Spectacular Failure—A View from the Epicenter

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The question these billions ask is—what are you doing you in whom we have placed our trust, what are you doing to end the deliberate and savage violence against us that, everyday, sentences many of us to a degrading and unnecessary death!

—President Thabo Mbeki, U.N. Millennium Summit, 2000[1]

INTRODUCTION

In 2000, at the XIII International AIDS Conference in Durban, Jeffrey Sachs spoke of the "shocking disregard" shown by the international community in its failure to respond to the AIDS epidemic.[2] "How could the world," he asked, "have stood by for the first 20 years of this pandemic, letting it reach 35 to 40 million people before any real funding started?"[3] Two years later, at the XIV International AIDS Conference in Barcelona, speakers again decried the world's inaction; Dr. Peter Piot, Executive Director of the Joint United Nations Programme on HIV/AIDS (UNAIDS), lamented, "Why are only 30,000 Africans getting antiretroviral treatment, when a hundred times that number need it?"[4]

It was at the Barcelona Conference that an inspiring call was issued to

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1. South African President Thabo Mbeki, Statement at the U.N. Millennium Summit (Sept. 7, 2000), http://www.anc.org.za/ancdocs/history/mbeki/2000/tm0907.html (last visited Jan. 7, 2004). *See generally* Tim Trengove Jones, CTR. FOR THE STUDY OF AIDS, *Who Cares? AIDS Review 2001*, http://www.csa.za.org/filemanager/list/3/ (last visited Jan. 7, 2004) (discussing Mbeki's speech at the U.N. Millennium Summit).

2. Jon Cohen, *Companies, Donors Pledge to Close Gap in AIDS Treatment*, 289 SCIENCE 368, 368 (2000) (quoting Sach's comments at the XIII International AIDS Conference).

3. *Id.*

4. Peter Piot, Keeping the Promise, Address at the Opening Ceremonies of the XIV International AIDS Conference (July 7, 2002), http://www.hivandhepatitis.com/2002conf/14th_aids/4.html (last visisted Jan. 7, 2004).

make antiretroviral (ARV) treatment available to three million people in the developing world by the end of 2005.[5] Providing treatment to three million—when twenty million are infected—does not seem like an ambitious plea. Yet, even this somewhat modest goal is unlikely to be reached, given the ongoing failure to mobilize international resources for the provision of HIV/AIDS drugs in the developing world. Just a few months ago, on the very day the World Health Organization launched its 5.5 billion dollar so-called "three by five" plan to meet the treatment challenge outlined in Barcelona in 2002,[6] speculation about the organization's inability to meet the plan's financial requirements began to appear in the media[7]—leaving many to wonder whether the next International AIDS Conference will be yet another reprise of the previous two.

At the very least, the implications of this failure to mobilize resources will need to be recognized at the upcoming 2004 International AIDS Conference in Bangkok. The responsibility for the largely avoidable deaths that have resulted from this failure must be laid firmly where it belongs. Unfortunately, it belongs everywhere: Responsibility lies with the international community, particularly the wealthy G8 countries which have been unwilling to adequately support the Global Fund on AIDS, Tuberculosis and Malaria. It lies with the United Nations, which has failed to exercise decisive leadership. It also lies with governments in Africa, which have not met their obligations to their own citizens. Finally, and most generally, responsibility for these catastrophic losses lies within an approach towards globalization and development that lacks a moral foundation, and in doing so, often pits economics against ethics. These failures have combined to produce one of the greatest betrayals and tragedies of all time.

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5. Thomas H. Maugh, *Bleak AIDS Conference Reports Deliver a Global Reality Check*, L.A. TIMES, July 15, 2002, at A3.

6. *See* Gautam Naik, *U.N. Agency Sets $5.5 Billion Plan To Fight AIDS: World Health Organization Aims to Distribute Drugs To 3 Million by End of 2005*, WALL ST. J., Dec. 1, 2003, at B4, *available at* http://www.aegis.com/news/wsj/2003/WJ031201.html (last visited Dec. 17, 2003).

7. *See, e.g., id.*; *WHO Launches Campaign To Give Life-Extending Drugs to 3 Million with AIDS by 2005*, Africa Recovery, *at* http://www.un.org/ecosocdev/geninfo/afrec/newrels/wtoaids.htm (last visited Jan. 6, 2004).

AFRICAN AIDS—THE EPICENTER OF THE CRISIS

The statistics describing the HIV/AIDS epidemic are well known and need little elaboration, but a brief reminder is timely. No region has been harder hit by AIDS than sub-Saharan Africa, which is home to over seventy percent of those infected by HIV—nearly thirty million adults and children in the region are living with HIV.[8]

Why have African countries been so badly affected? What are the factors influencing individual and community vulnerability? The answers to these questions are many, and have triggered sometimes heated debate among economists, social development experts, epidemiologists and behavioral scientists. Among the many responsible factors are the legacies of colonialism and neo-colonialism, poverty and economic underdevelopment, the effects of structural adjustment, the failure of rural agriculture, continuing gender inequalities, lack of good quality education, differences in sexual behavior and political indifference and denial.[9] These conditions, combined with the world's inability—or perhaps unwillingness—for many years to talk about the Africa of AIDS, have made HIV/AIDS the most serious threat the continent has yet faced.[10] More than twenty million Africans have died—many at the height of their productive and reproductive years—stretching the medical, educational and welfare capacity of states beyond their limits, undermining development efforts and casting a shadow over the future of the continent.[11]

Ensuring access to essential ARV medications and health education would have an enormous impact on the rate and pace of the epidemic in Africa, on the ability of people, families and communities to deal with HIV and AIDS, and on the ability of Africa to meet development challenges and ultimately to take its rightful place in the world. There is currently an unprecedented international interest in the African epidemic. Much is written about the need for treatments and the urgent need to mobilize resources to secure the provision of ARV drugs, but thus far little has come of this.

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8. *See* UNAIDS, AIDS EPIDEMIC UPDATE (Dec. 2003), *available at* http://www.unaids.org/wad/2003/Epiupdate2003_en/Epi03_03_en.htm#TopOfPage.

9. Mary Crewe & Peter Aggleton, *Racism and HIV/AIDS and Africa*, 10 S. AFR. J. INT'L AFF. 140 (2003).

10. *Id.* at 141.

11. *See* CAROLYN BAYLIES ET AL., AIDS, SEXUALITY AND GENDER IN AFRICA 1 (2000); *HIV/AIDS in Africa*, The World Bank, *at* http://www.worldbank.org/afr/aids/ (last visited Jan. 6, 2004).

From the ground, it seems clear that we have not yet answered the simple question "Does the international community care about African AIDS?"[12] Inspiring declarations and promising protocols are relatively easy to draft. Indeed, in recent years, increased commitments at the international, regional and domestic levels toward the realization of human rights related to HIV/AIDS, including improved access to treatment, have been enthusiastically adopted.[13] Yet, in the end, it is concrete actions that count. And to date, there has been regrettably little action to demonstrate the concern of the United Nations, the international community, and even of many of Africa's sovereign governments. From the epicenter of the pandemic it is with disbelief that one comes to realize the stark reality of international trade and intellectual property agreements, and how these are allowed to trump creative and imaginative plans to quickly develop treatment routes, which hold the potential to save lives and to vest real meaning in the many existing political statements.[14]

Since 1996, people with HIV and AIDS who live in well-resourced countries have benefited from taking a combination of HIV ARV drugs. These drugs have resulted in an enormous decrease in the number of people dying from AIDS-related illnesses.[15] Many people who were seriously

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12. Jones, *supra* note 1, first asked this question in reviewing the response of the international community.

13. Key among these are the Declaration of Commitment on HIV/AIDS, the Millennium Development Goals, General Comment Fourteen of the Committee on Economic, Social and Cultural Rights, and resolutions by the Commission on Human Rights on the right to the highest attainable standard of health and access to medication. There is growing recognition that fundamental principles of human rights dictate that essential medical goods, services and information should not only be universally available, acceptable and of good quality, but also within physical reach and affordable for all.

14. The impact of trade negotiations on the accessibility of drugs in the developing world is of tremendous concern to many public health advocates. *See, e.g.*, Brook Baker, *U.S. Trade Negotiations with the South African Customs Union Undermine Access to Medicines and Violate U.S. Law* (July 7, 2003), *at*
http://www.cptech.org/ip/health/trade/sacu/hgap07072003.html (last visited Jan. 7, 2004);
Press Release, Health GAP, "Free Trade" Costs Lives: Access to Medicines, the AIDS Crisis, and the Free Trade Area of the Americas (June 2003),
http://www.healthgap.org/press_releases/03/0603_HGAP_FTAA.pdf (last visited Jan. 7, 2004); *see also*
Ellen 't Hoen, *TRIPS, Pharmaceutical Patents, and Access to Essential Medicines: A Long Way from Seattle to Doha*, 3 CHI. J. INT'L L. 27 (2002).

15. Senegal and Uganda are countries where effective education programs have

ill have been able to return to work. Yet, most Africans living with HIV/AIDS do not have the opportunity to make such decisions about their health and to exercise choice about which medications to use. Despite a significant decline in the prices of principal ARVs in Africa, these life-sustaining drugs remain out-of-reach for more than ninety-five percent of those whose lives they would save.[16]

One is tempted to ask if an underlying racism towards Africa lies beneath the complacency that allows this treatment gap to persisit and even to grow. As in colonial times, do the lives of Africans not matter when profits and trade are at stake? Is the failure to mobilize international resources for the provision of drugs to the developing world—thereby creating large-scale denial of treatment—colonialism of a special kind? There is a great deal of rhetoric about providing treatments in Africa, which slides between myth and reality.[17] Arguments are raised about the economic viability of AIDS treatments in Africa, about the greater effectiveness of prevention, about the danger of starting treatments that cannot be sustained potentially leading to the development of resistant viruses, and about Africa's weak and underdeveloped health infrastructure.[18] These concerns are seldom raised in Europe or in North America, and it is particularly incomprehensible that the lack of infrastructure should still be an argument when we now have so much data available on the viability of treatment in resource poor settings.[19] Much of the resistance to large-scale funding of programs to combat HIV/AIDS in Africa is grounded in a discourse about the continent's inadequacy, its corruption, its poor governance, and its need for technical assistance and capacity building. Even "development agencies" have rightly drawn criticism for exaggerating and constructing many of the so-called problems

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worked, coupled in some cases with treatment programs. Botswana remains a very interesting example of treatment access that to date seems to be having little impact on the epidemic and stigma.

16. *See, e.g.*, Robert Walgate, *As AIDS Drug Prices Plummet for Third World, Questions Still Abound*, THE SCIENTIST, Apr. 3, 2001, *at* http://www.biomedcentral.com/news/20010403/04/.

17. *See* Hans Bingswanger, *Willingness to Pay for AIDS Treatments: Myths and Realities*, 362 LANCET 1152 (2003).

18. *See id.*

19. *See, e.g.*, Jennifer Singler & Paul Farmer, *Treating HIV in Resource-Poor Settings*, 288 JAMA 1652 (2002); *see also* Justice Edwin Cameron, Opening Address at AIDS in Context Conference, University of Witwatersrand, South Africa (Apr. 4, 2001) (transcript available at the South African History Archive).

that keep African countries from "developing."[20] While there is some truth to the criticisms—there are *some* examples of corruption, *some* poor governance—the fact that these examples have taken over the discourse can be seen as the arrival of the new colonialists, whose language silences the voices of the continent and in doing so treats Africa as if it were one homogenous whole, a move which fails to acknowledge many areas of success and advancement.

Given the host of current statements of international commitment and intent regarding provisions for HIV/AIDS,[21] one cannot help but return to the simple question: What has gone wrong? Why have promises been made but not kept?[22] Why does it seem that Africa is simply not important enough for the commitments to be translated into sustained action—for serious work to begin with governments to develop ARV programs and care initiatives? Perhaps the answer lies in a new accomplice to the familiar specter of colonialism: the phenomenon of globalization. In this modern world of globalization, people are only as important as the financial and trade returns they give to the world order, and Africa, with her stumbling economies and falling share of the world trade exports, does not offer enough in return. Indeed, most Africans are worse off now than they were twenty-five years ago and sub-Saharan Africa has the world's lowest rate of economic growth.[23] Compounding this problem are the annual debt repayments of the continent, which if channeled into HIV/AIDS drugs would provide more than the projected amounts needed to address the epidemic effectively.[24] These economic conditions foment a dangerous relationship between the new trends of globalization and old attitudes of colonialism, whereby the suffering of those afflicted with diseases such as

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20. *See* JAMES FERGUSON, THE ANTI-POLITICS MACHINE: "DEVELOPMENT," DEPOLITICIZATION, AND BUREAUCRATIC POWER IN LESOTHO (1990).

21. *See supra* note 13.

22. At the Barcelona Conference in 2002, Peter Piot poignantly and aptly remarked, "Together, we have moved beyond the point where world leaders have ignored our pleas. The promises have been made. Now, they need to be kept." Piot, *supra* note 4. For a discussion of the delays in Bush' promised emergency AIDS funds, see, for example, Linda Bilmes, Op-Ed, *A Poor Start for Bush's Aids Programme*, FIN. TIMES, July 7, 2003, *available at* http://www.informationclearinghouse.info/article4043.htm (last visited Jan. 7, 2004).

23. For an expanded discussion, see AFRICA IN CRISIS: NEW CHALLENGES AND POSSIBILITIES (Tunde Zack-Williams et al. eds., 2002).

24. The debt repayment figures for Africa exceed the amount needed by the Global Fund on AIDS, TB and Malaria. *See* Peris Jones, When "Development" Devastated: Donor Discourses, Access to HIV/AIDS Treatment in Africa and Reconstituting the Terrain of Development, Seminar at the University of Pretoria Department of Sociology (May 2003).

AIDS becomes an economic condition for the "developers" to overcome. True, Africa's economic development challenges are formidable, and the ferocity of the AIDS epidemic both exacerbates these issues and gives an important urgency to them, but to meet these challenges the nature of the engagement of the Western nations with African countries must change. Globalization needs to have an ethical dimension added to it—a moral foundation from which it will serve to address, as a priority, the issues of poverty and marginalization and not to intensify them.[25]

CONCLUSION

The failure of the international community to mobilize the resources needed to ensure that Africans have access to treatment is an affront to all humanity, not just to the millions of people living with HIV who at the very least would like to be able to exercise choice with regard to treatment options. From the financial and political capitals of the world it is easy to romanticize poverty and local attempts to deal with it. And it is easy, while not confronted daily with the reality of this epidemic to debate about international trade, security issues, profits and the costs of intellectual property and research.

No matter how much anguish is expressed, no matter how many times the reality of the suffering is exposed and the deaths mourned, what counts is that those with the capacity and the resources to act to save millions of people, have not. It is hard not to read this response as underpinned by racism, a callous lack of real concern, and a spectacular failure of commitment to the rights, dignity and life of all Africans.

25. *See* Ethical Globalization Initiative, *at* http://www.egiinitiative.com (last visited Dec. 17, 2003).