of patent rights trying hard to fight back the new position represented by Brazil.

The negotiations at the Doha Ministerial Conference in November 2001 turned into one of several battlefields. Brazil, as one of the important actors and with the fundamental support of many developing countries, defended the prevalence of the human right to health, which for the very first time in the history of the WTO led to a declaration that interpreted intellectual property rights in the light of public health. The resulting Doha Declaration on the TRIPS Agreement and Public Health represented a significant step in the formal recognition of Brazil's approach to fighting HIV/AIDS and further isolated the US position by stating that intellectual property rights should not prevent WTO members' duties to protect public health. The remaining paragraph-6-problem was resolved in 2003 and built on the broader use of compulsory licences agreed in November 2001 in Doha by specifying that least-developed countries with no or insufficient manufacturing capacities for the production of generic drugs would be eligible to use compulsory licences in public health emergencies.

The WHA sessions turned into another battlefield. Following Brazil's first two successful WHA resolutions in 2001, the government was able to build on this success in the following years and further enforce the human right to access to medicines. Brazil's successful resolutions contributed to the establishment of the idea that the use of compulsory licences, parallel imports or the local production of medicines were legitimate tools to combat public health crises in developing countries. Brazil's success in the WHA was also critical due to the WHA's characterisation as the principal super-structural node in global health governance and its nature as the central platform in the decision-making processes among all WHO member states, developed and developing countries alike, of global health governance (Hein and Moon 2013: 40–1).

Brazil repeated its success in the UN Human Rights Council along with a number of other developing countries by reinforcing the idea that the human right to health was fundamental in providing affordable access to medicines.

Brazil's activities at key sites of global health governance – the WTO, the WHA and the UN Human Rights Council – contributed to strengthening Brazil's core message, namely that the successful fight against HIV/AIDS in a developing country is only possible when the intellectual property rights of pharmaceutical products are interpreted from a perspective which focuses on public health concerns and the human right to health. The use of the tools which are necessary for this approach – the use of compulsory licences, parallel imports and the local production of generic versions of medicines – was increasingly legitimised through several significant steps, which included the Doha Declaration on the TRIPS Agreement and Public Health, the resolved pargraph-6-issue and the resolutions adopted at the WHA and in the UN Human Rights Council. At the same time, Brazil, along with other developing countries, seriously put into question the position of the US and other developed countries with an emphasis on the primacy of patent rights over human rights.

All these activities on the organisational interface, however, would have been fruitless without Brazil's activities on the resource-transfer interface. Through its efforts on the resource-transfer interface, Brazil took advantage of the principal tools (the threat to issue a compulsory licence and the local production of medicines) which had been legitimised through the Doha Declaration on the TRIPS Agreement and Public Health and the resolutions adopted at the WHA and in the UN Human Rights Council.

e) The resource-transfer interface

The resource-transfer interface analyses Brazil's efforts in transferring its material and immaterial resources related to its experience in the fight against HIV/AIDS to international organisations and other countries in the developing world. The analysis concentrates on the international activities of the Ministry of Health and the Oswaldo Cruz Foundation (Fiocruz).

The main actors in Brazil's technical cooperation efforts in health are both the Ministry of Health and the Brazilian Cooperation Agency (ABC),[39] a department of the Ministry of Foreign Affairs, which over the last decade significantly deepened and consolidated its cooperation efforts, particularly regarding HIV/AIDS. Brazil took its first steps in technical assistance on HIV/AIDS in 1996, when in Rio de Janeiro the 'Office for Strategic Planning and Horizontal Cooperation for the Prevention of HIV/AIDS in Latin America and the Caribbean' was established.

As a result of the work of this Office, the 'Group of Cooperation on Horizontal Technical Cooperation on HIV/AIDS in Latin America and the Caribbean' was born, which initiated Brazil's technical cooperation activities in the region (ABC 2007: 11–12).

The first cooperation efforts with African countries started in 1999, and involved South Africa, Namibia, Kenya and Zimbabwe, with the Brazilian Ministry of Foreign Affairs organising two missions to analyse the public health situation in these countries (ABC 2007: 12). In this context, Brazil, via the Oswaldo Cruz Foundation, was engaged in transferring technology for the production of AZT to South Africa and turned its focus to the Portuguese-speaking countries in Africa (ABC 2007: 13).

These first steps taken at the end of the 1990s in the developing world were further intensified at the turn of the 21st century and gradually consolidated over the following years through the cooperation efforts between the Ministry of Health and ABC. The Department of Sexually Transmitted Diseases, HIV/AIDS and Hepatitis in the Ministry of Health and the Oswaldo Cruz Foundation, a governmental agency linked to the Ministry of Health, became the main pillars in Brazil's intensifying technical cooperation efforts on HIV/AIDS.

The Ministry of Health

In May 2002, the Ministry of Health launched its International Cooperation Programme (Programa de Cooperação Internacional para Ações de Controle e Prevenção ao HIV/AIDS para Países em Desenvolvimento) which aimed to finance ten pilot projects in ten different countries worth about US$1 million each (Ministério da Saúde 2002). This kind of international assistance in the form of exporting AIDS drugs, which had been produced in Brazil, was intended for five Latin American countries (Dominican Republic, Colombia, El Salvador, Bolivia and Paraguay) and five African countries (Namibia, Burundi, Burkina Faso, Kenya and Mozambique) (Ministério da Saúde 2003: 9).

In 2004, the Ministry of Health further intensified its technical cooperation efforts on HIV/AIDS by including partnerships with other key actors in the global fight against HIV/AIDS such as UNAIDS. Peter Piot, then UNAIDS executive director, proposed to establish the first International Centre for the Cooperation on HIV/AIDS (Centro Internacional de Cooperação Técnica em HIV/AIDS – CICT) in Brazil which should comprise UNAIDS, the Brazilian government and other developing countries in order to scale up the efforts in the global fight against HIV/AIDS. Piot explained that both Brazil's leadership in the fight against HIV/AIDS and the international recognition of Brazil's National AIDS Programme as a global reference were the decisive factors for the decision to establish this International Centre in Brazil (Fiocruz 2004). Based in the Ministry of Health, the Centre served as a key tool to further institutionalise Brazil's technical cooperation efforts by transferring its experience, know-how and technical resources to other countries and to further promote the Brazilian model in the global fight against HIV/AIDS (UNAIDS n.d.).

CICT had the objective to establish a network of international organisations, NGOs and technical organisations like the UK's Department for International Development (DFID) or Germany's Gesellschaft für Internationale Zusammenarbeit (GIZ), to develop study and training programmes and disseminate good practices on the basis of the experience accumulated in developing countries (ABC 2007: 14, 16). CICT worked together with UNAIDS to implement Brazil's HIV/AIDS strategy (apart from projects in Brazil) in countries all around the developing world.[40] In 2009/2010, however, the work of CICT came to an end due to a shift in financial resources. Given administrative changes, the main financial resources were no longer provided by external sources such as international organisations or technical cooperation agencies. Instead, the activities which had been carried out by CICT became the sole responsibility of the Brazilian government, with the financial resources provided by ABC and the Department of Sexually Transmitted Diseases, HIV/AIDS and Hepatitis in the Ministry of Health (Ministério da Saúde 2011: 11).

In the context of a more institutionalised approach in Brazil's technical cooperation efforts on HIV/AIDS, in 2004, the Ministry of Health set up an International Cooperation Network on Technology (Rede de Cooperação de Tecnologia) – financially supported by the Ford Foundation and in cooperation with Russia, China, Ukraine, Nigeria and Thailand – with the principal objective to exchange technology for the treatment and prevention of HIV/AIDS (Ministério da Saúde 2004a). The participating countries were included in the network due to the strategic position they occupied in their regions, which allowed them to exercise significant leadership in the production of AIDS drugs with the potential to increase their own bargaining power vis-à-vis the pharmaceutical companies (UOL 2008). In 2010, Farmanguinhos joined the network, which had been extended by the new members Argentina and Cuba, to develop a generic version of the strategic AIDS drug Ritonavir (Fiocruz 2010a). In 2011, the network initiated official tests on the new version of Ritonavir, produced by Farmanguinhos/Fiocruz with raw materials from China (Estado de São Paulo 2010).

Also in 2004, the Ministry of Health built on the rationale of its International Cooperation Programme by calling into life the South-South Link Network (Rede Laços Sul-Sul) which included Bolivia, Cape Verde, East Timor, Guinea Bissau, Nicaragua, Paraguay, and São Tome and Principe. In a partnership with UNICEF and UNAIDS, Brazil committed itself to distributing its nationally produced AIDS drugs to the participating countries. Brazil also helped to strengthen the respective national health policies and the whole response of the participating countries to HIV/AIDS. Apart from UNAIDS and UNICEF, other organisations such as UNESCO, UNFPA and the CICT were involved in the programme (Ministério da Saúde 2010a: 62). In the following years, the whole network became much more institutionalised. The originally bilateral network between Brazil and the participating countries developed into a common partnership of all eight countries with the support of UNICEF, UNAIDS and UNFPA, which focused its activities on strengthening the National AIDS Programmes, social mobilisation and civil society participation schemes and monitoring systems (Laços Sul-Sul/UNICEF 2007/2008: 23–4). Brazil was committed to providing free AIDS drugs (produced in Brazil) to the participating countries, together with exchanging consultants and training personnel. It was also committed to sharing information and offered logistical and technical support for counselling and testing activities (Laços Sul-Sul/UNICEF 2007/2008: 23). In 2008, the UN selected the network as a role model for its activities in strengthening South-South cooperation and furthering sustainable development in the participating countries (UNICEF 2008).

Besides these highly institutionalised programmes, several individuals who were key figures in Brazil's national response to HIV/AIDS since the early 1980s have also left a mark on the global response to the disease.

Paulo Roberto Teixeira is one of the most important HIV/AIDS professionals in Brazil. He gained valuable experience when he coordinated the São Paulo State Programme against HIV/AIDS over the course of several years (1983–1987; 1990–1991; 1995–1996). In 1994, he worked with the Pan-American Health Organization (PAHO) and served, from 1996 to 1999, as a Senior Consultant to UNAIDS for Latin America and the Caribbean, before becoming the director of Brazil's National AIDS Programme from 2000 to 2003 (San Juan França 2008). He was also a member of the UN task force on HIV/AIDS, Malaria, Tuberculosis and Access to Essential Medicines of the UN Millennium Project, an independent advisory body commissioned by the UN Secretary General to propose strategies in the fight against HIV/AIDS in the developing world (UNDP 2005: x).

Between 2003[41] and 2004, he directed the AIDS Programme of the WHO (Ministério da Saúde 2004). After joining the WHO in 2003, Teixeira became responsible for coordinating WHO's '3 by 5-initiative', which had been called into life by the UN General Assembly with the main target of treating 3 million people living with HIV/AIDS in developing countries with antiretroviral therapy by the year 2005 (Fleshman 2004; WHO 2003a, 2003d). The initiative had named Brazil and its model as the answer to how this ambitious target could be achieved (WHO n.d.).

The WHO's 2006 evaluation of the '3 by 5-initiative' emphasised that it was a first major step in institutionalising the human right to health and promoting both the benefits of antiretroviral treatment and the idea of universal access in the global fight against HIV/AIDS, even though the initiative had failed to reach its original target (Battistella Nemes et al. 2006: xx).

Two further prominent Brazilian individuals in the global fight against HIV/AIDS are Pedro Chequer and Luiz Loures. Like Teixeira, they are founders and key figures of Brazil's National AIDS Programme and have occupied important positions at UNAIDS. Chequer worked for the National AIDS Programme since its establishment in the 1980s and served as its director twice (1996–2000; 2004–2006) (Ministério da Saúde 2013). He has held several positions at UNAIDS since 2001, serving as UNAIDS regional adviser to the Southern Cone in Argentina, the UNAIDS representative in Russia and, until April 2013, the UNAIDS representative in Brazil (Assis 2006; Farah 2002; Ministério da Saúde 2013).

Luiz Loures left the National AIDS Programme in the mid-1990s for the UNAIDS headquarters in Geneva, where he held several leading positions before being nominated as Deputy Executive Director of Programme of UNAIDS in January 2013 (UNAIDS 2013).

The Oswaldo Cruz Foundation

Fiocruz as a governmental agency

The Oswaldo Cruz Foundation (Fundação Oswaldo Cruz – Fiocruz), with its headquarters based in the city of Rio de Janeiro, is a public science and technology agency linked to the Ministry of Health as one of several executive agencies in carrying out the functions of Brazil's Unified Health System (Sistema Único de Saúde – SUS) (Fiocruz 2010b: 5). In the area of public health, Fiocruz covers a wide range of activities including research, technological development and innovation,

education, information and communication, pharmaceutical assistance, healthcare, health surveillance, health policy management, and institutional development (Fiocruz 2010b: 27–39). By assuming responsibility for this impressive kaleidoscope of activities Fiocruz has made itself indispensable to the realisation of the human right to health in the context of Brazil's Unified Health System.

Apart from its outstanding contributions to the functioning of Brazil's public health sector, the vast experience of Fiocruz in the sector of public health represents another crucial factor in its significance. The history of Fiocruz starts in 1900 with the creation of the Federal Serum-Therapeutic Institute,[42] which was transformed into the Oswaldo Cruz Institute in 1908 and later, in 1974, officially renamed as Oswaldo Cruz Foundation (Fiocruz 2010b: 44–5). Among several historic achievements including the discovery of the vaccine against symptomatic anthrax (lameness) in 1908 and the discovery of Chagas Disease[43] in 1909, Fiocruz scientists isolated HIV in 1987 for the first time in Latin America, which allowed Fiocruz to join the WHO's International Network of Laboratories for the Isolation and Characterisation of HIV-1 (Fiocruz 2010b: 40–6). Fiocruz has always relied on strong relations with the Pasteur Institute and is one of the 32 participating institutions of the Institut Pasteur International Network (Institut Pasteur 2012). Since 1991, Fiocruz has also been involved in cooperating with the French National Institute of Health and Medical Research (INSERM) through furthering scientific cooperation, exchange and development between Brazil and France (Fiocruz 2011a).

Fiocruz itself can be best described as a complex web consisting of various decision-making bodies and more than 20 technical and administrative units including specialised research institutes, pharmaceutical laboratories, the Sergio Arouca National School of Public Health (ENSP), the Joaquim Venâncio Polytechnical School of Health (EPSJV), the Oswaldo Cruz Institute (IOC) and other institutes dedicated to healthcare, health management and administrative issues on its main campus in the city of Rio de Janeiro's neighbourhood of Manguinhos (North Zone of Rio de Janeiro) alone (Fiocruz 2010b). This dense web of technical and administrative units is further complicated through a regional directorate in Brasília, additional technical offices and temporary facilities in other parts of Brazil (Belo Horizonte, Curitiba, Manaus, Recife and Salvador) and a second campus in the Atlantic Forest, in the West Zone of the city of Rio de Janeiro (Fiocruz 2010b: 4–5; 86–91). This decentralised, and in its decision-making processes highly democratic structure was officially approved and signed into law in 2003 by Lula da Silva (Decreto N° 4.725). Given its structural complexity, Fiocruz's activities in global health governance are shared by various units.

The most important units engaged in international cooperation efforts are the Fiocruz Global Health Centre, ENSP, EPSJV and the pharmaceutical laboratory Farmanguinhos. In all international activities, these units work together with the Ministry of Health and the Ministry of Foreign Affairs by following and implementing the guidelines elaborated by the Brazilian government (Matida and Fonseca 30 August 2012).

International networking activities

Fiocruz takes advantage of different organisational forms to contribute to Brazil's increasing influence in global health governance. Global and regional networks play a fundamental role in this strategy. In this context, Fiocruz units not only participate in these networks as mere members, as in the case of INSERM or the Institut Pasteur International Network, but also assume a coordinating role in a variety of international and regional networks.

Fiocruz is one of the seven founding partners of the 'Drugs for Neglected Diseases initiative' (DNDi), which was called into life in 2003 with the objective of finding new innovative strategies for the development of new and affordable medicines for neglected diseases (DNDi 2012). In addition, Fiocruz is one of the founding members of the International Association of National Public Health Institutes (IANPHI), which was formally launched in 2006 at its first annual meeting in Rio de Janeiro (IANPHI 2012a, 2012b). In this context, Fiocruz helped to establish two sub-networks called Network of National Health Institutes (Rede de Institutos Nacionais de Saúde – RINSP) to strengthen public health policies and institutions in the participating countries, one for the South American countries (RINSP-UNASUL) in 2010 and the other one for the Portuguese-speaking countries in 2011 (CPLP-RINSP) (CPLP 2011; Fiocruz 2011b: 67).

Fiocruz also established the Network of Human Milk Banks.[44] In 2003, supported by PAHO, Brazil expanded its successful national Network of Human Milk Banks to other Latin American countries, which resulted in the Latin American Network of Human Milk Banks in 2005 (Fiocruz/Ministry of Health 2012). In 2008, Fiocruz became the official executive secretariat of the Ibero-American Network of Human Milk Banks, formally launched in 2007, and began to establish a similar network for the Portuguese-speaking countries (Fiocruz/Ministry

of Health 2012; iberBLH 2012). The network received several international awards and was recognised as an international role model by the WHO in combating infant mortality (Fiocruz 2009b; Ministério da Saúde 2010b: 1–2).

On the regional level, with particular focus on the South American and Portuguese-speaking countries, Fiocruz was responsible for establishing and coordinating similar initiatives. Since 2005, The Joaquim Venâncio Polytechnical School of Health (EPSJV/Fiocruz) has been coordinating the International Network of Health Technicians Education (RETS) with the objective of training health technical staff in the countries of the Americas/Caribbean and the Portuguese-speaking countries in Africa (RETS 2012). The major achievement of the Brazilian coordinating role lies in the creation of two sub-networks, RETS-CPLP for the Portuguese-speaking countries and RETS-UNASUL for the South American countries, to strengthen technical health education in these countries. RETS-CPLP was called into life in 2009 following the 2009 CPLP Strategic Plan in Health Cooperation with the goal to strengthen the health systems of the CPLP member states (RETS 2012: 7). RETS-CPLP concentrates on strengthening the infrastructure of the technical health schools, improving the teaching programmes and increasing the exchange of information, experience and expertise between the different technical health schools (RETS 2012: 7). Also in 2009, a similar sub-network was established for the UNASUL member states, with the objective of strengthening the health systems of these countries by improving the technical health schools (RETS 2012: 15).

The Leônidas and Maria Deane Institute at the Fiocruz Regional Office in Manaus/Amazonia (ILMD/Fiocruz Amazônia) coordinates the Pan-Amazonian Network for Science, Technology and Innovation, in partnership with WHO/PAHO and OTCA (Organization of the Amazon Cooperation Treaty), to strengthen the health systems of the OTCA member states (Buss et al. 2011: 224).

In 2011, the National School of Public Health (ENSP/Fiocruz) founded the Network of Public Health Schools (RESP-UNASUL) integrating all UNASUL member states. With the executive secretariat located at ENSP/Fiocruz, RESP-UNASUL represents another network whose objectives of strengthening the national and regional infrastructure of the participating countries' National Public Health Schools and improving the coordination mechanisms among them are coordinated by a Fiocruz unit (Fiocruz 2011b: 67).

Fiocruz also participates in virtual public health networks. The Virtual Public Health Campus (Campus Virtual de Saúde Pública) was developed by ENSP/Fiocruz as a platform for the exchange of information and dialogue on public health issues for participating countries in the Americas, WHO/PAHO and the Inter-American Center for Social Security Studies (Campus Virtual 2012). ePORTUGUÊSe represents another virtual network which was launched in 2004 by WHO to create a platform for the exchange of information on public health issues in the Portuguese-speaking countries and is technically assisted by several partners, among them Fiocruz and the Brazilian Ministry of Health (WHO 2012b).

Nodal design activities in Africa

In Africa, the work of Fiocruz goes beyond working through regional and international networks alone and takes advantage of the existing regional organisations to reinforce its presence in Africa. The most strategically important regional organisation for Brazil is the Community of Portuguese-speaking Countries (Comunidade dos Países de Língua Portuguesa – CPLP). Brazil initiated its cooperation efforts with the CPLP countries in 2000, but has reinforced its activities significantly since 2006 (Fiocruz 2010b). Fiocruz was granted observer status of the CPLP in 2007 and collaborates together with Brazil's Ministry of Health and the Brazilian Cooperation Agency (ABC) in the implementation of its projects in the CPLP countries (Fiocruz 2008a: 2).

In 2008, Fiocruz established its first regional office outside of Brazil in Maputo (Mozambique) (Fiocruz-Africa) with the main responsibility being better coordination of Fiocruz's technical cooperation projects in the region, particularly as far as the CPLP countries are concerned (Fiocruz 2010c). According to Célia Almeida, representative of Fiocruz-Africa from 2008 to 2011, the most significant tasks of the new regional office include the representation of Fiocruz at the African Union, the assistance in the coordination of the CPLP's 'Strategic Health Cooperation Plan', adopted in 2009, and the support of the health projects carried out by Fiocruz and the Ministry of Health in Mozambique and other African countries (Fiocruz 2010c). The activities of Fiocruz-Africa in the context of the CPLP's Strategic Health Cooperation Plan involves the improvement and strengthening of all facets of the public health infrastructure in the CPLP countries and focuses specifically on the following tasks: Fiocruz-Africa is involved in the organisation of the regional RETS-CPLP and RINSP-CPLP networks, the coordination of various parts of the virtual ePORTUGUÊSe network (establishing virtual libraries and organising virtual documentation centres), the strengthening of scientific public health research and the contribution to the

development of a more independent pharmaceutical industry in the CPLP countries through the construction of pharmaceutical laboratories (CPLP 2009: 7–12).

Célia Almeida and other Fiocruz representatives emphasised that Fiocruz-Africa clearly expressed Brazil's increased engagement in the health sector on the African continent, in particular with the CPLP countries, as envisioned by former President Lula da Silva (Fiocruz 2010c; Matida and Fonseca 30 August 2012). Brazil's inauguration of a medicines production factory in July 2012 in Maputo, Mozambique, only corroborates this crucial role in health cooperation in Africa and represents the most straightforward expression of Brazil's global fight against HIV/AIDS in Africa by transferring its own experience and expertise in fighting the disease and producing generic versions of ARVs to Mozambique (Fiocruz 2012a). The new factory, which is supposed to produce ARVs and other medicines not only for Mozambique but for sub-Saharan Africa in general, represents the first public pharmaceutical institution on the African continent (Fiocruz 2012a). The construction of the factory, which started in 2003, was supported by Farmanguinhos, the pharmaceutical laboratory of Fiocruz, and several private sector organisations from Brazil and Mozambique (Fiocruz 2012a).

Nodal design activities in Latin America

In Latin America, Fiocruz is most active in the Union of South American Nations (UNASUL), founded in 2008 by the South American states. In 2009, the UNASUL member states called into life the South American Health Council, composed of the states' health ministers, to provide a better coordination mechanism on public health issues in the South American region (UNASUR-ISAGS 2011). The Coordinating Committee of the Council, composed of representatives from the member states and the most important international organisations in the Americas, PAHO, MERCOSUR, OTCA and the Andean Health Organization (ORAS CONHU), was to promote the following objectives (UNASUR-ISAGS 2011): The creation and maintenance of several public health networks (RETS, RESP, RINSP and other surveillance and monitoring networks), the promotion of action on social determinants of health, the development of universal public health systems in South America, the strengthening of human resources in public health issues and the increase of the universal access to medicines.

In the same year, at one of the new Council's meetings, the health ministers discussed the idea of establishing a proper institution responsible for the governance of health in South America and commissioned

Fiocruz to further elaborate on the plan (Otávio 2012). In only two years this idea had developed into the South American Institute of Health Governance (Instituto Sul-Americano de Governo em Saúde – ISAGS), an intergovernmental institution by now completely financed and coordinated by the Brazilian government, with Fiocruz in the role of the main coordinator (Matida and Fonseca 30 August 2012). The fact that, by now, ISAGS relies completely on Brazilian resources and that its office is located in Rio de Janeiro with its first executive coordinator being the former Brazilian Minister of Health, José Gomes Temporão, only bears testimony to the key role of Brazil, and Fiocruz more specifically, in the establishment of this institute and Brazil's continuous insertion in both regional and global heath governance (Matida and Fonseca 30 August 2012). In the same vein, Temporão emphasised that the new UNASUL Health Council, along with ISAGS, would play a strategic role not only in the South American integration process with a particular focus on public health policies, but also in a wider context by collaborating with the EU, WHO, WHO/PAHO and other multilateral organisations (Lobato 2012).

Fiocruz and the production of generic AIDS drugs

Farmanguinhos, Fiocruz's Institute of Pharmaceutical Technology (Instituto de Tecnologia em Fármacos), was created in 1976 and is recognised as the official pharmaceutical laboratory of the Brazilian government, with the mission to produce the medicines for Brazil's Unified Health System (ABIA 2005: 7; Fiocruz 2010b: 72). The local production of ARVs since 1997 by Farmanguinhos and other private and public laboratories was fundamental in the implementation of Brazil's access-to-medicines policy in the context of its National AIDS Programme (Chaves 2007a: 7; Petry 2001).

In 2001, Farmanguinhos produced seven[45] of the twelve ARVs which made up Brazil's arsenal of AIDS drugs at that time, corresponding to 40 per cent of Brazil's total production of these ARVs (ABIA 2005: 7; Petry 2001). Another 30 per cent originated from other government laboratories and a further 30 per cent from the private sector (Petry 2001).

In 2001, Brazil's Ministry of Health was involved in negotiations with the pharmaceutical companies Merck (Efavirenz), Roche (Nelfinavir) and Abbott (Lopinavir/ritonavir) (Chaves 2007b: 17). During the negotiations, Farmanguinhos was responsible for establishing the potential local production costs of these ARVs, providing the Ministry of Health with a strong bargaining tool vis-à-vis the pharmaceutical companies

(Chaves 2007b: 17). In 2001, for instance, Brazil threatened Roche to break the patent of Nelfinavir and have the generic version of the drug manufactured by Farmanguinhos, which would have been able to produce the drug at a price 40 per cent lower than that offered by Roche (Ministério da Saúde 2001). This threat was enough for Roche to reduce the price of Nelfinavir by a further 40 per cent to avoid having Brazil break the patent by issuing a compulsory licence (Rich 2001). The Ministry of Health applied the same strategy to its negotiations with Abbott and Merck and achieved a price reduction on Merck's Efavirenz by 59 per cent and Abbott's Lopinavir/ritonavir by 46 per cent (Chaves 2007b: 17; Globo 2001).

In early 2005, Brazil mounted further attacks against the pharmaceutical industry when the Ministry of Health threatened Merck, Gilead and Abbott with patent-breaks on three drugs (Merck's Efavirenz, Gilead's Tenofovir, and Abbott's Lopinavir/ritonavir), if they did not agree to Brazil's request to grant a voluntary licence to the government to produce the generic versions of the drugs in question (*Medical News Today* 2005). In 2005, Lopinavir/ritonavir (Kaletra) alone represented 30 per cent of the National AIDS Programme's expenditure on ARVs, while all three drugs together consumed 67 per cent of Brazil's expenditure on ARVs (Ahmad 2005; Reis et al. 2009: 33–4). After considerable pressure from the Brazilian government, Abbott committed itself to further reducing the price for Kaletra to US$ 0.63 per capsule, which would result in savings of US$ 339 million for Brazil over the following six years, and donating drugs worth US$3 million, while Brazil agreed not to produce a generic version of Kaletra (Acordo entre o Ministério da Saúde e o Laboratório Abbott 2005; The Body PRO 2005).

In 2007, the continuing negotiations with Merck on Efavirenz took a new turn, when Brazil for the first time delivered on its threats and issued its first compulsory licence on the drug. Efavirenz is the ARV most used in Brazil (38 per cent or 75,000 of 200,000 patients needed Efavirenz in Brazil by the end of 2007) (Greco 2011: 22). The Ministry of Health had to pay US$ 580 per patient/per year, with a total spending only on Efavirenz in 2007 of US$ 42.9 million, while the price of a generic version of the drug varied between US$ 163.22 and US$ 166.36 per patient/per year (Greco 2011: 22). By issuing a compulsory licence it was estimated to save up to US$ 236.8 million by the end of 2012 when the patent of Efavirenz ran out (Greco 2011: 22). This unprecedented step provided Brazil with the opportunity to import a generic version of the drug, before Farmanguinhos began in February 2009 with the local production of the drug (Chaves 2007b: 24).

It is important to know that Brazil's arsenal of AIDS drugs did not remain constant. Over the last decade the Ministry of Health had to expand the amount of AIDS drugs from 12 ARVs in 2001 to 20 ARVs in 2010 to include the latest drugs available on the market, with Farmanguinhos's production capabilities increasing from producing seven ARVs in 2001 to ten in 2011 (Londres 2011). Since 2003, the approved budget for ARVs has risen continuously due to the inclusion of new patent-protected ARVs, and made up more than US$ 3 billion between 2003 and 2010. In the same period the Ministry of Health saved approximately US$ 260 million due to its aggressive confrontational strategy with pharmaceutical companies (Greco 2011: 18).

This impressive achievement was possible due to the technical support of Farmanguinhos, which was directly involved in all negotiations carried out by the Ministry of Health with the pharmaceutical companies. The studies issued by Farmanguinhos on all technical aspects of Brazil's production capacity of generic versions of ARVs (production costs and time of generics, availability and importation of raw materials, etc.) provided the basis for the decisions taken by the Ministry of Health (Bermúdez 09 October 2012).

Fiocruz as a trademark

Fiocruz has also been engaged in research on global health governance and diplomacy. ENSP/Fiocruz, the National Public Health School, is the responsible unit for research activities in global health governance and has distinguished itself through the establishment of National Public Health Schools and the training of health professionals in many parts of the developing world. In this capacity, ENSP and other Fiocruz units hosted and organised a myriad of seminars, workshops, conferences and courses on public health training and education, which were particularly directed at health professionals from the UNASUL and CPLP countries. These efforts also included the creation of several Master Programmes in health (public health, health sciences, epidemiology in public health) in Angola, Mozambique and Argentina (ENSP/Fiocruz 2012; Fiocruz 2011b: 70–1). In this context, Fiocruz received students from the developing world to study at different Fiocruz units. ENSP, for instance, received 53 students from other Latin American countries and 15 students from CPLP countries to study public health courses offered by the school between 2001 and 2005 (Fiocruz 2008a, 2008b).

In 2008, Fiocruz offered its first specialisation course in Global Health and Global Health Diplomacy at the Fiocruz regional directorate in Brasília with the overall aim to familiarise students with the dynamics

of globalisation processes and their impact on health policies and systems on the national and international levels (Almeida 2010: 147–8). Fiocruz Brasília further intensified its research efforts in global health by launching the virtual study centre on bioethics and health diplomacy in 2010. The study centre was set up in partnership with the University of Brasília and PAHO to analyse the connections between bioethics and health diplomacy through seminars, conferences, publications and other educational activities (NETHIS 2012).

In its international cooperation efforts, lots of health professionals trained by Fiocruz have been involved in a myriad of projects carried out by WHO/PAHO and other international organisations. Three of these health professionals (Paulo Buss, Jorge Bermúdez and José Gomes Temporão), which were all educated by Fiocruz's National School of Public Health ENSP, have left a strong mark on the mechanisms of regional and global health governance. By providing a short summary of their respective achievements, I would like to underline the significance of Fiocruz as an educational system of excellence (and a trademark) that provides health professionals with unique opportunities to contribute to shaping the mechanisms of regional and global health governance.

Paulo Buss

Buss graduated from ENSP/Fiocruz in 1975, acted as the vice director of ENSP from 1985 to 1989 and twice as its director (1989–1992 and 1998–2000), before assuming the position of the director of Fiocruz from 2001 to 2008 (ENSP/Fiocruz 2010). Buss represented Brazil on the WHO executive board from 2008 to 2011 and was elected vice president of the board in May 2010 for the period of one year (ENSP/Fiocruz 2010). Currently, Buss acts as the director of the Fiocruz Global Health Centre and represents Brazil both in the UNASUL Health Council and the CPLP (Fiocruz 2012b, 2012c).

As one of the representatives of the Fiocruz Global Health Centre explained, Buss's personal activism and his personal relationship with the then Minister of Health José Gomes Temporão must have been crucial in the involvement of Fiocruz in establishing the UNASUL Health Council and ISAGS:

> [...] When UNASUL was created [in 2008] Paulo Buss [as the then president of Fiocruz] said that there had to be a UNASUL Health Council. So, he encouraged, together with the then Minister of Health [José Gomes] Temporão the official part of the issue. He was very involved [...] personally because he got to know all the [health] ministers [of the UNASUL member states], it is almost a personal network. [...] ISAGS was created with funds which [Buss] had brought to the Fiocruz Global Health Centre.
>
> (Fonseca 27 September 2012)

Jorge Bermúdez

Jorge Bermúdez collected profound experience in the area of medicines production. He was the director of Farmanguinhos from 1985 to 1987 and afterwards assumed the presidency of the Vital Brazil Institute, which besides Farmanguinhos is one of the official governmental laboratories for the production of medicines, and the Brazilian Association of Official Pharmaceutical Laboratories (1987–1991; 1999–2001) (Fiocruz 2012d). He did his postgraduate studies in Public Health at ENSP/Fiocruz and succeeded Paulo Buss as the director of the same organisation from 2001 to 2004 (Fiocruz 2012d). Between 2004 and 2007, he headed the PAHO unit for Essential Medicines, Vaccines and Health Technologies, before he became the executive secretary of UNITAID from 2007 to 2011 (Fiocruz 2012d; UNITAID 2011b). Currently, he heads the Fiocruz vice-presidency of Health Production and Innovation (Fiocruz 2012d).

Bermúdez's leading position at UNITAID is of particular importance because of the organisation's crucial role in the access-to-medicines debate. The basis for Bermudez's nomination was laid when UNITAID was founded. In 2006, Brazil along with Chile, France, Norway and the UK created UNITAID as an innovative tool to decrease the price of medicines for pandemics like HIV/AIDS (Bermúdez 09 October 2012).

UNITAID works as an international drug purchase facility financed by budgetary contributions and a tax on airline tickets in several participating countries. Even though Bermudez conceded that due to domestic regulations, Brazil did not contribute to the innovative flight tax, Brazil did contribute with approximately US$12 million per year to UNITAID's budget[46] and was involved in all important decisions taken by the UNITAID executive board (Bermúdez 09 October 2012).

UNITAID provides the best example of the international institutionalisation of Brazil's strategy to reduce the prices of life-saving drugs (UNITAID 2011a). In cooperation with other countries, international organisations like the WHO, the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria and philanthropic foundations, UNITAID is committed to reducing the prices of life-saving drugs by creating market incentives for companies and increasing the competition among them (UNITAID 2010). The creation of a new market for life-saving

drugs led to extraordinary results (UNITAID 2011c): Between its creation in 2006 and 2011, UNITAID reduced the price of second-line AIDS drugs from US$ 1,500 per patient per year in 2006 to about US$ 450 in 2011. The organisation created a new market for child-friendly AIDS drugs and reduced the price of these drugs by an overall 80 per cent. UNITAID also created a new market for AIDS drugs directed at the treatment of adults, which more than 200,000 adults living with HIV/AIDS benefitted from. In 2009, the UNITAID executive board approved a new mechanism, called the Medicines Patent Pool for HIV/AIDS, which aimed to further reduce the price of life-saving medicines and stimulate the production of generics (Boseley 2009). The aim of the patent pool is to 'offer licenses for patents held by pharmaceutical companies, universities and government institutions to other manufacturers including generic producers, in return for royalty payments' (UNITAID 2010: 4).

According to Bermúdez, a lot of the activities carried out in other countries in the fight against HIV/AIDS were inspired by Brazil's actions (Fiocruz 2009a). With regard to Brazil's influence on UNITAID's decision-making process it is telling that the executive board, UNITAID's main decision-making body, met at the Brazilian Ministry of Foreign Affairs in Brasília in 2008 (Bermúdez 09 October 2012; ENSP/Fiocruz 2008). During their stay in Brazil, the first meeting of the executive board that took place outside of Geneva,[47] several board members also visited Fiocruz and its laboratory Farmanguinhos, interacted with the Ministry of Health, the Ministry of Foreign Affairs and the President's office, which provided the board members with more insight into the development, the structure and the rationale of Brazil's National AIDS Programme (ENSP/Fiocruz 2008).

José Gomes Temporão

José Gomes Temporão did his postgraduate studies in Public Health at ENSP/Fiocruz. Since 1980, Temporão has worked as a lecturer and researcher at ENSP/Fiocruz. He also worked in various positions in the government of the city of Rio de Janeiro and the Ministry of Health, served as the president of the Vital Brazil Institute (1992–1995) – as Jorge Bermúdez – and the president of Brazil's National Cancer Institute (2003–2005), before he was nominated Brazil's Minister of Health during Lula da Silva's second term as president (2007–2010) (CNPq 2012; INCA n.d.). After he had left the federal government, he became the first executive coordinator of the recently established ISAGS (Cappelano 2012).

During his post as the Minister of Health he took, together with President Lula da Silva, the decision to issue a compulsory licence on Efavirenz in 2007 and was directly involved in the whole process which led to the establishment of the UNASUL Health Council (UNASUL-Saúde) in 2009 and ISAGS in 2011 (Temporão 20 September 2012). After he had left the Ministry of Health, he was invited by the UNASUL member states to lead the further consolidation process of ISAGS which resulted in his current position as the executive coordinator of ISAGS (Cappelano 2012; Temporão 20 September 2012).

Also as Brazil's Minister of Health, he started to intensify Brazil's cooperation efforts in health with China, when in 2009 Temporão visited China to present the key aspects of Brazil's National Health System to the government and the private sector. In 2011, he joined a group of international experts[48] invited by the Chinese government to carry out an external evaluation of China's challenges in the public health sector (Cappelano 2012; Temporão 20 September 2012).

Networks and gateway nodes

On the resource-transfer interface, Brazil managed to informally enforce[49] those key elements of its National AIDS Programme which it had also advocated through its activities on the organisational interface (the human right to health, the local production of AIDS drugs, the legitimate use of compulsory licences in public health crises and the generic production of AIDS drugs). At the same time, Brazil's activities also contributed to further reinforcing the legitimacy of its role as a hero in the global fight against HIV/AIDS vis-à-vis the US and the pharmaceutical industry as the villains.

The Department of Sexually Transmitted Diseases, HIV/AIDS and Hepatitis in the Ministry of Health and the Oswaldo Cruz Foundation served as the key actors in the development of Brazil's resource-transfer power in global health governance. The Ministry of Health established various cooperation programmes and networks with the aim to transfer Brazil's knowledge and know-how based on its National AIDS Programme to African and Latin American countries. The Ministry of Health worked together with international partners to promote the local production of generic versions of AIDS drugs in Africa and Latin America. It was engaged in knowledge-sharing and capacity-building activities with respect to the successes of Brazil's National AIDS Programme on both continents. Through the transfer of these material and immaterial resources, Brazil actively helped other developing countries in Africa and Latin America in the

implementation of programmes similar to its own National AIDS Programme. The promotion of Paulo Roberto Teixeira, Pedro Chequer and Luiz Loures, key figures in the development of the National AIDS Programme, to leading positions in the WHO and UNAIDS added to the global dissemination of Brazil's ideas about how to successfully fight HIV/AIDS.

The Oswaldo Cruz Foundation contributed to these efforts through its own international networking activities and nodal design efforts. Figure 3.1 illustrates its complex insertion in the mechanisms of global health governance.

With regard to its networking activities, Fiocruz has been extremely active on both the international and regional level. On the international level the organisation plays a key role (------→) in several influential international networks such as DNDi, IANPHI, INSERM or the Institute Pasteur International Network. In addition, Fiocruz, through one of its technical units, established and coordinates (⟶) the highly successful and exemplary International Network of Human Milk Banks. On the regional level, Fiocruz concentrates its efforts on South America and the Portuguese-speaking countries in Africa, two regions of geostrategic importance to Brazil. In both regions, Fiocruz was able to establish and coordinate (⟶), with the participation of its technical units, several regional networks (RINSP, RESP and RETS) and actively participates (⟶) in two virtual networks which were designed for the respective regions (Virtual Public Health Campus and ePORTUGUÊSe). Through these networking activities, Fiocruz exchanges both material and immaterial resources in form of technology, know-how, technical staff, experience and expertise with internationally recognised research institutes and governments from all over the world, in particular from South America and the Portuguese-speaking African countries.

Apart from its international networking activities, Fiocruz has also been engaged in nodal design efforts. Fiocruz created two nodes ( ) outside of Brazil with the aim to better coordinate its activities in South America and Africa. In South America, Fiocruz was directly involved in the conception and the establishment of UNASUL-ISAGS (South American Institute of Health Governance) which was called into life to better coordinate and structure regional health governance among the UNASUL member states. In Africa, Fiocruz established its very first office outside of Brazil in Maputo, Mozambique, which is to serve as a coordinating platform for its activities in Africa in cooperation with regional organisations like the African Union, the CPLP and PAHO (-·-·-·→). As a

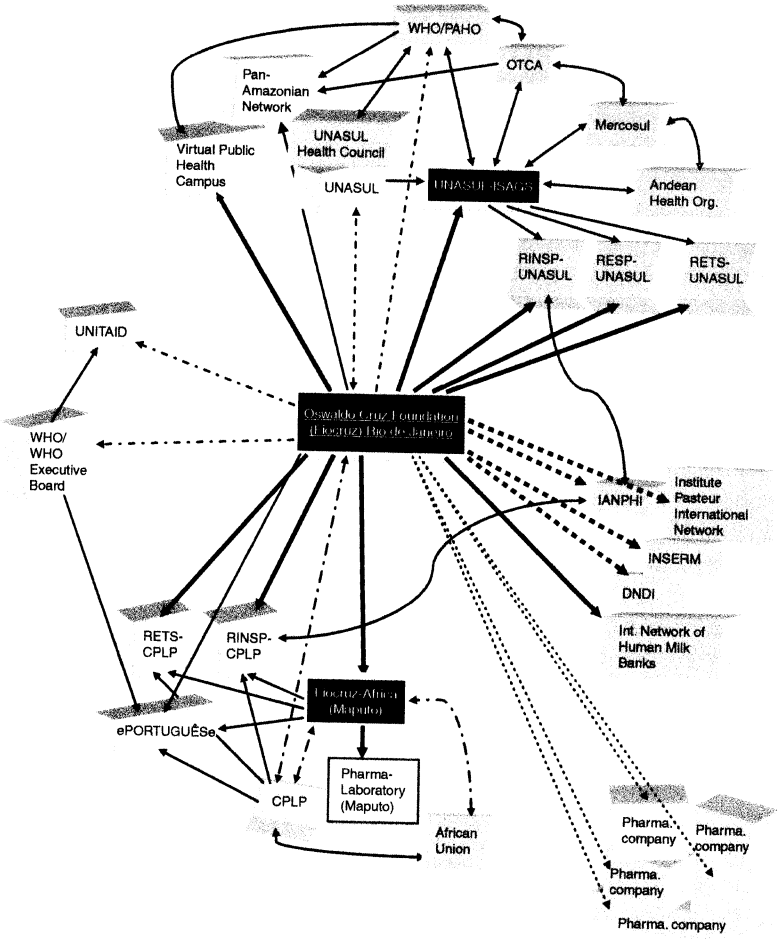

Figure 3.1 The Oswaldo Cruz Foundation

further achievement, Fiocruz was actively involved in the establishment of a pharmaceutical laboratory in Maputo which is to further stimulate the transfer of generic medicines, in particular AIDS drugs, from Brazil to Africa.

As a further aspect of Fiocruz's significance for Brazil in global health governance the organisation, via its pharmaceutical laboratory Farmanguinhos, was crucial in the negotiations of the Ministry of Health with pharmaceutical companies like Merck, Roche or Abbott to

reduce the prices of various essential AIDS drugs (·····▸). The increasing production capabilities of Farmanguinhos over the last decade in producing generic AIDS drugs allowed the Ministry of Health to take an aggressive stance against the pharmaceutical industry, which resulted in Brazil's decision to issue for the very first time in its history a compulsory licence of Merck's Efavirenz in 2007.

The involvement of many Fiocruz health professionals in international projects also demonstrates the success of the organisation in its contribution to Brazil's global fight against HIV/AIDS. The private achievements of three health professionals who were promoted to leading positions in the mechanisms of global health governance (- - - - - ▸) – Paulo Buss (UNASUL, WHO), Jorge Bermúdez (UNITAID), and José Gomes Temporão (UNASUL-ISAGS) – bear testimony to Fiocruz's important role in Brazil's global fight against HIV/AIDS.

Taking into account this impressive kaleidoscope of activities, I decided to describe Fiocruz as Brazil's fundamental governmental gateway node in global health governance. Through Fiocruz, Brazil was able to engage in much more than just networking activities. Fiocruz has thoroughly expanded its activities throughout the last decade through nodal design efforts.

Fiocruz meets all the four characteristics of a basic node. It has a *common strategy* (or way of thinking) which is based on the development of public health research in all its aspects. It has a *set of methods* to implement this strategy, which is to carry out public health research. It relies on a *significant amount of resources*, generally derived from the Ministry of Health, to support the functioning of the whole organisation. And Fiocruz has a *highly complex institutional framework* which enables the mobilisation of resources and allows the organisation to pursue its common strategy. In addition to these basic characteristics, Fiocruz is involved in activities which go beyond those carried out by a mere node. Besides its *international networking activities*, Fiocruz has distinguished itself in *creating and coordinating new governing nodes* in South America and Africa ( ), which led to the creation of new regional health governance mechanisms, and the *coordination of its activities in a complex network of interconnected nodes*. In this role Fiocruz serves Brazil (1) as *an access point and pathway to the complex web of global governance mechanisms* and (2) as *a platform to disseminate Brazil's ideas* (among others the key ideas of the National AIDS Programme, such as the human right to health, the human right to access to medicines, the local production

of AIDS drugs and the use of compulsory licences) and *increase Brazil's presence in the mechanisms of global health governance*.

The activities of this gateway node, along with the Department of Sexually Transmitted Diseases, HIV/AIDS and Hepatitis, were crucial to the development of Brazil's resource-transfer power. By transferring material (raw material for the production of generic AIDS drugs, etc.) and immaterial (knowledge, know-how, expertise, etc.) resources to many developing countries in Africa and Latin America, both Fiocruz and the Department of Sexually Transmitted Diseases, HIV/AIDS and Hepatitis contributed to Brazil's role as a hero in the global fight against HIV/AIDS and further undermined the position upheld by the US and the pharmaceutical companies.