DIVERGENT CAMPAIGNS TOWARDS GLOBAL HEALTH GOVERNANCE: CANADIAN AND U.S. APPROACHES TO THE GLOBAL HIV/AIDS PANDEMIC

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I. INTRODUCTION

In June 2001, delegates representing countries from around the world met in New York City for a United Nations (UN) General Assembly Special Session on HIV / AIDS. This meeting took place at the start of a new millennium in an international environment where states had grudgingly begun to recognize the huge geographic scale and enormous human toll that the disease had inflicted on developing countries around the world. However, a noticeable division had emerged between delegations over the wording of the draft declaration of the Special Session. The United States (US), siding with the Vatican and Islamic states, struggled to expunge any mention in the draft declaration of groups at particularly high risk of HIV infection. Meanwhile, Canada, along with Australia and various Latin American and European countries, had urged a much more explicit declaration with the stated goal of reducing in-

cidence among those at high risk of infection. Civil society organizations that had earlier that spring contributed to the wording of this draft declaration, but which had been excluded since that time as negotiations took place between delegations in secret, decried these divisions. The non-governmental organization (NGO) Human Rights Watch noted that "at a conference devoted to fighting AIDS, governments must not replicate the silence and denial that have driven the spread of the disease."[1]

It is hard to overstate the dimensions and consequences of infectious disease, particularly HIV/AIDS, which are crippling sub-Sahara Africa, and increasingly threatening other developing areas of the world as well. However, the response of developed countries to this crisis has been uniformly underwhelming relative to what is needed. As suggested by this division over the wording of the UN draft declaration, the response has revealed radically different approaches to global health concerns between two geographic neighbors and historic allies, Canada and the US. Beyond what have become commonplace rhetorical divisions in international conferences, we can identify other contrasts in the approach each country takes to affordable medications and financial aid provided to some of the hardest hit areas.

Canada has passed legislation facilitating developing countries' access to affordable generic medications at the same time that the US has aggressively pursued multilateral and bilateral trade agreement protections for the brand-name pharmaceutical indus-

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try. Canada has also put most its financial contributions into multilateral vehicles such as the Global Fund to Fight AIDS, Tuberculosis and Malaria, and the World Health Organization's (WHO) "3 x 5" (3 million in treatment by 2005) initiative. The US meanwhile has placed the vast majority of its resources into its bilateral President's Emergency Plan for AIDS Relief (PEPFAR) targeting fifteen countries. Though less obvious, the two countries have also pursued very different policies regarding prevention, in terms of funding priorities and the above noted ideological positions at international meetings, as well as overall development goals in vulnerable countries as well. How might we account for these differences in ideological, financial and policy approaches between Canada and the US to the HIV/AIDS pandemic?

II. FRAMING DIVERGENT STATE APPROACHES TO THE HIV/AIDS PANDEMIC

The global HIV/AIDS pandemic and the international response have major implications for both the study of international relations and the practice of global governance. In addition to the moral imperative of preventing the deaths of untold millions of people worldwide who are either now HIV positive or soon will be, the global pandemic has exposed further gaps in so-called have and have not countries, exacerbating global inequity, gender discrimination and the growing roster of weakening or failing states. Our approach to this issue begins with one of the more enduring analytical and systematic approaches for developing explanations for foreign policy and international relations outcomes: levels of analysis.

Obviously, there are many other analytic frameworks available for this analysis. Social scientists have examined HIV/AIDS using a variety of policy perspectives and approaches for topics ranging from comparative blood policy[2] to the development of care and support policies for HIV positive persons[3] to the highly controversial issue of supervised injection facilities for controlling HIV spread.[4] Another common set of theoretical frameworks has been furnished by social movement theories, including the political process model[5] and Keck and Sikkink's model of transnational advocacy networks.[6] Social movement theory has been employed to explain AIDS activism via the Internet,[7] the rise of the activist organization ACT UP[8] and the growth of domestic and global AIDS treatment activist movements.[9]

Despite the utility of the approaches mentioned above, we chose the levels of analysis approach as the one that best allows us to explain a variety of factors operating on multiple levels simultaneously. We think the contrasting cases of the US and Canadian approaches to this pandemic highlight the role of people, power and national interest and international systemic trends in inhibiting or constructing appropriate responses to this pandemic. The levels of analysis approach to the study of international relations helps to identify the different foreign policy priorities of the US and Canada as well as the preferred albeit different international outcomes in each state's response to the pandemic. Historically, the US's penchant for unilateralism contrasts starkly with the Canadian multilateral response. The extent to which the global response to the HIV/AIDS pandemic is likely to evolve into a more robust system of global health governance, we argue, is rooted in a broader clash between power and multilateralism.

A level of analysis approach provides a comprehensive framework for classifying factors that account for either a state's foreign policy or broader international outcomes.[10] Depending on the level adopted, one can specify conditions that cause an international phenomenon to occur. In the increasingly complex environment of global health governance responses to the HIV/AIDS pandemic, one may encounter an otherwise bewildering array of states, non-state actors including NGOs, transnational movements, multinational corporations (MNCs), intergovernmental organizations (IGOs) and other regional and global institutions, regimes, treaties, and laws. The levels of analysis approach helps to bracket out this blizzard of information and specifically identify different explanations at different levels for the still unsatisfactory global governance response to HIV/AIDS monitoring, prevention and treatment. Three distinct levels of analysis provide divergent explanations for understanding the approaches taken by the US and Canada to the global HIV/AIDS pandemic and the competing outcomes that are stalling the construction of a more robust regime of global health governance: the individual, state and international.[11]

The individual level of analysis focuses on policy-relevant individuals responsible for political outcomes. We can study the personality, perceptions, choices, roles, belief systems and activities of key policy-relevant individuals to understand how individuals influence foreign policy and international events. Key individu-

als monitor developments external to a state but are also clearly shaped by internal political developments as well as personal considerations. We are especially interested in focusing on several key individuals who have been active in debates and policy-making around the global HIV/AIDS pandemic in both the US in Canada. At the state level, explanations for policy outcomes can be derived from characteristics of the state. An analysis at this level might focus on specifying a number of variables including the structure and nature of the different political systems, interest groups within different states, public opinion, political culture, and broader national traditions.

Finally, an analytical approach at the international level would locate relevant explanations with the anarchic characteristics of the international system as well as with state relationships to each other and the broader array of international and regional IGOs. The web of interstate relations, the relative power differences between states, the presence or absence or regional or international organizations and their strengths and weaknesses, the patterns of international trade and finance, and the presence of global norms and international law all provide constraints and opportunities at the most analytically broad level to understand variances in policies and international outcomes.

In the following two sections we consider the influence of all three levels of analysis on the policies Canada and the US adopt to combat the global HIV/AIDS pandemic. First, we assess a variety of possible general influences on AIDS policy, adopting a broad and brief "thick" description, not necessarily all inclusive, to identify individuals and trends at different levels that could be considered as shapers of AIDS policy. Next, we use two cases studies to provide a more detailed discussion of the intervening influences of individuals, actors and events within the states, and international trends and characteristics on Canadian and US global HIV/AIDS policy. The first case contrasts the approaches taken by Canada and the US towards improving access to generic medications for developing countries afflicted by large numbers of people infected with HIV/AIDS. The second case looks at the divergent approaches adopted by each state towards providing greater assistance to developing countries facing the HIV/AIDS crisis. In each case, we see the influence of all three levels of analysis, which help to illustrate the unilateral versus multilateral impulses of the US and Canada

Table 1. Diverging Approaches of the United States and Canada

Issue	Canada	United States	Policy Implications
Significant individual level figures	• Stephen Lewis, UN Special HIV/AIDS Envoy • Jean Chrétien, retiring prime minister	• George W. Bush, strong proponent of unilateralism • Philanthropists: Clinton, Gates and Soros	• Canadian leaders support multilateral initiatives, US government support unilateral programs, philanthropists multilateral
Important state level actors and orientations	• Active rights-oriented AIDS and allied NGO sector • Pharmaceutical industry interests compete with generic industry interests	• Active fundamentalist Christian lobby competing with rights-oriented AIDS NGOs • Very strong pharmaceutical lobby	• Canada supports rights-based prevention; US supports morality-centered prevention policies • Canada passes bill for generic drug export; US impedes generic drug availability
Orientation to international politics	• Policy historically supports multilateralism, foreign aid • Proud of leadership of multilateralism for governance and aid	• Historic policy of unilateralism as global superpower • Has aggressively promoted use of hard and soft power in war, trade policy, and other areas deemed of national interest	• US creates own bilateral program (PEPFAR) • Canada supports Global Fund, international initiatives on vaccines, microbicides, and WHO 3x5 plan

in international HIV/AIDS funding. A summary of the diverging approaches of Canada and the U.S. to the pandemic is provided in Table 1.

III. POSSIBLE INFLUENCES CANADA AND US GLOBAL HIV/AIDS POLICY

General Considerations at the International Level

The United States' unilateral approach towards many foreign policy challenges contrasts sharply with traditionally more multilateral Canada. We find these traditional foreign policy orientations worthy of consideration in a level of analysis approach to understanding each state's preferred strategy towards the global HIV/AIDS pandemic. Canada has traditionally held a position of global prominence—perhaps above what Canada's economic and military capabilities would normally warrant—by advancing diplomacy to address economic, security and human rights issue in a rules-based context. From the Cold War characterized by bipolarity through the current post-Cold War context of relative unipolarity, the US has pursued its national interests backed by its superpower status, which often has put it at odds with a variety of multilateral initiatives.[12]

Additionally, general post-Cold War developments in the global economy have coalesced to support a neoliberal project that has dramatically shaped the globalization of the world economy. Neoliberalism, the Washington Consensus, or the ideology of market orthodoxy differently describe the privileging of international negotiations and agreements of the liberalization of trade and investment, cuts to social spending and government programs, deregulation and privatization at the expense of more national and autonomous development policies.[13] Key international actors promoting neoliberalism have included not only the U.S. but such IGOs as the World Trade Organization (WTO), the International Monetary Fund (IMF), through its structural adjustment programs, and the World Bank. Of particular interest to the question of HIV/AIDS policy is the emphasis placed on the protection of intellectual property rights in international negotiations, at the expense of considerations of debt relief, generic pharmaceutical competition and increased spending on social and economic development.

Finally, another arguably important factor at the international level potentially affecting divergent state approaches to the HIV/

AIDS pandemic is the existence and growing number of an array both IGOs and NGOs mobilizing on behalf of the prevention and treatment of the pandemic. The Special Session of the UN General Assembly on HIV/AIDS, held in New York in June 2001, encouraged widespread mobilization by constituencies of church, human rights, social welfare and developmental NGOs both transnationally and within home states for more effective action against the pandemic. What has unfolded since 2001 in fact is the development of more substantive global governance responses. Global governance—what has been called "cooperative problem-solving by a changing and often uncertain cast"[14]—as it has combated HIV/AIDS has activated numerous civil society organizations and transnational networks along with other IGOs and states. Major initiatives and actions promoting greater international attention to HIV/AIDS have included the UNAIDS, the Special UN Sessions on HIV/AIDS, the WHO, other biennial international conferences on AIDS, and dozens of states around the world committed to the birth and financing of the Global Fund to Fight AIDS, Tuberculosis and Malaria. In the years since the Declaration of Commitment on HIV/AIDS, moreover, the global governance response to the pandemic, as noted by a report of the UN Secretary General, has been "unparalleled," with financial targets in the Declaration of Commitment achieved by making an estimated $8.3 billion available for HIV programs in 2005.[15]

In addition, beyond mobilizing issues, information, finances and constituencies, IGOs, NGOs and transnational social movements—representing the internationalization of conscience—have encouraged the development of what we might call a moral imperative to combat the HIV/AIDS pandemic. Certainly, the evolving post-Cold War norm of human security, that the physical safety and material well-being of people is at least as conducive to international security and peace as traditional preoccupations with hard power and a strong national defense[16], represented a broader frame under which the moral imperative of combating HIV/AIDS could find a thematic home. Human security involves "unilateral or multilateral governmental and non-governmental actions aimed at enhancing individual protection and well-being."[17] It is based on an appreciation of changes to the international system in the post-Cold War era. HIV/AIDS has increasingly been framed in human security terms under the norm "duty to treat" as destructive to indi-

vidual welfare and safety as well as to the broader viability of states across the developing world.[18]

We suggest that the collective efforts of states, IGOs and NGOs to place the pandemic near the top of the international agenda while framing AIDS prevention and treatment as a developing norm, has added new constraints and opportunities to foreign policy and foreign aid agendas. The Special Session of the UN General Assembly on HIV / AIDS in 2001 stated in its Declaration of Commitment that the pandemic is "one of the most formidable challenges to human life and dignity,"[19] while the UN Human Development Report 2005 implicated AIDS as having encouraged the "single greatest reversal in human development."[20] The combination of hundreds of NGOs mobilizing these norms internationally, alongside the post-9/11 fears of failed states as terrorist breeding grounds, attracted greater attention to HIV / AIDS prevention internationally. The disease had emerged as a human and national security concern that states could no longer ignore.

General Considerations at the State Level

There are obviously any number of actors and relationships within the state as possible explanations for divergent Canadian and US responses to the HIV / AIDS pandemic. Certainly, the Canadian public's long-standing support for a more multilateral foreign policy would help us understand Canada's active support for the UN, the Global Fund, the WHO and other multilateral initiatives.[21] Public opinion research, for example, has shown that Canadians remain well-educated and highly interested in foreign policy. They strongly support taking an active role internationally. Perhaps as a result and to a greater degree than Americans, Canadians support increased spending on foreign aid, and more interaction with the UN.[22] The recent "Dialogue on Foreign Policy"—a consultation exercise between Canada's Department of Foreign Affairs and International Trade and the public—as well as the more recent Liberal government's April 2005 International Policy Statement reiterated Canada's commitment to multilateralism. The latter document also assigned high priority to effective governance and institution building in failing states.[23]

Moreover, Canadian NGOs have been some of the more politically smart, information skilled, and internationally engaged in the post-Cold War era.[24] Canadian civil society groups have been active in developing transnational NGO linkages to challenge neoliberal

trade and investment agreements, the development of the convention banning the use of anti-personnel land mines, and the International Criminal Court. At the same time, civil society groups have mobilized in cross-country and cross-sectoral fashion to advance the "Four Steps to Canada" platform for combating HIV/AIDS.

Canada has also enhanced its reputation in the HIV/AIDS fight through moving quickly to combat some of the inequities in AIDS treatment. In 2004 Canada became the first country in the Group of Eight (G8) to allow generic pharmaceutical companies to export life-prolonging medicines to developing countries that did not have the capacity to manufacture drugs themselves. Initially labeled the Jean Chrétien Pledge to Africa Act, since renamed Canada's Access to Medicines Regime, the legislation was facilitated by the speed and efficiency afforded legislation by Canada's parliamentary system of government. From June 1993 to June 2004, Canada was governed by the federal Liberal Party through three consecutive majority governments, ensuring little of the legislative gridlock that is a hallmark of the US presidential-congressional system. Moreover, the Canadian government's broad commitment to the HIV/AIDS struggle has not been undermined by well-funded and mobilized socially conservative and evangelical groups or by the pharmaceutical industry, as in the US.

By way of contrast, the unilateral international posture of the Bush Administration differs sharply from Canada. It has clearly shaped foreign policy activity of the US at all levels, priorities and programs. The terrorist attacks on the US on September 11, 2001 (9/11), had a dramatic impact on the Bush Administration's foreign policy priorities. The unipolarity characteristic of the international system only served to further support those actors within the Bush Administration who clearly favored a more muscular, assertive and preemptive foreign policy.[25] It is reasonable to consider whether US national interests were served through supporting bilateral programs as represented by PEPFAR and limiting funding of the multilateral Global Fund to maximize leverage in the treatment of the pandemic.

As in Canada, the United States is home to a vibrant array of progressive NGOs, beginning with the well-known ACT UP chapters which began in 1987 in protest of the high price of the first approved antiretroviral medication, AZT. By the late 1990s ACT UP and other AIDS NGOs had found common cause with anti-glo-

balization and other human rights-based social movement organizations. They moved the availability of affordable medications squarely on to the agenda of the broader global justice social movement. However, 9/11 marked a major reversal for AIDS and other activist organizations for several reasons. First, anti-terrorist legislation such as the USA Patriot Act made certain direct action, especially civil disobedience against the state, more difficult to organize and more heavily penalized. Perhaps even more importantly, the 9/11 events massively shifted the public policy agenda of both the U.S. government and its citizenry. Almost overnight, national security became the national priority. The political party perceived as best able to tackle that priority, the Republicans, was given wide latitude.

This critical political control over Congress held by the Republicans during much of the time period analyzed herein is important because the Republicans are a party strongly influenced by a more socially conservative ideology towards domestic and international policy. Thus, one important consideration at the state level for understanding US HIV/AIDS policy is the role a conservative ideology may have played in shaping public policy towards the HIV/AIDS pandemic.[26] Many U.S. civil society groups have insisted that partial funding be devoted to sexual abstinence and fidelity-promoting programs as well as zero tolerance of drug use,[27] or they have proposed significant funding cuts to the Global Fund.[28] Moreover, some view US HIV/AIDS funding as a way of providing financial support to Christian missionaries already working especially in Africa in private missionary hospitals, education and social service provision. Another important actor in the US is the powerful pharmaceutical industry, which has lobbied aggressively for the use of expensive drugs through bilateral trade deals and through PEPFAR.

The power of the pharmaceutical industry in the shaping of both domestic and international drug policy is hard to overstate, in part because of another major source of state-level divergence between Canada and the United States: the greater vulnerability of the U.S. Congress to corporate lobbying influence. One of many important differences between the Canadian parliamentary and United States congressional models of governance is the relative influence of campaign finance. In the parliamentary model, elections are quick and relatively inexpensive, while decisions are based on

voters' overall party preferences. In such a system, the dollars and media work of corporate interests, including the pharmaceutical companies, are not determining factors in elections. In the United States, by contrast, where campaigns have become increasingly more expensive with every election cycle and where members of the House of Representatives must stand for re-election every two years, corporate lobbying interests have much clout. Among those with the heaviest influence are the ones with the most to spend, like the pharmaceutical industry, which was found in a 2005 study to be second only to the insurance industry in combined lobbying and campaign contributions.[29]

General Considerations at the Individual Level

Individual level considerations for international HIV/AIDS policy influence could center on any number of influential people in Canada and the US. For example, Canadian Stephen Lewis, UN Special Envoy on HIV/AIDS in Africa, has been a powerful force in shaping Canadian consciousness towards the pandemic and in challenging the Canadian government towards addressing inequities in HIV/AIDS treatment. Lewis has been an outspoken advocate raising awareness of the terrible impact the disease has been having on generations across Africa. He has challenged Canada and other rich states to take bolder action to improve access to cheaper, generic drugs to battle HIV/AIDS.[30] His keynote address at the annual general meeting of the Canadian HIV/AIDS Legal Network in September 2003, followed a week later at a conference on AIDS in Nairobi, Kenya, helped pressure Canada's federal government to put on its agenda improving access to generic drugs for poorer developing countries and moving more quickly to pass supportive legislation in this regard.[31] Additionally, former Canadian Prime Minister Jean Chrétien, nearing retirement and conscious of his potential legacy, played an important role in pushing for passage of the Jean Chrétien Access to Medicine Regime, which Lewis called a "stunning breakthrough."[32]

On the US side one might consider three high-profile philanthropists who have been active in supporting HIV/AIDS initiatives: Bill and Melinda Gates, Bill Clinton and George Soros. All three have foundations (Bill and Melinda Gates, Clinton and the Open Society Institute respectively) and all have made major donations to treatment and especially prevention initiatives not emphasized by the Bush Administration. Significantly, however, though all three—

especially Clinton and OSI[33]—work to change policies with foreign governments particularly around treatment and prevention, none of these foundations with the partial exception of OSI have pushed hard against the policies of the Bush Administration. Instead, they tend to circumvent the U.S. government, rather than directly confronting it, preferring instead to focus on internal private philanthropy and policy advocacy outside US borders.

In addition, U.S. President George W. Bush and many of his closest advisors especially within the executive branch have a long record of disdain for multilateral initiatives, which is apparent in their lackluster support for the Global Fund. Bush and his policy advisors have also been heavily influenced by two special interests which have been critical in determining global AIDS policy in the US—the brand-name pharmaceutical industry and the Christian religious right. Both constituencies have interests in the treatment and prevention work on the global pandemic and the distribution of AIDS funds to Christian missionary work, the latter again an important overall component of US international AIDS policy.

IV. TWO CASE STUDIES: ILLUSTRATING INFLUENCES ON HIV/AIDS POLICY

Opposite Ends of the Spectrum: Approaches to Treatment in Developing Countries

The most immediately apparent and obvious contrast between Canada and the US on global AIDS policy is the approach taken to the availability of medication to treat HIV/AIDS in developing countries. Indeed, we suggest that if the responses of developed countries on this issue were arrayed on a continuum, Canada and the US would define the polar ends of the scale. The US is well known for its defense of intellectual property rights, which translates in the context of AIDS to support of the brand-name pharmaceutical industry. Canada, conversely, has pioneered the path on the opposite side of the debate, passing in 2004 the Jean Chrétien Pledge to Africa. In the process Canada became the first developed country to allow the manufacture of generic medications for the purpose of exporting those medications to developing countries.

These divergent paths may have originated in the 1994 adoption by the members of the WTO of the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS). The TRIPS agreement required member countries to agree to a variety of intellectual

property protections, including the granting of twenty year patents on pharmaceutical products. Although high income countries were required to comply with the TRIPS pharmaceutical patent protections by 1996, developing countries were given a longer window to fall into compliance. In fact, in the case of least developed countries (LDCs), the requirement for patents on pharmaceuticals has been extended to 2016.[34]

Although this agreement applies to all medications, it is AIDS drugs that have brought the issues involved into sharp focus because of two other developments in the 1990s. First, by approximately 1996, triple combinations of antiretroviral medications became the standard of care for people living with AIDS in developed countries. Secondly, in the late 1990s developed countries belatedly began to acknowledge the hugely disproportionate impact of AIDS in developing countries, particularly in sub-Saharan Africa. Initially, the reaction to the growing realization of the enormity of the African pandemic was much global hand-wringing followed by declarations that any resources spent on the problem would have to be devoted to the prevention of further infections, and perhaps the amelioration of some of the worst effects of the pandemic. Given the ten to twenty thousand dollar costs of the combination therapies being used in developed countries, it was widely agreed that treatment in developing countries was inconceivable.

That perception began to shift in the late 1990s, thanks in large part to the success of Brazil in providing its own citizenry with free access to these medications produced by generic manufacturers. As an increasingly connected and sophisticated transnational advocacy network came together, a new message began to emerge, first within the network, and then radiating out to a larger audience. As widely and loudly as possible they marked the success of Brazil in using generic drug production to bring the $10,000-plus annual price for treatment in the US to roughly $700 in Brazil. They noted that only a few billion dollars was needed to bring the cheaper drugs (whose prices have fallen to less than $200) to millions who need them in the poorest areas of the world.

With the old message that AIDS in Africa was a tragic but untreatable phenomenon now competing with a new mantra that AIDS was very treatable if developed countries donated money for the least expensive versions of the drugs, the stage was set for the battle of competing treatment approaches. Advocates of intellectual

property protection argued that the treatment issue should be addressed through a combination of charity and price reductions by the brand name pharmaceutical industries, financed in large part by developed countries' donations. Most members of the global activist network rejected that approach as unsustainable. The further development and growth of a generic drug industry would not only aid in the self sufficiency of countries capable of developing their own domestic manufacturing capacity (as Brazil had done), but the generic industry would help drive down prices worldwide.

The forum where this discussion was most explicitly taken up was the November 2001 meeting of the WTO in Doha, Qatar. Arriving as the meeting did soon after the 9/11 terrorist attacks, protests similar to those a year prior at the Seattle WTO meeting were limited both in numbers and intensity. Yet inside the halls of the meeting, the few activists and NGOs that managed to attend had an impact, particularly by connecting with developing country delegations. This collaboration was resented by developed country delegations who claimed that "developing countries are getting wound up by NGOs" to be "unrealistic" and "intransigent" in their bargaining.[35]

Although developing countries were hearing from one part of global civil society, the US delegation was hearing from a different sector, namely the pharmaceutical industry. The head of the U.S. delegation, Trade Representative Robert Zoellick, had been given specific instructions in a letter from Alan Holmer which defined the opening position of the United States in the negotiations.[36] Yet it was the cooperation between developing country delegations (which explicitly formed a negotiating bloc) and the attending treatment activists and NGOs that carried the day. Over the opposition of the brand-name pharmaceutical industry, which ominously warned of calamitous disincentives to research and development, the meeting negotiators produced the "Doha Declaration" that explicitly clarified that the TRIPS agreement should not stand in the way of governments attempting to protect public health. Specifically, it states in part that "the [TRIPS] Agreement can and should be interpreted and implemented in a manner supportive of WTO Members' right to protect public health and, in particular, to support access to medicines for all."[37]

Reaction to the Doha Declaration's importance ranged from those who saw it as a crucial concession to those who questioned

its overall impact. But it was universally seen as a positive development which represented a departure from the usual US position of the total centrality of intellectual property protection. There are at least two ways to explain this apparent concession on the part of the United States. The first has to do with the timing of the meeting, coming as it did only two months after 9/11. Although it has receded in the minds of Americans, there was a second threat that followed the first attack on the World Trade Center and Pentagon, and that was anthrax.[38] In the first two weeks of October postal workers, individuals working for the media and staffers for US Senators in Florida, New Jersey and Washington, DC showed the symptoms, and five people died, of anthrax that appeared to have traveled through letters in the US postal system. Most of those known to have been exposed survived because they were quickly treated with a highly effective antibiotic called ciprofloxin, or simply Cipro. In the charged post-9/11 atmosphere, US Secretary of Health And Human Services Tommy Thompson estimated that, to be safe, there should be sufficient Cipro in the United States to treat 10 million people. For the full 120 day course, 1.2 billion pills would be necessary. Yet the Cipro patent holder, Bayer, had the capacity to produce only two million pills per day, which meant that it would take almost two years to produce that much medicine.

On October 16, New York Senator Chuck Schumer called on the US government to issue a compulsory license that would allow three or more other manufacturers to produce generic versions of Cipro. Three days later the Canadian government moved more decisively. It actually issued such a license and ordered a million pills from a Canadian generic company, which a Health Canada spokesperson justified with the argument that "Canadians expect and demand that their government will take all steps necessary to protect their health and safety."[39] In the United States, the anthrax scare subsided as no further cases were reported. Bayer lowered its prices from $1.77 to $.95 per pill for the first 100 million. Yet the message, played out in newspapers around the world, was that the United States considered five American deaths an emergency worthy of considering the breaking of patents, but not the illness and deaths of thousands in sub-Saharan Africa. Thus, the United States went into the Doha meeting in a compromised ethical position: How could it insist on the supremacy of intellectual property over public health when it had so recently been ready to reverse those

priorities in its own domestic emergency of far smaller proportions than developing countries face?

Another explanatory factor for this concession is that, although it was widely trumpeted as a major breakthrough, the concession left a number of loopholes to be closed at some future point. Arguably, the most significant of these was the issue of compulsory licensing for the export of medicines. Although the Doha agreement made it easier for countries that needed to issue compulsory licenses to allow generic manufacture of drugs to meet the needs of their own citizens, these countries were still limited by the TRIPS provision that products made under these licenses must be predominantly for domestic markets. Under this provision, small and/or very poor countries lacking a domestic drug manufacturing capability remained unable to provide drugs to their citizens because countries manufacturing generics remained unable to export the drugs. Resolution of these countries' predicaments was deferred indefinitely.

Two years later, under pressure from activists and developing countries, WTO members attempted to adopt a solution, only to watch the United States singlehandedly veto a deal that all the other 140 WTO member states had agreed upon. The US, on the behest of its pharmaceutical industry, blocked the deal because it would have allowed a full range of medicines to be imported to developing countries in Africa and Asia. The US wanted to restrict the deal to drugs used only to treat HIV/AIDS, malaria, tuberculosis and a small number of other diseases specific to Africa.[40] After months of intense negotiation in the run-up to the 2003 Cancun meeting of the WTO, member states finally agreed to adopt an "interim waiver" allowing developed countries to produce significant quantities of generic medications for export, albeit on a drug-by-drug and country-by-country basis that activists criticized for providing little incentive to generic companies to produce even small quantities of drugs.

There were already discernible differences in Canadian and US policy approaches up to this point, in terms of both Canada's willingness to issue compulsory licenses at home and the far greater intensity with which the United States had opposed relaxed interpretations of the TRIPS agreement at WTO and other international meetings. But it was after this point that the differences became particularly stark. A little more than a month after the interim waiver

was announced, Stephen Lewis and a Canadian coalition called the Global Treatment Action Group (GTAG) – with membership from a wide variety of groups including labor unions, human rights and faith-based NGOs, and student and development groups -- successfully pressured the Canadian government to commit itself to a measure to implement the new TRIPS flexibilities. However, Bill C-56, introduced on November 6, 2003, disappointed many who had called for its creation, as it gave concessions to the brand-name pharmaceutical industry not required under the new TRIPS waiver.

With only 24 hours remaining in the parliamentary session, civil society members called upon Parliament to withhold its support of the bill and refer it to committee, thus increasing the chances that it could be taken up, amended and passed expeditiously in the next session. The opposition New Democratic Party, in particular, was sympathetic to activists' concerns and signaled its willingness to oppose the bill if called upon to vote. Fearing the lack of all-party assent, the government referred the bill to committee, where it was taken up by the new session on February 12, 2004. With civil society lobbying actively through GTAG in hearings and in the media, the bill was significantly altered in spring 2004. On May 14, 2004, the Jean Chrétien Pledge to Africa Act (JCPA) passed into law.[41]

The reaction in the United States could not have been more different. Rather than passing legislation allowing U.S. companies to produce generic AIDS medicines for export, the United States government sought to reinforce the primacy of the intellectual property rights of the brand name companies through both official trade agreements and market-based support of the brand-name industry.[42] These official trade agreements have included both bilateral and regional deals. All also include "TRIPS-plus" measures that raise the cost, in both money and time, of manufacturing generic medications. A recent analysis listed such practices as extending patents beyond the 20 year period found in the TRIPS agreement; practicing data exclusivity (that protects manufacturers' drug testing data for five years); allowing known substances to be re-patented for additional uses; freezing generic manufacturing of AIDS medications; and reducing the number of inventions that can be excluded under patent law. [43] Such TRIPS-plus measures have been and are being applied to the Central American Free Trade Agreement (CAFTA), bilateral agreements with Singapore, Chile, Peru, Columbia and Morocco, and deals currently under negotiation with

Panama and Thailand as well as the five-nation Southern African Custom Union.[44]

The market-based support that the US government has given to the brand-name industry has been tied to its bilateral initiative, the Presidential Plan for AIDS Relief. When the plan was first announced by US President George W. Bush in his January 2003 State of the Union Address, activists were astonished to hear him talk about the affordability of treatment. He specifically mentioned the $300 cost of the cheapest yearly supply of (generic) AIDS drugs at the time. When the plan was launched, however, it became clear that the government planned instead to be using heavily discounted brand name drugs. Even with the discount these drugs could cost four times as much as their generic equivalents, leading activists to argue that the PEPFAR could be treating more people if it would use the less expensive medicine.

Additionally, the generic medications, which were already being used on the ground by some NGOs such as Doctors without Borders, were available as fixed dose combinations (FDCs) of three medications in a single capsule. FDCs had the added advantage of being easier to administer, and had a better record of patient compliance. In the face of these arguments, PEPFAR administrator Randall Tobias, the former CEO of drug giant Eli Lilly, convened a meeting in Botswana to discuss why the US proposed not using these pills. He argued that the US wanted to rely on the Food and Drug Administration (FDA) rather than the WHO as the regulatory body approving the medication. Although the WHO's process known as prequalification already had approved FDCs, the US opposed giving Africans these drugs without FDA approval.

The debate hinged on more than the fact that fewer people would be treated with the more expensive drugs. It was also an issue of efficiency. Since some countries and NGOs had already started using FDCs, already scant and strained health care systems would have to accommodate both types of treatment regimens. Additionally, there was a sovereignty issue at stake: PEPFAR was essentially overriding the regulatory decisions of PEPFAR beneficiary countries that had already decided to allow the FDCS. Moreover, the US was asserting the unilateral superiority of the FDA over the multilateral WHO.

The FDC debate was waged in and outside Botswana by both US-based and international actors. The Bush Administration found

allies for its position from conservative think tanks and writers such as the Manhattan Institute's Robert Goldberg, who editorialized in the *Washington Times* against AIDS activists trying to "force the United States to spend every dime of its $15 billion on this deadly dose." James Glassman delivered a similar message in *Newsday* accusing activists of "imperiling millions of Africans" with "treatment with drugs unfit for the West."[45] This newfound concern with double standards for Africa did not impress groups already administering treatment, however. Doctors without Borders, which had pioneered treatment in many areas of sub-Saharan Africa, argued that it had been regularly providing information about the safety and efficacy of FDCs. But the Bush Administration was "moving the goal post every time a concern had been addressed."

The Catholic Relief Services Consortium, one of the four major awardees of PEPFAR money, buttressed the arguments of Doctors without Borders, by offering testimony at the Botswana meeting about the many lives that would needlessly be lost because of the proposed refusal by the US to purchase generic FDCs. The European Union (EU) was clearly frustrated with the US position, a message that was communicated by a pointed decision by the European Agency for Medicinal Products (the largest drug regulatory agency in the EU) not to attend the meeting. Meanwhile, activists found allies in both houses of the US Congress, where Representative Henry Waxman and six prominent Senators sent letters to the President urging him to accept the WHO prequalification process.[46] In the face of relentless pressure from domestic activists and anger from NGOs and governments abroad, the Administration ultimately agreed to put the generic medicines submitted to the FDA for "Fast Track" review. Although this process took months rather than the few weeks optimistically projected by the US government, twelve drugs (only one a double therapy and no triple therapies) received tentative FDA approval between January and November 2005[47] Yet, even this decision, as opposed to one that would have accepted the efficacy of the WHO system, suggested the extent of unilateral thinking in US AIDS policy.

Policy Making through Spending Priorities: PEPFAR versus Multilateral Initiatives

The starkly differing approaches to affordable medications are mirrored by divergent approaches to financial assistance to developing countries struggling with HIV/AIDS. These differences can

be analyzed along several dimensions including bilateral versus multilateral priorities, proportionate levels of donations, and a focus of spending priorities such as abstinence-only prevention funds for Christian missionary groups (US) versus prevention spending on microbicide and vaccine development (Canada).

Since 2002 two programs emerged as the largest initiatives designed to combat the global HIV/AIDS pandemic: the PEPFAR, announced in January 2003 and begun in 2004, and the Global Fund for AIDS, Tuberculosis and Malaria (Global Fund), called for by UN Secretary General Kofi Annan in April 2001 and making its first grant commitments in April 2002. The first is a bilateral initiative focusing on fifteen countries identified by the US government as priorities. Except for Guyana, Haiti and Vietnam, all the PEPFAR target countries (Botswana, Cote d'Ivoire, Ethiopia, Kenya, Mozambique, Namibia, Nigeria, Rwanda, South Africa, Tanzania, Uganda and Zambia) are in sub-Saharan Africa. Touted on its web site as "the largest commitment ever by any nation for an international health initiative dedicated to a single disease,"[48] the program plans to spend $15 billion over a five year period in order to treat two million people (of approximately 6.5 million estimated by the WHO to need such treatment), prevent seven million new infections by 2010, and provide support and care for ten million people infected and affected by AIDS, including orphans and vulnerable children. Of the $15 billion, approximately nine billion would represent new funding to the target countries, and about five billion would consist of existing bilateral funding in other countries. Additionally, the PEPFAR included the Global Fund in its overall plan, noting its intent to donate $1 billion of the total $15 billion package over the same five years (i.e. $1 billion total, not annually).

The Global Fund differs from the PEPFAR in a number of fundamental ways. Most obviously, the PEPFAR is a bilateral initiative developed in the United States, and using US-based "partners" – including Columbia and Harvard Universities, a cluster of groups (including faith-based organizations) known as the AIDS Relief Consortium, and the Elizabeth Glaser Foundation. The program is overseen by the U.S. Global AIDS Coordinator, an ambassador level position within the State Department, occupied first by Randal Tobias, former CEO of Eli Lily, and currently by Dr. Mark Dybul, who was promoted from his Deputy role. The Global Fund is a multilateral initiative that disburses contributions from developed countries

(as well as smaller contributions from philanthropists, foundations, corporations and private citizens) to developing countries which bid for the grants through competitive proposals. A major component of the Global Fund's design is the incorporation of ground-up decision making, in contrast to the PEPFAR's top-down decisions in beneficiary selection and program design.

A country seeking Global Fund support is required to convene a Country Coordinating Mechanism (CCM) composed of stakeholders including representatives of government ministries (particularly ministries of health), faith based communities, commercial interests, and civil society (with particular representation from people living with the three diseases addressed by the Global Fund). The job of the CCM is to put together a coherent, multi-year plan to address the prevention and treatment needs of communities suffering with the three diseases, with attention paid to the country-specific risk groups and needs of differing populations. These plans are then vetted through a Technical Review Panel (TRP) which assesses how well the submitted plans appear to address the problems outlined and the prospects for success if the plans are funded. Those which are highly rated are then passed to the Global Fund for the awarding of grants based on available resources.

Underfunding has posed another continuing challenge in the six rounds of competitive bidding undertaken by the Global Fund. Since its inception, but especially in its most recent rounds of grant decisions, the Global Fund has faced funding gaps. For example, the Global Fund Board went into the process of Round Six on May 2006 facing the reality that it would not be able to fund any of the new proposals it was receiving. All the money pledged by donors had already been obligated to renewals of previously-awarded grants. Since that time, donors have pledged several hundred thousand additional dollars. Still, there remains an atmosphere of uncertainty, and with each additional round the overall legitimacy of the organization weakens. Many donor countries increasingly fear for the sustainability of proposed programs, which in some cases (such as AIDS antiretroviral treatment) will require lifelong provision of drugs.[49] The United States, as the world's global superpower, has a relationship to the Global fund noted by other countries around the world. Recognizing this, UN Secretary General Annan came first to the US to seek an inaugural donation of $2 billion. President Bush offered a tenth of the requested amount, $200 million, while

arguing that the US would provide more money for its own initiative which was revealed a year later as the PEPFAR. This low offer, however, had global repercussions. Given that the United States has one third of the world's wealth and economic activity, other developed countries expected it to pay one third of the cost of the Global Fund. By lowballing the amount donated, the US began a race to the bottom, with other developed countries pegging their donations in proportion to that of the United States.

While the trajectory of US spending has been away from investment in multilateral donor programs, Canada has been, and continues to be staunchly supportive of them, encouraged by vocal and consistent pressure from coalition members of the Canadian civil society GTAG and high-profile calls to action from UN HIV/AIDS envoy Stephen Lewis. Significantly, Lewis is not only is not only extraordinarily well-regarded in Canada, he is also the former leader of the Ontario New Democratic Party. Although it is a minority party in both the current Conservative-led parliament and the previous one led by the Liberals, the NDP, in its adoption of the political demands of Lewis and Canadian civil society coalitions, has helped shape policy around the JCPA and the Canadian approach to multilateral financial commitments. In contrast to the US, the NDP has supplied Canada with a minority party that explicitly pushes the government to move in a direction that focuses on certain international development goals and commitments. These include fulfilling the UN Development Goals (in furtherance of which the Canadian government has called for an increase of $274 million over the next five years for international development spending), and pledging a specific timetable to reach the target of 0.7% of gross national income as foreign aid.[50]

Given the enormous differences in size of the economies of Canada and the US, direct comparisons of their contributions are difficult. However, one interesting contrast that speaks directly to the difference in multilateral versus bilateral support would compare the total proportion of aid for HIV/AIDS spending in each category. A 2004 Kaiser Family Foundation study found that Canada's AIDS contribution of $77.9 million represented 9.1% of the overall contribution to the Global Fund, whereas the United States' donation of $275.3 million for the same year was 32.2% of the total overall. Perhaps more telling, however, was the proportion of AIDS donor spending each sum represented for the respective countries. In

the case of Canada, the Global Fund (multilateral) contribution was 41% of commitments for that year, with 59% being spent on bilateral programs, whereas the US contribution represented only 17% of the country's overall contribution with 83% being spent bilaterally.[51] Although it is certainly true that in absolute numbers, the US contributes more to both bilateral programs and the Global Fund, the advantage disappears when the numbers are standardized by the Gross National Income (GNI) of each country. Accounting for 2004 combined contributions to the Global Fund and bilateral contributions yields a proportionately more generous Canada, which turns out as the second most generous country of the G7 (after the UK), contributing $194 per million in GNI to the United States' $137.[52]

It is also a point of pride in Canada that, at a moment when it was faltering from lack of support, the ambitious WHO "3 x 5" effort was saved by Canadian support of $100 million. The 3 x 5 initiative was a program created by the WHO to coordinate efforts and provide technical support to developing countries to reach the overall goal of three million people in treatment by 2005. Although the initiative fell far short of its aim (with only an estimated 1.3 million in treatment by that date), Canada's supportive role was critical. In an Op-Ed entitled "3 x 5 Earns Kudos for Canada" in the *Toronto Star,* the then WHO Director General praised Canada as "among the select few nations that not only believed in this effort from the inception, but also supported it generously. Canada's contribution reaffirmed its leadership role in global development, and was instrumental in encouraging more countries to provide crucial political and financial support to 3x5."[53]

In addition to the contrasts on proportional generosity and proportional donations to multilateral versus unilateral initiatives, Canada and the US differ widely on the substantive spending categories they emphasize. This is especially true in the area of AIDS prevention, where the US approach has been viewed as maintaining a focus on behavioral change, and within that, an abstinence-based model for both sexual and drug using risk behaviors. By contrast, in its funding for behavioral interventions, Canada takes the approach advocated by most AIDS activists, known as harm reduction, which views abstinence as one option (and not necessarily a feasible one) in an array of possibilities that may limit the risk of HIV transfer. Further, it places heavy donor focus on potential interventions that

empower women, such as microbicide development, and that do not rely on behavior change, namely vaccine development.

The Canadian International Development Agency's (CIDA) web site is instructive: the second and third lines in CIDA's HIV/AIDS overview boast of interventions that would be an anathema in the United States: "A homeless boy in Vietnam, addicted to heroin, takes advantage of a needle-exchange program. A Tanzanian sex worker convinces her HIV-positive client to use a condom." At the end of this paragraph is noted "these are some examples of progress in the global battle against HIV/AIDS." It would be hard to find a stronger contrast with the US, which explicitly bans funding for harm reduction approaches, such as needle exchange at home and abroad, and requires organizations who receive PEPFAR money to have explicit policies opposing prostitution. This requirement is impossible to meet for many organizations working with or doing outreach to sex workers.[54]

V. ABERRATION OR LONG TERM TREND? THE IMPACT OF A CONSERVATIVE TURN IN CANADA

On January 23, 2006, the leader of Canada's federal Conservative Party, Stephen Harper, was elected Canada's 22nd Prime Minister, as the Conservatives won a plurality of seats in the 39th general election. With 124 of a possible 308 seats, the Conservatives won 36% of the popular vote and a minority government. The opposition Liberals, New Democratic Party and Bloc Québéçois took the remainder of the seats and formed a sizeable and hostile opposition. This federal election ended over twelve years of uninterrupted federal Liberal Party government, and raised the prospect of a changed policy approach on the part of the Canadian government to the global HIV/AIDS pandemic. In fact, during Prime Minister Stephen Harper's first year in office, there were a number of indicators that suggested a less financially generous, more cautious and more ideologically conservative response to this pandemic. The new policy reflected Harper's more conservative ideological disposition, the influence of more socially conservative constituents who formed the core of the Conservative Party's electoral support, the general orientation of the Conservative Party platform, and a less tangible but still noticeable sense that Harper's government was much more accommodating towards the Bush Administration on a variety of foreign policy initiatives.

From an individual level standpoint, Harper is clearly more conservative ideologically than any of his recent predecessors, including not only the recent Liberal Prime Ministers Chrétien and Martin but also even then-named Progressive Conservative Party Prime Ministers Joe Clark and Brian Mulroney. In fact, Harper is no red Tory, having overseen in 2003 the merging and ultimately marginalization of the Progressive Conservative Party within the much more ideologically conservative and Western-based Canadian Alliance Party. In Harper's previous writings and comments in and out of Parliament, he has expressed sometimes socially conservative views on abortion and spousal benefits for same sex couples. A founding member of the Reform Party (the ideologically conservative predecessor to the Canadian Alliance), his intellectual links to the rightward leaning and so-called "Calgary School" and his work for the National Citizen's Coalition, a conservative interest group that supports tax cuts, reduced government spending and privatization, all suggest a political-ideological disposition arguably less sympathetic to Canada taking a proactive internationalist stance on the HIV/AIDS pandemic.

Beyond what are admittedly more speculative assumptions about how Harper's individual ideological orientations might color his approach to the pandemic, there are a number of recent examples over the nearly two years of Conservative Party minority rule where Harper and his government have betrayed indifference at best to Canada's HIV/AIDS policy commitments. For one thing, the Conservative Party platform during the January 2006 federal election campaign made no mention of Canada's policy towards HIV/AIDS. None of the Conservatives' electoral campaign policy announcements spoke to the question of maintaining or advancing Canada's financial commitments to the pandemic. Prior to the election, the party had provided only a limited response to questions on its approach to HIV/AIDS posed by a variety of Canadian civil society groups.[55]

Harper's refusal to accept an invitation to attend and speak at the opening ceremony of the XVI International AIDS Conference in Toronto (AIDS 2006) in August proved more discouraging for those observers concerned about a rightward tilt in Canadian government policy towards HIV/AIDS. Harper and his health minister, Tony Clement, claimed that the meeting, with over 30,000 delegates attending from around the world, had become too politicized. So

Harper kept to his scheduled tour of the Arctic during the conference.[56] More disconcerting was Clement's last minute cancellation of a planned press conference where the government was to reveal how much money the Canadian government would commit to fighting HIV/AIDS. Harper's absence, the cancelled press conference and the general lack of leadership by Canadian government representatives at the major international AIDS conference ironically being held in Canada, provoked a storm of domestic and international criticism. Many questioned whether this signaled an important shift away from what had been a growing international commitment on Canada's part towards tackling the pandemic.[57] Shortly after the conclusion of the conference, moreover, the opposition New Democratic Party joined with UN special envoy Stephen Lewis and a coalition of Canadian civil society organizations to condemn the Conservative government's inaction on HIV/AIDS, and endorsed the Global Treatment Access Group's "Four Steps for Canada Platform" for combating the global AIDS crisis.[58]

Following the Toronto AIDS conference, the Conservative government throughout fall 2006 took no new initiatives and issued no new policy statements to address how Canada planned to meet its already stated international commitments to the pandemic. Stephen Lewis decried Canada's "delinquent" and "hypocritical" posturing on AIDS, while the news media and Canadian civil society groups continued to criticize Harper and his government for inaction.[59] One of the main points of contention related to the government's inaction involved the growing disappointment, inadequacies and increasingly apparent failings of the originally much touted Jean Chrétien Pledge to Africa Act, renamed the Canada Access to Medicine Regime by the Conservatives.[60] Designed to help developing countries import life-saving medicines from Canada to combat the HIV/AIDS pandemic, with Canadian generic drug companies gaining compulsory licensing, the legislation still had failed to deliver a single pill to countries in need more than two years later. The legislation at that time was clearly hampered by a variety of challenges, including a lack of financial incentives for generic drug companies, bureaucratic red tape hampering the procedure for acquiring the compulsory licenses to produce inexpensive drugs, and intractable tensions between brand-name and generic drug companies.[61] Yet many civil society groups perceived that the Conservative government's inaction on this issue showed a lack of

political will and made an ideological statement on Canada's apparent loss of leadership in the global HIV/AIDS fight. While the federal government led by Health Minister Clement had announced a formal review of the legislation in August 2006, with a report due to Parliament in 2007, the government's further delay in responding to the mounting criticisms seemed to suggest that Canada's HIV/AIDS international commitments were falling victim to an emerging social conservative agenda.[62]

There were two policy statements by Harper Conservative government that seemingly recommitted Canada to its activist and internationalist stance on tackling the AIDS crisis. On December 1, 2006, World AIDS Day, Harper's government announced its HIV/AIDS initiative package, delayed since August, pledging to keep its commitment to spend C$250 million to the Global Fund to Fight AIDS, Tuberculosis and Malaria over 2006 and 2007, while adding an additional C$120 to support prevention programs, research, care and protecting the rights of women and children.[63] This announcement was followed by another that the Canadian government would be joining with the Bill and Melinda Gates Foundation in a C$139 million project to accelerate research and development into a vaccine against HIV. In a press conference, Bill Gates and Stephen Harper pledged to combine the resources towards what would be labeled the "Canadian HIV Vaccine Initiative," with Canada contributing C$111 million and Gates $28 million. During the news conference, Harper said, "the global HIV/AIDS pandemic is one of the most heart-wrenching health crises the world has ever seen. Forty million people currently infected, over 25 million dead and millions of children orphaned. HIV/AIDS is a killer that must be stopped."[64]

Nonetheless, many groups across Canada remained unhappy about the Harper government's general approach to fighting global HIV/AIDS and to its slow review of the Access to Medicines Regime.[65] While again the Regime's proponents had envisioned a process making it much easier for developing countries to import lifesaving medicines from Canada to combat the HIV/AIDS pandemic, the legislation after three years had proved cumbersome and ineffective, resulting in only one compulsory license issued for export to Rwanda.[66] Despite pleas by Canadian civil society groups for Parliament to act forcefully to improve the Regime to speed up the process for transferring affordable drugs to developing countries,

little improvement had been made into 2007. The Canadian HIV/AIDS Legal Network in April 2007 presented a brief to the House of Commons Standing Committee on Industry, Science and Technology, recommending for example that authorization be given to "any pharmaceutical firm to produce generic versions of any drug patented in Canada for export to any eligible developing country listed in the law." [67]

That same month, Canadian civil society groups hosted in Ottawa an International Expert Consultation on Canada's Access to Medicines Regime, drawing participants from around the world to reflect on recommendations and strategies to reform the Regime and more generally reduce the challenges facing millions of citizens from developing countries still seeking to access affordable life-saving medications.[68] In August 2007, marking the one-year anniversary of the international AIDS conference in Toronto, coalitions of Canadian civil society groups remained critical of the Harper government's commitment to fighting the pandemic, with Stephen Lewis asking, "Where is Canada? Where is Canada's voice?"[69] Lewis added, "What we need is a government with a voice that spends rather less money on defence and armaments, whether it's Afghanistan or elsewhere, and rather more money on the human condition...That requires leadership from the present government, which frankly does not exist."[70] The Harper government's December 2007 tabling in Parliament of its months-long review of the Regime, in which it failed to see the need for legislative or regulatory changes to the Regime, may do little to quell civic concern.[71] In general, the Conservative government's unwillingness to expedite granting compulsory licenses has been perceived as another example of a lack of political will and follow through—perhaps by an ideologically conservative government some of whose constituencies find little of value in combating the pandemic—and another indication of Canada's apparent loss of leadership and effectiveness in a global crisis demanding constructive international engagement.

Hesitations and delayed responses to Canada's international commitment to combating HIV/AIDS are only part of a larger and still emergent pattern that some observers critical of the Conservative government argue reflects a Canada moving further from its accustomed brand of constructive multilateralism. Byers has recently catalogued three further areas where Harper's government seems to have turned towards more overtly siding with the Bush

Administration, in Canada's muddled position on climate change and its more consistently taking the US position in international climate discussions, in the more aggressive use of Canada's military abroad, principally in the counter-insurgency anti-Taliban efforts within NATO in Afghanistan, and in Harper's more overt support for Israel in the Middle East.[72] Added to this list could be Harper's obvious sympathies for deeper integration with the United States, illustrated by his support for the ongoing negotiations towards the trilateral NAFTA-plus Security and Prosperity Partnership Agreement including Mexico that seeks to harmonize a wide range of continental regulations. In short, critics still assert that Stephen Harper has done little to improve Canada's faltering image as constructive internationalist middle power, having distanced his government from the Department of Foreign Affairs and International Trade, and marginalizing many of the bureaucrats steeped in the multilateral tradition in favor of a consolidation of the office of the Prime Minister.[73]

The confusing Canadian approach to international issues was perhaps further on display in June 2007, when leaders of the G8 met in Heiligendamm, Germany, with great expectations that these wealthy states would finally commit to spending billions more to combat HIV / AIDS, malaria and other diseases afflicting millions of poor people across Africa. Anti-poverty and development activists had already strongly criticized the G8 for not honoring its pledges to increase financial support and development aid to the world's poorest two years prior at the G8 summit in Gleneagles, Scotland. In Germany, however, Canada came under specific attack for purportedly encouraging the other G8 states to not make specific targets in the group's multilateral humanitarian aid package. Prime Minister Harper allegedly prevented the leaders of the G8 from fulfilling their previous financial pledges for financial aid. "A man named Stephen Harper came to Heiligendamm but Canada stayed at home," said Bob Geldof, one of the celebrities, including U2's Bono, who singled out Harper and Canada for criticism.[74] While Harper strongly denied Canada's part in blocking development aid, a senior Canadian official admitted to reporters that the $60 billion (US) the G8 promised over the next several years to fight global communicable disease was just an "aspirational" estimate.[75]

Anecdotal complaints from aging rock stars is slim evidence on which to convict Canada of shirking its multilateralist tradition,

but it does add to a much larger and growing list of contradictions in the professed values of Canadians and the recent foreign and domestic policy record. What remains to be seen, and what will be better illustrated following another federal election, is whether the Harper government's more ideologically conservative turn reflects the preferences of the voting public or instead is a short-term aberration from the "pan-Canadian consensus"[76] and specifically Canada's history of constructive internationalism.[77]

VI. CONCLUSION

To summarize, we see the behavior of Canada and the US towards international HIV/AIDS policy, despite the actions of the minority Conservative government in Canada, largely conforming to multilateral rather than unilateral patterns. Shaped by an internationalist tradition in foreign affairs, and coaxed by especially active civil society groups and prominent spokespersons, Canada has adopted a more active approach to encouraging the producing of generic AIDS medicines for export (pending the review noted above), and has supported multilateral financing for those countries grappling with the tremendous toll of HIV/AIDS. The US, on the other hand, has clearly embraced opportunities provided by this post-Cold War unipolar moment. It has aggressively promoted the protection of intellectual property rights of largely US-brand name drug companies, while emphasizing behavioral change as a partial condition for HIV/AIDS funding under the influence of powerful conservative ideological constraints.

We find these divergences in state approach to the HIV/AIDS pandemic significant because they highlight some of the challenges facing global health governance. After 25 years, more than 33 million people are living with HIV/AIDS worldwide, and an estimated 20 million have died. In 2007 alone, UNAIDS estimates that 2.5 million people were newly infected and another 2.1 million died of AIDS.[78] While disproportionately affecting sub-Sahara Africa, AIDS also threatens many highly populated countries including China, Russia, and India. HIV/AIDS knows no legal or international boundaries. Beyond the enormous human toll, the disease threatens the political stability of states and the wider international system.

Given the enormity of the global AIDS pandemic's tragic consequences, any action that wastes the energy and resources of do-

nor nations in a position to help is not merely ill-advised; it can actually be deadly. Yet, the unilateral approach espoused by the United States creates a race to the bottom among wealthy nations unwilling to contribute proportionally more to multilateral efforts than the world's superpower. It also creates needless duplication of resources. This includes two systems, one for the US and one for the rest of world, for approving drugs provided for developing countries. Worse, parallel systems of health care within developing countries have appeared. At the level of programmatic content, the unilateral approach substitutes the will of a few ideological and commercial interests for a broader rights-based approach favored by most of the rest of the wealthy countries supporting multilateral programs and global governance. That power and national interest continue to trump more collective solutions and global governance responses to the pandemic illustrates the continued limits to international society and a more norms-based international system in the post-Cold War era.

NOTES

[1] See "U.N. AIDS Conference Whitewash: U.S., Vatican, Egypt Undermining Frank Language in Conference Document," 20 June 2001. *Human Rights News*. Available at http://hrw.org/english/docs/2001/06/20/global143.htm. This was neither the first nor the last time the US found itself on the side of somewhat unusual allies in drafting international declarations that touched on the HIV/AIDS pandemic. The US sided with the Vatican and Islamic states in the final wording of a declaration on global children's health convened by the UN Children's Fund in May 2002. See "U.N. Children's Summit Hits Snag," 10 May 2002. Available at http://cbsnews.com/stories/2002/05/10/world/printable508694.shtml.

[2] Ronald Bayer, "Blood and AIDS in American: Science, Politics and the Making of an Iatrogenic Disaster" and Norbert Gilmore and Margaret A. Somerville, "From Trust to Tragedy: HIV/AIDS and the Canadian Blood Supply" in Eric A. Feldman and Ronald Bayer, eds. *Blood Feuds: AIDS, Blood and the Politics of Medical Disaster.* New York: Oxford University Press, 1999.

[3] Patricia Siplon, *AIDS and the Policy Struggle in the United States.* Washington, DC: Georgetown University Press, 2002.

[4] Dan Small, Anita Palepu and Mark W. Tyndall, "The Establishment of North American's First State Sanctioned Supervised Injection Facility: A Case Study in Culture Change," *International Journal of Drug Policy,* Vol. 17, Issue 2, March 2006: 73-82.

[5] Doug McAdam, *Political Process and the Development of Back Insurgency, 1930-1970.* Chicago: University of Chicago Press, 1982.

[6] Margaret E. Keck and Kathryn Sikkink, *Activists beyond Borders.* Ithaca: Cornell University Press, 1998.

[7] James Gillett, "Media Activism and Internet Use by People with HIV/AIDS," *Sociology of Health and Illness,* Vol. 25, Issue 6, 2003: 606-624.

[8] Benjamin Shepard, "The AIDS Coalition to Unleash Power: A Brief Reconsideration," in John Berg, ed., *Left Political Movements.* New York: Rowman and Littlefield, 2002.

[9] Raymond A. Smith and Patricia D. Siplon, *Drugs into Bodies: Global AIDS Treatment Activism.* Westport, CT: Praeger, 2006.

[10] Kenneth Waltz, *Man, the State and War: A Theoretical Analysis*. New York: Columbia University Press, 1959; David Singer, "The Levels of Analysis Problem in International Relations," in Klaus Knorr and Sidney Verba, eds, *The International System: Theoretical Essays*. Princeton, NJ: Princeton University Press, 1961; James Rosenau, *The Scientific Study of Foreign Policy*, revised edition. London: Pinter, 1980; Bruce Russett and Harvey Starr, *World Politics: A Menu for Choice.* Fifth Edition. New York: WH Freeman and Co, 1996; and Bruce Russett, "International Relations," in Kimberly Kempf-Leonard, ed. *Encyclopedia of Social Measurement*. San Diego, CA: Academic Press, 2003.

[11] For the sake of simplicity we have chosen a more classic three levels approach. Also common is an expanded six levels approach as found in Russett and Starr (1996).

[12] See for example Samuel Huntington, "The Lonely Superpower," *Foreign Affairs*, March/April 1999: 35-49; and Immanuel Wallerstein, "The Eagle Has Crash Landed," *Foreign Policy*, July/August 2002: 60-68.

[13] Jeffrey Ayres, "Transnational Political Processes and Contention Against the Global Economy," in Hank Johnston and Jackie Smith, eds., *Globalization and Resistance: Transnational Dimensions of Social Movements*. Lanham, MD: Rowman and Littlefield, *2002*: 191-205; and Manfred Steger, *Globalism: the New Market Ideology*, 2nd Edition Lanham, MD: Rowman and Littlefield, 2005.

[14] Ann-Marie Slaughter, "The Real New World Order," *Foreign Affairs*, September/October 1997: 184.

[15] See Declaration of Commitment on HIV/AIDS: five years later, Report of the Secretary General. Follow up to the outcome of the twenty-sixth special session: implementation of the Declaration of Commitment on HIV/AIDS, United Nations General Assembly, 24 March 2006.

[16] See Lloyd Axworthy, *Navigating a New World: Canada's Global Future*. Toronto: Alfred A. Knopf, Canada, 2003 for a lengthy explica-

tion of the human security paradigm by one of its chief proponents, a former Canadian foreign affairs minister.

[17] Prosper Bernard, Jr., "Canada and Human Security: From the Axworthy Doctrine to Middle Power Internationalism," *American Review of Canadian Studies*, Vol. 36, No. 2, Summer 2006: 233-263.

[18] See Holly Burkhalter, "The Politics of AIDS," *Foreign Affairs*, January / February 2004.

[19] Declaration of Commitment on HIV / AIDS: Five Years Later: 3.

[20] Quoted from World Council of Churches Office of Communication, *Press Update*, 28 June 2001. Also see http://hdr.undp.org/reports/globa/2005/.

[21] Denis Stairs, "Choosing Multilateralism: Canada's Experience after World War II and Canada in the New International Environment," *CANCAPS Papier*, July 1994.

[22] See Jennifer Welsh, *At Home in the World: Canada's Global Vision for the 21st Century*. Toronto: Harper Collins, 2004; and Jennifer Welsh, "Fulfilling Canada's Global Promise," *Policy Options*, February 2005: 56-60.

[23] Government of Canada. *A Dialogue on Foreign Policy: Report to Canadians*. Department of Foreign Affairs and International Trade, Ottawa, 2003; and Government of Canada, "Overview." *Canada's International Policy Statement: A Role of Pride and Influence in the World*. Department of Foreign Affairs and International Trade, Ottawa, 2005.

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