

Negotiating Health in Thailand:
AIDS, Global Patent Regime, and Health Social Movement

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After twenty-five-year fight with the devastating HIV/AIDS disease, the epidemic is still the greatest public health crisis in the contemporary human society. While the sub-Saharan Africa is the region with the largest population of the AIDS epidemic, the number of HIV infections in Asia has increased dramatically in the past two decades. Thailand, a country with prosperous sex industries, is one of the most ravaged countries. Since its first AIDS cases in 1984, Thailand has cumulated rough 1 million HIV-positive people among its population of 63 millions and 501,600 already die of AIDS, according to a 2001 report. Fortunately, new infection cases and HIV prevalence has gradually declined after the mid-1990s due to the national reporting system and effective prevention projects. While most studies about HIV/AIDS in Thailand mainly focus on the dimension of epidemic prevention, such as the promotion of condom use or the sex education, the aspect of treatment, the access to antiretroviral drugs in particular, has been relatively ignored in the existing literature. This paper aims to bring the attention to this life-and-death issue of hundreds and thousands Thai living with HIV and illustrate the challenges that Thailand faces to enhance the availability of HIV/AIDS medicines in the context of global political economy.

The HIV Epidemic

The first case of AIDS in Thailand was reported in September 1984 (Limsuwan et al. 1986). Early cases were sporadic among homosexual males. The outbreaks of HIV infection

among injecting drug users (IDUs) in Bangkok in 1987 and female commercial sex workers (CSWs) in Chiang Mai in 1989 changed the demography of HIV epidemic in Thailand greatly. The explosive epidemic spread nationally, including rural areas. The prevalence of HIV among IDUs in Bangkok increased from less than 1% before 1987 to 43% in 1988 (Weniger *et al.* 1991; Kitayaporn *et al.* 1994; Siraprapasiri *et al.* 1991; Gray *et al.* 1994; Kilmarx *et al.* 2000). Female sex workers in the upper north areas were reported to suffer the even higher prevalence rate of 63% in 1991 (Weniger *et al.* 1991; Kitayaporn *et al.* 1994). Since the early 1990s, many provinces had reported HIV infection cases through heterosexual and mother-to-infant transmission (Anupong 2004, p.141-57).

Under the leadership of then Prime Minister Anand Panyarachun, the National AIDS Preventive and Control Committee adopted a public information campaign on HIV/AIDS prevention and the “100% Condom Programme” nationwide since 1991. During 1992 to 1996, a national AIDS plan was launched under the National Economic and Social Development Board. In addition to the government, domestic NGOs, and private institutions’ involvement, several foreign governments and international organizations also participated. This five-year AIDS control programme stressed the importance of prevention of HIV infection, the care for the patients, and reducing discrimination towards HIV-positive people. In the period of 1997-2001, the National Plan for Prevention and Alleviation altered existing policy from state-centered to decentralization of prevention and care work. Communities and civil society

are mobilized to launch their own programs, such as empowerment of community and family, psycho-social care for people living with HIV/AIDS, and medical care for HIV/AIDS disease (Wiput 2005).

After two-decade old national plans and the government and NGOs' interventions, the battle against HIV/AIDS in Thailand is a "disputable success" (UNAIDS 2004).¹ According to UNAIDS report, the number of new infections has dropped gradually from a peak of 142,891 in 1991, to around 21,000 in 2003. The prevalence rate among all adults was estimated at 1.4% in 2005. Despite the decline of new infections, Thailand still faces serious challenges in terms of treatment. It is estimated that around 1 million Thais have been infected with HIV since 1984, more than 500,000 have died and about 570,000 are living with the virus. The huge number of infections makes providing treatment extremely important. HIV/AIDS treatment includes several aspects, such as testing and consulting, nursing care, and access to antiretroviral (ARV) medicines. The issue about access to anti-AIDS drugs covers many dimensions in the developing countries: the access to a limited number of ARV drugs, health service infrastructure, health care personnel, selection and consulting of treatments, and drug deliver system to rural areas (Pontali *et al.* 2005).

In this paper I would like to focus on the first topic—the challenge of unaffordable,

¹ Although UNAIDS and Thai government claim the prevention strategy against HIV/AIDS in Thailand is quite successful, the issues of human rights violation of so-called "risk groups" such as CSWs and IDUs have been criticized by some human rights and AIDS activists. For instance, Human Rights Watch made sharp comments on the "100% Condom Use" and "Wars on Drug" programs. The latter project even caused the deaths of 2,000 suspects in 2003. See Human Rights Watch 2004a and 2004b for the detail.

expensive ARV drugs— in Thailand for two reasons. First, although ARVs are not a cure for people living with HIV/AIDS, they extend life, reduce the mortality and morbidity due to HIV/AIDS, improve the quality of life, and even let people go back to their work and family life. It is because of the introduction of ARVs that the AIDS epidemic is no longer a death sentence but rather a chronic disease. Therefore, the access to ARVs is vital to HIV positive people. Secondly, ARV drugs cost almost ninety per cent of medical services for patients with HIV/AIDS and the availability of low-cost ARV drugs is critical to people living with HIV/AIDS (PLHA) (Tsutomu et al. 2003: 2375-81).² However, even after almost twenty years of introduction of ARVs, the costs are still unaffordable to most of the world. As I will argue in this article, the unavailability of life-saving drugs to PLHAs is not merely a question of supply-demand or cost-effective management of health system. Rather, it should be understood beyond a national scope and be contextualized in the setting of political economy of global health. Thailand, like many developing countries ravaged by HIV/AIDS disease, is struggling to make more people have the access to HIV/AIDS.

Access to HIV Treatment

Since the first drug for AIDS treatment, azidothymidine (known as AZT) had been approved by Food and Drug Administration (FDA) of US government and introduced to

² According to their study in 2003, the average charge for outpatient per visit and inpatient per day were USD292 and USD347.1, among that the cost of medicine were USD289.2 and USD328.3 respectively.

market in 1987, the research of new treatment and accessibility of existing medicines became the focal point to health policy makers as well as AIDS communities. Concerning the high price--\$10,000 per patient for a year's supply (New York Times, March 25, 1987), it is not surprising to realize that the introduction of new ARV drugs often came along with AIDS activists' protests in the early period. For example, the famous AIDS advocacy group in the United States, AIDS Coalition to Unleash Power (ACT UP), was founded soon after the introduction of AZT and its first activity was held on Wall Street in New York to protest the profiteering of pharmaceutical companies and the overpriced AZT.³ One year later, ACT UP demonstrated at FDA headquarters in Washington D.C. in protest at slow pace of drug approval and testing process.⁴

According to UNAIDS's *Report on AIDS Epidemic* in 2005, an estimated 38.6 million people globally were infected with HIV in 2005, while 4.1 million were estimated to be newly infected with HIV and 2.8 million died of AIDS in the same year. Sub-Saharan Africa remains the worst-affected region in the world under the attack of this epidemic. It is the home to over 60 % of all people (24.5 million), including 90% of children, living with HIV. Next to sub-Saharan Africa, Asia is the region with the second largest burden of AIDS epidemic. The latest report estimated around 8.3 million PLHAs in this region by 2005 (UNAIDS 2006: 1-50). The access to treatment is even worse. WHO estimated there were 6

³ See <http://www.actupny.org/documents/cron-87.html> . Azidothymidine (AZT) is a production of Burrough Welcome.

⁴ See <http://www.actupny.org/documents/cron-88.html>

million PLHAs in developing countries immediately needing ARV treatment, but only 5 per cent of them (rough 400,000) were able to receive it by 2003, over a third of them in Brazil (WHO 2003: 5). The WHO late director-general Lee Jong-wook warned that failure to provide ARV treatment was a global health emergency. Soon the WHO and UNAIDS launched “3 by 5” Initiative in 2003: “to provide three million people living with HIV/AIDS in low- and middle-income countries with life-prolonging antiretroviral treatment (ART) by the end of 2005.”⁵

Although Thailand experienced a noticeable triumph in prevention policy and successful reduction of new HIV infections, the new AIDS cases developing from over 600,000 HIV infected Thais is estimated to continually increase at the rate of approximately 50,000 cases per year from 2000 to 2010.⁶ The limited access to life-saving medicines thus is a severe problem of national public health. Few Thais can afford to pay for their own drugs and almost all health insurance companies in Thailand refuse to pay for ARVs. Drug donation from patients from developed countries and locally raised funds are used to support ARV treatment but continuity is a problem (Phanuphak 2004: S35).

Thailand started its government-subsidized ARV programme in 1992 based on a single-drug regimen, AZT. Only limited patients who participated certain clinical trials could get AZT. The programme expanded gradually but the number of patients who enrolled in the

⁵ See <http://www.who.int/3by5/en/>

⁶ Thai Working Group on HIV/AIDS Projection 2001, cited from Thanprasertsuk, S. *et al* 2004, p.314.

program was still few by 2000. It is estimated a few thousand PLHAs out of the more than 50,000 new AIDS cases got the ARV treatments each year (Thanprasertsuk et al 2004: 315-6). In resource-poor regions, the situation is even worse. For instance, in the northernmost province Chiang Mai, fewer than 100 of tens of thousands of PLHVs were receiving highly active antiretroviral therapy in the late 1990s (Kilmarx 2000: 2736-7). It was until 2002 that the numbers of patients who could receive ARV treatment has increased greatly. The latest figures indicated the patients received antiretroviral treatment have increased from 13,000 in 2003 to 50,000 in 2004 and 80,000 by the end of 2005 (Thanprasertsuk et al 2004: 316-20; UNAIDS 2006). The local generic mass production of ARV drugs to halve drugs prices is the key factor contributing to greater access to ARV treatments. On the one hand, individuals may be capable of paying for their own drugs; on the other hand, the Thai government is more willing to provide funds for “cost-effective” and sustainable HIV treatments (Phanuphak 2004: S36).

In fact, Thailand has been capable of producing good-quality, cheap generic ARV drugs since mid 1990s, not to mention being able to import generic versions from other countries, like India.⁷ However, increasing international trade pressures, with the United States in particular, and the formation of global patent regime both have shaped Thai regulations of drug patents and forced the Thai government to be unwilling to use its legal leverage to

⁷ Indian generic manufacture Cipla has produced zidovudine (AZT) since 1991 and lamivudine (3TC) since 1998. <http://www.cipla.com/corporateprofile/milestones.htm>

encourage generic drug production or cheap imports. The negative result is the limited access to life-saving medicines to the Thai people. In the following sections I will elaborate on the political economy root and process of this public health crisis.

US Trade Policy and Thai Drug Patent Laws

The Thai Patent Act was originally passed in 1979 (hereafter 1979 Act). As in many developing countries, the 1979 Act did not include pharmaceutical, agricultural, and biological inventions as patentable categories, which cause the US a great loss of royalties and revenues.⁸ The 1979 Act only granted 15 years for patent protection, which was too short for US owners. Additionally, the 1979 Act provided the Thai government with the authority to issue compulsory licenses⁹ or revocation of certain products. Meanwhile, the increasing US trade deficit made the losses for businesses more unacceptable. These reasons successfully persuaded the US Congress to increase trade barriers and enforce US-style intellectual property (IP) protection in specific developing countries. With other failures to comply with US IP rights, Thailand, with China and India, became the first groups of “priority watch list” under US “Special 301” and faced trade sanctions since 1991

⁸ According to a report from US Pharmaceutical Manufacturers Association in 1984, unauthorized sales of patented US pharmaceuticals by local firms in just five foreign countries amounted to \$ 192 million, comparing to \$ 162 million sales by US drug firms. Mossinghoff 1987, cited in Kirchanski 1994.

⁹ “A compulsory license is a grant by patent-issuing government to a third party of the right to market, use, or sell a patented product without the patent holders consent.”Adelman et al. 1998, p.1235, cited in Sweeney 2000, p.449.

(Kirchanski 1994: 569-74).¹⁰ The United States was Thailand's largest export market, constituting about twenty-five per cent of Thai exports. It was not surprising that when exporters of gems, jewellery, garments and other textiles products threatened with retaliation, the Thai government had to yield to the US Trade Representative (USTR) (Ungphakorn 1991: 34).

The amended Thai Patent Act in 1992 (hereafter the 1992 Act) could be understood as a response to US economic pressure, which was part of US protectionism and its less advantaged role in the international trade relationship (Ungphakorn 1992: 3). The 1992 Act provided patent for pharmaceuticals for the first time in Thailand and extended the patent term from fifteen to twenty years. The new law did not completely eliminate compulsory licensing but burdened the applicants to initiate negotiate with patentees before issuing one. Fortunately the law left the government some power to cope with the abuse of monopoly. According to the 1992 Act, the Pharmaceutical Patents Board was created to monitor pricing and availability of medicines, to supervise drug patents holders, and to initiate a compulsory license process if necessary. The mechanism was designed to control drug prices while introducing patent protection under US threat of trade sanctions (Sweeney 2000: 449-58; Kirchanski 1994: 591-95.). Critics argued that the law yielded too much to the U.S and was concerned that this case would encourage Washington to use unilateral negotiation instead of

¹⁰ The "Special 301" section is from Omnibus Trade and Competitiveness Act of 1988, Pub. L. No.100-418, 1301, 1303, 102 Stat. 1107. In addition to patent protection, US government also accused these three countries of not provide protection for copyright, such as for American movies. See Gedda 1991.

working through the international agreements about trade and IP. Some worried that the introduction of drug patents would sharply raise prices of medicines and make them out of the reach of poor people, the majority of Thais (New York Times, May 22, 1991; Ungphakron 1992: 3). Although access to HIV/AIDS drugs did not yet appear in the discussions of Thai patent laws in the early 1990s, the worries about unilateral trade talks and unaffordable prices of drugs became parts of the AIDS nightmare. Moreover, a global patent regime has been developing and increasing its influence worldwide at the same time.

WTO/TRIPS, Access to ARV Drugs, and Right to Health

IP protection has been the hottest issue not only in the US trade laws but also in international negotiations and agreements since the early 1980s, for instance, Uruguay Round of General Agreement on Tariffs and Trade (GATT) talks (Sell 1998). The latest and most influential one is the Trade Related Aspects of Intellectual Property (TRIPS) under the structure of World Trade Organization (WTO) since 1995. TRIPS was initiated by US-based Intellectual Property Committee¹¹ and embedded in a broader background of global political economy with increasing mobility of transnational capital and the ideology of neo-liberalism and extremely free market. Unlike the agenda of liberation and deregulation of global trade, TRIPS, in contrary, promotes “universality” or “re-regulation” in intellectual property

¹¹ The committee members were: Bristol-Myers; CBS; Du Pont; General Electric; General Motors; Hewlett-Packard; IBM; Johnson & Johnson; Merck; Monsanto; and Pfizer (Sell 2003: 1-2).

protection. It creates new substantive laws and imposes member states to accept them while requiring member states to amend national civil and criminal laws to maximize the legitimacy and power of TRIPS Agreement.¹² In the case of pharmaceutical patents, each member state has to grant patent protection for a minimum of 20 years. Developing and least developed countries have grace period from 5-10 years.

In theory, TRIPS allows member states to protect national public health. Although TRIPS imposes certain restrictions on compulsory licensing and parallel importing,¹³ the articles still can be used as legal instruments to keep the balance between IP protection and public health.¹⁴ For example, Article 31 allows a member nation grants a patent on a product may grant a third party the right to produce the patented product without the patentee's consent only in some situations. A country "in the case of a national emergency or other circumstances of extreme urgency or in cases of public non-commercial use" can waive the requirements.¹⁵ But in reality, the practice of TRIPS was not so optimal. TRIPS caused a lot of contentions soon after its adoption in 1995 for the following reasons: it was mandatory for WTO member states; no fine negotiation mechanism for developing countries to gain their reciprocal benefits; few developing countries dared to use compulsory licensing and parallel

¹² Nevertheless, it also reserves some flexibility for global IP protection, such as compulsory license and parallel importing in some certain situations. Sell 2003.

¹³ Parallel importing is a practice that businessmen/women buy a patented product in one country and resell it in another country. In the case of drug, if the price of drug X is cheaper in country A than it is in country B, the parallel importer will sell drug X from country A at a lower price than the same product in the country B. See Sweeney 2000, p.449.

¹⁴ See WTO, TRIPS Articles 6; 8.1; 31. Available at http://www.wto.org/english/docs_e/legal_e/27-trips.pdf (last visited Sep. 20, 2006)

¹⁵ WTO, TRIPS, Article 8.1.

importing to protect their people's health ('t Hoen 2002; Gupta 2001; Sell 2003). The unaffordable ARV drugs and the production of generic versions in developing countries became the most debated issue at both national and international level.

South Africa is a country with estimated 4 million PLHAs in the late 1990s. Conforming with TRIPS, South Africa included pharmaceuticals into its patent protection since 1997. The Medicines and Related Substances Control Amendment Act of 1997 (hereafter Medicines Act) also passed by the South African Parliament in the same year, aiming to enable the government to import generic drugs at affordable prices from other countries. The Medicines Act provoked multinational pharmaceutical companies and the US government. Pharmaceutical Manufacturers' Associations of South Africa filed a lawsuit against the South Africa government in 1998. Meanwhile the USTR put South Africa on the watch list of Special 301. The tough situation forced South Africa government to promise to limit the authority of Health Minister in terms of parallel importing and compulsory licenses in Medicines Act and guaranteed it would not appeal to WTO/TRIPS for great HIV/AIDS infected population in South Africa as a "national emergency" (Marc 2001; 't Hoen 2002). Limited by its Medicines Act, South Africa faces barriers to make ARVs affordable to its people. Less than one percent of the South African HIV-infected population had access to antiretroviral treatment by 2003 (UNAIDS 2003: 60.).¹⁶

¹⁶ Pharmaceutical Manufacturers' Associations of South Africa finally withdrew the lawsuit in 2001. To defend South Africa from US pressure, the health activists launched AIDS Treatment Action Campaign (TAC) on 10 December 1998 and proposed a national treatment plan for PLHAs. TAC believed that the introduction of

Comparing to South Africa, Brazil was more successful in terms of providing her people broader access to ARVs since 1996. The government provided ARV treatments to around 159,000 Brazilians living with AIDS, nearly half of all infected persons who receive therapy in all poor countries by 2005. The reasons that Brazil's anti-AIDS program can cover so great population are due to its national abilities to produce ARVs and the strategies to adopt domestic and international pharmaceutical patent laws. According to the Brazilian patent laws passed in 1997, which conform to TRIPS, the drugs manufactured in Brazil before 1995 are not eligible for patent protection. This made Brazilian local pharmaceuticals produced several ARV drugs without compulsory license. As for the new ARV drugs invented after 1995, the Brazilian government deliberately used its national patent laws and the TRIPS articles of possibility of compulsory license and the definition of national emergency to introduce and produce new drugs, like efavirenz (EFV) and Nelfinavir (NFV), into Brazil with the cost lowered by 50 to 60 percent, whereas the prices of imports dropped less than 10 % over the same period (Gillman 2002; Marques et al. 2005.).¹⁷

Ironically, TRIPS did not affect patent protection in Thailand as much as the two nations I outline above because the 1992 Act was even stricter than TRIPS regulations. TRIPS

generic competition of ARVs, rather than drug donations and price reductions of brand name drugs, would be a sustainable supply of affordable ARVs. TAC also used litigation against the South Africa government as a tool to arise international public awareness of human rights and public interest. See Berger 2002.

¹⁷ Public health specialists and AIDS activists praised the Brazilian government's wit and political will to exert the possibility of compulsory licenses to pressure global pharmaceutical companies to lower their prices on ARV drugs. This is also the case shows how law may effectively used to balance between respect for public health and human rights and protection of intellectual property rights (Marques et al. 2005: 471-74; Viana 2002).

requires all the member countries to grant pharmaceuticals patent protections for 20 years,¹⁸ which already was done in its 1992 Patent Act under the US pressure.¹⁹ The 1992 Act provided the Pharmaceutical Patented Board some flexibility to issue compulsory license when the patent holders failed to provide patented drugs in adequate quantities and at reasonable prices. TRIPS kept this part but the Thai government became very conservative regarding this issue. Worst of all, another amendment of the Thai patent law was going on in Parliament in 1998. Once again, the pressure from the USTR played a crucial role. The Asian economic crisis in 1997 caused huge economic damage in Thailand and made the government more vulnerable to pressure from the USTR. The amendment bill would weaken Thai government's right to initiate compulsory licenses by dismissing the "safeguard" Pharmaceutical Patent Review Board and prohibit parallel importing of generic drugs without the patentee's consent. As the AIDS epidemic became a national crisis, the patent law amendment bill caused more public attention than the 1992 Act. When the bill was due for its second reading in Parliament in September 1998, about 50 health non-government organizers, like the Thai NGO Coalition on AIDS, and patients demonstrated in front of the US Embassy in Bangkok, protested against American pressure exerted on behalf of US pharmaceutical companies and opposed to the change in legislation which would lead to affordable prices of essential drugs for Thais (United Press International, September 4, 1998; Aphaluck 1998; The

¹⁸ WTO, TRIPS, Article 27.1 and Article 33.

¹⁹ Otherwise Thailand could have 5 year grace period and did not have to amend its 1979 Act before 2000.

Nation (Thailand), September 4, 1998). Unfortunately, the government who under pressure of trade sanction was unable and unwilling to positively respond the AIDS activists' petition and the amendment bill was enacted in 1999 (Sweeney 2000: 451-63).

The Thai government's pessimistic attitude toward compulsory licensing became a hot issue in 1999 when the Governmental Pharmaceutical Organization (GPO)²⁰ submitted a letter to the Department of Intellectual Property (DIP) seeking compulsory licensing of didanosine or known as ddI under the patent of a US-based pharmaceutical company Bristol Myers Squibb (BMS) (Anjira 1999). The GPO started to produce AZT since 1993 and competition had dramatically cut the monthly price of standard dose of 600 mg per day from USD324 in 1992 to USD87 and USD36 in 1995 and 1999 (Wilson et al. 1999, p.1894; Fuller 1999). DDI cost USD160-250 monthly and a Thai worker earned about USD110 at the time. The GPO was capable to produce ddI and initiated negotiations with BMS in 1997 but had not yet go thru approval from BMS by 1999. Worried that the negotiation would be lengthy, the GPO asked for the possibility of compulsory licensing granted by the Article 51 of Thai Patent Act, but the DIP rejected. Several NGOs, including Thai Foundation for Consumers (TFC), Thai NGO Coalition on AIDS (TNCA), Thai Network for People Living with HIV/AIDS (TNP+), and Medicins Sans Frontieres (MSF)²¹ submitted a petition in November

²⁰ The GPO is a state pharmaceutical enterprise under the supervising of Ministry of Public Health, which is crucial in the battle to both AIDS and unaffordable medicines in Thailand. GPO established in 1966 and has been responsible to producing and supplying quality medicines at affordable prices. See the history of GPO on its website. <http://inter.gpo.or.th/Default.aspx?tabid=40> (last visited September 20,2006).

²¹ For their brief history, see Ford et al. 2004, p.561. These four organizations are the main groups that uncompromisingly promote access to essential medicine in Thailand. In addition to the ddI case, they also

1999 to urge the Minister of Public Health Korn Dabaransi to act justly to ensure that negotiation was done in the public interest. They also asked Korn to urge the DIP to issue a compulsory license, if the agreement could not be reached within a proper time (Mukdawan 1999a and 1999b). Even after another protest outside the Ministry of Public Health, Minister Korn finally rejected AIDS activists' call for compulsory licensing of ddI but permitted the GPO to produce ddI in powdered form, which was not under patent of BMS so the Thai government "won't be sued" (Aphaluck 2000a). AIDS activists remained unsatisfied and believed that the Ministry's compromise would not solve the problem of monopolization of ARV drugs in Thailand. Because of their deep fear of trade sanctions by the US, the Thai government was hesitant to compulsory license, even the USTR's Joseph Papovich stated that "if the Thai government determines that issuing a compulsory license to address its health care crisis, the United States will raise no objection" in a reply letter to the Thai NGOs (Woranuj et al. 2000). The officials in Ministry of Public Health and Commerce treated Papovich's letter as "a diplomatic way of answering such issues" and expressed great caution against US retaliation since they realized "they [USTR and drug companies] don't want the ddI case in Thailand to set a precedent for other countries to follow" (Aphaluck and Woranuj 2000). The Thai officials' worries were understandable, considering the ddI case attracted international notice at the time and Thailand would be the first developing country to use

launched and participated in almost every protest for unaffordable drugs and the negotiation about drug patent with USTR.

compulsory license if the DIP would accept the GPO's request. The Thai government's reluctance was also due to the uncertainty about when to implement compulsory licensing under WTO/TRIPS would be legitimate without causing disputes. "If the partners disagree with our interpretation, that poses a big problem for Thailand," the Deputy Director of the DIP explained to a reporter from Japan (Supalak 2000).

Indeed, TRIPS set the frame of global patent regime based on US style. But TRIPS has its own flexibility as well because the operation of WTO leaves space for multilateral negotiation. More challenging power is from the disputes between developing countries and multinational drug companies which have captured the international society's attention on the issue about access to lifesaving medicines. The WHO, UN, NGOs, and the governments of developing countries began to emphasize the priority and significance of public health over trade profit and successfully pushed WTO member nations to solve the conflict collectively.²²

Before the fourth WTO Ministerial Conference, the TRIPS Council held a special session in 2001 to discuss the interpretation of the TRIPS, in particular the relationship of intellectual property protection and access to essential medicines (Sell 2003: 159-60; Gathii 2002: 296-9.). Another crucial event was the 911 terrorist attack and bioterrorism scare of anthrax in the United States. Both Canada and the United States considered the compulsory licenses

²² There were some projects outside of WTO/TRIPS structure tried to widen the access of anti-AIDS drugs, for instance, the Accelerating Access Initiative (AAI). This project was launched in 2000 by several transnational organizations and pharmaceuticals giants (Abbott Laboratories, Boehringer Ingelheim, Bristol-Myers Squibb, GlaxoSmithKline, Gilead Science, Merck & Co., Inc. and F. Hoffmann-La Roche). See AAI 2004 and WHO&UNAIDS 2002.

to get Cipro, an antibiotic produced by Bayer. Though both of them eventually did not issue compulsory licenses, the threat to do so resulting in getting great price cut with Bayer. Comparing to what the United States did to developing countries, this incident just showed the United States had double standards in terms of drug access issue and patent protection (Sell 2003: 160).

In November 2001, the fourth WTO Ministerial Conference in Doha, Qatar, passed “Declaration on the TRIPS Agreement and Public Health” (hereafter “Doha Declaration”), a breakthrough of international public health and access to essential medicines. The Doha Declaration claims that intellectual property protection is crucial to the research and development of new drugs; it also realizes that the prices of drugs as a matter in terms of improving public health. Therefore, most paragraphs of Doha Declaration aim to reconfirm the importance of public health and strengthen the measures to protect it under WTO/TRIPS. First, TRIPS “does not and should not prevent members from taking measures to protect public health”.²³ Beside, the Agreement “can and should be interpreted and implemented“ to support its member nations’ rights of public health, especially, “to promote access to medicines for all”.²⁴ To do so, Doha Declaration reaffirms the right of WTO member nations to use the provisions of TRIPS in a more flexible. The most important one is “each member has the right to grant compulsory licenses and the freedom to determine the grounds upon

²³ World Trade Organization, “Doha Declaration on the TRIPS Agreement and Public Health”, para.4. (WT.MIN(01)/DEC/W/2). Available at

http://www.wto.org/english/thewto_e/minist_e/min01_e/mindecl_trips_e.htm

²⁴ Ibid.

which such licenses are granted”.²⁵ Doha Declaration defines the arguable term “national emergency” in a more flexible way, including public health crises, and grants each member nation right to determine what constitutes its national emergency or extreme urgency.²⁶ In addition, the Declaration also allows for the parallel importing of drugs.²⁷ Last but not least, if a member nation wants to use the Dispute Settlement Body of WTO, it is the plaintiff’s responsibility to prove that the “national emergency” or “extreme urgency” does not exist (Correa 2002: 16-17).

Thailand in Post-TRIPS era: Free Trade Agreements and Health Social Movements

The impact of the Doha Declaration in Thailand was multidimensional. On the one hand, the Declaration reaffirmed Thai HIV/AIDS activists’ belief that ensuring access to essential medicines is a basic human right and should be prior in importance to trade benefits. The provisions provide more freedom for developing countries to decide the grounds for compulsory licensing. Also considering the fact that Thailand has its own capacity to produce generic copies of anti-AIDS medicines, the Declaration also encourages the activists to take

²⁵ Doha Declaration, para. 5(a).

²⁶ “Each member has the right to determine what constitutes a national emergency or other circumstances of extreme urgency, it being understood that public health crises, including those relating to HIV/AIDS, tuberculosis, malaria and other epidemics, can represent a national emergency or other circumstances of extreme urgency.” Doha Declaration, para 5(c).

²⁷ “The effect of the provision in the TRIPS Agreement that are relevant to the exhausting of intellectual property rights is to leave each member free to establish its own regime for such exhaustion without challenge, subject to the MFN and national treatment provisions of Article 3 and 4.” Doha Declaration, para. 5(d).

the idea of a “right to health” as a practicable agenda. The development of ddI is an excellent example here. Since the 2000 effort to push the government failed, the AIDS activists decided to resort to the court. With system assistance from the Law Society of Thailand, the AIDS Access Foundation and two patients with HIV filed a lawsuit against BMS and Thai DIP in 2001. After one-year legal process, the court ruled that the BMS ddI patent only covered tablets containing 5-100 mg instead of exclusive right, so the GPO or any drug companies in Thailand could produce ddI tablets with dosages of more than 100 mg (Aphaluck 2000b; Mukdawan 2000; Ahmad 2002; Ford *et al.* 2004). To answer the question about whether individuals have the right to challenge a patent, the court stated that “medicine is one of the fundamental factors necessary for human being, as distinct from other products or other invention” so “lack of access to medicine due to high price prejudices the human rights of patients to proper medical treatment.” Employing Doha Declaration, the court went on: “it was insisted that TRIPS be interpreted and implemented so as to promote the right of members to protect public health, especially the promotion and support of access to medicines,” and concluded that “those in need of the medicine are also interested parties to the granting of the patent.” The verdict also mentioned the AIDS Access Foundation as an interested party to affirm the important role of civil society groups.²⁸ This is the first time worldwide a court decision used Declaration to assert the priority of public health and

²⁸ The verdict is cited of Ford et al. 2004: 561; Kazmin 2004.

patients' right to health and treatment. It is also a great victory that shows how the AIDS activists successfully managed the strategies and used discourse to challenge legal practice, paving the way to more protection of public health. In addition to the mobilization of domestic NGOs, the ddI case also gained support from several transnational advocacy groups of human rights, gay movements, and health movements, such as International Gay and Lesbian Human Rights Commission (IGLHRC) and Health Global Access Project Coalition.²⁹

On the other hand, the Thai government, the administrative sectors in particular, has not changed its conservativeness in terms of implementing the legal tools of TRIPS. The role of the GPO is an example of Thai government's dilemma between people's health and nation development. In mid 2002, GPO began production of its own cocktail therapy, GPO-VIR, a three-in-one, fixed-dose combination made up of three anti-retroviral drugs whose patents in Thailand had expired or been relinquished. But GPO cannot legally produce second line treatment since other newer drugs are still under patented and the government is still unwilling to issue compulsory licensing to some patented essential medicines. Thai AIDS activists have complained Thai government that even the Doha Declaration gives developing countries the right to use compulsory licenses in public health emergency, "Bangkok is unlikely to take any action that could upset Washington, its closest ally." Given the factors

²⁹ See IGLHRC website at <http://www.iglhrc.org/site/iglhrc/section.php?id=5&detail=36> (last visited September 20, 2006)

such as the economic dependence on the United States as the biggest exporting market, over USD 20 billion two-way trade, and US as Thailand's second largest foreign investor, following Japan, with total accumulate investment USD16 billion in energy, petrochemical, automotives, and electronics industries, Thailand has never used compulsory licensing as a policy tool to increase the access to ARVs for her people.

From the perspective of the USTR, since Thailand has become an important trade partner with the United States (the 18th largest in 2002), how to set stricter intellectual property protection than TRIPS in Thailand became a crucial trade issue. Free trade agreement (FTA) seemed an option. According to other countries' experience, the FTAs with the United States were a part of a larger ambition of the US government and USTR to employ their bilateral trade authority to undermine public health below drug patents in developing countries. Since 2002, the United States has entered into FTAs with Chile, Singapore, Australia, and Morocco, etc and provisions of patent protection in FTAs were tougher. In a letter to USA House of Representatives and Congress, Robert B. Zoellick, the director of USTR, demonstrated the extent that the United States has to negotiate FTA with Thailand in terms of intellectual property rights:

In areas such as patent protection and protection of undisclosed information,
seek to have Thailand apply levels of protection and practices more in line with U.S law

and practices, including appropriate flexibility. Seek to strengthen Thailand's laws and procedures to enforce intellectual property rights.....Seek to strengthen measures in Thailand that provide for compensation of right holders for infringements of intellectual property rights and to provide for criminal penalties under Thai law that are sufficient to have a deterrent effect on piracy and counterfeiting.³⁰

It was obvious that USTR intended to block Thailand from putting public health over protection of drug patents, the right granted by TRIPS and reconfirmed in Doha Declaration. . Thai HIV/AIDS activists and transnational coalitions, such as FTA Watch, Protection of Consumer Union, TNP+, were aware of this new tension and engaged in drawing public attention to the disadvantage and trade away that might caused by US-Thailand FTA talks. They were cautious of US's expectation in IP protection, the issues of patent in particular, such as extending the period of patent protection and restricting the use of compulsory licensing. They called on several issues to both the US and Thai governments, which showed the deliberation and agency of civil society in Thailand:

(1)The issue of extending or strengthening intellectual property rights should be

³⁰ USTR, Letter to House of Representatives on Intent to Negotiate FTA with Thailand (2/24/2004). Available at http://www.ustr.gov/Document_Library/Letters_to_Congress/2004/Letter_to_House_of_Representatives_on_Intent_to_Negotiate_FTA_with_Thail.html (Italic added)

taken out of the FTA negotiations. Thailand already operates in accordance with the WTO agreement on intellectual property.... There is no just reason for further intellectual property requirements under the FTA, especially with regard to extending patent protection and data exclusivity.... (2) A referendum should be held on whether Thailand should sign the FTA with the US, since signing the FTA is an extremely important matter for Thailand and the lives and livelihoods of Thai people in all professions, both now and in the future.... (3) A process should be established to ensure the broad participation of the people. This should involve the gathering of information, the expression of opinions, and decision-making. This will be of great benefit to the Thai negotiating team, who will have comprehensive information and recommendations for use in the negotiations. This will increase their negotiating power. The Thai preparations for earlier negotiations were the work of individuals from a restricted circle (Civil Society and FTA Watch 2005).

Some scholars warned the Thai government not to be too optimistic about the FTA between Thailand and the US because it would be with less equality as the Thai FTA with other countries, like China or India. They also worried that the ministers lack of proper offensive and defensive strategies when they engage in the talks (Maneerungsee 2004). Maybe it was

unsurprising that through mobilization, protests and demonstration of the American bad record in other FTAs, rather than Thai government's capacity of negotiation, the advocates refuted the claims of FTA proposal and successfully pressured both parties to remove the issues of IP protection from several rounds negotiation in 2005 and 2006.

The post-TRIPS Thailand is intertwined with FTA talks and anti-FTA movements. The human rights to health, access to essential medicines, and protection for public health have become dominant parts of these emerging social movements. For transnational HIV/AIDS activists, such as Medecins Sans Frontieres or Oxfam, AIDS treatment programs are relatively successful among developing countries due to Thailand's capacity to produce affordable generic AIDS medicines and active civil society to voice on behalf of patients with HIV (Oxfam 2004; Cawthorne 2005). They have made much effort to bring the issues about access to ARVs to international medical community and public attention while been disappointed by the Thai government's little action to resist the US pressure, comparing to its counterparts, like Brazil and India. These two countries have the similar medical technology and industrial infrastructure as Thailand, but have stronger political will to challenge the patented ARV drugs if necessary for their people's lives (Oxfam 2004; Wilson et al. 1999; Von Schoen-Angerer and Limpananont 2001). Even the local NGOs' action have successfully stopped, or at least delayed, the issue of intellectual property becoming one part of the US-Thailand FTA talks, will health as a fundamental human right be at risk of being trading

away under US economic pressure is remained to see (Cawthorne 2005).

Concluding Remarks

In 1999 World Health Assembly (WHA), according to the meeting resolution, WHO was given a mandate to monitor the public health consequences of international trade agreements. Since then the issues of international trade and health continually appear in the WHA records. In 2002 WHO and WTO published a joint study *WTO Agreements and Public Health* which explains how international trade regulations under WTO relate to different aspects of health policies, such as drugs and IP rights, food safety, tobacco and other hot issues. After Doha Declaration, this study is another endeavor of WTO to release the tension between trade and health by asserting “health concern can take precedence over trade issues” (WTO & WHO 2002). The formation and change of WTO in the past decade is also part of a brief history about emerging health social movements, their challenges, and their gains.³¹

In the cases of limited access to essential drugs in developing countries, the unequal structures include not only the national poverty resulting unaffordable expensive medicines but also more about the politics of international trade and commercial benefits.³² In this paper

I examined the complex relationship of public health, patent protection, and international

³¹ Scholars from the fields of public health and international relationship start to pay attention to the relationship between international trade, laws, negotiations, and health. See Lee (ed) 2003; Odell and Sell 2006. But few research focuses on coalition among health activists in developing countries and their mobilization. This should be an interesting topic for sociologists of social movements.

³² Here I agree with Paul Farmers’ analytical approach that complicating the causes of health disparities in developing countries. See Farmer 2003.

trade regulations in the case of Thailand. I trace the historical process back to the 1980s of how the USTR used its economic pressure to force Thai government amending the patent laws to fit the US-style patent protection. The 1995 TRIPS encouraged the protectionism and exclusionism for intellectual property rights that strengthened patent protection for pharmaceutical industry and prohibited producing cheaper generic versions of essential drugs. These made Thai people more vulnerable to the public health crisis: HIV/AIDS epidemic. In fight against the global patent regime, Thailand and several developing countries called on access to essential medicines as basic human right. Doha Declaration of 2001 and WTO positive attitude toward improvement of public health can be considered as a success of the advocacy of right to health. However, in the post-TRIPS era, when FTA is becoming another tool of the US government to reassure the intellectual property protection in developing countries, hence, how to overcome new obstacles to cheaper ARV drugs and public health remain tasks of AIDS activists. Another important issue deserving continue observations is to what extent the US-style unilateral pressure and bilateral trade agreements will undermine the credibility of multilateral decision-making and global governance based on consensus. The case of Thailand shows the limitation and resistance of developing countries when they struggle with two needs of public health and international trade. This chapter concludes that the challenges of HIV/AIDS epidemic in developing countries, including Southeast Asia, cannot be understood completely without concerning the public health and its relations with

global political economy, such as international trade laws, the US pressure, and emerging counter-hegemony movements in the name of health.

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