

**STUDY GUIDE FOR THE FILM**

**PILLS PROFITS PROTEST:  
CHRONICLE OF THE GLOBAL  
AIDS MOVEMENT**

**A film by Anne-christine d'Adesky, Shanti Avirgan, and Ann T. Rosetti**

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## **I. INTRODUCTION: How to Use This Study Guide:**

This study guide is intended as a resource to help educators and activists use the “Pills Profits Protest” DVD and website more effectively.

Before viewing the film, you can familiarize yourself with some of the diverse people and viewpoints represented in this documentary by scrolling through the online Slide Show, which contains images and quotes from characters in the film, as well as links to some of the organizations they represent.

The DVD contains eleven thematic scenes, which you can play individually in order to have a more in-depth discussion. Use the Film Scenes: Quotes, Discussion Questions and Readings section of this Study Guide to guide your conversation and learn more about the issues and places in the film. The readings include chapters of from the accompanying book, “Moving Mountains: The Race to Treat Global AIDS (Verso 2004), as well as key primary documents from AIDS activist campaigns from around the world. Use the **Glossary of Key Terms** available on the website to clarify some of the policy, medical and legal terms used in the film and accompanying materials. The **Bibliography of Readings**, at the end of this Study Guide, lists additional readings for you if you’d like to further explore any particular subject.

Also available on our website is a comprehensive **Who’s Who in the Film** -- the documentary’s cast of characters -- ranging from scientists, to community organizers, to policy makers and journalists. The **Timeline of Key Events** describes in chronological form the historical events that unfolded during the five crucial years (2000-2005) covered in the film. We’ve also included some **Resources for Taking Action** – a list of organizations and key players who are playing a front-line role in the global arena and the battle for universal access to treatment.

## II. SCENE SELECTIONS: Quotes, Discussion Questions and Readings

### 1. South Africa

“I’ve heard bits and bits about antiretroviral drugs and I don’t even understand what that means... Is it in tablet form? Is it in a shot? I don’t know....”

*Lungi Mazibuko, Umbumbano Lo Mama*

“Here I have in front of me a box of Fluconazole that would cost 200 Rand but if you bought it from a South African chemist, it would cost you 4,000 Rand. There is no doubt that we will be bringing large amounts of this into the country to ensure that people have access to good quality and safe generics. We won’t stop doing it until our government and the drug companies have brought the prices of all essential medicines down.”

*Zackie Achmat, Treatment Action Campaign (TAC)*

Q: How many people are living with HIV in South Africa today? How many have access to treatment?

Q: What impact did the XIII International AIDS Conference in Durban have on South African and global AIDS activists?

Q: What kinds of tactics have activists from the Treatment Action Campaign used to pressure the South African government to provide antiretroviral treatment? Have they been successful?

### **READINGS:**

MEMORANDUM “Global Manifesto to Save 34 Million Lives: Measures Needed to Rapidly Expand Access to Essential Treatments for HIV/AIDS,” Issued on July 9<sup>th</sup> 2000, in Durban, South Africa by Health GAP and TAC and the March for HIV/AIDS Treatment.

Mark Heywood, “The Price of Denial” INTERFUND. (2005); “Development update: From disaster to development: HIV and AIDS in Southern Africa.” *Development Update*, 5(3).

### 2. Profits

“Why is it so expensive for us to have drugs? Why are there no cheaper drugs for the people who are affected?”

*Rita Bantjies, Ubumbano Lo Mama, South Africa*

“They’re businesses. They want to sell you stuff. There’s two things they’re trying to sell you. They’re trying to sell you a product and they’re trying to sell you R&D. The problem is that the guys who sell you the product, the ‘Big Pharma’ guys, are not very good at the R&D part.”

*Jamie Love, Consumer Project on Technology, Washington DC, USA*

Q: What kinds of treatments exist today for AIDS patients and people living with HIV?

Q: How is the price of medicines determined and how does that affect access to treatment for HIV?

“The key contribution the pharmaceutical industry will continue to make is research and development. There are over a hundred new HIV products in the research-based pipeline.”

*Dr. Harvey E. Bale, Jr., Director General,  
International Federation of Pharmaceutical Manufacturers Associations*

“I think that what the drug companies are really afraid of is that news about how cheap it actually is to make some of these products gets back to their primary markets and causes people to want to lower prices here.”

*Tina Rosenberg, The New York Times, USA*

“There’s a crime being committed here. This is a crime. You cannot have 40 million people dead, and more dying every year and then the issue should be about money.”

*Chatinkha Nkhoma (Kundwenda), Ubumbano Lo Mama, South Africa*

Q: What are patents and how do they impact the price of medicines?

Q: What is “research and development”? How much do we know about levels of pharmaceutical companies’ investment in this sector?

### **READINGS:**

Anne-christine d’Adesky, *Moving Mountains: The Race to Treat Global AIDS*, Verso 2004.

Marcia Angell, "The Truth about Drug Companies," *New York Review of Books*, 51, No. 12, July 15, 2004.

Donald W. Light and Joel Lexchin, “The International War on Cheap Drugs,” *New Doctor 81*, Winter 2004

P. Boulet, C. Garrison and E. ‘t Hoen, “Drug Patents Under the Spotlight: Sharing practical knowledge about pharmaceutical patents,” Report by Medecins Sans Frontieres, London, Third Edition, June 2004.

### **3. AIDS on the Global Agenda**

“We are here today to discuss an unprecedented crisis, but one which has a solution: an unprecedented response from all of us. We are here to agree on the action we will take.”

*Kofi Annan, Secretary General of the United Nations*

“I think it’s been the grassroots groups and people living with HIV that have sparked the social forces that have demanded this UNGASS session. This is not just the result of high-level UN officials or governments all of a sudden realizing that there is a catastrophe in the world - it's because they felt pressured.”

*Dr. Alan Berkman, Health GAP Coalition, USA*

Q: What was UNGASS and why was it seen as a turning point in the global response to AIDS? What were the commitments made by the UN and by governments?

Q: What is the DOHA Declaration and how does it affect access to HIV drugs?

### **READINGS:**

Declaration on the TRIPS Agreement and Public Health, Adopted on 14 November 2001 by the World Trade Organization, MINISTERIAL CONFERENCE, Fourth Session, Doha, Qatar.

S-26/2. “Declaration of Commitment on HIV/AIDS,” UN Declaration No. 55. Resolution adopted by the United Nations General Assembly Special Session on HIV/AIDS, 8<sup>th</sup> Plenary meeting, 26<sup>th</sup> Special Session, 27 June, 2001.

### **4. Prevention vs. Treatment?**

“There’s still this silly debate between prevention and treatment. It doesn’t have to be a silly debate; it can be very serious. And I think, eventually, it will mature into a serious debate. But right now you have camps.” *Paul Farmer, MD, Partners in Health*

“I am convinced that if somebody gets good care, they will not go out and spread HIV. So prevention and treatment are complementary. And in a population where one in four people are living with HIV, unless you target that one, other prevention efforts may not be as successful.” *Milly Katana, Global Fund Community Representative, Uganda*

Q: How do HIV prevention and treatment strategies complement or compete with one another? What is the relationship between access to treatment and HIV prevention in community settings?

Q: What kinds of debates about HIV prevention and treatment happened at the UNGASS meetings? What was at stake?

### **READINGS:**

Joyce Millen, Dorothy Fallows, and Alexander Irwin, *Global AIDS: Myths and Facts*, South End Press, Cambridge, MA, 2003. Excerpt from “Myth Four: Prevention vs. Treatment?”

## 5. Brazil

“Although we do not have a cure for AIDS, we do know that consistent and courageous policies can halt the spread of the disease and let those infected with HIV live a normal and a dignified life.”  
*Jose Serra, Minister of Health, Brazil*

“I went to work for the State and said: ‘The State can lower prices and give access.’ When the law passed in 1996 guaranteeing free and universal access to the cocktail, I checked with the Health Ministry and we realized that there was no way we could pay for the medications... The prices for antiretrovirals were extremely high. So we developed two patented drugs, Nelfinavir and Efavirenz, in order to compare costs and regulate prices. And - if necessary - to claim a compulsory license and make them ourselves. Either way, it allows the state to say: ‘The price can be lower.’ And the price of pharmaceuticals has, in fact, dropped internationally.”

*Dr. Eloan dos Santos Pinheiro, Director, Far-Manguinhos Laboratory, Brazil*

Q: What has the Brazilian government’s response to the AIDS epidemic been? What was the role of civil society in shaping the official policy?

Q: How has the Brazilian Health Ministry laboratory, Far Manguinhos, worked with the government to lower prices of antiretrovirals? What is a “compulsory license” and when should it be used?

Q: Is Brazil’s approach to AIDS treatment possible to replicate in other contexts? Is it sustainable within Brazil?

### **READINGS:**

Tina Rosenberg, “Look at Brazil,” *The New York Times Sunday Magazine*, January 28, 2001.

“Non-Governmental Organizations and Access to Antiretroviral Treatments in Brazil,” by Carlos André Passarelli and Veriano Terto Junior. *Divulgação em Saúde para Debate*, Rio de Janeiro, n. 27, p. 252-264, August 2003.

## 6. Haiti

“There are just so many people living with HIV who have been written off. But the argument that there are settings in which it’s not cost effective to treat HIV is ultimately an argument that some people are too poor to treat, but that’s not how the patients regard it.”  
*Paul Farmer, MD, Partners in Health, Haiti and USA*

Q: What is the relationship of poverty to HIV in Haiti? How are patients in Haiti responding to ARV treatment?

Q: What are some challenges to providing treatment in rural settings like Cange, Haiti versus urban settings like Port-au-Prince, the capital?

**READINGS:**

”Cange Declaration,” issued by HIV patients at Clinique Bon Sauveur, Partners In Health, Cange, Haiti, August 24, 2001.

Anne-christine d’Adesky, *Moving Mountains: The Race to Treat Global AIDS*, Verso 2004.

\_Chapter VI excerpt, “HAITI: HIV Medicines Come To Rural Haiti.”

**7. India**

“The emergency button has been pressed in India. This is a national emergency, and we need to prevent the disease. The numbers of AIDS patients who are going to come in are going to be so rapid in number that it is not going to be possible for our health care system to sustain them.”

***Shashank Joshi, MD, Bombay, India***

“This country, which has an opportunity because of five or six drug companies making the cheapest antiretrovirals in the world, is saying to our citizens— ‘Look, we don’t care about your life, you can die. But Brazilians can live because they have a provision for antiretrovirals.’”

***Anand Grover, Lawyers' Collective, Bombay, India***

Q: Why has AIDS become a national emergency in India? How does treatment activism in India compare to TAC’s activities in South Africa?

Q: If India makes generic HIV drugs to export, why can’t Indians access these same drugs?

Q: What is the cost difference between a generic vs. a brandname ARV pill being sold in the poorest countries?

Q: What role did the Indian company Cipla play in the AIDS access battle?

**READINGS:**

Asia Russell, “Changes to India's Patents Act and Access to Affordable Generic Medicines after January 1, 2005,” *Health GAP*, December 14, 2004.

**8. Activist Strategy**

“I think that the activists in India... they are not really activists. They are actually service organizations right now. They have to become activists and that is what they have to learn from the US and South Africa.”

***Anand Grover, Lawyers' Collective, Bombay, India***

“The reality here is not the same reality as in Uganda. I think we should look at what the reality in Uganda is and help them develop something that accommodates their needs in Uganda.”  
*Jesús Aguáis, Aid for AIDS, NY, USA*

“Some of us are living with a wound of having buried a woman who was stoned to death because of her seeing the need to say, “I am HIV positive and educating a community.”  
*Mercy Makhalamale, Sisters in Action, South Africa*

Q: As AIDS activists increasingly cross borders to work together, what kinds of challenges and opportunities do they face?

Q: Who was Gugu Dlamini? How did her death affect other South African AIDS activists?

Q: What impact does stigma have on people’s access to HIV services?

Q: What are examples of discrimination facing people living with HIV/AIDS and their families?

Q: What role should US activists play in pushing for treatment access in Africa or Asia or Latin America or the Caribbean?

Q: What do African activists from the Treatment Action Campaign and others have to teach US activists?

## **READINGS:**

“The Denver Principles,” Founding Statement of People with AIDS/ARC, June 1983.

“Rights and Responsibilities of People Living with HIV and AIDS,” National Association of People Living with AIDS(NAPWA), 2003. Reprinted from Staying Alive conference program book, NAPWA.

## **9. Solidarity Movement**

“There needs to be a conference that brings women in South Africa together to start revolution and the movement of women. And we can only be able to do that if we host a conference of women from different sectors, so that if the Americans go, we still have business women, women who are working in public circuits, we have women who are health care providers, women who are HIV positive mothers.”

*Mercy Makhalamale, Sisters in Action, South Africa*

“Women living with HIV in this country face a double tragedy. Being a woman is enough trouble, and being a woman with HIV adds on to your woes. So, women come together to form this community of women living with HIV.”

*Milly Katana, Global Fund, Community Representative, Uganda*

Q: How is HIV impacting women in Africa? In Asia? In the world? In the US?

Q: Why are women particularly vulnerable to HIV? How does women's status in their society play a role in access to care or prevention?

Q: How are women in Africa responding to the crisis of HIV?

Q: What role do HIV-positive women have to play in this fight?

Q: How can US and international women's groups and activists best support women in poor countries to access treatment?

Q: What is the global impact of HIV on girls? Are they more vulnerable than boys to HIV? If so, why?

### **READINGS:**

“Declaration from A Focus on Women,” satellite conference of the 3rd International Conference on Global Strategies for Prevention of HIV Transmission from Mothers to Infants, 9-13th September, 2001, Kampala, Uganda

## **10. USA**

Domestic activists need to wake up to what's happening in the U.S. We may lose all the gains we've made over the past 20 years in HIV ... A lot of energy of the domestic AIDS movement has been focused on the international arena lately, but again it's a question of balance. We need to fight for the rights of the poor everywhere, whether they're a subway ride away or a world apart.

*Gregg Gonsalves, Gay Men's Health Crisis (GMHC), USA*

Q: Who has access to AIDS treatment in the United States? How much does it cost and who pays for it?

Q: What has been the Bush administration's response to AIDS in the United States?

Q: How has the US government responded to Africa's needs for AIDS drugs? Why are activists critical of the Bush global AIDS plan?

### **READINGS:**

“4 x 4” Platform Declaration, Campaign to End AIDS, USA, September 2005.

“21 Points Platform,” document issued by Campaign to End AIDS, September 2005.

## **11. Looking Ahead**

“Be careful when you declare victory, because so many of the victories that we have all celebrated over the last two years have still not translated into any real wide-scale access to treatment in developing countries. Because as long as the victories exist only on paper, they can’t be considered victories; as long as they only exist in e-mails or newspaper articles or in radio interviews or on television, they don’t translate into anything that will fundamentally change access to treatment in poor countries.”

*Rachel Cohen, Médecins Sans Frontières (MSF), USA*

Q: What are some of the victories of the grassroots access movement?

Q: Are the goals and commitments made by the United Nations (at UNGASS) and the World Health Organization (in the “3 x 5” plan) being met? Why or why not?

Q: What are the challenges now facing the global access movement?

Q: What role can Americans play to support global treatment access?

Q: What are different ways citizens of any country can get involved in this movement?

Q: What resources exist for people who want to join or support US and international grassroots organizations or NGOs working in Africa and Asia and elsewhere that are trying to deliver treatment?

**READINGS:**

Belinda Beresford, “Reflections and lessons from frontline treatment providers” report, INTERFUND. (2005); “Development update: From disaster to development: HIV and AIDS in Southern Africa.” *Development Update*, 5(3).

### **III. GLOSSARY OF KEY WORDS**

#### **Acquired Immune Deficiency Syndrome (AIDS)**

A severe immunological disorder caused by the human immunodeficiency virus, HIV, a retrovirus that attacks cells of the immune system. HIV infection renders the body vulnerable to a range of opportunistic infections such as tuberculosis, Pneumocystis carinii pneumonia, and cryptococcal meningitis. HIV is transmitted via direct contact with blood and sexual body fluids, but not by casual contact, kissing or touching a person with HIV. Over 40 million people globally are living with HIV, 95% live in developing countries. Two-thirds are in sub-Saharan Africa, where treatment access is very limited.

**Antiretroviral (ARV)** drugs are medications for the treatment of infection by retroviruses, primarily HIV. Different classes of antiretroviral drugs attack the virus to block its activity at different stages of the virus' life cycle.

#### **Combination therapy**

HIV treatment consists of combining ARVs from at least two drug classes – an approach called combination therapy (triple therapy) or Highly Active Anti-Retroviral Therapy (HAART).

**Compulsory licensing** are provisions in patent laws that allow public authorities to grant licenses to a third party without the consent of the patent holder. Patent-holders receive adequate compensation, generally a royalty. Compulsory licenses may be issued on various grounds of general interest, including public health, and are a common feature of patent law. Compulsory licenses are neither a form of pirating, a legal loophole, nor a way of stealing intellectual property. Rather, they are part of any good intellectual property legislation, and ensure that a government can counter the negative effects of patents to protect the public interest.

**Differential pricing** the practice of charging different prices in different markets. *See equity pricing.*

#### **Doha Declaration**

The November 2001 Doha Declaration reaffirmed flexibility of TRIPS member states in circumventing intellectual property rights for better access to essential medicines.

In Paragraphs 4 to 6 of the Doha Declaration on TRIPS (Trade-related aspects of intellectual property rights) and Public Health, governments agreed that:

"4. 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.

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.

5. Accordingly and in the light of paragraph 4 above, while maintaining our commitments in the TRIPS Agreement, we recognize that these flexibilities include:
- (a) In applying the customary rules of interpretation of public international law, each provision of the TRIPS Agreement shall be read in the light of the object and purpose of the Agreement as expressed, in particular, in its objectives and principles.
  - (b) Each Member has the right to grant compulsory licences and the freedom to determine the grounds upon which such licences are granted.
  - (c) Each 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.
  - (d) The 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, subject to the MFN and national treatment provisions of Articles 3 and 4.

6. We recognize 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. We instruct the Council for TRIPS to find an expeditious solution to this problem and to report to the General Council before the end of 2002."

These provisions in the Declaration ensure that governments may issue compulsory licenses on patents for medicines, or take other steps to protect public health.

### **Drug cocktail See combination therapy**

Equity pricing Pricing policies that ensure that, from the point of view of the community and the individual, the price of a drug is fair, equitable and affordable, even for a poor population and/or the health system that serves them. Equity pricing is based on the principle that the poor should pay less for, and have access to, products such as essential medicines. The terms "differential", "tiered", "preferential", and "discounted" pricing, and "market segmentation" are also often used to describe the practice of charging lower prices in different markets. However, they do not necessarily result in affordability or equitable access to a product. Rather, they are commercial terms for pricing practices aimed at maximizing profits of the seller. While these practices may lead to equitable access to medicines, they do not necessarily mean that even the lowest prices charged will be affordable.

### **Essential drugs**

Drugs selected for their efficacy and safety to meet the priority health needs in a given country or region. The essential drugs concept has been the basis of WHO's drug strategy since 1975. The criteria for incorporating a drug in the WHO list of essential drugs also includes price considerations. When MSF uses the term "essential drugs," it refers to those drugs considered medically essential based on need, efficacy, and tolerance. It

explicitly refers to drugs beyond those included on the WHO Essential Drugs List, because certain drugs which are essential from a medical point of view will be excluded from the list because of the high cost related to their use.

### **Generic drug**

A pharmaceutical product usually intended to be interchangeable with the innovator product, which is not protected by a patent in the country or is licensed. Generic drugs are marketed either under a non-proprietary or approved name rather than a proprietary name.

### **Human Immunodeficiency Virus (HIV)**

A human virus called a retrovirus that appears to have evolved from simian viruses. HIV weakens the immune system, causing the death of CD4 T cells which coordinate the immune system's response to intruders. After a number of years (typically 5 - 10), this weakening of the immune system leaves the body open to attack from opportunistic infections, eventually leading to the development of Acquired Immune Deficiency Syndrome (AIDS).

### **Intellectual property (IP)**

This term covers a number of different legal rights that are awarded by states to persons in return for some valuable "creative" activity. Two well-known examples of intellectual property are patents, which may be awarded to protect inventions, and copyright. A patent allows its owner to stop anybody else from making use of their invention, unless given permission (in return for a payment for example). Intellectual property rights only last for a limited period of time, for example, 20 years for patents, 70 years for copyright. *See patent protection.*

**Mother to child transmission (MTCT) Transmission** of HIV from mother to child during pregnancy, at the time of birth, and after delivery, through breast milk. In the absence of any HIV drug treatment or therapeutic intervention, transmission occurs approximately 25 - 35% of the time. Short courses of antiretroviral therapy using AZT and nevirapine can reduce this risk by 50% or more, while longer duration treatment with a 3-drug combination of antiretrovirals can almost eliminate the risk of maternal HIV transmission.

### **Opportunistic infection (OI)**

An illness that takes advantage of HIV's weakening of the immune system to cause disease. Many OIs occur almost exclusively in people with HIV (e.g., cryptococcal meningitis, pneumocystis carinii pneumonia, toxoplasmosis), while others are simply more likely to cause disease in people whose immune system have been weakened by HIV (e.g., candidiasis, herpes, tuberculosis).

### **Parallel importation**

Importation of a patented product without the approval of the patent-holder. Parallel importation allows a country to shop around for the best price of a branded (brand name) drug on the global market. It is an attractive option for developing countries when the

same branded medicine is being sold for different prices in different markets. Parallel importing does not involve the purchase of generics. It would allow a country like Mozambique, where 100 units of Bayer's ciprofloxacin (500mg) costs \$740, to import the same product from India where Bayer sells it for \$15 (lower price is due to generic competition in India). Many European countries, such as the United Kingdom, allow parallel trade to reduce the overall cost of medicines.

A parallel import, also known as a *grey product*, refers to a genuine (ie. non-counterfeit) product placed on the market in one country, which is subsequently imported into a second country without the permission of the owner of the intellectual property rights which attach to the product in the second country. In the United States, parallel importation is prohibited, and the United States Trade Representative lobbies other governments to prevent parallel importation in their respective jurisdictions.

### **Patent (patent protection)**

Title that confers upon the creator of an invention (product or process) the sole right to make, use, import and sell that invention for a set period of time. Patent protection lasts at least 20 years from the date the patent application was filed. The TRIPS agreement requires patent protection to be available for inventions in all fields of technology in all WTO Member States. This provision is essentially aimed at pharmaceutical products, for which certain developing countries, as well as developed countries, had refused to grant patents. Patent protection has been an incentive for research and development of new drugs, but questions remain as to whether the patent system will ensure investment in medicines needed by the poor.

### **Protease inhibitor**

A drug that works by inhibiting HIV protease, an aspartyl enzyme (protein) the virus uses to replicate, or make copies of itself, inside a cell. Protease inhibitors include amprenavir, indinavir, nelfinavir, ritonavir and saquinavir and are used in combination therapies to treat HIV/AIDS.

### **R&D (Research and Development)**

In the context of commerce, "research and development" normally refers to future-oriented, longer-term activities in science or technology, using similar techniques to scientific research without pre-determined outcomes and with broad forecasts of commercial yield.

### **Regulatory approval (regulatory authorisation)**

Government authorisation of the production and marketing of a drug following proof of its safety and efficacy. This is a process distinct from patenting and takes place on a national level.

### **TRIPS**

WTO's Agreement on Trade Related Aspects of Intellectual Property Rights. The WTO Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPs) is an international treaty which sets down minimum standards for most forms of intellectual property regulation within all member countries of the WTO. Although subsequent

developments (see below) have expanded the original requirements of TRIPs, the agreement itself introduced intellectual property law into the international trading system for the first time, and remains the most comprehensive international agreement on intellectual property to date. Since TRIPs came into force it has received a growing level of criticism from developing countries, academics, and NGOs, on the basis that the WTO system in general and the TRIPs system in particular encapsulates all that is socially, politically and economically unjust about globalization (see also anti-globalization). However, due to the rule-based system of the WTO, and the technical complexities of applicable laws, many commentators consider that only extensive and intense social and political opposition is likely to overcome the perceived unequal application of TRIPs upon lesser-developed countries and communities.

The most visible conflict has been over AIDS drugs in Africa. Despite the role which patents have played maintaining higher drug costs for public health programs across Africa, this controversy has not led to a revision of TRIPs. Instead, an interpretive statement, the Doha Declaration, was issued in November 2001, which indicated that TRIPs should not prevent states from dealing with public health crises.

TRIPs safeguards Precautionary measures included in the TRIPs agreement to ensure affordability and availability of patented technologies in cases of patent abuse or emergency situation. These safeguards include compulsory licensing, exceptions to exclusive rights and other measures that promote generic competition, and extension of the transitional period. Parallel importation of a patented drug from countries where it is sold more cheaply can also be authorized by governments.

### **UNGASS**

The UN General Assembly Special Session on AIDS was held in 2001. It issued a Declaration of commitment that is not a legally binding document, but it is a clear statement by member governments who have agreed about what should be done to fight HIV/AIDS and what they have committed to doing, often with specific deadlines. As such, the Declaration is a powerful tool with which to guide and secure action, commitment, support and resources for all those fighting the epidemic, both within and outside government.

### **World Trade Organization (WTO)**

The World Trade Organization is an international, multilateral organization which sets the rules for the global trading system and resolves disputes between its member states, all of whom are signatories to its about 30 agreements. The stated aim of the WTO is to promote free trade, stimulate economic growth and hence make people's lives more prosperous. However, since its inception in 1995, the WTO has been a major target for protests by the anti-globalization movement, which charge that it has partial and unfair bias toward multinational corporations and wealthy nations. As of December 15, 2005, there are 150 members in the organization.

### Sources:

MSF Access to Essential Medicines Campaign, Glossary of Technical Terms  
Wikipedia

#### IV. BIBLIOGRAPY OF READINGS

Anne-christine d'Adesky, *Moving Mountains: The Race to Treat Global AIDS*, Verso 2004.

\_Chapter I excerpt, "Moving Mountains."

\_Chapter II excerpt, "AIDS AND EMPIRE I: A Brief Chronology of Recent Events."

\_Chapter VI excerpt, "HAITI: HIV Medicines Come To Rural Haiti."

Joyce Millen, Dorothy Fallows, and Alexander Irwin, *Global AIDS: Myths and Facts*, South End Press, Cambridge, MA, 2003. Excerpt from "Myth Four: Prevention vs. Treatment?"

P. Boulet, C. Garrison and E. 't Hoen, "Drug Patents Under the Spotlight: Sharing practical knowledge about pharmaceutical patents," Report by Medecins Sans Frontieres, London, Third Edition, June 2004.

"Cange Declaration," issued by HIV patients at Clinique Bon Sauveur, Partners In Health, Cange, Haiti, August 24, 2001.

"Declaration from A Focus on Women," satellite conference of the 3rd International Conference on Global Strategies for Prevention of HIV Transmission from Mothers to Infants, 9-13th September, 2001, Kampala, Uganda

Tina Rosenberg, "Look at Brazil," *The New York Times Sunday Magazine*, January 28, 2001.

"The Denver Principles," Founding Statement of People with AIDS/ARC, June 1983.

"Rights and Responsibilities of People Living with HIV and AIDS," National Association of People Living with AIDS(NAPWA), 2003. Reprinted from Staying Alive conference program book, NAPWA.

S-26/2. "Declaration of Commitment on HIV/AIDS," UN Declaration No. 55. Resolution adopted by the United Nations General Assembly Special Session on HIV/AIDS, 8<sup>th</sup> Plenary meeting, 26<sup>th</sup> Special Session, 27 June, 2001.

Marcia Angell, "The Truth about Drug Companies," *New York Review of Books*, 51 no. 12 July 15, 2004.

Donald W. Light and Joel Lexchin, "The International War on Cheap Drugs," *New Doctor* 81, Winter 2004

Belinda Beresford, "Reflections and lessons from frontline treatment providers" report, INTERFUND. (2005); "Development update: From disaster to development: HIV and AIDS in Southern Africa." *Development Update*, 5(3).

Mark Heywood, "The Price of Denial" INTERFUND. (2005); "Development update: From disaster to development: HIV and AIDS in Southern Africa." *Development Update*, 5(3).

Declaration on the TRIPS Agreement and Public Health, Adopted on 14 November 2001 by the World Trade Organization, MINISTERIAL CONFERENCE, Fourth Session, Doha, Qatar.

Asia Russell, "Changes to India's Patents Act and Access to Affordable Generic Medicines after January 1, 2005," Health GAP, December 14, 2004.

MEMORANDUM "Global Manifesto to Save 34 Million Lives: Measures Needed to Rapidly Expand Access to Essential Treatments for HIV/AIDS," Issued on July 9<sup>th</sup> 2000, in Durban, South Africa by Health GAP and TAC and the March for HIV/AIDS Treatment.

Carlos André Passarelli and Veriano Terto Junior, "Non-Governmental Organizations and Access to Antiretroviral Treatments in Brazil," *Divulgação em Saúde para Debate*, Rio de Janeiro, n. 27, p. 252-264, August 2003.

"4 x 4" Platform Declaration, Campaign to End AIDS, USA, September 2005.

"21 Points Platform," document issued by Campaign to End AIDS, September 2005.