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The Politics of Receptivity and Resistance: How Brazil, India, China, and Russia Strategically use the International health Community in Response to HIV/AIDS: A Theory

Eduardo J. Gómez

Little is known about how emerging nations, such as Brazil, Russia, India and China (aka, B.R.I.C.), strategically use the international health community in order to strengthen their domestic HIV/AIDS programs. In this article, I introduce a new theoretical framework, strategic “receptivity” and “resistance,” in order to explain how and why this process occurs. Brazil emerges as the most successful case of how this process leads to the formation of international partnerships and domestic policies strengthening its AIDS program, with India gradually building such a response, followed by China and Russia. This article closes with an explanation of how this strategic interaction reflects the growing independence and influence of BRIC while highlighting how this framework applies to other cases.

INTRODUCTION

As nations continue to confront the AIDS epidemic, little is known about how and why they strategically interact with the international health community in order to enhance their domestic responses. The international health community is defined as bilateral and multi-lateral agencies providing financial and technical assistance for AIDS, advice on HIV prevention, as well as the global market for pharmaceutical products. As the AIDS epidemic progresses and nations become better at responding to it, some have become more financial and technically independent from the international community. This is especially the case for emerging nations such as Brazil, Russia, India, and China (B.R.I.C.), where sound economic performance and health system innovations have induced political elites to essentially break their dependence on the international community.

In this second phase of AIDS politics, emerging nations change the nature of their relationship with the international community. They become more strategic in their interaction with it, taking and in some instances giving back to it. While some nations still receive donor aid assistance, it is no longer a domineering factor shaping AIDS policy. Rather, aid is strategically used to sustain and enhance certain aspects of domestic programs. Thus, the running assumption in this paper is that interactions with the international community are used for domestic benefits. Nevertheless, even those nations having engaged in early and consistent partnerships with the donor community at times resist advice for AIDS prevention and treatment policy, as well as join international movements against the imposition of high prices for ARV.

How and why does this kind of response to the international community occur? And why are some nations more strategic and successful than others? In

answering these questions, I submit a new theoretical framework and explanation. Specifically, I argue that nations often engage in simultaneous “receptivity” and “resistance” of the international community. Receptivity is defined as a nation’s partnership with donor agencies for the expansion of AIDS administration; these partnerships vary in their length and breadth, with the more successful cases having longer, well-established partnerships. They often take the form of loans and in some instances grants. Moreover, partnerships are solidified over a long period of time and lead to an expectation of continued support, even if domestic commitment levels eventually surpass donor assistance.

Nevertheless, I argue that two conditions must be present for receptivity to occur: First, governing elites, acting autonomously from vested institutional interests, must be concerned about their reputation as nations capable of effectively responding to AIDS; Second, elites must be aware of their pre-existing history of international collaboration. When these conditions are present, elites have incentives to be receptive because this provides them with the resources needed to develop successful AIDS programs while further enhancing their reputation. In the end, I argue that reputation-building and historical precedents must be jointly present for receptivity to occur.

Receptivity provides the opportunity space for the emergence of another variable accounting for differences in outcomes: i.e., the emergence of tripartite partnerships between donors, AIDS officials, and NGOs. Here, AIDS officials have career incentives to forge close partnerships with donors and NGOs. This provides AIDS officials with career stability, which in turn inspires them to continuously work with donors and NGOs for the continued expansion of AIDS programs. The presence of a federal commission ensuring the representation of NGOs facilitates this process but by no means guarantees effectiveness.

On the other hand, a nation’s resistance to the international community occurs when external recommendations for AIDS prevention and treatment, when combined with high prices for ARV medication, challenge a nation’s preexisting normative structure and belief in how it should respond. That is, when recommendations go against deeply ingrained moral views, or when they threaten a nation’s belief in universal access to healthcare as a form of human rights, nations will resist the international community.

Furthermore, nations will resist the imposition of high market prices for ARV medication whenever normative commitments to universal healthcare combine with the pharmaceutical capacity to produce generic medication. Resistance may take the form of issuing compulsory licenses or issuing threats of doing so. Resistance occurs only when these two conditions are present; neither one on its own is sufficient for such a response. For example, even if nations have the pharmaceutical capacity to produce drugs, in the absence normative commitments to universal health care, they will refrain from resisting markets. This stems mainly from the fear of tarnishing their image as free trade partners; and this will occur despite their ability to easily resist markets, as outlined through the 2001 Doha declaration.

What all of this suggests is that emerging nations are willing to work with the international community as long as it does not threaten their pre-existing normative structure. What this further suggests is that emerging nations are keen on taking what they need from the international community while resisting other areas of recommendation and assistance. What this implies, and as I discuss at length in the conclusion, is emerging nations' recognition that they are independent and important enough to risk this kind of strategic interaction with the international community. This further underscores their rising influence and power.

STRATEGIC RECEPTIVITY AND RESISTANCE

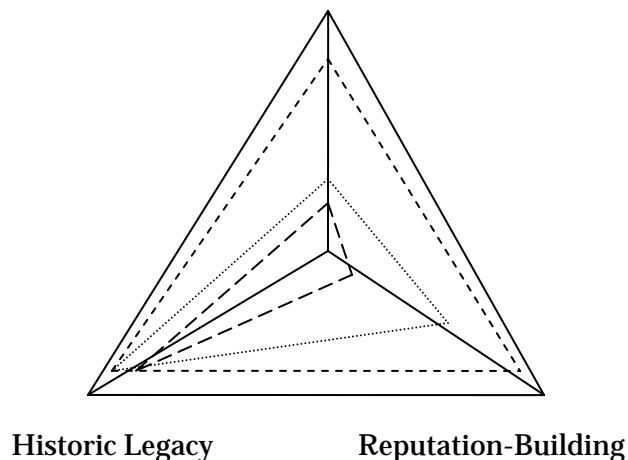
Because AIDS has been on the international agenda for quite some time, pressures from international agencies and NGOs generate incentives for politicians to respond more aggressively to the epidemic, while ensuring that they meet the needs of civil society. This is reinforced by new international norms and commitments advocating the full integration of civil society into the policy-making process.

During this period, emerging nations eager to respond to the needs of civil society will also begin to notice their differences with the international community. While nations may be receptive to establishing partnerships with donors, at the same time they may resist international recommendations challenging their approach to AIDS control.

This leads to what I call strategic internationalization in AIDS politics. It is marked by a nation's strategic usage of the international community for their domestic institutional and policy benefits: that is, being receptive to aid assistance while vehemently resisting recommendations for particular policy changes.

Graph 1.1 – Radar Map of Receptivity

Tripartite Partnership/Program Expansion



(Values increase expanding out from center)

Brazil = _____
 India = - - - - -
 China =
 Russia = - - - - -

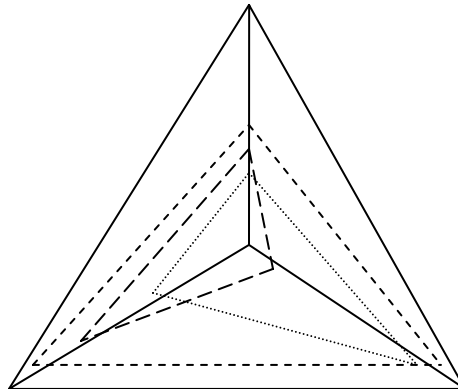
As Graph 1.1 here illustrates, receptivity to donor aid assistance is preconditioned by a nation's incentives to increase its reputation. In an effort to show the world that they are effective modern states, elites wish to reveal that they have always been committed to working with other nations in response to disease; they wish to show that they have modern agencies, resources, and are equally as capable of responding to AIDS when compared to advanced industrialized states; moreover, they have incentives to show that they can even outpace them in their response. Responding to international criticisms is thus viewed as an opportunity to illustrate state strength and commitment to combating AIDS while safeguarding human rights. Consequently, nations are receptive to donor aid assistance because this provides the *means* through which to not only maintain but also to further enhance their reputation.

Historic legacies also play an important role. Nations that have a long history of working with the international community will have an on-going legacy and commitment to do the same whenever a new epidemic emerges. Elite recollection of their nation's close partnership with other nations through international organizations will motivate them to do the same at subsequent points in time.

The end result of these two dynamics, reputation-building and historic legacies, is a nation's receptivity to donor aid assistance. This often entails technical assistance to strengthen AIDS administration, such as funding for staff and for initiatives to work closely with the states and NGOs.

Graph 1.2 – Radar Map of Rejection

Compulsory License, Threat/Resist Prevention Recommendations



Normative Structure

Pharmaceutical Capacity

GLOBAL HEALTH GOVERNANCE, VOLUME III, No. 1 (FALL 2009) <http://www.ghgj.org>

Brazil = _____
 India = - - - - -
 China =
 Russia = - - - - -

Alternatively, resistance emerges when nations challenge bi-lateral and multi-lateral pressures for certain types of prevention and treatment policies. Nations resist when international recommendations go against domestic normative structures, such as beliefs about the causes and consequences of AIDS and how the government should respond. But they also resist when global prices for ARV medication challenge pre-existing commitments to universal healthcare. Thus, resistance entails two policy areas: AIDS prevention and access to medicine.

Two sides of the normative sphere prompt resistance to prevention policy. On one hand, emerging nations with historic institutions, such as laws, upholding their moral beliefs will resist external advice challenging these beliefs – e.g., sex education and harm reduction. On the other hand, nations that do not institutionalize moral beliefs but rather their normative democratic commitment to human rights and universal access to medicine, solidified through democratization processes and constitutions, will adamantly resist international advice challenging these commitments. Nations will, for example, resist any donor aid conditionalities threatening their belief in human rights, such as providing assistance to sex workers, or donors arguing against the universal provision of ARV medication based on exorbitant costs to the economy.

Next, when normative commitments to universal healthcare combine with the infrastructural capacity to produce generic drugs, the second resistance impulse emerges, that is, resistance to global markets. Nations differ in their historical experiences, commitments, and capacity to develop pharmaceutical labs for vaccine production. When present, strong pharmaceutical capacity can motivate elites to use their knowledge and resources as a way to challenge global market prices and ensure that they can afford the universal provision of ARV medication.¹

Resistance to global market yields the following responses: either impose compulsory licenses for generic medication or issue the threat to do so. When nations have strong infrastructural capacity and normative commitments to universal healthcare, threats of imposing compulsory licenses will be credible and will lead to a lower price for ARV medicine, thus ensuring access to it.

Alternatively, nations may have strong pharmaceutical capacity but nevertheless fail to have normative commitments. In this scenario, nations may refrain from resisting markets and instead opt for price negotiations. For example, while the 2001 Doha declaration² of the 1995 TRIPS³ agreement, as well as paragraph 6 of Doha in 2003,⁴ certainly provides ample opportunity for nations to resist markets through compulsory licensing, a nation's concern about its reputation as a country committed to free trade may generate incentives not to do so.⁵ When this occurs, emerging nations will be more concerned about their trade reputation than they are with safeguarding the needs of civil society.

Consequently, instead of resisting markets, they will engage in price negotiations with pharmaceutical companies, even if they have the infrastructural prowess to challenge markets.

But is there really a global market for ARV medication? The market in its purest form is certainly not present. Because of the contributions of bilateral agencies, such as PEPFAR, multilateral organizations such as the Global Fund, and philanthropic donors such as the Gates and Clinton foundation and their provision of ARV medicine to developing nations, markets no longer impose a serious constraint. Moreover, there is now an ethical norm that that these organizations should delude the market through the provision of ARV medicine.⁶

These contributions notwithstanding, given the high costs associated with generic medication and the need for second-line drugs, assistance provided from the international community often falls short of meeting country needs. Domestic commitments to provide drugs through universal healthcare, limited fiscal (especially sub-national) constraints and the continued growth of AIDS cases requires that most nations still engage the global market; while it may no longer be as constraining, nations still find themselves in need of strategically working with it. How they respond to global markets reflects their ongoing domestic needs. And in cases where the international community's help still falls short of meeting needs, they will strategically resist markets in order to ensure the provision of ARV medication.

Tripartite Partnerships as a Receptivity Mechanism

Despite this resistance, when receptivity occurs this leads to new coalitional strategies advancing administrative and policy reform. More specifically, these conditions lead to the emergence of new tripartite partnerships between AIDS officials, donors, and NGOs. The availability of donor aid stipulating the incorporation of NGOs into the policy-making process creates incentives for AIDS officials to accomplish two things: First, to strengthen partnerships with NGOs; and second, to strategically use these partnerships in order to increase their influence within government. Moreover, the goal for AIDS officials is not only to increase administration and policy spending, but also to advance their careers. By working closely with NGOs, AIDS officials can strategically use these networks to obtain more funding from international creditors while maintaining government support. Because of this, AIDS officials take the lead in forming and sustaining these partnerships. I argue that the formation of these partnerships is necessary for the continued expansion of an AIDS program.

BRAZIL

Soon after increased pressures and criticisms of Brazil's delayed response to AIDS emerged, circa 1990,⁷ the president and senior health officials became increasingly concerned about the government's reputation.⁸ By 1994, President Fernando H. Cardoso strove to increase Brazil's reputation as a modern state capable of controlling AIDS.⁹ Cardoso recalled the long history that Brazil had of

eradicating disease, such as syphilis and TB.¹⁰ In essence, Cardoso viewed responding to AIDS as an opportunity to reveal Brazil's effective healthcare system and technical expertise.¹¹ Moreover, his views spread throughout the Ministry of Health. This changed the government's perception of the AIDS problem and increased its interest in strengthening the AIDS program.¹²

Yet it is important to note that democratic institutions and electoral pressures did not instigate Cardoso's response. In fact, during his 1994 presidential campaign, Cardoso never mentioned the AIDS program.¹³ Congress certainly did not influence Cardoso's decisions, while his health ministers were given complete autonomy and were isolated from external pressures.¹⁴

Concern about Brazil's reputation increased under the current Luiz Ignácio Lula da Silva "Lula" administration. Soon after Lula's arrival, he met with the director of the AIDS program, Dr. Paulo Teixeira, to see what they could do to increase Brazil's reputation and policy influence.¹⁵ Noticing how the media was praising Brazil for its success, Lula went as far as to meet with the Ministry of Foreign Affairs to see how they could market their AIDS program more effectively.¹⁶ Concern about the AIDS program's reputation has motivated Lula to remain committed to it while working with other nations and donors in order to strengthen his and other nation's response.

In addition to reputation-building, the government was also aware of the long history that it had of working with other nations to combat disease. In addition to sending teams of doctors to Europe to attend conferences in order to find a cure for syphilis, TB, and polio, Brazil was one of few nations to propose the creation of the World Health Organization in 1948. This history had a profound impact on President Cardoso's interest in maintaining this tradition and working with international organizations in response to AIDS.¹⁷ This knowledge and legacy permeated the Lula administration, moreover, and motivated his senior AIDS officials to work closer with the international community.¹⁸ Interest in working with the international community persists and represents an on-going legacy within government.

Receptivity

These two conditions, reputation-building and historic legacies, set the stage for Brazil's receptivity to donor aid assistance. Bilateral aid emerged early on. In 1992, the AIDS program received a bridge loan from the USAID to sustain its prevention activities while undergoing negotiations with the World Bank for its first loan.¹⁹ The USAID followed up with 5-6 year strategy grants to address HIV prevention among vulnerable groups, promote condom use and NGO support.²⁰ In 1992, moreover, France's ANRS (National AIDS Society for Research) provided funding to conduct HIV research. DFID also provided support during the 1980s, which was mainly focused on NGOs, and has continued to provide funding for prevention in the Amazons.²¹

Brazil was also open to multilateral assistance and philanthropy. As early as 1986, the government received funding from the WHO to construct the

national AIDS program.²² The Pan America Health Organization (PAHO) also provided financial and technical support during this period.²³ And finally, the government received financial assistance from philanthropic organizations, such as the Ford Foundation, to support NGOs.²⁴

These early partnerships notwithstanding, the biggest contributor to the AIDS program was the World Bank. Since 1993 the government has been receptive to a series of loans from the Bank to expand AIDS administration, create more effective prevention programs while providing funding to NGOs.²⁵ An ongoing relationship with the World Bank has developed a partnership that persists, grounded in the tenants of simultaneously working closely with NGOs and donors.

Receptivity to donors also provided the opportunity space for the emergence of an ongoing partnership between donors, AIDS officials, and NGOs. Since the early 1990s, previously ignored AIDS officials engaged in a partnership with the World Bank to work with NGOs in order to strengthen the AIDS program.²⁶ AIDS officials viewed working with the Bank and eventually other donors, such as USAID and the Global Fund, as a way to advance their careers.²⁷ Even though NGOs were essentially ignored during the first few years of the epidemic,²⁸ working closely with NGOs after the World Bank loans arrived increased the influence of AIDS officials, since civic incorporation was advocated by the World Bank and President Itamar Franco and Fernando Cardoso. Over the years, AIDS officials have had incentives to sustain this tripartite partnership and to use it in order to increase their legitimacy and bargaining power when seeking more congressional funding.²⁹

The presence of domestic institutions increasing the representation of civil society certainly facilitated the formation of a tripartite partnership; though by no means was this determining factor. In 1987, the National AIDS Commission within the AIDS program was created in order to solidify the representation of PLWHA and NGOs in the policy-making process. While the AIDS Program director did not immediately work closely with the Commission,³⁰ the latter did nevertheless facilitate the formation of a partnership between AIDS officials and NGOs throughout the 1990s.

Resistance

However, Brazil has not always been receptive to the international community. In 2003, for example, the Ministry of Health rejected a grant from the USAID for \$40 million dollars in response to the conditionality that the government sign an oath condemning prostitution and that no assistance be provided to sex workers. The director of the AIDS program, Dr. Pedro Checquer, immediately rejected this on the grounds that it violated the government's normative commitment to human rights and citizenship.³¹ In addition, in 1992 the Ministry of Health vehemently opposed the World Bank's mandate that it not finance the provision of ARV medication through its universal healthcare system. The Bank believed that doing this would essentially bankrupt the state, given the

dire fiscal conditions at the time. Once again, the AIDS program rejected this on the grounds that this advice violated the government's normative commitment to ensuring equal access to medicine, a right enshrined through the 1988 constitution.³²

Perhaps Brazil's most noteworthy example of its resistance to the international community has been its response to pharmaceutical markets. Brazil has shown resistance by strategically taking advantage of the 1995 TRIPS ruling, and subsequent 2001 Doha declaration. The Ministry of Health has periodically used this ruling as a bargaining chip when negotiating with pharmaceutical companies for price reductions.³³ By periodically threatening to produce generic versions of patented medicine, Brazil has been able to acquire medicine at a more affordable price. For several years the government has used this threat to successfully reduce the prices of several patented drugs. Until May 2007, when the government issued its first compulsory license for the production of Merck's *Efavirenz*, Brazil did not issue a compulsory license, mainly due to fears of the ramifications it would have for free trade with the US.³⁴

This effort to resist markets has been guided by the government's unwavering commitment to democracy and the belief that guaranteeing access to medicine is a human right.³⁵ The 1988 constitution's mandate for universal healthcare and equality solidified this belief. In this context, the government has perceived the imposition of high prices for ARV medication as a serious threat to its ability to maintain this democratic commitment.

Developing the infrastructural capacity needed to produce generic versions of ARV medication has also strengthened the government's interest and ability to resist markets. By investing in government-run institutions such as Far-Manguinhos in Rio, and other state-owned labs in São Paulo, the government has proven capable of developing the technology needed to produce generic drugs at a cheap price. In addition, the government's historic commitment to creating a strong pharmaceutical industry, when combined with unwavering political will, has not only facilitated the production of medicine but has also provided a resource with which to use as an effective bargaining chip when negotiating prices with pharmaceutical companies: that is, its ability to increase its knowledge and awareness of the costs involved in producing medicine that is patented on the international market.³⁶ With this knowledge, the Ministry of Health knows that it can use its infrastructural capacity to effectively bargain with pharmaceutical companies. Since 1994, it has done so successfully.

INDIA

Like Brazil, India also shares a rich history of working with the international community. While it did not join Brazil and China during the formation of the World Health Organization in 1948, it was the first in its region to participate in the creation of the South-East Asia regional office of the WHO in 1948.³⁷ Since then, India has worked closely with the WHO to eradicate disease in South-East Asia.³⁸ At the same time, it has worked closely with the WHO to eradicate

smallpox by working with health officials to strengthen India's National Smallpox Eradication Program (NSEP).³⁹ India viewed the WHO and other nations, such as Russia, as key partners in finding and distributing vaccines for smallpox eradication.⁴⁰

In addition, the government has been concerned about its reputation. In recent years, it has strengthened the AIDS program and engaged in partnerships with donors in order to enhance its reputation.⁴¹ The government has not responded favorably towards criticism, such as the Gates foundation's statement in 2001 that India would have 25 million cases of AIDS by 2010.⁴² Responding through an aggressive AIDS program has therefore been viewed as an important way to prove the international community wrong. As India strives to make its mark on the global sphere and enhance its regional influence, reputation-building has motivated the Prime Minister and AIDS officials to work with the donor community to strengthen its response.

In addition, institutional designs did not influence the Prime Minister's engagement with the international community. After a long delay in the PM's attention to AIDS, in 2001 PM Atal Vajpayee made proactive efforts to engage the international community and to increase the government's commitment to AIDS. While he obtained parliamentary and bi-partisan support for his statements,⁴³ they were by no means the main reason for why he responded. Vajpayee and PM Manmohan Singh were essentially working on their own.

Receptivity

Nevertheless, the two dynamics mentioned earlier, i.e., reputation-building and historic legacies, provided incentives for the government to work closely with the donor community. India's partnership with donors began during the early-1990s. State governments received technical and financial assistance from bi-lateral agencies, such as USAID and DFID. USAID was particularly instrumental in providing assistance to NGOs for AIDS prevention,⁴⁴ and continues to do so.⁴⁵ During the early-1990s, DFID also played a key role in providing the states with prevention and treatment services.⁴⁶ Since 1999, DFID has provided funding to NACO and state governments. More recently, DFID has provided funding to the NACO in order to strengthen its intervention at the state-level.⁴⁷

At the multi-lateral level, India entered into several early partnerships. In 1985, the WHO provided support for AIDS research. In 1987, the WHO helped the government create the National AIDS Control Program for strategy and planning prevention.⁴⁸ By 1989, the WHO started working with state governments to implement prevention policies.⁴⁹ The WHO continues to provide support, mainly through surveillance and technical assistance.⁵⁰

In 1992, the World Bank also began to provide support. That year, the Bank provided a loan of \$84 million, followed by yet another for \$191 million in 1999, with the government contributing \$14 million from its budget. These projects were aimed at improving the blood supply, increasing awareness of HIV

transmission, and creating State AIDS Control Societies (SACS) to help implement prevention policies.⁵¹

By 2002, the bulk of funding for NACO came from the World Bank, an estimated \$38.2 million, followed by the government at \$7.8 million and approximately \$10 million from other bilateral donors.⁵² When compared to other more burdensome diseases, however, the government commits most of its resources to AIDS.⁵³

Similar to Brazil, NACO officials and the PM continued to strengthen its partnership with the World Bank. In 2007, NACO approached the Bank for a Phase III credit of \$250 million dollars.⁵⁴ The goal of this project is to create a more comprehensive AIDS program, where NACO, SACS, and NGOs work together;⁵⁵ this partnership persists.

Yet another multilateral agency that has provided assistance is the Global Fund to Fight AIDS, TB, and Malaria. Since 2004, the Global Fund has provided the Department of Economic Affairs with grants to help mothers with HIV, PLWHA, and ARV treatment.⁵⁶ In addition, in 2004 the Global Fund provided the Department of Economic Affairs with a grant to address the TB-HIV co-infection problem. Since 2004, several grants totaling US\$ 505,653,939.00 have been provided.⁵⁷

Private philanthropy has also been helpful. In 2002, the Bill & Melinda Gates foundation provided \$258 million for the Avahan initiative. This is a HIV prevention program aimed at Indian truck drivers and the six highest prevalence states in India.⁵⁸ And in 2006, the Clinton Foundation provided funding to help NACO work with nurses in small communities.⁵⁹

India's continued partnership with the Global Fund, the World Bank and other donors seems to suggest that NACO officials are benefiting from an ongoing partnership. AIDS officials continue to be employed and advance within NACO as long as donor aid persists. In addition, NACO officials have increased their partnership with AIDS NGOs. This has occurred mainly between SACS, as they rely on NGOs to reach distance municipal districts.⁶⁰ As SACS continue to face technical and administrative difficulties, the NACO has continued to rely on NGOs.⁶¹

It is important to note, however, that donor aid assistance on its own has not been the key catalyst to government response, or to the subsequent formation of a tripartite partnership. Despite early donor assistance, the government did not begin to aggressively respond until 2001.⁶² Before then the states responded on their own, while the Ministry of Health and PM seemed to ignore the situation.⁶³ While the recent arrival of funding from the Global Fund, the World Bank, and the Gates foundation has certainly helped, the government's response was very much delayed.

When it comes to working with NGOs, the government's record has not been as stellar, though it is certainly improving. The absence of institutions such as a national AIDS commission mandating the representation of NGOs has limited NACO's ability to work closely with NGOs and to use them in order to increase NACO's influence. Moreover, NACO's commitment to working with

NGOs only recently emerged in 2003.⁶⁴ A National AIDS Committee exists; but it was not explicitly designed to insure NGO representation. Some officials have stated that there has been a consistent lack of clarity and interest on the part of NACO and local government officials to incorporate NGOs into the policy-making process.⁶⁵ There is now a stronger commitment to clearly delineate and increase NACO's partnership with NGOs, as well as including them in the National Strategic Plan on AIDS.⁶⁶

Resistance

While India has demonstrated receptivity to the international community, there have also been instances of resistance. Until recently, for example, it has gone against the international community's endorsement of harm reduction.⁶⁷ As part of NACO's second phase response in 1992, it essentially avoided this issue by devolving this responsibility to the states.⁶⁸ To this day, no federal harm reduction program exists, though recently NACO has considered developing such a program.⁶⁹ Alternatively, when it comes to prevention, India has resisted international suggestions for increased sex education in schools.⁷⁰ With the recent exception of some states, such as Maharashtra, Gujarat, and Madhya Pradesh, sex education has not been allowed, nor has NACO sought to enforce it.

When it comes to harm reduction, some attribute resistance to the fact that drug use is viewed as a social evil, and that the government does not want to condone such behavior.⁷¹ With regards to sex education, analysts attribute resistance to the government's view that it encourages the immoral act of sexual promiscuity.⁷² Both impulses suggest that the government's resistance is heavily influenced by deeply inculcated moral views.

When it comes to acquiring ARV medication, however, India has not shown as much resistance. This is particularly alarming considering the long history that India has of producing generic medication and distributing drugs throughout Asia.⁷³ Since agreeing to join TRIPS in 1995, the government has not tried to issue threats of compulsory licensing. This mainly reflects the government's fear of tainting its image of being a fair trade partner. The closest the government has come to resisting markets is to amend patent legislation in 2005 indicating that only new drugs deemed to be "new and innovative" can be patented and sold in markets. India's recent denial to recognize the patented drug *Novartis* for Leukemia in January 2006 suggests that the government may start doing the same for ARV medication.⁷⁴

Even more puzzling is the fact that India has a very strong domestic infrastructure for producing drugs.⁷⁵ Pharmaceutical companies such as *Cipla*, *Ranbaxy Laboratories*, *Matrix Laboratories*, and *Hetero drugs* all produce ARV medicine at cheap and affordable prices. In the future, India could very well use these laboratories to its advantage by threatening to issue compulsory licenses.⁷⁶ India also has superb medical research institutions, such as the National AIDS Research Institute (NARI), and gifted scientists. Under these conditions, India may eventually be in a good position to guarantee and provide ARV medication.

Yet another differentiating factor between India and Brazil is the fact that the evolution of India's national health insurance program was not born out of democratization processes. Efforts to provide a national based primary healthcare system originated shortly after India gained political independence in 1947.⁷⁷ The government's provision of healthcare was driven mainly to ensure socioeconomic development. Later in 1983, through the creation of the National Health Policy, the government mandated the creation of a universal healthcare system. Since then, healthcare delivery has been the primary responsibility of states, though most of the funding comes from the center.⁷⁸

In contrast to Brazil, the challenge is that because India's universal healthcare system was not born out of democratization processes, there were no incessant pressures and expectations that the government provide universal healthcare. Consequently, when AIDS emerged, India's political elites did not feel that it was their responsibility to ensure that all citizens have equal access to ARV medicine. Moreover, what this meant was that the pharmaceutical industry's imposition of high prices was not perceived as threatening the government's ability to maintain their normative democratic commitments. Consequently, the impulse to resist markets for the sake of democracy and human rights simply was not there.

RUSSIA

Russia shares with Brazil and India a rich history of working with the international community. While it was not an important player in the formation of the WHO, it did nevertheless work with other countries for the eradication of smallpox, syphilis, and Spanish flu. Russia's historic expertise in epidemiological research and surveillance lent itself to the sharing of knowledge and partnership with other nations.⁷⁹ While the focus in recent decades has been on strengthening state-level monitoring and response to disease, Russia's Ministry of Health and Social Development has not been entirely isolated from the international community.

What distinguishes Russia from other nations is the fact that its political leadership was never concerned about its international reputation. Beginning with the Mikhail Gorbachev administration, the government initially ignored the epidemic and was isolated in its response.⁸⁰ Even after the emergence of global pressures under the Boris Yeltsin administration, Yeltsin had no interest in increasing the government's reputation and response. What is more, little was done at the domestic level. Moral stigma, discrimination towards gays, and a commitment to a decentralized response essentially thwarted any attempts at responding to AIDS.⁸¹ In recent years, President Vladimir Putin has been more committed to strengthening the AIDS program. Part of this comes in response to increased global pressures, especially for helping other nations finance responses to AIDS. Yet at no point has Putin been concerned about his reputation.

Receptivity

Unlike Brazil and India, Russia has not been as committed to strengthening its partnerships with donors. In part this is a result of Russia's apathy towards increasing its reputation and influence. Furthermore, the Yeltsin and Putin administrations were autonomous from domestic political pressures. At no point did the Congress, public, and private sector interests influence the presidents' relationship with donors and domestic policy.⁸² Instead, the president and his health officials have responded to what they perceive to be genuine domestic health needs rather than international norms and expectations.⁸³

With regards to donor assistance, bi-lateral aid was the first to arrive. By 1998, USAID provided Russia with several million in aid through their IMPACT program (Implementing AIDS Prevention and Care Project) to work with the Ministry of Health and NGOs on prevention policy.⁸⁴ From 1998-2000, USAID also provided funding for HIV prevention among at-risk groups, while in 2005 USAID worked in partnership with Population Services International to launch the PreventAIDS initiative; this works with the Russian government and NGOs to improve prevention services, increase awareness, and build capacity in reaching vulnerable populations.⁸⁵

In 1999, the first major multi-lateral aid package arrived. That year, the World Bank offered its first loan for AIDS and tuberculosis (TB), totaling US\$150 million, with \$100 going to TB and \$50 going to HIV/AIDS.⁸⁶ After a long delay due to the Ministry of Health's resistance in adhering to the WHO's DOT standards, in 2003 the loan was finally provided.⁸⁷ The Bank had a hard time trying to re-establish its ties with Russia; it took the lead in doing this, suggesting that the government was not as committed to engaging in a partnership.⁸⁸

In 2005, the European Union provided 4million Euros to help Russia strengthen its AIDS program, which is focused on drug procurement and capacity-building.⁸⁹ Funding has also come from UNAIDS, WHO, UNESCO, UNDP, and the Swedish International Development Agency (SIDA).⁹⁰ And in 2005, the "Coordination in Action" initiative was initiated by DfID and SIDA, providing US\$2 million dollars for a "3 ones" approach to AIDS control.

The Global Fund to Fight AIDS, TB, and Malaria has also been an important contributor. Beginning in 2004, the Global Fund awarded a grant to the GLOBUS (a consortium of Russian and international NGOs) project in the amount of US\$34.2 million to provide AIDS prevention and treatment services. In 2005, another grant in the amount of US\$120 million was provided to help the Ministry of Health increase administrative and technical capacity and policy development.⁹¹

In recent years, Russia has also obtained funding from private philanthropists. The George Soros foundation's Open Society Institute (OSI), for example, has invested in harm reduction strategies and has funded several NGOs. The Ford Foundation has also given money to NGOs, such as the Russian Harm Reduction Network. And more recently, the Johnson & Johnson foundation, in partnership with the USAID, has worked with HealthRight International and

Doctors to Children, a Russian NGO, to fund projects providing prevention education to street children.⁹²

Despite these multiple sources of donor aid assistance, it is important to note that these partnerships are very recent and difficult to maintain. Unlike Brazil and India, Russia does not have long-term experience working with the World Bank and other donors. In fact, and as noted earlier, the government initially resisted the Bank's efforts to engage in a partnership for a loan in 1999, finally coming to fruition in 2003 due to the Bank's persistence.

Because this funding is so new, Russian AIDS officials have not had an opportunity to strengthen their ties with donors and establish a network of trust and support, as well as career notoriety and advancement. While new partnerships have been formed with the Global Fund and other donors, the government has been essentially forced to respond, due mainly to increased external pressure. The effective tripartite partnership that emerged in Brazil has not arisen in Russia.

Indeed, since AIDS emerged in Russia the Ministry of Health has not been committed to working closely with NGOs. In a political context where the governing party has historically limited the participation of civic associations involved in policy, the formation of NGOs has been difficult to achieve.⁹³ Consequently, those NGOs that exist are weak and poorly organized. Moreover, the Ministry of Health did not form an institution guaranteeing the participation of NGOs until 2004, at which point the Coordinating Council on HIV/AIDS was formed.⁹⁴ Even then, the Commission was powerless because high-level political party members were not present on the Commission.⁹⁵

Resistance

Russia has also been quite resistant when it comes to international recommendations for AIDS treatment. This is especially the case when one looks at harm reduction policies. For years, the government has vehemently resisted international pressures, especially from the UN and international NGOs, such as the International Harm Reduction Association, to introduce harm reduction strategies.⁹⁶ Russia, as well as the US and Japan, have incessantly ignored evidence showing that the usage of methadone and clean needle exchange can help reduce HIV transmission.⁹⁷ This is especially problematic in Russia, where most of HIV transmission is due to IDU.

Analysts attribute this resistance to the government's conservative moral belief, where drug usage has been condemned for years.⁹⁸ Several federal laws were also implemented during the 1980s based on these normative beliefs, laws that carried severe punishment.⁹⁹ This is an institutional legacy and mindset that has hampered federal and state government interest and commitment to harm reduction.

AIDS prevention through sex education has also confronted much resistance, notwithstanding international advocacy in favor of this.¹⁰⁰ For decades state governments, as well as the Russian Orthodox Church, has opposed

sex education, especially as it pertains to AIDS.¹⁰¹ Similar to Russia's position on harm reduction, scholars note that this response can be attributed to the government's morally conservative outlook.¹⁰² Some note that a very strong political coalition led by the Russian Orthodox Church, the communist party and Pro-Life movement has successfully pressured the parliament not to approve sex education in schools.¹⁰³

The Russian government has not been as resistant to markets for ARV medication. Rather than wholly accepting market value, the President and Minister of Health and Social Welfare have engaged in price negotiations through the WHO.¹⁰⁴ Russia has been able to demonstrate need and a fiscal incapacity to purchase drugs at regular prices. While the government committed approximately 70% percent of its total HIV/AIDS budget (totaling US \$4 million) from the Ministry of Health in 2005 for the purchase of ARV medication,¹⁰⁵ it is still in need; this is especially the case at the oblast level, where most states are often insolvent and incapable of purchasing ARV medicine.

Russia's response to pharmaceutical markets has therefore not been as aggressive as Brazil's. Russia has instead relied more on negotiations and an emphasis on demonstrating needs. It is not clear that the government is doing this out of fear of tarnishing its image as a nation committed to fair trade. This is mainly because of the fact that the government is not overly concerned about its international reputation.

The absence of government resistance also has to do with the fact that the government is not committed to producing generic medication. While Russia and other nations have recently come together to sign an agreement stating that the generic production of ARV should be pursued,¹⁰⁶ and while donors such as the Global Fund have suggested that Russia engage in this process,¹⁰⁷ this has not been a priority for the government.¹⁰⁸ This smacks of a genuine lack of interest in making sure that citizens have access to medicine. And this has occurred even when Russia has the medical expertise and infrastructure needed to produce generic drugs. This situation puts Russia at an extreme disadvantage when it comes to bargaining with pharmaceutical corporations.

In addition to the absence of sound infrastructural capacity, Russia's universal healthcare system did not evolve hand in hand with the transition to democracy. For years Russia provided universal healthcare as an important component to its decentralized healthcare system.¹⁰⁹ The quality and timeliness of healthcare services, in addition to federal funding for ARV medication, is still problematic.¹¹⁰ Yet political elites have never equated universal access to medicine as a democratic right, a norm that they are committed to. Consequently, the rise of pharmaceutical prices has never imposed a serious threat to political elites' commitment to democracy and human rights, thus failing to prompt resistance.

CHINA

China exhibits the most similarity to Brazil in its historic commitment to working with the international community. China and Brazil were two of the originating founders of the WHO.¹¹¹ By the late-1950s, China worked with other countries to eradicate smallpox.¹¹² During this period China also began to collaborate more with medical doctors from the West, as is evident through the rise of Western trained medical practitioners in China during this period.

To a certain extent this history of international collaboration influenced the government's interest in maintaining its reputation. China's leadership has always been sensitive to international pressures and criticisms of its response to disease. A good example of this is when the government, after increased criticisms of its weak health systems response to SARS, suddenly began to publicly declare its commitment to strengthening its response to AIDS.¹¹³ SARS revealed China's weak public health system and motivated the government to heighten its attention to AIDS.¹¹⁴ Others view this period as the "key turning point" in government response.¹¹⁵ The arrival of a new government in November of 2002, which was also committed to AIDS, certainly helped.¹¹⁶ The embarrassment associated with SARS behooved the government to rejuvenate its reputation.¹¹⁷ While China has certainly achieved this in the global South as a nation challenging Western views, especially as it pertains to the UN Security Council,¹¹⁸ reputation-building has certainly been a challenge when it comes to public health.

China's history of reputation-building is not as long-winded as Brazil's, however. While it had a history of international collaboration and prestige, there was a long period of time when China was isolated from the international community. Several structural conditions account for this. During the 1950s and 1960s, the government's focus was on strengthening domestic public health infrastructure and economic development. Syphilis posed such a threat. Mao Ze Dong's focus was therefore on his nation, not the international sphere.¹¹⁹ Mao created a strong public health system and established universal health care for all.¹²⁰ In addition, the great famine incident forced the government to focus on development issues. It was not until 1979 that China once again became active in the WHO and its collaboration with other nations to eradicate disease.

Thus in contrast to Brazil, China does not have a long, uninterrupted history of working with the international community and consolidating its reputation. It has only been more recently that the government has been concerned about this process, mainly because of SARS.

During the 1990s, China was not eager to engage the international community. Institutional designs facilitated this process. The Premier was autonomous from legislative and bureaucratic pressures when deciding to engage the international community. Notwithstanding an increased role in the ability of public health officials to provide policy ideas and recommendations, this was never the case under prior administrations.¹²¹ It was not until Hu Jintao's emergence that the President paid more attention to human development.¹²² Yet,

during the early and arguably most crucial years of the AIDS epidemic, the Premier was focused more on domestic issues, not the international community.

Receptivity

Consequently, it has not been until recently that the government has been receptive to donor assistance to strengthen its AIDS program. China did not engage in partnerships with the donor community until the late-1990s. While bi-lateral agencies such as DFID provided assistance during the early-1990s to help strengthen China's health systems,¹²³ loans for HIV prevention and treatment were not provided until 1999. That year, DFID provided L21million for HIV programs through its *Health VIII Support (1999-2002)* program.¹²⁴ In 2000, DFID gave another L15 million for five years for the China-UK HIV/AIDS Prevention and Care Program, which aimed to provide replicable models of successful prevention and treatment program in several provinces. In 2002, the National Institutes of Health (NIH) provided \$US 15 million to increase research for AIDS, while AusAID (Australian Agency for International Development) provided \$A14 million to work with China's CDC on increasing community-based intervention, build local government capacity, and increase the effectiveness of its public health system.

When it came to multi-lateral aid, in 1999 the World Bank gave China \$4.5 million for prevention programs in the Xinjiang province, followed by \$25 million for prevention in Fuijan, Shanxi, Guangxi, and Xianji through the Health IX HIV/AIDS Prevention and Care Program.¹²⁵ Multi-lateral assistance increased substantially after 2003.¹²⁶ That year, the Global Fund provided a grant to finance new equipment for China's CARE programs, as well as funding for health worker training, HIV prevention, and condom usage. In 2004, the Global Fund provided an additional grant to target IDUs in 7 provinces.

China has also benefited from philanthropy. Since the early-1990s, the Ford foundation provided support to NGOs working on prevention.¹²⁷ More recently, the Clinton foundation has provided US\$10 million for pediatric services for children suffering from AIDS. Merck and Bayer pharmaceutical corporations have also provided funding for treatment and prevention services.

Despite this assistance, it is important to note that these aid packages are new and did not provide enough time for China's AIDS officials to cultivate a close partnership with donors. Again, DFID's presence during the 1990s was focused on health systems and access to medicine, not AIDS. Donor assistance for AIDS did not emerge until 1999. Even then, funding was not provided for China's AIDS program but rather for provincial governments.

While a long-term partnership with donors is important for a successful tripartite partnership to emerge, equally if not more important is the government's commitment to NGOs. The upshot is that the government has not been committed to facilitating the incorporation of NGOs into the policy-making process. While the government, and especially the CDC (Chinese Center for Disease Control), has certainly gained an appreciation for the work of AIDS

NGOs, the Ministry of Health has not consolidated its partnership with them.¹²⁸ Furthermore, and in contrast to Brazil, there is no committee in the National Center for AIDS Prevention and Control (NCAIDS) formally incorporating NGOs into the policy-making process.

Two factors account for this lack of institutionalization. First, most of the AIDS NGOs working in China are GONGO's (Government Organized Non-Governmental Organizations).¹²⁹ Second, there is still a high degree of distrust among local government officials towards NGOs. While state-level CDC officials have been keen on using NGOs for reaching at-risk groups, local government officials still view NGOs as potentially revolutionary. This has limited AIDS NGO partnerships with local officials.¹³⁰

These constraints have motivated new non-governmental AIDS NGOs to emerge and seek ways of increasing their influence. As we saw with Brazil during the 1990s prior to the World Bank loan, beginning in 2002 non-governmental AIDS NGOs in China started to mobilize in response to the arrival of funding from the Global Fund.¹³¹ The Global Fund's mandate to increase the representation of NGOs and PLWAS in Country Coordinating Mechanisms (CCMs), in addition to the alleged failure of elections for civic members of the CCM in 2003, has prompted the Global Fund and UNAIDS to pressure the government to institutionalize civic participation and strengthen its relationships with NGOs.¹³² Though essentially forced to change its tone with civil society, the government is now much more open and committed to working with NGOs and the Global Fund.

Resistance

When it comes to international recommendations for prevention and treatment policy, China has not been as receptive. For years the government did not endorse harm reduction strategies, notwithstanding international recommendations for doing so.¹³³ It has only been recently that the Ministry of Health has condoned the usage of harm reduction strategies.¹³⁴ Some claim that the government initially resisted these measures because of the historic moral campaign against drug use.¹³⁵ During the 1950s, drug use was seen as a social evil and not to be encouraged; this normative legacy carried over to the 1980s, when drug use started to become more frequent. While the Ministry of Health and state governments have now become, at least in theory, more liberally minded and willing to use harm reduction, and while some states have experimented with clean needle exchange and methadone, some analysts claim that normative views and stigma still hamper the implementation of policy.¹³⁶

Similar resistance has emerged when it comes to sex education. Despite international recommendations,¹³⁷ for years the government did not approve sex education in schools, especially with regards to HIV. Once again, this resistance stemmed from deeply ingrained moral and conservative views seeing as a social taboo premarital sex and prostitution.¹³⁸ In recent years, the government has relaxed its moral impulse. Earlier this year, the government launched a sex

education awareness campaign to address HIV and other sexually transmitted diseases.¹³⁹ The government is now promoting commercials on safe sex.¹⁴⁰ Thus, in contrast to India and Russia, the historical institutional legacy of morality and conservatism has not generated as much resistance to international recommendations.

In addition, China's resistance of global markets for ARV medication has not been as austere as Brazil's. China has not issued compulsory licenses for ARV, despite the fact that it is a world leader in the production of active pharmaceutical ingredients and second line drugs.¹⁴¹ Nor has the government threatened to issue them. This derives mainly from the fear that the government has of violating TRIPS agreements and US patent laws.¹⁴² Officials fear that issuing compulsory licenses may have long term ramifications, such as generating few incentives for corporations to engage in drug experimentation, failure to improve the overall quality of drug products, while threatening the prospect of continued foreign direct investment.¹⁴³ Instead, the government has engaged in price negotiations with pharmaceutical companies.¹⁴⁴

Because China only produces seven of the over twenty necessary ARV medications, some have suggested that the government issue compulsory licenses to produce the rest.¹⁴⁵ The number of HIV positive in need of access to medicine has increased, while the actual provision and affordability of medicine has declined.¹⁴⁶ China has the infrastructural capacity needed to start producing the remaining medication. But the government has found it more advantageous, both economically and geopolitically, to engage in price negotiations.¹⁴⁷ It therefore seems that the government prioritizes securing foreign direct investment rather than ensuring that its citizens have access to medicine.

One reason accounting for this kind of response has to do with the fact that the imposition of high prices for ARV medication does not threaten the government's commitment to providing medication for its citizens. First of all, China does not have a free universal healthcare system. Citizens must pay fees for health services, while the government has repeatedly fallen short of funding all aspects of its public health system. Second, although the state provided universal healthcare in the past, and while it continues to provide some medical care for free, state health care never emerged in tandem with democratization processes. The state never viewed universal healthcare as a universal right, guaranteed through political opening and institutions. Thus, when high prices for ARV medication arose, state elites did not feel threatened in their ability to maintain their commitments to society.

The Chinese government did nevertheless eventually agree to start providing ARV medication for free to poor citizens in rural parts of China. From 2001 to 2003, through the government's CARES (China Comprehensive AIDS Response) initiative, the state allocated 100 million Yuan (\$112 million) per year to pay for this service. However, scholars note that this amount is far from sufficient in providing what is needed to cover all HIV infected.¹⁴⁸ The provision of a grant in 2005 for \$98 million from the Global Fund to pay for the importation of patent medicine may help the government address this issue.

While this may help alleviate short term needs, in the future the government will need to commit more domestic resources to the production and provision of ARV medicine.

CONCLUSION

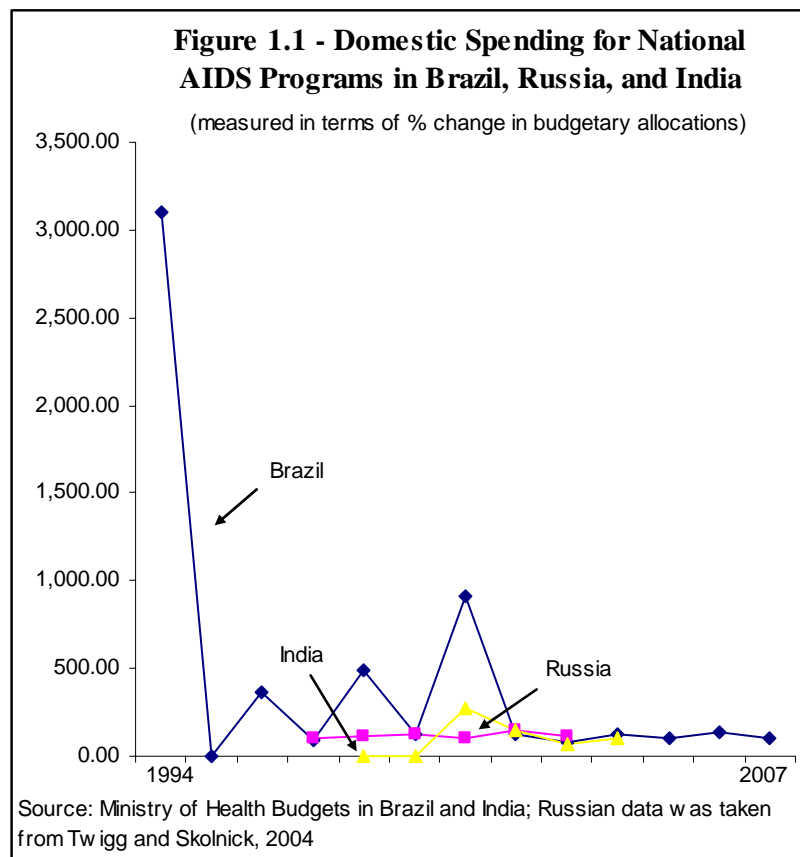
After several years of responding to the AIDS epidemic, emerging nations have become strategic in their interaction with the international community. I have put forth the theory that those nations concerned about their reputation and that have a long history of working with the international community will be continuously receptive to donor aid assistance in order to strengthen their AIDS programs. At the same time, however, they will resist international recommendations for prevention and treatment policy whenever the latter threatens domestic normative structures, such as morals and normative beliefs about universal healthcare, and when this combines with the pharmaceutical capacity needed to produce ARV medication. All of this is done in order to strategically *use* the international community for strengthening domestic programs.

Of the four case studies examined in this article, Brazil stands out as the most strategic. Reputation-building and historic legacies of cooperation have led to an ongoing tripartite partnership between AIDS officials, donors, and NGOs, in turn providing AIDS officials with the leverage needed to further expand its AIDS program; this has engendered a program that continues to grow and outpace its counterparts in domestic spending – see Figure 1.1. Of the cases compared to Brazil, India came closest in developing a tripartite partnership, though it is new and not yet firmly established.

But what is the deeper meaning underlying this strategic interaction? In essence, it is a reflection of an emerging nations' growing sovereignty. That is, by engaging in strategic behavior, nations have the opportunity to show the world that they are developing the resources, capacity, and experience needed to respond to AIDS on their own; they want to reinforce the fact that they are no longer dependent on donor assistance and prescriptions of prevention and treatment policy; they, in short, want to show that they are important sovereign players, capable of controlling their own problems.

Strategic interactions also provide an opportunity for emerging nations to eventually become leaders in the plight against AIDS. By developing unique, contextually-specific AIDS programs through their strategic usage of the international community, emerging nations can become models for other nations. For example, because Brazil's tripartite partnership and resistance to countervailing policy prescriptions has led to a massive expansion of its AIDS program, and because of the high degree of notoriety it has received, Brazil has used its reputation in order to help other nations combat AIDS through the construction of pharmaceutical labs and technology. Through this assistance, Brazil is also striving to shape international policy, specifically donor

commitments to Africa and Asia. As India, China, and Russia gradually build their tripartite partnerships, they may also join Brazil in these broader endeavors.



And finally, the breadth of my argument has the potential of going beyond B.R.I.C. I have limited the scope of my analysis to these countries mainly because of the history of each nation's engagement with the international community, their similar federal structures, economies, and growing influence in international politics. Keep in mind, however, that other emerging nations do not have this history of international cooperation, and thus the one element of receptivity that was important in Brazil, historic legacy in international cooperation, is absent.

In South Africa, for example, the application of my framework reveals a nation that has been isolated from the international community, one that is apathetic about asserting its independence and increasing its international influence. Early receptivity to donor aid assistance was never present, which in turn reflected elite disinterest in the AIDS crisis.¹⁴⁹ There was also a considerable amount of resistance to international recommendations for treatment policy. The presence of a relatively strong pharmaceutical sector,¹⁵⁰ when combined with the government's normative committed to universal healthcare,¹⁵¹ led to the issuance of a compulsory license in 2003.¹⁵² When it comes to prevention policy, it has not

resisted international recommendations; this is because stigma is not derived from morality but rather ethnic conflict and discrimination.¹⁵³ In the absence of strategic interaction, and in sharp contrast to Brazil, however, the AIDS program has not been very effective.

In Uganda, on the other hand, receptivity to donor aid assistance did occur early on, due mainly to government concern about its reputation.¹⁵⁴ Ongoing partnerships with donors and NGOs have led to a persistent increase in AIDS program expansion and effectiveness. Conversely, the absence of a strong pharmaceutical sector,¹⁵⁵ the absence of a universal healthcare system, and the fear that issuing compulsory licenses may have on the nation's trade status has not generated incentives to resist pharmaceutical markets. The absence of moral constraints, too, has not led to resistance towards international recommendations for sex education or harm reduction. Thus, Uganda exhibits a case where it takes resources from the international community while shying away from policy resistance. While the government has expanded its domestic programs through this interaction, it remains dependent on donor assistance and has not asserted its independence and influence.

And finally, Thailand exhibits the most similar case to Brazil. While Thailand's leadership was concerned about its reputation after 1991, it did not have a long history of working with other nations. Nevertheless, in order to sustain its reputation, it has worked closely with donors;¹⁵⁶ by doing the same with NGOs, moreover, a tripartite partnership has formed, which in turn has led to the continued expansion of its AIDS program. Thailand's strong political commitment to universal healthcare, as a normative democratic commitment, when combined with the presence of an effective pharmaceutical infrastructure, has created resistance to pharmaceutical markets, as evident through the imposition of compulsory licenses in 2007.¹⁵⁷ And finally, Thailand has resisted recommendations for harm reduction, as this goes against the government's moral views. Notwithstanding, the government has refrained from letting morality influence its unwavering commitment to sex education and condom use.¹⁵⁸ Receptivity and resistance suggests that Thailand is strategically using the international community for an expansion of its AIDS program. Moreover, and similar to Brazil, it is using its success to help other nations combat AIDS, thus enhancing its international influence while solidifying its reputation as an emerging nation.¹⁵⁹

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¹ Matthew Flynn, "The Evolution of Brazil's Public Production of Anti-Retroviral Medicines (1990-2007)," *Development and Change* 39, no. 4 (2009): 513-36.

² The 2001 Doha declaration further clarifies the 1995 TRIP ruling that under certain conditions, such as a public health emergency, nations can issue compulsory licenses. The declaration confirms this agreement and provides more autonomy in a nation's ability to define what constitutes a national emergency.

³ In 1995, the World Trade Organization (WTO) created the TRIPS agreement. This agreement provides minimum standards that all WTO participation nations must abide by for the protection of intellectual property rights, which includes patents for medicine.

⁴ Paragraph 6 of the Doha declaration, introduced in 2003, now permits nations producing generic medicine to export them to nations that do not have the pharmaceutical infrastructural capacity to do so. Thus, this allows nations issuing compulsory licenses to provide drugs for domestic and international use.

⁵ Vanessa Bradford Kerry and Kelly Lee, "TRIPS, the Doha Declaration and Paragraph 6 decision: What are the Remaining Steps for Providing Access to Medicines?" *Globalization and Health* 3, no. 3 (2007).

⁶ Jeremy Youde, "Is Universal access to antiviral drugs an emerging international norm?" *Journal of International Relations and Development* 11 (2008): 415-440.

⁷ *Jornal do Brasil*, "Uma luta de US\$ 100 milhões," March 30, 1994; *O Globo*, "Tuberculose ameaça elevar número de mortes port Aids," August 11, 1994.

⁸ Migel B Fontes, "Interface entre as Políticas Internacionais e Nacionais de Aids" [the interface between international and national politics of AIDS], in *Saúde, desenvolvimento e política: Respostas frente à Aids no Brasil* [Health, Development and Politics: Responses to AIDS in Brazil], eds. Richard Parker, Jane Galvão, and Marcelo Secron Bessa (Rio de Janeiro, Brazil: ABIA Press, 1999).

⁹ Author's interview with former President of Brazil Fernando H. Cardoso, November 22, 2007.

¹⁰ *Ibid.*; Sergio Carrara, "A geopolítica simbólica da sífilis: Um ensaio de antropologia histórica" [the geopolitical symbolism of AIDS: an essay of historical anthropology], *Historia, Ciências, Saúde – Minguinhos* III Nov. 1996-Feb (3) (1997): 391-408.

¹¹ *Ibid.*

¹² Migel B Fontes, "Interface entre as Políticas Internacionais e Nacionais de Aids" [the interface between international and national politics of AIDS], in *Saúde, Desenvolvimento e Política: Respostas Frente à Aids no Brasil* [Health, Development and Politics: Responses to AIDS in Brazil], eds. Richard Parker, Jane Galvão, and Marcelo Secron Bessa (Rio de Janeiro, Brazil: ABIA Press, 1999).

¹³ Varun Garui and Evan Lieberman, "Boundary Politics and Government Response to HIV/AIDS in Brazil and South Africa" *Studies in Comparative International Development* 41, no. 3 (2006): 47-73.

¹⁴ Paulo Teixeira, "Políticas públicas em Aids" [Public politics of AIDS] in Richard Parker, ed., *Políticas, instituições e Aids: enfrentando a epidemia no Brasil* [Politics, Institutions, and AIDS: Confronting an Epidemic in Brazil] (Rio de Janeiro, Brazil: ABIA Publications, 1997).

¹⁵ Interview with Paulo Teixeira, former director of the national AIDS Program, June 8, 2008.

¹⁶ *Ibid.*

¹⁷ Author's interview with former President of Brazil Fernando H. Cardoso, November 22, 2007.

¹⁸ Author's interview with the former director of the national AIDS Program, Dr. Pedro Checquer, August 9, 2008; author's interview with Dr. Paulo Teixeira, June 8, 2008.

¹⁹ Garui and Lieberman, "Boundary Politics and Government Response to HIV/AIDS in Brazil and South Africa," 47-73.

²⁰ US Department for Aid and Development (USAID), *Brazil: Country Profile* (Washington, DC: USAID, 2004).

²¹ Department for International Development (DFID), *Facts to Fight AIDS in Rural Brazil* (London, UK: Department for International Development, 2009).

²² Chris Beyrer, Varun Gauri, and Denise Vaillancourt, *Evaluation of the World Bank's Assistance in Responding to the AIDS Epidemic: Brazil Case Study* (Washington, DC: The World Bank, 2005).

²³ *Ibid.*

²⁴ *Ibid.*

²⁵ Author's interview with Veriano Terto Jr., President of ABIA (Brazilian Inter-Disciplinary Association for AIDS), June 22, 2006, September 8, 2008.

²⁶ Jane Galvão, *Aids No Brasil: A agenda de construção de uma epidemia* (São Paulo, Brazil: ABIA Publishers, 2000).

²⁷ Author's interview with Dr. Eduardo Barbosa, Under-Secretary, national AIDS Program, August 13, 2008.

²⁸ Author's interview with Ezio Santos Fihlo, President of Pella-Vida, NGO, June 30, 2006; author's interview with Veriano Terto Jr., President of ABIA (Brazilian Inter-Disciplinary Association for AIDS), September 8, 2008.

²⁹ Author's interview with Dr. Eduardo Barbosa, Under-Secretary, national AIDS Program, August 13, 2008 and Veriano Terto Jr., President of ABIA (Brazilian Inter-Disciplinary Association for AIDS), September 8, 2008.

³⁰ Dilene Raimundo Nascimento, *As Pestes do Século XX: Tuberculose e Aids no Brasil, Uma História Comparada* [The Pests of the 20th Century: A Comparative History of Tuberculosis and AIDS in Brazil] (Rio de Janeiro, Brasil: Editora FIOCRUZ, 2005); Jane Galvão, *Aids No Brasil: A agenda de construção de uma epidemia* [AIDS in Brazil: an agenda for constructing an epidemic] (São Paulo, Brazil: ABIA Publishers, 2000); author's interview with Ezio Santos Fihlo, President of Pella-Vida, NGO, June 30, 2006.

³¹ Bill Hinchberger, "Brazil Leads from the Front on AIDS" *The Lancet* Vol. 365, Issue 9472 (2005).

³² Beyrer, Gauri, and Vaillancourt, *Evaluation of the World Bank's Assistance in Responding to the AIDS Epidemic: Brazil Case Study*.

³³ Jane Galvão, *Aids No Brasil: A agenda de construção de uma epidemia* [AIDS in Brazil: an agenda for constructing an epidemic] (São Paulo, Brazil: ABIA Publishers, 2000).

³⁴ Roger Bate and Richard Tren, *Brazil's AIDS Program: A Costly Success* (Washington, DC: American Enterprise Institute, 2005).

³⁵ Kurt Weyland, *Democracy with Equity: Failures of Reform in Brazil* (Pittsburgh, PA: University of Pittsburgh Press, 1996).

³⁶ Flynn, "The Evolution of Brazil's Public Production of Anti-Retroviral Medicines (1990-2007)."

³⁷ World Health Organization, *History of WHO Support to HIV/AIDS in India* (Geneva, Switzerland: World Health Organization, 2009).

³⁸ Deepankar Srigan, *Social-Hygienic Problems of Public Health and Public Health Systems in Countries Around the World: India* (Russia: Department of Medicine, People's Friendship University of Russia, 2008).

³⁹ University College London, Wellcome Trust Center, *Smallpox History* (2009); <http://www.smallpoxhistory.ucl.ac.uk/>

⁴⁰ *Ibid.*

⁴¹ Devi Sridhar, "The Politics of Government Response to AIDS in India," Center for Global Economic Governance, Oxford University, unpublished manuscript, 2008.

⁴² BBC, "Gates on India AIDS Mission," November 11, 2002.

⁴³ Evan Lieberman, "A Model-Testing Case Study of Strong Ethnic Boundaries and AIDS Policy in India," in Lieberman, *Boundaries of Contagion: How Ethnic Politics Have Shaped Government Response to AIDS* (Princeton, NJ: Princeton University Press, 2009).

⁴⁴ Government Accounting Office, *USAID and UN Response to the Epidemic in the Developing World* (Washington, DC: Government Accounting Office, 1998).

⁴⁵ Family Health International, *IMPACT: Russia Final Project* (Arlington, VA: Family Health International, 2007).

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- ⁴⁶ World Bank, *HIV/AIDS in India* (Washington, DC: The World Bank Group, 2005).
- ⁴⁷ House of Commons, *HIV/AIDS: DFID's New Strategy: Government Response to the Committee's Twelfth Report of Session 2007-08* (London UK: House of Commons, 2009).
- ⁴⁸ World Health Organization (WHO), *History of WHO Support to HIV/AIDS in India* (Geneva, Switzerland: World Health Organization, 2009).
- ⁴⁹ *Ibid.*
- ⁵⁰ *Ibid.*
- ⁵¹ Mead Over, Peter Heywood, Julian Gold, Indrani Gupta, Subhash Hira, and Elliot Marseille, eds., *HIV/AIDS Treatment and Prevention in India: Modeling the Cost and Consequences* (Washington, DC: The World Bank Group, 2004).
- ⁵² *Ibid.*
- ⁵³ Devi Sridhar and Eduardo J. Gómez, "Comparative Assessment of Health Financing in Brazil, India, Russia, and India: What Role does the International Community Play?" Center for Global Economic Governance (Oxford: Oxford University, unpublished manuscript, 2009).
- ⁵⁴ World Bank, *HIV/AIDS in India* (Washington, DC: The World Bank Group, 2009).
- ⁵⁵ *Ibid.*
- ⁵⁶ Global Fund to Fight AIDS, TB, and Malaria, *India and the Global Fund* (Geneva: GFATM Press, 2009).
- ⁵⁷ *Ibid.*
- ⁵⁸ Bill & Melinda Gates Foundation, *Avahan: Indian AIDS Initiative* (Seattle, WA: Bill & Melinda Gates Foundation, 2009; <http://www.gatesfoundation.org/avahan/Pages/overview.aspx>)
- ⁵⁹ Medical News Today, "Clinton Foundation to help Train Nurses in India in HIV/AIDS Care," February 24, 2006; <http://www.medicalnewstoday.com/articles/38253.php>
- ⁶⁰ Pramit Mitra, "India at the Crossroads: Battling the HIV/AIDS Pandemic," *The Washington Quarterly* 27:4 (2004): 95-107.
- ⁶¹ *Ibid.*
- ⁶² Lieberman, "A Model-Testing Case Study of Strong Ethnic Boundaries and AIDS Policy in India"; Maria Ekstrand, Lisa Garbus, and Elliot Marseille, *HIV/AIDS in India*, AIDS Policy Research Center (San Francisco: University of California, San Francisco, 2003).
- ⁶³ Lieberman, "A Model-Testing Case Study of Strong Ethnic Boundaries and AIDS Policy in India."
- ⁶⁴ *Ibid.*
- ⁶⁵ Government of India, "Participation of NGOs/CBOs; National AIDS Program" Embassy of India (Mumbai: India, 2009); http://www.indianembassy.org/policy/aids/NGO_CBO.html
- ⁶⁶ UNGASS, *India Country Progress Report* (New Delhi, India: Ministry of Health and Family Welfare, 2009).
- ⁶⁷ World Health Organization, "Injecting Drug Use (IDU) and Prisons" (Geneva: Switzerland, 2009); available at <http://www.who.int/hiv/topics/idu/en/index.html>
- ⁶⁸ Smita Baruagh, "Never Mind the Numbers: India's HIV/AIDS Crisis is Large Enough" *AIDSLink*, no. 107 (2008); <http://www.globalhealth.org/publications/article.php3?id=1781>
- ⁶⁹ Nirmala George, "Needle Exchange Program on Rise in India," FOX News, 2006; <http://origin.foxnews.com/wires/2006Nov29/0.4670.IndiaAIDSInjectingDrugs.00.html>
- ⁷⁰ World Health Organization, "World Health Organization Urges Sex in Schools to Prevent AIDS," *Soz Preventivmed* 39, 25 (1994).
- ⁷¹ *Ibid.*
- ⁷² Monica Chadha, "Indian state bans sex education," *BBC News*, April 3, 2007.
- ⁷³ Daniel Cook, "India's Cheap Drugs Under Patent Threat," *BBC News*, February 15, 2009.
- ⁷⁴ *Ibid.*
- ⁷⁵ Mitra, "India at the Crossroads."
- ⁷⁶ *Ibid.*
- ⁷⁷ Ma Sai and Neeraj Sood, *A Comparison of Health Care Systems in China and India*, Occasional Paper, RAND Corporation (Arlington, VA: RAND Corporation Press, 2008).

⁷⁸ *Ibid.*

⁷⁹ JF Hutchinson, *The Politics of Public Health in Revolutionary Russia, 1890-1918* (Baltimore, MD: Johns Hopkins University Press, 1990).

⁸⁰ DE Powell, "The Problem of AIDS," in Judy Twigg and Mark Field eds., *Russia's Torn Safety Net* (New York, NY: St. Martin's Press, 2000).

⁸¹ *Ibid.*

⁸² Celeste A. Wallander, "The Politics of Russian AIDS Policy," *PONARS Policy Memo*, No. 389, 2005.

⁸³ Sridhar and Gómez, "Comparative Assessment of Health Financing in Brazil, India, Russia, and India."

⁸⁴ Family Health International, *IMPACT: Russia Final Project* (Arlington, VA: Family Health International, 2007).

⁸⁵ USAID (United States Agency for International Development), *Russia: HIV/AIDS Health Profile* (Washington, DC: USAID, 2008).

⁸⁶ World Health Organization, *Russian Federation: Country Summary Profile for HIV/AIDS* (Geneva, Switzerland: World Health Organization, 2005).

⁸⁷ *Ibid.*; Peter Webster, "World Bank approves loan to help Russia tackle HIV/AIDS and tuberculosis," *Lancet* Vol. 361, no. 9366 (2003): 1355.

⁸⁸ Judith Twigg and Richard Skolnik, *Evaluation of the World Bank's Assistance in Fighting the AIDS Epidemic: Russia Case Study*, Working Paper, The World Bank Group, 2004.

⁸⁹ World Health Organization, *Russian Federation: Country Summary Profile for HIV/AIDS*.

⁹⁰ *Ibid.*

⁹¹ Global Fund to Fight AIDS, TB, and Malaria, "The Global Fund Welcomes Russian Contribution," Press Release; http://www.theglobalfund.org/en/pressreleases/?pr=pr_060717

⁹² USAID (United States Agency for International Development), "Partnership and Prevention among Vulnerable Russian Youth," USAID Press Release; http://www.usaid.gov/press/releases/2009/pr090318_1.html

⁹³ Wallander, "The Politics of Russian AIDS Policy."

⁹⁴ *Ibid.*

⁹⁵ *Ibid.*

⁹⁶ World Health Organization, "Injecting Drug Use (IDU) and Prisons" (2009) <http://www.who.int/hiv/topics/idu/en/index.html>; International Harm Reduction Association, "IHRA Makes Statement on UN Commission on Narcotic Drugs" (2009); <http://www.ihra.net/March2009>

⁹⁷ International Harm Reduction Association, "IHRA Makes Statement on UN Commission on Narcotic Drugs" (2009); <http://www.ihra.net/March2009>

⁹⁸ William E. Butler, *HIV/AIDS and Drug Misuse in Russia: Harm Reduction Programs and the Russian Legal System* (London, UK: International Family Health Publishers, 2003).

⁹⁹ *Ibid.*

¹⁰⁰ World Health Organization, "World Health Organization Urges Sex in Schools to Prevent AIDS," *Soz Preventivmed* 39, no. 25 (1994).

¹⁰¹ Blaine Stothard, Olga Romanova, and Larissa Ivanova, "Recent Developments in HIV/AIDS Prevention for Russian Adolescents," *Journal of Sex Education* 7 (2) (2007).

¹⁰² *Ibid.*

¹⁰³ V Chervykov, "Sex Education and HIV Prevention in the Context of Russian Politics" *Int Conf AIDS*, 12, no. 496 (1998).

¹⁰⁴ Sarah Rainsford, "Russia's AIDS Timebomb," *BBC news*, December 3, 2003; World Health Organization, *Russian Federation: Country Summary Profile for HIV/AIDS*.

¹⁰⁵ World Health Organization, *Russian Federation: Country Summary Profile for HIV/AIDS*.

¹⁰⁶ Arthit Khwankhom, "Retro-Virals: Major Pact for Cheap Drugs," *The Nation*, July 14, 2004.

¹⁰⁷ Global Fund to Fight AIDS, TB, and Malaria, *Russian Federation and the Global Fund* (Geneva, Switzerland: GFATM Press, 2003).

- ¹⁰⁸ Rossiyskaya Gazeta, "Russia: virology center seen threatened by financial crisis, short-time working," *World News Connection*, November 11, 2003.
- ¹⁰⁹ Twigg and Skolnik, *Evaluation of the World Bank's Assistance in Fighting the AIDS Epidemic: Russia Case Study*.
- ¹¹⁰ *Ibid*.
- ¹¹¹ J Charles, "Origins, History, and Achievements of the World Health Organization," *British Medical Journal* 2, no. 5600 (1968): 293-296.
- ¹¹² Scott Barrett, "The Provision Status of Disease Eradication," *UNDP/ODS Background Report*, Office of Development Studies, United Nations Development Program, December 16, 2004.
- ¹¹³ Yanzhong Huang, "The Politics of HIV/AIDS in China," *Asian Perspective* 30, 1 (2006): 95-105; Andrew Thompson, *China confronts HIV/AIDS*, Population Reference Bureau (Washington, DC: 2005).
- ¹¹⁴ *Ibid*; Wu Zunyou and Sheena Sullivan, "China," in *Fighting a Rising Tide: The Response to AIDS in East Asia*, eds. Tadashi Yamamoto and Satoko Itoh (Tokyo, Japan: Japan Center for International Exchange, 2006).
- ¹¹⁵ Thomas Schwartz, "The Impact of Crisis on Social Welfare Provision in China," in Jonathan Schwartz and Shawn Sheih eds., *State and Society Responses to Social Welfare Needs in China: Serving the People*, eds. (Florence, KY: Routledge, 2009); Joan Kaufman, "The Role of NGOs in China's AIDS Crisis," in *State and Society Responses to Social Welfare Needs in China*.
- ¹¹⁶ Thompson, *China confronts HIV/AIDS*.
- ¹¹⁷ Joan Kaufman, "The Role of NGOs in China's AIDS Crisis."
- ¹¹⁸ Joel Wuthnow, "The Concept of Soft Power in China's Strategic Discourse," *Issues & Studies* 44, No. 2 (2008): 1-28.
- ¹¹⁹ T Hesketh, XJ Ye, and WX Zhu, "Syphilis in China: The Great Comeback," *Emerging Health Threats Journal* (2008).
- ¹²⁰ *Ibid*.
- ¹²¹ Huang, "The Politics of HIV/AIDS in China."
- ¹²² *Ibid*.
- ¹²³ DFID (UK Department for International Development), *China: Health Briefing Paper* (London, UK: Department for International Development, 1999); China Brief, "Donor Profile – DFID: Shifting roles in quest of impact," 2005; <http://www.chinadevelopmentbrief.com/node/266>
- ¹²⁴ DFID, *China: Health Briefing Paper*.
- ¹²⁵ World Bank, "Fighting AIDS in China," 2003; found at: <http://web.worldbank.org/WBSITE/EXTERNAL/NEWS/0,,contentMDK:20140632~menuPK:34458~pagePK:64003015~piPK:64003012~theSitePK:4607,00.html>; Wu and Sullivan, "China."
- ¹²⁶ Bates Gill, *Assessing HIV/AIDS Initiatives in China: Persistent Challenges and Promising Ways Forward* (Washington, DC: Center for Strategic and International Studies, 2006).
- ¹²⁷ Joan Kaufman, "The Role of NGOs in China's AIDS Crisis," in *State and Society Responses to Social Welfare Needs in China: Serving the People*, eds. Jonathan Schwartz and Shawn Sheih (Florence, KY: Routledge Publications, 2009).
- ¹²⁸ *Ibid*.
- ¹²⁹ *Ibid*.
- ¹³⁰ *Ibid*.
- ¹³¹ China Development Brief, "HIV/AIDS: NGOs proliferate as the Global Fund steps in," 2007; available here: <http://www.chinadevelopmentbrief.com/node/1109>
- ¹³² Joan Kaufman, "The Role of NGOs in China's AIDS Crisis," in *State and Society Responses to Social Welfare Needs in China: Serving the People*, eds. Jonathan Schwartz and Shawn Sheih (Florence, KY: Routledge Publications, 2009).
- ¹³³ World Health Organization, "Injecting Drug Use (IDU) and Prisons," 2009; <http://www.who.int/hiv/topics/idu/en/index.html>; Bojon Poncevski, "UN Yields to Pressure on Needle Exchange Programs," *Lancet Infectious Diseases* Issue 5, Vol 5 (2005).

- ¹³⁴ Bojon Poncevski, "UN Yields to Pressure on Needle Exchange Programs," *Lancet Infectious Diseases* Issue 5, Vol 5 (2005).
- ¹³⁵ *Ibid.*
- ¹³⁶ Han-Zhu Qian, Joseph Schumacher, and Huey Chen, "Injection Drug Use and HIV/AIDS in China: Review of Current Situation, Prevention, and Policy," *Harm Reduction Journal* 3:4 (2008): 1-8.
- ¹³⁷ World Health Organization, "World Health Organization Urges Sex in Schools to Prevent AIDS," *Soz Preventivmed* 39, 25 (1994).
- ¹³⁸ BBC, "Changing HIV/AIDS Trends in China," August 22, 2007.
- ¹³⁹ *Ibid.*
- ¹⁴⁰ *Ibid.*
- ¹⁴¹ Vanessa Bradford Kerry and Kelly Lee, "TRIPS, the Doha Declaration and Paragraph 6 decision."
- ¹⁴² Wu and Sullivan, "China."
- ¹⁴³ China Daily, "Access to drugs key to controlling AIDS" (2004); available here: http://www.chinadaily.com.cn/english/doc/2004-06/28/content_343452.htm
- ¹⁴⁴ *Ibid.*
- ¹⁴⁵ *Ibid.*
- ¹⁴⁶ *Ibid.*
- ¹⁴⁷ *Ibid.*
- ¹⁴⁸ Bates Gill, *Assessing HIV/AIDS Initiatives in China: Persistent Challenges and Promising Ways Forward* (Washington, DC: Center for Strategic and International Studies, 2006).
- ¹⁴⁹ Lieberman, "A Model-Testing Case Study of Strong Ethnic Boundaries and AIDS Policy in India."
- ¹⁵⁰ Reuters News, "UN: Africa Must Develop its own Drugs," 2009; <http://74.125.47.132/search?q=cache:G72lc7zGiG0J:www.msnbc.msn.com/id/30350835/+African+countri+es+producing+generic+medication&cd=7&hl=en&ct=clnk&gl=us&client=firefox-a>
- ¹⁵¹ Physicians for a National Health Program, "International Health Systems," 2009; http://www.pnhp.org/facts/international_health_systems.php?page=all.
- ¹⁵² KEI, "Recent Examples of Compulsory Licenses," 2007; <http://74.125.95.132/search?q=cache:oQknV1dVc4YJ:www.keionline.org/content/view/41/+Sou+th+Africa+issues+compulsory+license+AIDS&cd=4&hl=en&ct=clnk&gl=us&client=firefox-a>
- ¹⁵³ Lieberman, "A Model-Testing Case Study of Strong Ethnic Boundaries and AIDS Policy in India."
- ¹⁵⁴ James Putzel, "The Politics of action on AIDS: A Case Study of Uganda," *Public Administration and Development* 24, no.1, (2004): pp. 19-30.
- ¹⁵⁵ Medical News Today, "Uganda Pharmaceutical Plant Begins Production of Generic Antiretrovirals," January 31, 2008; <http://www.medicalnewstoday.com/articles/95697.php>
- ¹⁵⁶ United Nations, "Thailand Overview on Emerging Status," 2008; <http://www.un.or.th/thailand/development.html>
- ¹⁵⁷ N Wong-Anan, "Thailand stuns drug firms with generic licenses," *Reuters News Agency*, January 25, 2007; <http://hicomrade.wordpress.com/2007/01/25/thailand-stuns-drug-firms-with-generic-licenses/>
- ¹⁵⁸ Avert, "HIV & AIDS in Thailand," 2009; <http://www.avert.org/aidsthai.htm>
- ¹⁵⁹ Associated Press, "Thailand Helps Other Nations Combat AIDS," November 26, 2003; <http://www.aegis.org/NEWS/AP/2003/AP031158.html>