GETTING INVOLVED IN AFRICA PANEL
RESPONDING TO THE AIDS PANDEMIC – A CALL TO ACTION

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Over the last seven years I have spent twelve months in South Africa teaching on two law faculties, the University of Durban-Westville (UDW), a formerly all-Indian university, and the University of Natal-Durban (UND), a formerly all-white elite university, both of which have substantially integrated with Black African students in the 1990's. When I first arrived for a six-month sabbatical in 1997, I was politically and culturally naïve about my prospective students, the two law schools, and the South African legal system, all of which bore the wounds of apartheid and all of which were struggling, despite limited resources, to transform themselves and South African society. Over time, my planned focus of adapting a U.S.-based legal skills and legal writing pedagogy to the South African context transitioned to a focus on culturally competent collaboration with my new colleagues. As I struggled with cross-cultural challenges arising from working in a law school clinic where I supervised students who were advising clients from Indian and Zulu communities, my focus shifted again as I came to learn, slowly, about the HIV/AIDS pandemic that was decimating sub-Saharan Africa. By the end, my stances as a legal educator and a global citizen had shifted from cross-cultural collaboration to international solidarity and I have since become a HIV/AIDS treatment activist.

A MISSING BABY: CHAOS AT A PEDIATRIC MORGUE

On April 16, 2002, while I was again working at the UDW law clinic, a young Zulu man in his early twenties came to the clinic with a story involving a missing baby and institutional chaos at a pediatric mortuary. The client told his student interviewer that his girlfriend had had a baby the previous year and that the baby was born "very sick" and had been kept in the hospital. The mother stayed with her baby as much as possible and the client visited the hospital once to bring his girlfriend a change of clothes and some baby clothes. At that time, he acknowledged his paternity to the hospital staff. As the baby's condition worsened, the baby was transferred to another public hospital where he died at the age of six weeks on Easter weekend.

The client and his girlfriend were inconsolable, but they went home to plan the funeral. Having scraped together money for a coffin and burial ceremony, planned atypically for a Wednesday rather than a Saturday, they contacted a funeral home to prepare the body for burial. On Tuesday morning the funeral home told the young couple that there was a problem at the hospital and that they should go to the morgue to identify their baby. Upon arriving at the morgue, the mortician told the couple that there had been a mix-up and that they would have to return on Thursday.

Accordingly, the parents rescheduled the funeral and returned to the hospital as directed. The mortician took them into the morgue, opened a drawer and asked the couple if the baby inside was theirs. Instead of a small, dark-skinned, six-week old baby boy, the body in the mortuary drawer was that of a much larger and much lighter-skinned infant. When the couple said that the baby was not theirs, the mortician told them that there must have been a mix-up and that their baby had been given mistakenly to another family for burial. Although the mortician had the other family's last name and the distant township in which it lived, he did not have an address.

At this point, the mother was crying hysterically and wailing that she wanted her baby. The mortician suggested that the couple "bury this baby because the other family has buried yours." When the couple expressed outrage at this suggestion, they were referred to the hospital's medical superintendent. The superintendent promised to investigate the matter and get back to them. Although nearly a year had passed, the couple had heard nothing further from the hospital.

During a break in the interview, the student interviewer brought this story to me and another clinical supervisor. As we explored the case, we tried to find out more about the mother and why the unmarried boyfriend was there by himself. The student told us that the client had said that his girlfriend was too upset to come to the office and that she was still crying all the time over her missing baby. Allegedly, the girlfriend wanted the client to handle the matter because "he was the man." When we asked the student what relief the client wanted, we were told that he wanted compensation for the missing baby, but that he was no longer interested in discovering the current whereabouts of the baby or in giving his son a proper burial. We were curious about the client's desire for compensation only, given the importance of a proper burial in Zulu custom and given the mother's reported grief. We decided that we would have to follow up these issues with the client directly.

In addition, we would have to investigate the father's relationship to the child and whether he had sufficiently acknowledged paternity to bring a claim on his own behalf. According to South African law, the mother of a child born out of wedlock is the natural guardian and would stand as the legal representative for this kind of claim. Thus, we anticipated that we would have to explain to the client that his girlfriend might have to become involved, at least as a witness and possibly as the nominal client. Complicating the matter even further, we learned that the mother was not yet 21, meaning that she too had not yet reached the age of majority. Technically, therefore, the young woman's parents would ordinarily be the formal clients, acting for their daughter. The case was becoming increasingly complex, even more so because the one-year statute of limitations was set to expire in seven days.

After discussing these issues among ourselves, we collectively re-interviewed the client, who fortunately spoke a little bit of English. The client confirmed the information that the student had given us and reiterated his position that he and his girlfriend could not stand the trauma of digging up their baby's body only to rebury it. He assured us that his girlfriend would come to the office, but that she would want him to handle the case. Accordingly, we arranged for the client to return with any documentation he could find about the hospitalization, the cause of death, and the inquiries he had made at the hospital morgue.

During the afternoon grand rounds, we discussed this case at length. We tried to brainstorm how the mix-up could have occurred. For example, given the physical differences between the babies, we could not figure out how the other family had not recognized that the baby they took was not theirs. We asked students whether burial customs for a child included an open or closed casket and were told that practice varied. Based on the presence of the second body in the mortuary drawer, it seemed clear to us that there had been more than one baby's body at a time. Therefore, we asked students why they thought there might have been such dramatic overcrowding at the morgue. Finally, to understand our client's wishes more clearly, we asked about the strength of tradition that the child be properly buried in order to "appease the ancestors."

As the story unfolded, my body and soul filled with dread, not just for the tragedy that had overtaken this one young man and his girlfriend, but the greater tragedy of which it was part. Although the client had not said one word about AIDS, I had a growing suspicion, shared by the other clinicians, that HIV had not only killed this baby but that HIV also explained the

overcrowding at the morgue in which this mix-up occurred. We were familiar with the rising death toll among children born HIV-positive, many of whom died before six months of age. We had heard of bodies piling up in morgues as families, HIV-positive themselves, struggled to borrow money for funerals. We had also heard that many of these babies were abandoned at the hospital, abandoned by parents who couldn't cope because of distance and dismay or orphaned by parents, especially mothers, who may have died in the interim.

Our suspicions were confirmed when the client and his girlfriend returned to the clinic with a one-page record from the hospital indicating the baby's death was "AIDS-related." Seeing the mother in the waiting room, painfully thin, listless, and jaundiced, we had little doubt that she too was dying of AIDS. Even though the boy friend appeared healthier, it seemed likely that he too could be HIV positive. Perhaps this unacknowledged illness explained the client's interest in monetary compensation; perhaps the couple wanted money for medicines instead of the certainty of a shared grave with their child. However, given that the client had not come to us to discuss his HIV statuswe now faced the moral and ethical dilemma of whether to raise the cause of death with him and whether to refer him and his girlfriend for voluntary HIV counseling and testing. Alternatively, if the couple knew their status, we might need to help them try to access palliative treatment for opportunistic infections since anti-retrovirals were not available in the public sector. As we considered these options, we were frankly overwhelmed by the task of representation and by the disease at the heart of the client's dilemma.

THE ESCALATING AIDS PANDEMIC

At present, over 40 million people are living with HIV/AIDS, including nearly 27 million in Africa. Although nearly six million people in developing countries need immediate access to affordable, high quality anti-retroviral medicines or they will die within two years, 93% of people with treatable AIDS in developing countries and 98% in Africa are living – and dying – without medicines that have dramatically extended lives in the U.S. It is against this backdrop of 8600 lives lost each and every day that we must judge the world's hesitant and often counter-productive response and applaud the corresponding activism of people living with HIV/AIDS and their supporters to catalyze the rapid deployment of life-saving treatment.

4.4 million Africans with AIDS are in a treatment-deprived death queue and only 100,000 are receiving anti-retroviral therapy. This gap in access to medical treatment reflects a massive disconnect between the perceived interests of rich countries in the global North, including the proprietary pharmaceutical companies that research, develop and produce patented medicines, and the interests of developing countries in the global South that require life-saving medicines to fight the catastrophic HIV/AIDS pandemic that is decimating their poverty-stricken populations. This disconnect occurs at the intersection of three separate systems: national and international intellectual property regimes, especially the World Trade Organization (WTO) Agreement on the Trade Related Aspects of Intellectual Property Rights (TRIPS),[1] national and regional capacities to manufacture and market pharmaceutical products efficiently, and global patterns of income inequality and poverty. While the U.S. government connives to guarantee bloated profits for the U.S. pharmaceutical industry, the body count rises through a vicious form of medical apartheid best called death by patent.

Neo-liberal theory promotes strong and enhanced intellectual property rights, including those of pharmaceutical producers, as the magical route to development, where the rising tide of import-

[1] Art. 8(1), Marrakesh Agreement Establishing the World Trade Organization, Annex 1C, 33 I.L.M. 81 http://www.wto.org/english/docs_e/legal_e/27-trips.pdf (1994).

export economies will rehabilitate failed public health sectors and IP protection will promote local research and development of medicines for indigenous diseases, including the clades of HIV that are found in Africa and Asia. Public goods theory imagines that benign and well-funded multilateral institutions can take over the research, development, and manufacture of new drugs for neglected diseases and in addition supply large quantities of low cost medicines to poor consumers. These two theories, preposterous or utopian[2] in turn, offer little solace for tens of millions of people living with a disease that will kill them in the prime of life within eight years.

A more pragmatic solution, pursued by treatment activists internationally, is the promotion of robust generic production by a limited number of manufacturers at sufficient economies of scale so that medicines can be accessed at lowest cost. To enable production and trade in these generic medicines, treatment activists have launched a broad-based attack on recently enshrined intellectual property rights. To enable purchase of these drugs, activists have succeeded in establishing funding structures such as the Global Fund to Fight AIDS, TB, and Malaria[3] and in agitating for greatly enhanced bilateral and multilateral donations so that there are reliable and sustainable reservoirs of purchasing power sufficient to provoke generic entry and to finance purchase of large quantities of medicine.

Neglect and neo-liberalism have intensified the pandemic, but trade U.S. trade policy and pursuit of enhanced intellectual property rights has prevented a viable response. In place of a robust global reaction speeding medical care to the heart of Africa, the U.S. and its European allies have erected a pharmaceutical embargo, a protectionist system of intellectual property protections that keeps drugs from people in need. This system of pharmaceutical apartheid seeks to preserve drug company access to a narrow spectrum of rich elites, especially in middle income developing countries, but in low income countries as well, at the same that that it forestalls access to 95% of the people living with AIDS who are in immediate need of anti-retroviral therapy.

In terms of trade policy, the U.S. government has consistently pursued the commercial interests of the hugely profitable U.S. patent pharmaceutical industry[4] at the expense of access to more affordable medicines in developing countries. The prime example of this warped sense of priorities occurred in multilateral negotiations that established a uniform system of international intellectual property rights, the WTO TRIPS Agreement.

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[2] Although I call international, public sector research and development of medicines for neglected disease and multilateral, public-sector production of low cost generic medicines utopian, that doesn't mean that I don't think such a solution has merit. Moreover, certain elements of such an approach are underway. *See*, Medecins Sans Fronieres Access to Essential Medicines Campaign and the Drugs for Neglected Disease Working Group, *Fatal Imbalance: The Crisis in Research and Development for Drugs for Neglected Diseases* (Sept. 2001).

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> The concept for an international funding mechanism to fight HIV/AIDS, TB, and malaria began at the Okinawa G8 Summit in July 2000. At the urging of UN Secretary General Kofi Annan and many national leaders, the concept of the Fund was unanimously endorsed in June 2001 at the first UN General Assembly Special Session to focus on HIV/AIDS. In July 2001 at its meeting in Genoa, G8 leaders committed US $1.3 billion to the Fund.

The Global Fund to Treat AIDS, TB, and Malaria: FAQ <www.globalfundatm.org/faq_gfund.html> (Feb. 2002).

[4] Pharmaceuticals have ranked as the most profitable sector in Fortune 500 rankings for the past three decades. The top ten U.S. drug makers increased their profits by 32% from $28 billion in 2000 to $37 billion in 2001. Together these ten companies report profits of 18.5 cents for every dollar of sales, eight times higher than the median for all Fortune 500 industries. Scott Gottlieb, *Drug Companies Maintain "Astounding" Profits*, 324 B.M.J. 1054 (May 4, 2002).

The TRIPS Agreement introduced minimum global standards for protecting and enforcing nearly all forms of intellectual property rights, patents, copyrights, and trade secrets, including those applying to pharmaceuticals. The Agreement covers basic principles, standards and use of patents, enforcement, dispute settlement and multiple other subjects, many of which are tilted in favor of intellectual property owners and against the interests of consumers. Under key provisions in TRIPS, member countries must provide patent protection for a minimum of 20 years from the filing date of a patent application,[5] for any invention, including a pharmaceutical product or process, that fulfils the criteria of novelty, inventive step and usefulness. Although preceding patent-rule pluralism in both the developed and undeveloped world had allowed discrimination between fields of invention, for example by excluding medicines, TRIPS expressly outlawed such discrimination.[6] Similarly, it was no longer permissible to discriminate routinely against imports in favor of locally produced products, thus allowing major pharmaceutical companies to control the *place* of production.[7] Because of TRIPS, the major pharmaceutical producers succeeded in consolidating their monopoly power internationally – they have exclusive rights under Article 28 to exclude others from "making, using, offering for sale, selling, or importing" patented pharmaceutical products or products made with a patented process. In addition, the Agreement has provisions protecting undisclosed information (including clinical test data) that impede registration of generic drugs.[8] Given its advantage in conducting research and development (96% vs. 4%), the developed world secured near absolute competitive advantage over the developing world in intellectual property rights via the TRIPS Agreement.[9]

Even after the passage of TRIPS, the U.S. continued a heavy-handed trade policy that threatened developing countries such as Thailand, South Africa, and Brazil with trade sanctions because they refused to grant even greater TRIPS-plus rights to patent holders and/or because they proposed using TRIPS compliant means to access more affordable medicines.[10] More recently, after initially agreeing in the Doha Declaration[11] to give developing countries increased leeway to utilize loopholes in TRIPS to access cheaper generic medicines, the U.S. has reneged on its binding commitment and temporarily blocked meaningful efforts to liberalize access to generics, particularly with respect to the production-for-export problem, until August 30, 2003, when it

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[5] Article 33.
[6] Article 27.
[7] Article 27.
[8] *See* Article 39.3. For an extended discussion of options concerning appropriate use of undisclosed data, *see* Carlos Correa, *Protection of Data Submitted for the Registration of Pharmaceuticals: Implementing the Standards of the TRIPS Agreement* (South Centre, 2002).
[9] World Bank, *World Development Indicators 2000*, Table 5-12.
[10] *See, e.g.*, Omnibus Consolidated and Emergency Supplemental Appropriations Act, Pub. L. No. 105-277, 112 Stat. 2681 (1999):

> [N]one of the funds appropriated under this heading may be available for assistance for the central Government of the Republic of South Africa, until the Secretary of State reports in writing to the appropriate committees of the Congress on the steps being taken by the United State Government to work with the Government of the Republic of South Africa to negotiate the repeal, suspension, or termination of section 15(c) of South Africa's Medicines and Related Substances Control Amendment Act No. 90 of 1997.

For a discussion of early pro-pharma U.S. trade policy, *see* Patrick Bond, *Globalization, Pharmaceutical Pricing and South African Health Policy: Managing Confrontation with U.S. Firms and Politicians*, 29 Int'l J. Health Services 768 (1999). For a more recent history, *see* Ellen 't Hoen, *TRIPS, Pharmaceutical Patents, and Access to Essential Medicines: A Long Way from Seattle to Doha*, 3 Chi. J. Int'l Law 27, 30-33 (2002) (detailing U.S.T.R. and pharmaceutical industry actions against South Africa and Brazil).
[11] Declaration on the TRIPS Agreement and Public Health, Ministerial Conference, Fourth Session, Doha, Nov. 9-14 2001, WT/MIN(01)/DEC/2 (Nov. 20, 2001) (hereinafter Doha Declaration).

imposed a highly conditionalized and procedurally burdensome compromise on developing countries. Finally, despite trade authorization legislation to the contrary, the U.S. Trade Representative continues to seek enhanced, TRIPS-plus intellectual property protections in bilateral and regional trade negotiations, including those affecting the Southern Africa Development Union.[12] There is a strong argument that these efforts violate U.S. law[13] and an even stronger argument that they violate international human rights law.[14]

Paradoxically, activists have turned to the market to solve market failure; they have resorted to pre-monopoly competition and assured purchasing power as tools of choice, tools which must be further actualized by reforming international trade agreements and national patent schemes to facilitate global commerce in standard-quality, low-cost generic medicines. Nonetheless, their campaign has been radically successful producing medicines that are unbelievably cheaper than their brand name, patent-protected counterparts, which cost well over $10,000 per year. Thus, this fall, a new benchmark price has been established by four generic producers, three Indian and one South African – less than $140 per year for WHO pre-qualified and preferred fixed-dose combination medicine.[15] Accordingly, standard quality generics are now available for **a penny on the dollar** of what the major pharmaceutical companies charge in rich markets.[16]

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[12] Pursuing this end-run strategy, on November 5, 2002, United States Trade Representative Robert B. Zoellick formally notified Congressional leaders of the Administration's intent to initiate negotiations for a free trade agreement with the nations of the South African Customs Union: Botswana, Lesotho, Namibia, South Africa and Swaziland. To meet "standards of protection similar to that found in U.S. law and that build on the foundation established" in TRIPS, SACU nations would be required to limit compulsory licenses to national emergencies or to governmental, non-commercial use only. They would be required to bar parallel trade, to extend patent monopolies for administrative delays, and to link drug registration rights to patent status. Finally these nations would be required to enhance protections for clinical trial testing data and to adopt criminal enforcement for patent violations, including improvidently granted compulsory licenses. In sum, the proposed negotiation objectives would completely eviscerate the Doha flexibilities, dramatically increase IP protection, and shamefully reduce access to more affordable generic products.

[13] These intellectual property negotiation objectives also directly violate the principal negotiating objectives in the Trade Act of 2002, which requires the U.S. " to respect the Declaration on the TRIPS Agreement and Public Health, adopted by the World Trade Organization at the Fourth Ministerial Conference at Doha, Qatar on November 14, 2001." 19 U.S.C. § 3802(b)(4)(C) (2002). Similarly, by seeking TRIPS-plus provisions found in U.S. law, the U.S. Trade Representative is also directly violating Executive Order 13155, 3 C.F.R. 268 (2000), which in relevant part, reads:

(a) In administering sections 301-310 of the Trade Act of 1974, the United States shall not seek, through negotiation or otherwise, the revocation or revision of any intellectual property law or policy of a beneficiary sub-Saharan African country, as determined by the President, that regulates HIV/AIDS pharmaceuticals or medical technologies if the law or policy of the country: (1) promotes access to HIV/AIDS pharmaceuticals or medical technologies for affected populations in that country; and (2) provides adequate and effective intellectual property protection consistent with the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS Agreement) referred to in section 101(d)(15) of the Uruguay Round Agreements Act (19 U.S.C. 3511(d)(15)).

[14] Richard Elliott, *TRIPS and Rights: International Human Rights Law, Access to Medicines and the Interpretation of the WTO Agreement on Trade-Related Aspects of Intellectual Property* (Nov. 2001) (prepared for the Canadian HIV/AIDS Legal Network and the AIDS Law Project of South Africa) http://www.aidslaw.ca/Maincontent/issues/cts/briefs/TRIPS-human-rights-briefPDF.pdf .

[15] Mark Schoofs, *Clinton Program Would Help Poor Nations Get AIDS Drugs*, Wall Street Journal (October 23, 2003).

[16] Admittedly, several major pharmaceutical companies have offered price discounts in Africa and elsewhere, particularly through the WHO co-sponsored Accelerating Access Initiative. However, this Initiative has gotten off to a painfully slow start such that only 36,000 additional patient received medicines from the new program between May of 2000 and March of 2002. WHO & UNAIDS Progress Report,

At the same time that they have turned pragmatically to the market, activists have advocated for a more benign form of globalization, for multilateral structures, such as the Global Fund, to coordinate the international response to the pandemic. Activists have humanized their "free generic trade" and "multilateralist" rhetorics, however, with a call to human rights, a call for the immediate, or at least expedited, realization of access to medical care and affordable medicines. They have done so forcefully, even theatrically with mass demonstrations, civil disobedience, and intense lobbying both in the North, the belly of the beast, and in the South, the scene of the crime. Often they have done so by concerted action by calling for global days of protest against drug companies,[17] against governments,[18] and against multinational corporations.[19]

The rebuff of patents and the ascendancy of trade in generics and of the right to treatment is a case study of the impact that coordinated social movements can have on the reconstruction of public imagination, social institutions, and legal arrangements, a reconstruction that has moved the world from thinking that treatment of people living with AIDS in developing countries was an impossibility, or in the words of the World Bank, "not economically efficient," to a world where it is now likely that a greatly increased percentage of people living with AIDS might begin to receive anti-retroviral care. One by one, activists have attacked structural and legal barriers to access and have imagined and then advocated for new institutional arrangements and new policies that might make treatment a reality.

The preliminary and partial success of the global access-to-treatment campaign is founded in the ruins of failed law, failed ideology, and failed development. It is a campaign that has deployed conflicting discourses – competition, public health, anti-globalization, and human rights – in pursuit of a precondition upon which all development depends: a population healthy enough to survive past middle age. In this regard, activists' amalgamated right-to-treatment discourse, unlike some mainstream human rights discourse, is neither individual nor negative; it is instead a discourse of community and of positive and equitable rights whereby the great global imbalance in access to medical care is subject to radical redistribution, North to South, rich to poor, white to Black, and male to female.

In describing successes in access to medicines, it is crucial to interweave an account of the vision, bravery, and solidarity of people living with HIV/AIDS and their allies who have forged a small but growing international coalition of treatment activists. The power of their moral campaign has temporarily chastened one of the world's most powerful industries and the world's remaining superpower. Although much has been accomplished – drug prices have plummeted (to as little as $140 a year), AIDS funding in developing countries has multiplied 500% (to $4.7 billion between 1996 and 2003), and treatment is finally beginning to reach a portion of the poor (from 20,000 in Africa to 100,000 in three years) – much remains undone. Thus, the campaign continues, organized around the bedrock principal that the human right to health, and to life itself, trumps intellectual property rights, the Washington Consensus, and MNCs' right to maximize profits.

Accelerating Access Initiative: Widening access to care and support for people living with HIV/AIDS 1-2 (June 2002). Although the figure has now risen to 76,300 people, the conditions that companies impose and the requirement for country-by-country, drug-by-drug negotiations have resulted in a widening, not narrowing, gap in access to treatment.

[17] Treatment Action Campaign Global Day of Protest, March 8, 2001.

[18] Treatment Action Campaign, April 27, 2003.

[19] Health GAP's Treat Your Workers Campaign, October 17, 2002, targeting Coca-Cola.

In the U.S., the ongoing campaign includes demands against the federal government for greatly increased bilateral and multilateral aid for comprehensive HIV/AIDS prevention, care, and treatment in developing countries. It includes demands for debt forgiveness and for an end to ruinous trade policies that privilege pharmaceutical profits over human life. Activist campaigns also target pharmaceutical companies demanding unconditional, deeply discounted prices, non-exclusive voluntary licenses for generic producers, and relaxation of patent rights in developing countries. Even more recently, the campaign has made successful demands on multinational corporations like Anglo-America, the mining conglomerate, and Coca-Cola, the world's best known consumer product, that they provide anti-retroviral (ARV) and opportunistic infection (OI) treatment for their direct and indirect workers and workers' dependents overseas. Finally, the U.S. campaign tries to hold multilateral institutions like the World Bank, the International Monetary Fund (IMF), the World Health Organization (WHO), the Global Fund, and UNAIDS accountable for their obligations to respond to the pandemic.[20]

Activists in the South are even more intensely engaged in similar campaigns, often with a broader base including labor, religious leaders, and organized civil society. The Treatment Action Campaign in South Africa,[21] for example, has successfully completed a five-year campaign for prevention of patent-to-child transmission of HIV, a campaign that culminated in the Constitutional Court's condemnation of the government's hesitant, pilot-project approach.[22] Even more recently TAC launched a campaign of civil disobedience against the ANC government for its failure to sign a national treatment plan that it had negotiated in 2002 with labor, industry, and activist partners,[23] and on November 19, 2003, won a firm commitment from the government that it would begin an ARV treatment program that will eventually provide universal treatment for 1.5 million PWAs within five years.

In addition to demanding vision and action by government, TAC joined the government in beating back a 1998-2001 lawsuit by the pharmaceutical industry,[24] and more recently in challenging excessive pricing by the patent drug industry at South Africa's Competition Commission. On December 10, TAC and other complainants reached a historic settlement with GlaxoSmithKline and Boehringer-Ingelheim granting an expanded number of licenses permitting generic companies to supply public and private sectors throughout sub-Saharan Africa.[25] Supplementing its local focus on pharmaceutical practices, TAC has urged reform of the TRIPS Agreement and has helped forged a continental coalition of treatment access activists.[26] And that network has become increasingly active in demanding an end to governmental lethargy in African countries, many of which have failed to mount credible response to the escalating crisis.

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[20] *See* Health GAP webpage: http://www.healthgap.org/index.html .

[21] *See* Treatment Action Campaign webpage: http://www.tac.org.za/ .

[22] *Minister of Health v. Treatment Action Campaign*, 10 B.C.L.R. 1033 (S.A. Con. Ct. 2002).

[23] *On February 14, 2003, TAC led a mass demonstration of 20,000 people, demanding that the government launch a comprehensive HIV/AIDS treatment plan.* See *[Ip-health] Dying for Treatment -- The TAC Civil Disobedience Campaign,* http://lists.essential.org/pipermail/ip-health/2003-March/004451.html (March 7, 2003).

[24] *Pharmaceutical Manufacturers' Association of SouthAfrica v. President of the Republic of South Africa*, Case No. 4193/98 (filed Feb. 18, 1989). The lawsuit was unconditionally dismissed in April 2001 following "strong international public outrage." Ellen t' Hoen, *TRIPS, Pharmaceutical Patents, and Access to Essential Medicines: A Long Way from Seattle to Doha*, 3 U. Chi. J. Int'l L. 27, 31 (2002).

[25] Brook K. Baker, Threat of Compulsory Licenses at the South African Competition Commission Results in Generic licenses for AIDS Medicines, http://lists.essential.org/pipermail/ip-health/2003-December/005713.html.

[26] *[Ip-health] Pan-African HIV/AIDS Treatment Access Movement: Declaration of Action, http://lists.essential.org/pipermail/ip-health/2002-August/003411.html (Aug. 28, 2002).*

A number of legal academics, law students, and legal activists in the U.S. have become aware of the AIDS pandemic and the complex mix of structures, norms, policies, and law that complicate a more heroic global response to the preeminent human rights crisis of our time. However, there is very little public presence or concerted action by U.S. legal academics to reverse the tide of disease or to confront global decision-makers who erect and enforce barriers to treatment. It is a frank aim of this presentation to urge a larger number of legal scholars, especially those who are interested in and knowledgeable about Africa, to make the AIDS pandemic a centerpiece of their practice. Thus, I conclude with a call to action.

CALL TO ACTION

- What is our response to the most devastating public health crisis of the last six hundred years?

- What is our response to the most pressing human rights dilemma of our times?

- What is our response to 11 million children orphaned by AIDS in Africa and to 27 million Africans standing in line – in a death queue – unless the world responds to this crisis as the crisis it is?

- America has the financial resources, the drugs, and the technical know-how to respond to this crisis, but our leaders are indifferent.

- They would rather pay billion dollars a week for a war in Iraq or a billion dollars a week in farm subsidies than pay one billion dollars a year for antiretroviral therapy that would treat a million Africans living with AIDS.

- They would rather give a trillion dollar tax break to rich Republicans than fulfill their promise to pay $3 billion a year for Global AIDS, let alone the $6 billion they should be paying.

- They would rather protect the profits of our multi-billion dollar drug industry instead of relaxing intellectual property rules and trade rule that restrict access to affordable, standard quality, generic medicines.

- They would rather procrastinate and lie and blame infrastructure, absorptive capacity, and the ability of Africans to tell time and to take medicine than respond urgently and massively to this crisis.

- They would rather go it alone, betting on a long-delayed, poorly planned, and politically expedient bilateral program than fund the only program that is currently putting resources on the ground – namely the Global Fund to Fight AIDS, TB, and Malaria.

- They would rather keep collecting interest income on an obscene and odious debt - $14 billion a year than forgive a debt that never should have been incurred.

- What are we going to do?

- Do we have power as legal activists, interested in Africa, to act?

- What should we do with the enormous privileges we have individually and collectively.

- Can we actually connect in our hearts and in our imaginations with our brothers and sisters living and dying with HIV/AIDS halfway around the world?

- I urge us to join the campaigns that are currently being waged, here in America, here in the belly of beast, where indifference and avarice condemn a continent to death.

    - The presidential 04-Stop-AIDS Campaign

    - Fund the Global Fund campaign

    - $3 billion not $2 billion 2004 and even that's far to little

    - Drop the Debt

    - Stop seeking heightened intellectual property protections at the WTO, in the South African Customs Union, in Central America, and throughout the Americas in the FTAA.

    - Attack the structural features and the neo-liberal policies that intensify the pandemic.

    - Fulfill the promise of WHO – 3 million in treatment by the end of 2005

    - Supply condoms, stop interfering with family planning, stop blaming individuals, and stigmatizing men who have sex with men and IV drug users

- There are dozens of important campaigns each one of us can join. We do not have to be indifferent. We do not have to feel paralyzed. We do not have live in a world where racist indifference condemns the children of our common ancestors to an early grave.

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