

The Bush Administration's Global AIDS Promises—and Praxis

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In other words, we want to join you in the war against the pandemic of AIDS. We want to be on your side in a big way. . . . I believe we have a responsibility—my country has got a responsibility. We are a great nation, we're a wealthy nation. We have a responsibility to help a neighbor in need, a brother and sister in crisis. And that's what I'm here to talk about.

—President George Bush, 2003¹

INTRODUCTION

In Senegal on July 7, 2003, President Bush began his five-country, five-day tour of sub-Saharan Africa, the region most devastated by the AIDS pandemic.² Mr. Bush's public statements during his brief time in Africa characterized the United States as a global leader, willing and able to confront global AIDS.³ The President's Emergency Plan for AIDS Relief (PEPFAR), a bilateral program announced during Mr. Bush's 2003 State of the Union address, was held up as evidence of the United States' commitment. PEPFAR will commit approximately \$10 billion in new money and \$15 billion total over five years to global AIDS treatment and prevention in twelve African and two Caribbean countries.⁴ PEPFAR's

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1. Pres. George W. Bush, Remarks to the AIDS Support Organization (TASO) Centre at Entebbe, Uganda (July 11, 2003), <http://www.state.gov/p/af/rls/rm/22366.htm> (last visited Dec. 16, 2003).

2. UNAIDS, REPORT ON THE GLOBAL HIV/AIDS EPIDEMIC 22 (July 2002).

3. See, e.g., Bush, *supra* note 1; Jim Fisher-Thompson, *Bush Welcomed Exuberantly in Botswana*, WASH. FILE (International Information Programs, U.S. State Dep't), July 10, 2003, available at <http://usinfo.state.gov/regional/af/potus2003/a3071002.htm> (last visited Dec. 16, 2003).

4. Pres. George W. Bush, State of the Union at the U.S. Capitol (Jan. 28, 2003), available at <http://www.whitehouse.gov/news/releases/2003/01/20030128-19.html> (last visited Dec. 27, 2003).

clinical goals are to avert seven million new HIV infections, start two million people on antiretroviral treatment, and extend care to ten million HIV affected people. The initiative also described a plan to set United States contributions to the Global Fund To Fight AIDS, Tuberculosis, and Malaria (Global Fund) at \$200 million per year starting in 2004.⁵ These are welcome steps, but they are countered by other United States actions that undermine vital multilateral AIDS interventions, likely with a negative impact on the viability and success of the President's own program.

For example, during President Bush's visit to Botswana, he remarked that "the average citizen cares deeply about the fact that people are dying in record numbers because of HIV/AIDS. We cry for the orphan. We care for the mom who is alone. We are concerned about their plight, and therefore, will respond as generously as we can."⁶ However, less than one week after President Bush's return from his five-country tour of Africa, White House officials began obstructing the efforts of Congressional appropriators to increase United States funding of the Global Fund for fiscal year 2004 to a maximum of \$1 billion, an amount beyond the \$200 million requested by President Bush.⁷ The recently appointed clinical director of PEPFAR and the current director of the Office of National AIDS Policy, Dr. Joe O'Neill, made a series of arguments in letters to Congressional leadership, claiming that insufficient infrastructure exists to absorb the additional \$1 billion authorized by Congress, despite extensive evidence to the contrary.⁸

5. Press Release, The White House, Fact Sheet: The President's Emergency Plan for AIDS Relief (Jan. 29, 2003), *available at* <http://www.whitehouse.gov/news/releases/2003/01/20030129-1.html> (last visited Dec. 29, 2003).

6. Pres. George W. Bush, Remarks by President Bush and President Mogae of Botswana in a Photo Opportunity (July 10, 2003), *available at* <http://usinfo.state.gov/regional/af/potus2003/a3071002.htm> (last visited Dec. 13, 2003).

7. *See, e.g.*, Letter from Dr. Joseph O'Neill, Director, Office of National AIDS Policy, to Rep. Jim Kolbe, US House of Representatives (July 16, 2003), *available at* <http://www.globalaidsalliance.org/oneillmemo.html> (last visited Dec. 29, 2003); Letter from Dr. Joseph O'Neill, Director, Office of National AIDS Policy, to Bill Frist, Majority Leader, U.S. Senate (July 17, 2003), *available at* <http://www.oneworld.net/article/view/66291> (last visited Dec. 29, 2003).

8. *See* Physicians for Human Rights, A Health Action AIDS Briefing Paper: Administration Claims that \$3 Billion Cannot Be Effectively Used To Fight Global HIV/AIDS Are Mistaken (July 31, 2003), *at* <http://www.phrusa.org/campaigns/aids/briefing080403.html> (last visited Nov. 10, 2003); *see also* PROGRAMME COORDINATING BOARD, UNAIDS, FINANCIAL RESOURCES FOR HIV/AIDS

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A second example of United States actions thwarting global efforts to combat the HIV/AIDS pandemic was on display just two weeks prior to President Bush's departure for Africa, when U.S. trade negotiators attending a World Trade Organization (WTO) informal ministerial meeting in Sharm el-Sheikh, Egypt, continued their longstanding opposition to a straightforward, economically viable WTO deal. This deal would have focused on how poor countries with insufficient domestic drug manufacturing capacity could obtain exported, low-cost generic versions of patented medicines, including medicines for HIV and its complications.⁹ Bush stated during his 2003 State of the Union address that "the cost of [anti-HIV medication] has dropped from \$12,000 a year to under \$300 a year," a price reduction which "places a tremendous possibility within our grasp. . . . [s]eldom has history offered a greater opportunity to do so much for so many."¹⁰ Only generic manufacturers offer antiretroviral prices as low as \$300 per year. Despite Bush's tacit endorsement of procurement of generics as part of his own plan, his trade negotiators were blocking a WTO agreement that would increase access to generic medicines in poor countries.

These examples signal the pattern of contradiction between word and deed, between best practice and political calculation, which currently characterizes White House policies on global AIDS and access to affordable medicines. President Bush's Administration now readily acknowledges the magnitude of the global AIDS crisis, although earlier comments by President Bush during a debate with Al Gore, in which Bush stated that Africa would not be a priority for his Administration, cast a long shadow over his presidency.¹¹ This shift in rhetoric did not happen by accident. Public pressure including coalition protests, non-violent civil disobedience, and other forms of grassroots activism and policy work forced the White House to express a commitment to scaling up the United States government's response to the crisis.¹² Grassroots pressure also

PROGRAMMES IN LOW- AND MIDDLE-INCOME COUNTRIES OVER THE NEXT FIVE YEARS (Nov. 28, 2002), available at http://www.public-info.org/Pages/PagesDossiers/FINANCEMENT%20VIH/PCB13_FinancialResources_en.doc (last visited Dec. 16, 2003).

9. *U.S. Government, Industry, Wrestle with New Approach to TRIPS and Health*, INSIDE U.S. TRADE, June 27, 2003.

10. Bush, *supra* note 4.

11. Derrick Z. Jackson, *No Bush Gaffes, but Plenty of Holes*, BOSTON GLOBE, Oct. 13, 2000, at A23.

12. See e.g., Jon Cohen, *Tough Challenges Ahead on Political and Scientific Front*, 297 SCIENCE 312 (2002); Manny Fernandez, *Protesters Take AIDS Message to the White House*, WASH. POST,

helped reverse more than a decade of United States government opposition to funding access to life-saving antiretroviral treatment.¹³

Unfortunately these changes have translated neither into full support for the Global Fund nor an end to White House obstruction of pro-public health trade policies that facilitate robust generic competition. The Administration's AIDS policies are more likely to be guided by the perceived political risk associated with supporting effective interventions than by the evidence base supporting the need for such interventions. This piece will focus on one such intervention, the Global Fund, and will examine efforts by the Administration, despite its promises, to avoid effective implementation of the Global Fund.

THE GLOBAL FUND—
AN EMERGENCY RESPONSE FORGED BY INTERNATIONAL PRESSURE

During the last four years, international AIDS activism focused attention on the tremendous gap in access to affordable HIV treatment that renders AIDS a death sentence for 95% of the world's 42 million HIV positive people, and a chronic, manageable illness only for the remaining 5%.¹⁴ AIDS activists criticized what they identified as the etiology of a deadly "medical apartheid" that creates two standards of clinical care—one for the rich and one for the poor. Activists highlighted:

- Pharmaceutical company pricing policies, which bear little relation to the cost of bringing a drug to market;
- Resistance to integration of "First World" standards for clinical care into the impoverished settings relied upon by the world's poor;
- Trade policies, enforced by the United States, that block poor countries from using compulsory licenses¹⁵ and other

Nov. 27, 2002, at A8.

13. John Donnelly, *Prevention Urged in AIDS Fight: Natsios Says Fund Should Spend Less on HIV Treatment*, BOSTON GLOBE, June 7, 2001, at A8; Sabin Russell, *AIDS Activists in Uproar over Official's Remarks on Africa*, S.F. CHRON., June 8, 2001, at A5.

14. INTERNATIONAL HIV TREATMENT ACCESS COALITION, A COMMITMENT TO ACTION FOR EXPANDED ACCESS TO HIV/AIDS TREATMENT 3 (2002), available at http://www.who.int/hiv/pub/arv/who_hiv_2002_24.pdf (last visited Dec. 16, 2003).

15. "Compulsory licensing" refers to government authorization for the manufacturing of a patented product without the consent of the patent holder, breaking a patent monopoly and resulting in competition among suppliers, and subsequently driving down prices. Compulsory licensing is permitted according to guidelines set out in many trade agreements, including the WTO's Agreement on Trade-Related Aspects of Intellectual

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mechanisms to promote access to cheaper generic versions of essential medicines;

- The need for wealthy donor countries to pay their fair share, as calculated by country wealth and global need, toward closing the massive gap in financing AIDS treatment, prevention, and care.

From 1999 until 2001, pressure from the emerging global social movement¹⁶ for treatment access forced initial changes in U.S. trade policy regarding patents and access to affordable medicines.¹⁷ Generic competition was facilitated, which in some cases helped reduce the prices offered by proprietary pharmaceutical companies for important drugs.¹⁸ And the definition of the minimum standard for a comprehensive response to HIV disease management in poor countries was revolutionized.¹⁹ For the first time, the human right of universal access to HIV treatment was being expressed not as a radical idea, but as part of a comprehensive clinical response to the disease.

At the same time, Brazil's program of universal HIV treatment access—made possible by government provision of low-cost, generic HIV medicines—was dramatically reducing morbidity and mortality. Data from Brazil clearly demonstrated that delivering triple combination therapy in a resource poor setting worked.²⁰ From 1996 to 2002, Brazil experienced a 40-70% reduction in AIDS-related mortality.²¹ Treatment access was linked with a reduction in stigma, increased hope, more rapid uptake of HIV testing, and potentially a reduction in infectiousness—the latter related to

Property Rights, and the North American Free Trade Agreement (NAFTA).

16. See *supra* note 13 and accompanying text.

17. See Exec. Order No. 13,155, 65 Fed. Reg. 30,521 (May 12, 2000).

18. See Barton Gellman, *Death Watch: The Global Response to AIDS in Africa*, WASH. POST, July 5, 2000, at A1; Barton Gellman, *A Turning Point that Left Millions Behind*, WASH. POST, Dec. 28, 2000, at A1; Barton Gellman, *An Unequal Calculus of Life & Death*, WASH. POST, Dec. 27, 2000, at A1.

19. See Ariel Pablos-Mendez, *AIDS Care Is Learnt by Doing It*, 79 BULL. WORLD HEALTH ORG. 1153 (2001); HARVARD UNIVERSITY, CONSENSUS STATEMENT FOR ANTIRETROVIRAL TREATMENT OF AIDS IN POOR COUNTRIES (Apr. 4, 2001), available at http://www.cid.harvard.edu/cidinthenews/pr/consensus_aids_therapy.pdf (last visited Dec. 16, 2003).

20. Tina Rosenberg, *Look at Brazil*, N.Y. TIMES MAG., Jan. 28, 2001, at 26.

21. WORLD HEALTH ORG., FACT SHEET NO. 274: GLOBAL AIDS TREATMENT EMERGENCY (Sept. 2003), available at <http://www.health.fgov.be/WHI3/krant/krantarch2003/kranttekstsept3/030924m02a-who.htm> (last visited Dec. 16, 2003).

increased control of viral load as a result of powerful and effective combination antiretroviral therapy.²² Finally, generic competition in Brazil and India reduced the cost of antiretroviral treatment from \$15,000 per year to \$700 per year, and then to less than a dollar per day—beating the “best offers” of brand name companies and showing the world that anti-HIV treatment was economically feasible.²³

On April 26, 2001, United Nations Secretary General Kofi Annan called for the creation of a Global Fund which would serve as a “war chest” to attract the billions in new resources needed to fight AIDS and other infectious diseases with both treatment and prevention. Annan’s remarks echoed those of activists fighting for realization of the right to access to affordable, life-saving medicines: “[T]here has been a world-wide revolt of public opinion. People no longer accept that the sick and dying, simply because they are poor, should be denied drugs which have transformed the lives of others who are better off.”²⁴

The Global Fund is structured differently than other responses to AIDS. Rather than an unresponsive bureaucracy, the Global Fund is designed to be a streamlined mechanism driven by country-level demand to attract resources and fund effective programs. Proposals incorporating antiretroviral treatment would be explicitly eligible for Global Fund grants, unlike many bilateral funding streams that refused to fund HIV treatment, deeming it not “cost effective.”²⁵ The Global Fund was to be guided by best practices as determined by science and human rights rather than the dictates of foreign policy as established by one donor country or another.

For example, the Global Fund would not require that countries procure brand name drugs. On the contrary, Global Fund policy supports procurement of the lowest cost medicines, whether brand name or generic.²⁶ Likewise, effective prevention interventions such as

22. Thomas Quinn et al., *Viral Load and Heterosexual Transmission of Human Immunodeficiency Virus Type 1*, 342 *NEW ENG. J. MED.* 921 (2000).

23. C. Perez-Casas et al., *Untangling the Web of Price Reductions: A Pricing Guide for the Purchase of ARVs for Developing Countries*, MÉDECINS SANS FRONTIÈRES (Apr. 24, 2003), available at <http://www.accessmed-msf.org/documents/untangling4thapril2003.pdf> (last visited Dec. 16, 2003); see also *Clinton Group Gets Discount For AIDS Drugs*, *N.Y. TIMES*, Oct. 24, 2003, at A8.

24. U.N. Secretary General Kofi Annan, Address to the African Summit on HIV/AIDS, Tuberculosis, and Other Infectious Diseases (Apr. 26, 2001), available at <http://www.cptech.org/ip/health/abuja/annan04262001.html> (last visited Dec. 16, 2003).

25. INTERNATIONAL HIV TREATMENT ACCESS COALITION, *supra* note 14, at 12.

26. GLOBAL FUND TO FIGHT AIDS, TUBERCULOSIS, AND MALARIA, GUIDELINES FOR PROPOSALS (March 2003), available at <http://www.theglobalfund.org/en/apply/proposals> (last visited Dec. 16, 2003).

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comprehensive sex education, harm reduction strategies, condom access, and needle exchange, while controversial in the United States, are supported by the Global Fund precisely because they are proven to be effective. In contrast, the White House favors funding for “abstinence-only” HIV prevention efforts, which educate about abstinence as a sole intervention, rather than incorporating it as part of a comprehensive framework of HIV prevention options. Abstinence education alone has not been proven effective in preventing HIV transmission, but is strongly supported by extreme religious conservatives.²⁷

In 2001, the United States pledged to donate a mere \$200 million dollars as a “down payment” to the Global Fund. In response to a call for an international effort to raise the \$7 to \$10 billion annually needed to turn back the tide on this disease, and to launch the first comprehensive funding mechanism to address the related pandemics of AIDS, tuberculosis and malaria, the United States gave a sum that totaled about a fifth of what it spends on one cruise missile, or the budget of one Hollywood blockbuster. Activists raised the possibility that, without sufficient funding, the Global Fund would be unable to show clear clinical results, thus shielding donors ad infinitum from committing the billions needed for HIV treatment programs. The remaining Group of Seven leading industrialized countries (G7) announced contributions even lower than that of the United States, adding to the funding crisis. Activism had created a promising and independent multilateral emergency funding mechanism committed to supporting treatment access, but G7 donors, lining up behind the mediocre commitment from the United States, were refusing to fund it in proportion to their wealth.

FUNDING THE GLOBAL FUND

On May 27, 2003, before departing for the G8 Summit in Evian, President Bush signed into law an authorizing bill, the United States Leadership Against HIV/AIDS, Tuberculosis and Malaria Act of 2003. This new law authorized expenditures of up to \$3 billion for global AIDS programs in 2004, including \$1 billion for the Global Fund, as long as the \$1 billion from the United States did not exceed 33% of total Global Fund contributions.²⁸ By July, President Bush’s initial 2004 budget request asked

27. Emily Wax, *Ugandans Say Talk, Not Abstinence Will Win AIDS War; Bush Likely to Hear Dissent on Policy*, WASH. POST, July 9, 2003, at A18; Tina Rosenberg, *On Capitol Hill, Ideology Is Distorting an African AIDS Success*, N.Y. TIMES, April 28, 2003, at A30.

28. H.R. 1298, 108th Cong. (2003) (enacted).

for only \$2 billion for global AIDS spending. Furthermore, only \$200 million of this amount was earmarked for the Global Fund, despite having approved \$1 billion in the authorizing bill. This represented a one-third *decrease* in the United States contribution to the Global Fund—from \$350 million in 2003 to \$200 million in 2004.²⁹

During Congressional consideration of the 2004 authorizing bill, the White House lobbied aggressively to undermine amendments that would increase contributions to the Global Fund. Instead of allowing appropriators to increase funding for global AIDS programs, the White House intervened, opposing any proposal that would provide more than \$200 million for the Global Fund in 2004. Ultimately, \$500 million in appropriations for the Global Fund passed the House, with a looming veto threat from the President.³⁰ Following the work of House-Senate Conferees, Congress approved \$2.4 billion in global AIDS spending, \$550 million allocated for the Global Fund—far less than the \$1 billion President Bush promised to the Global Fund when he signed the authorizing bill, but incrementally more than the \$200 million advocated by the White House.³¹

The White House defended its reduced contribution to the Global Fund by arguing that the nascent infrastructure of poor countries would be unable to absorb an additional \$1 billion. This argument flies in the face of available data.³² The Bush Administration's resistance to the Global Fund is motivated not by logic and facts but by political considerations. In reality, the cash-strapped Global Fund is the only funding mechanism currently operational that has the capacity to absorb—and accountably award—such sums. Religious conservatives and Congressional and White House officials have criticized the Global Fund as being unaccountable to American taxpayers.³³ But the United States Health and Human Services Secretary

29. U.S. STATE DEP'T, U.S. GOVERNMENT SUPPORT FOR THE FIGHT AGAINST HIV/AIDS (June 18, 2003), *available at* <http://www.state.gov/g/oes/rls/fs/2003/21742.htm> (last visited Dec. 29, 2003).

30. Jim Abrams, *House Approves \$17.1B Foreign Aid Measure*, ASSOCIATED PRESS, July 24, 2003; Sheryl G. Stolberg, *House Wrangles Over Level of Spending on Global AIDS*, N.Y. TIMES, July 23, 2003, at A9.

31. The Bush Administration recently proposed a 63% reduction in funding for the Global Fund for fiscal year 2005—from the \$550 million approved for 2004 to \$200 million. U.S. Dep't of State and Int'l Assistance Programs, Budget of the United States Government, Fiscal Year 2005 (Feb. 2, 2004).

32. *See supra* note 8.

33. *See* Press Release, Office of Congressman Joe Pitts, Rep. Pitts Decries Committee Action on HIV/AIDS Bill (April 2, 2003), *available at*

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Tommy Thompson is the Chair of the Global Fund's Board, and the Global Fund is subjected to regular audits by the General Accounting Office.³⁴ This is unlike traditional bilateral funding programs, whose quantitative clinical accomplishments are frequently inscrutable, severely limiting accountability.³⁵

THE GLOBAL FUND AND THE BUSH AIDS INITIATIVE:
COMPLEMENTS OR ADVERSARIES?

The United States has refused to promise an annual contribution to the Global Fund that represents a fair share of the overall financial need of the Fund. This refusal is illogical and immoral. If the Global Fund falters and is unable to fund significant quality HIV proposals, in particular proposals that fund HIV treatment, the success of the administration's own PEPFAR program will also be compromised. Unlike PEPFAR, which will not be able to show results for years, the Global Fund is the one mechanism that is actually equipped to responsibly absorb a \$1 billion contribution, as well as the billions in donations from other donors that the United States contribution will leverage.

G7 countries have already promised to spend between \$7 and \$10 billion each year fighting AIDS in low and middle-income countries, as one of a series of targets committed to by all United Nations members.³⁶ UNAIDS projects that funding needs in poor countries will reach \$10.5 billion by 2005, and will reach \$15 billion by 2007³⁷—and this is without taking into account the funding needed to build and develop human and non-human infrastructure. Global AIDS spending in poor countries from all sources is estimated to be \$4.7 billion—with only \$1.6 billion, or 34%,

<http://www.house.gov/pitts/press/releases/030402r-AIDSbillIR.htm> (last visited Dec. 16, 2003).

34. U.S. GEN. ACCOUNTING OFFICE, THE GLOBAL FUND TO FIGHT AIDS, TUBERCULOSIS AND MALARIA HAS ADVANCED IN KEY AREAS, BUT DIFFICULT CHALLENGES REMAIN (May 2003), available at <http://www.gao.gov/new.items/d03601.pdf> (last visited Dec. 16, 2003).

35. See Derek Link & Mark Harrington, *Exploring the American Response to the AIDS Pandemic*, Treatment Action Group Report (July 2000); see also U.S. GEN. ACCOUNTING OFFICE, U.S. AGENCY FOR INTERNATIONAL DEVELOPMENT FIGHTS AIDS IN AFRICA, BUT BETTER DATA NEEDED TO MEASURE IMPACT (March 2001), available at <http://www.gao.gov/new.items/d01449.pdf> (last visited Dec. 3, 2003).

36. U.N. G.A., Special Session on HIV/AIDS, *Declaration of Commitment* (June 2001), available at <http://www.un.org/ga/aids/docs/aress262.pdf> (last visited Dec. 16, 2003).

37. UNAIDS, FACT SHEET, MEETING THE NEED (Sept. 1, 2003), available at <http://www.unaids.org/Unaid/EN/media/fact+sheets.asp> (last visited Nov. 10, 2003).

from the combined multilateral and bilateral commitments of the seven wealthiest countries in the world.³⁸ Current spending patterns mean funding goals, and clinical goals whose fulfillment is dependent on money, will be unmet as long as donor neglect continues.³⁹

Examples of the potential synergy of the Global Fund and PEPFAR generate additional arguments for the immediate full funding of both programs by the United States. A multilateral mechanism like the Global Fund is a necessary part of an effective response to the AIDS catastrophe. Multilateral mechanisms pool donor efforts, are less affected by country politics, have low overhead costs relative to bilateral aid, and support the coordination of international efforts. The lessons learned from meaningful cooperation between civil society and government in Global Fund grant writing and program implementation will be essential to PEPFAR's attainment of its clinical goals, in particular the goal of treating two million people with antiretrovirals by 2008.⁴⁰

The White House appears willing, for now, *not to object* to the use of PEPFAR money to purchase generic versions of medicines.⁴¹ What is unclear is whether in the future, in order to respond favorably to pressure from the pharmaceutical industry lobby, the United States will develop a procurement policy for PEPFAR that *de facto* excludes most generic suppliers, for example by subjecting suppliers to unnecessarily high standards that do not increase patient safety but do eliminate generic companies from eligibility. Likewise, it is unclear whether PEPFAR will

38. KAISER FAMILY FOUND., FACT SHEET, GLOBAL HIV/AIDS SUPPORT FROM G8 COUNTRIES, (May 2003), *available at* <http://www.kff.org/hivaids/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=14377> (last visited Dec. 16, 2003).

39. Press Release, United Nations, Two Years After Historic Session on HIV/AIDS, New Reports Show Progress but Member Nations Fall Short of Goals (Sept. 22, 2003), *available at* <http://www.un.org.in/News/2003/pr/pr166.html> (last visited Dec. 16, 2003).

40. PEPFAR is already imposing artificial, external restrictions on funding for civil society mobilization—an intervention that is a critical element of successful HIV treatment scale-up efforts. *See* CTRS. FOR DISEASE CONTROL, RAPID EXPANSION OF ANTIRETROVIRAL THERAPY PROGRAMS FOR HIV-INFECTED PERSONS IN SELECTED COUNTRIES IN AFRICA AND THE CARIBBEAN UNDER THE PRESIDENT'S EMERGENCY PLAN FOR AIDS RELIEF, *available at* <http://www.cdc.gov/od/pgo/funding/04080.htm> (last visited Dec. 20, 2003). The Global Fund, in contrast, permits CCM applicants to make independent determinations regarding the proportion of spending needed to support civil society involvement in building local demand for treatment access.

41. *See* Bush, *supra* note 4. Bush's mention of the cost of generics suggests this lack of objection.

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solicit direct in-kind donations of medicine to offset additional costs and therefore favor the procurement of brand name pharmaceuticals, despite a resounding international consensus that in-kind donations of chronically administered medicines decrease program sustainability.⁴²

The Global Fund is providing grantees with funding used to procure low-cost, generic antiretroviral medicines. This ensures that finite resources will be used in a way that will benefit the greatest number of sick and dying people, while increasing international acceptance of the procurement of generic HIV medicines.⁴³ Without adequate funding, the ability of the Global Fund to set independent standards in the critical area of drug procurement will likely be undermined by the competing political interests of the private sector, to the detriment of people living with HIV.

OVERCOMING WHITE HOUSE RESISTANCE
TO EFFECTIVE RESPONSES TO THE AIDS CRISIS

An essential test of the commitment of the United States and other wealthy donor countries to winning the war against AIDS is whether they are committed to providing adequate levels of funding to pay for the interventions—prevention, care, and treatment—that are the weapons in this war. Donor nations are currently failing this test. A new paradigm in resource mobilization, built on the mutual commitment of all partners to contribute equitably to interventions that will most wisely use limited resources for prevention and treatment, is desperately needed. The current “supply-driven” system, where donor countries capriciously decide when they will give and how much, has increased doubt that the international community will commit the money needed to close the massive *existing* funding gap, much less mobilize the *additional* finances needed to expand and build new infrastructure.

During the sixth Board Meeting of the Global Fund, donor countries on the board rejected proposals to require contributors to give based on

42. See, e.g., Alain Guilloux & Suerie Moon, *Hidden Price Tags: Disease Specific Drug Donations, Costs and Alternatives*, MÉDECINS SANS FRONTIÈRES, DRUGS FOR NEGLECTED DISEASES WORKING GROUP (2001).

43. The presence of more than one or two medicine suppliers is the factor most strongly associated with low medicine prices. See Stéphane Lucchini et al., *Decrease in Prices of Antiretroviral Drugs for Developing Countries: From Political “Philanthropy” to Regulated Markets?*, in *ECONOMICS OF AIDS AND ACCESS TO HIV/AIDS CARE IN DEVELOPING COUNTRIES, ISSUES AND CHALLENGES* 169 (J.P. Moatti et al., Agence Nationale de Recherches sur le Sida eds., 2003), available at http://www.iaen.org/files.cgi/11088_part_1_n7_Luchini.pdf (last visited Dec. 3, 2003).

their fair share of global need. This decision imperils the “demand-driven” ethos of the Global Fund—where recipient countries’ resource gaps define the Global Fund’s outstanding funding needs. Advocates will be forced to communicate conflicting messages—that G7 countries should contribute proportionately to their wealth, but poor country applicants must submit substantial requests for funding, regardless of the stinginess of donor nations. Ultimately, this stinginess will exacerbate what the Global Fund’s Technical Review Panel has already described as the “shyness” of applicants in requesting funding for antiretroviral treatment, a historically neglected intervention.⁴⁴

The most promising models for resource mobilization have been suggested elsewhere.⁴⁵ These support a framework in which the financial burden of each donor country is calculated proportionately to its wealth and to overall financial need, as determined by transparent analyses. Such a model of “equitable contribution” would require donors to commit prospectively to a regular, agreed upon schedule, so that continuity of care in poor countries would be assured and sustainable, short-term and long-term planning by government, care providers, people living with HIV, and other experts would be possible. In this manner, donors’ obligations would be determined based on what people with HIV and people at greatest risk of infection need, rather than what donors independently determine they are willing to commit—the latter being the hallmark of the current, unsuccessful global AIDS resource mobilization framework. The promises made by donor countries to correct the global AIDS funding crisis will continue to be broken, so long as donors resist a coherent, transparent, and equitable framework for their contributions.

In the last four years, international demand for access to HIV treatment for all has helped catalyze a dramatic shift in the rhetoric of decision makers in the United States, as well as other donor countries. The United States now claims it is willing to lead the fight against the global AIDS epidemic. But the promises of the current Administration are worth little without a commitment to full, sustained funding for mechanisms that work, particularly the Global Fund as discussed above, and full support for trade policies that prioritize public health and access to affordable generic

44. GLOBAL FUND TO FIGHT AIDS, TUBERCULOSIS, AND MALARIA, SIXTH BOARD MEETING, REPORT OF THE SECRETARIAT AND THE TECHNICAL REVIEW PANEL ON ROUND 3 PROPOSALS (Oct. 15-17, 2003).

45. *See, e.g.*, Marie-Josée Mbuzenakamwe, Address at the Second International AIDS Society Conference on HIV Pathogenesis and Treatment (July 13, 2002), *available at* <http://www.actupparis.org/article1205.html> (last visited Dec. 29, 2003).

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medicines over the commercial interests of the proprietary pharmaceutical industry.